LATINO CAREGIVERS AS A LOCUS FOR ADOLESCENT SUICIDE PREVENTION:

A MIXED METHOD DISSERTATION

by

TATIANA VILLARREAL-OTÁLORA

(Under the Direction of Jane McPherson)

ABSTRACT

Since the 1990s, the need for suicide prevention research has drastically increased in the United States. Though this need is particularly evident among Latino families. Latino caregivers are underrepresented in suicide prevention research. The lack of research leaves significant gaps in knowledge which may hinder the effectiveness of suicide prevention among Latino adolescents. Specifically, there is limited information on the relationship between Latino caregivers' suicide-related prevention communication (SPC) self-efficacy and even less on how they can and may want to be involved in suicide prevention. This three-article dissertation uses an integrated mixed method design to start remedying these gaps. The study analyzes both quantitative and qualitative data collected from the existing literature on suicide among Latino adolescents and a sample of Latino caregivers ($N$ = 133) in Georgia to elucidate Latino caregivers' (a) role in suicide prevention; (b) their levels of suicide prevention engagement, suicide literacy, and SPC self-efficacy; and (c) their recommendations for a culturally responsive suicide prevention program targeting them as agents of change. The first article, a scoping study, summarizes the existing literature on Latino families — especially caregivers — within Latino adolescent suicide research. The second article builds on the scoping study findings to develop a

survey instrument to explore Latino caregivers' knowledge, engagement, and self-efficacy about adolescent suicide in their communities and its prevention. The third article focuses on a subsample of the survey participants ($n$ = 22) to conducts in-depth interviews. These interviews expand on the quantitative survey findings regarding Latino caregivers' endorsed desire for a culturally specific suicide prevention program that involves them. Implications for social work practice, education, policy, and research from the three studies are presented.

INDEX WORDS: Latino, Parents, Family, Youth, Suicide, Prevention, Culturally responsive, Program recommendation

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December 2021

# DEDICATION

To God

To my best friend, my love, my serenity — Christian Xavier Villarreal

To my inspirations — my mom, dad, and sister

To the Latino immigrant parents in the United States who sacrifice every day for their family's well-being

# ACKNOWLEDGEMENTS

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# CHAPTER 1

# INTRODUCTION

Suicide prevention research in the United States routinely underrepresents Latino[1] individuals and caregivers. By analyzing both quantitative and qualitative cross-sectional data collected from the literature on suicide among Latino adolescents and a sample of Latino caregivers in Georgia, this dissertation study aims to elucidate the ways that Latino caregivers can be an engine for suicide prevention for their adolescents. This dissertation study follows a mixed method approach, which I present in the form of three manuscripts. Throughout this dissertation, I use terminology that can vary in meaning depending on its usages, such as "culture," "Latino," and "suicide-related prevention communication." For a list of the commonly used terms in this dissertation and their definitions, refer to Appendix A. In this chapter, I reflect on what led me to conduct this dissertation; define the study's problem; offer a brief literature review on suicide-related prevention communication; and describe the dissertation study's purpose, theoretical approach, and methodological framework. The chapter ends with the three manuscripts' abstracts.

## A 360

Life sometimes leads you in a full circle: right back to those early passions. As a young Latina immigrant, I witnessed multiple peers struggle with suicidal ideation. I also struggled with suicidality as an adolescent. I remember witnessing my and my friends' caregivers' pain,

[1] I recognize the ongoing controversies and debates surrounding terminology describing individuals with Latin American roots (García, 2020). Nonetheless, the dissertation participants self-identified as Latino/Hispanic on the study survey and verbally referred to themselves and their community members as Latinos during the interviews. Therefore, to honor their preference and represent them more closely, I use the "Latino/a" rather than "Latinx."

confusion, and desperation as they tried to help while navigating a foreign country's mental health system in a foreign language. Those experiences shaped my desire to help Latino immigrant communities. At the onset of my career, I thought macro-level work would be the best way to reach my goals. Thus, I pursued a political science degree, but I yearned for that one-on-one interaction. Based on that yearning and my earlier experiences with mental health challenges, after my undergraduate degree, I decided to pursue a clinical social work career.

While providing clinical social work services to Latino immigrant families, I again encountered families struggling with suicidality. While these families differed in terms of education, ethnicity, nativity, and many other sociodemographic variables, they had one thing in common: a deep desire to help their adolescents. I kept hitting a wall as I desperately searched for psychoeducation on suicide prevention programming to support the caregivers. Most of the information was based on non-Latino adolescents and developed without Latino caregivers in mind. Routinely, I would verbalize my frustration with the lack of support for Latino families to a colleague. After hearing me day after day for nearly a year, in 2016, that colleague gave me a response that changed my life: "This really bothers you, but you can change that. Have you thought about pursuing a Ph.D. and focusing on increasing Latino immigrant adolescent well-being and services?" A Ph.D. was something I had been considering since preparing for my clinical licensure exam, and that response pushed me to pursue it, setting me on the path which now produces this dissertation.

Given my closeness to the issue of suicidality among Latino communities both professionally and personally, at the onset of this process, I recognized and embraced that my desire and concern for producing knowledge contributing to change would drive the dissertation. Based on this value-driven and needs-based decision, this dissertation asserts that Latino families

have the potential to help and possibly lead suicide prevention for their adolescents. However, to tap into their potential, we must first understand what they know about suicide prevention and their self-efficacy related to suicide prevention strategies.

## Suicide Prevention and Latino Families

In the fight against suicide, families are the first and last defense (Frey et al., 2016). The importance of family in suicide prevention is particularly salient for adolescents as their caregivers are essential figures in implementing (or not implementing) suicide prevention and intervention strategies (Dueweke & Bridges, 2016; King et al., 2013). Caregivers can be on alert for non-verbal suicide-related personal communication (e.g., warning signs) and directly ask their adolescents if they are experiencing thoughts about killing themselves, both of which are effective suicide preventative strategies (Mo et al., 2018). Also, caregivers can create a safer environment for an adolescent struggling with suicidality by securing lethal means, which decreases the likelihood of a fatal suicide attempt (Stone et al., 2017; Zalsman et al., 2016). Moreover, parental monitoring and supportive parent-adolescent communication can reduce suicidal ideation and prevent suicide attempts (Boyas et al., 2019; Frey & Hunt, 2018). Most importantly, after an adolescent expresses suicidal ideation or attempts suicide, caregivers are critical actors in whether adolescents engage and continue mental health services (Dueweke & Bridges, 2016).

Despite their influential role, suicide prevention tends to exclude family members as research predominately targets adult figures in school and healthcare settings (Mo et al., 2018; Zalsman et al., 2016). The exclusion of caregivers from suicide research is especially noticeable for Latino communities. In a systematic review that spanned more than two decades, Frey and Hunt (2018) were only able to identify 13 suicide prevention and intervention efforts that

included caregivers. Of these efforts, less than one-fourth included Latino caregivers. Such a low number is surprising considering the growing U.S. Latino population (U.S. Census Bureau, 2019) and their significant rates of suicidality and suicide (Division of Adolescent and School Health, 2018).

The U.S. Census Bureau (2019) estimates that by 2050, Latino individuals will comprise the largest ethnic minority group in the United States. These estimates further project that 33% of the U.S. adolescent population will be of Latino descent. Per the most recent findings, the Centers for Disease Control and Prevention (CDC; Ivey-Stepheson et al., 2020) estimates that 17.2% of Latino adolescents seriously considered death by suicide, 14.7% made a suicide plan, and 8.9% attempted to kill themselves at least once within twelve months. These rates are similar to those observed in the general population (CDC, 2020). However, Latino adolescents are more vulnerable because they seem to progress from suicidal ideation to a suicide attempt at a higher rate than their non-Latino peers. For example, in 2017, the percentage of Latino adolescents who attempted suicide after experiencing suicidal ideation was nearly 5% higher than their non-Latino peers (respectively 41.86% versus 37.50%) (CDC, 2018).

Of the few suicide prevention and intervention strategies developed with this population in mind that involve caregivers, three stand out: (a) Rotheram-Borus and colleagues' (1996) specialized emergency room intervention; (b) Life is Precious (Humensky et al., 2017); and, (c) Project Wings (Garcia et al., 2013). These three programs stand out because they incorporate Latino cultural values, such as familism, personalism, and respect (Villarreal-Otálora et al., 2019). Positive outcomes across these prevention efforts include an increase in help-seeking behaviors and communication between caregiver and adolescent, as well as a slight reduction in adolescent suicidal ideation. While these programs have promising outcomes, they present two

significant limitations. First, most of them focus exclusively on Latinas, excluding Latinos in their efforts, and second, they only measure adolescent behavioral factors. Thus, there is no information regarding the caregivers' suicide-related prevention communication, such as whether they engaged in them, how confident they felt in carrying them out, and what propelled or deterred their engagement. This dissertation study takes steps towards addressing those knowledge gaps.

## Overview of Literature

The CDC outlines seven overarching suicide prevention strategies (Stone et al., 2017). These strategies are located in multiple systems and aim to reduce the occurrence of suicide by targeting individuals who have attempted suicide or are at risk for suicide and the general population. See Stone et al. (2017) for the complete list of the CDC's suicide prevention strategies and approaches.

While the recommended CDC suicide prevention strategies vary in their breadth, ranging from micro to macro efforts, they share one common thread: the family. That is, all of them indirectly or directly impact the family, and most of them need the caregiver's direct involvement and buy-in for implementation. For example, the CDC recommends creating protective environments by reducing an individual's access to lethal means (Stone et al., 2017). Family members, particularly the caregivers, can assists in restricting an adolescent's access to lethal means. The CDC also recommends promoting connectedness through peer programs and community activities (Stone et al., 2017). Many times, for a minor to engage in such activities, they need parental consent. Most importantly, the CDC directly endorses suicide prevention through parenting skills and family programs (Stone et al., 2017). Admittedly, the caregiver's

buy-in is needed to implement such an approach. Thus, as stated earlier, in the fight against suicide, families are the first and last defense (Frey et al., 2016).

A robust amount of literature supports the hypothesis that the family system and caregiver-adolescent interactions influence adolescent mental health outcomes, such as suicidality and suicide. Intuitively such a hypothesis makes sense because within the family system is where the adolescent's development unfolds (Bronfenbrenner, 1979), which may influence interactions. Furthermore, family members' intimate interactions, communications, and beliefs unfold within the family system. Within Latino families, empirical evidence supports this hypothesis as research findings continuously suggest that Latino caregivers play a significant role in adolescents' mental health and behavioral outcomes (Dwight-Johnson et al., 2010; Garcini et al., 2017; Martinez Tyson et al., 2016). Multiple studies' results find strong associations between the family system factors and suicidality (e.g., Cervantes et al., 2014; Gulbas et al., 2018; Gulbas & Zayas, 2015; Hausmann-Stabile et al., 2013, 2017). This association can function as a positive (i.e., protective) or adverse (i.e., risk) factor.

Empirical evidence suggests that pervasive family conflict can be a risk factor for suicide among Latino adolescents. Results from Cervantes and colleagues (2014) suggest a strong negative correlation between Latino adolescent suicidality and caregiver-adolescent conflict and acculturation. Chronic discord, particularly between family members, and isolation are commonly reported characteristics in the lives of Latina adolescents that attempt suicide (Gulbas et al., 2011). Multiple Latina adolescent suicide attempters mention acculturation gaps, family conflict, and dysfunctional parent-adolescent interactions as factors precipitating their suicide attempts (Gulbas et al., 2018; Gulbas & Zayas, 2015). Findings from other qualitative studies suggest that Latina suicide attempters and their caregivers' aspirations profoundly differ, creating

tension within the family system and the adolescent's developmental psychological push towards autonomy (Hausmann-Stabile et al., 2013).

There is significantly more research on family system factors that increase Latino adolescent suicidality and suicide versus those that serve as protective factors. Nonetheless, the few studies examining Latino families through a protective lens shed light on ways caregivers can serve in preventing suicide. For example, the literature continuously notes that Latino caregivers play a vital role in promoting and deterring formal help-seeking behaviors. Overall, formal help-seeking behaviors are particularly low among Latino individuals (Dueweke & Bridges, 2016). Even when an individual seeks out help (explicitly or implicitly), follow-up care, while outlined in multiple healthcare guidelines and programs, is not routinely done (Etter et al., 2018). Thus, scholars in their conclusion and discussion sections suggest that including caregivers in this process may significantly enhance the likelihood that Latino adolescents will receive follow-up care after disclosing suicidal ideation or having a suicide attempt (Dwight-Johnson et al., 2010; Rotheram-Borus et al., 1996).

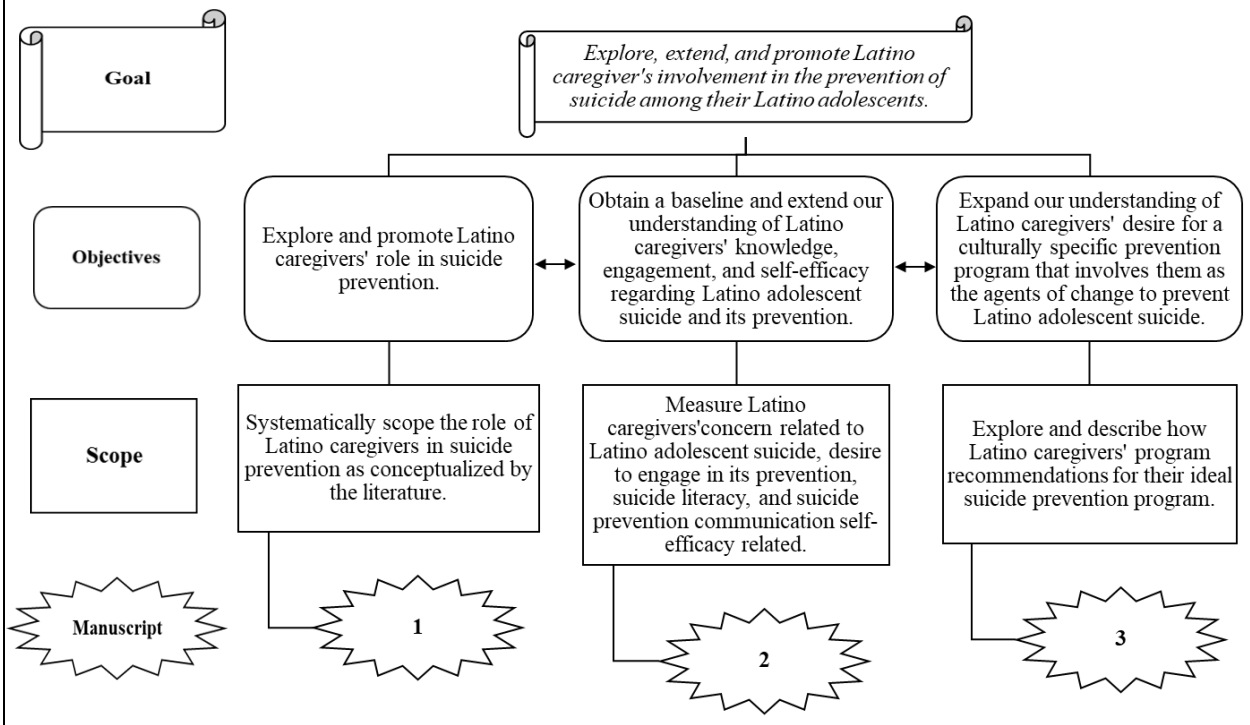
Despite Latino caregivers' potential protective role, there is minimal research examining them as a locus for suicide prevention. This lack of literature may stem from the relative "newness" of the research field, which has previously focused on Latino suicide's epidemiology. The field has only recently begun participating in prevention work. Nonetheless, the few studies exploring the role of caregivers in suicidality and suicide among adolescents reiterate caregivers' impact on the development of these phenomena (e.g., Calear et al., 2016; Frey & Cerel, 2015; Frey & Hunt, 2018; Gould et al., 2003; Wagner et al., 2003). Unfortunately, none of these are Latino-specific.

## Study Purpose

This mixed method study aims to explore, extend, and promote Latino caregivers' involvement in preventing suicide among Latino adolescents. Its overarching goal is broken down into three broad objectives, each of which has a specific focus and yields one manuscript. See Figure 1 for a description of this study's objectives and scopes.

**Figure 1.**

*Mixed Method Dissertation Study Purpose*




## Theoretical Approach

By obtaining a deeper understanding of Latino caregivers' views and needs related to Latino adolescent suicide-related prevention communication, this dissertation study seeks to make a meaningful contribution to improving support for Latino families. This goal-oriented

focus follows a pragmatism philosophical stance (Johnson et al., 2007; Morgan, 2007). In this section, I describe this stance in relation to the dissertation study design.

From the works of classical thinkers, such as Charles Sanders Peirce, William James, John Dewey, and George Herbert Mead, the tenets of pragmatism emerged (Johnson et al., 2007; Morgan, 2007). Pragmatism is the middle ground between philosophical dogmatism and skepticism seeking to find practical solutions to social problems (Johnson & Onwuegbuzie, 2004). This philosophical approach views methods and theory in a study as instrumental to the extent to which they work (Johnson & Onwuegbuzie, 2004).

The methodology selection influencing pragmatism is based on warranted assertions, practicality, and possible consequences, and the selection of theory is judged by its workability (Johnson & Onwuegbuzie, 2004). More specifically, a theory is judged in terms of its predictability and applicability. Thus, this dissertation is guided by two major theories that help predict individual and family behavior, and is influenced by a suicide-risk model applicable to ethnic minority groups. The multiple theories that inform my conceptual framework, will be explained in Chapter 2.

## Methodological Framework

A methodology that closely aligns with and is widely employed in a pragmatic approach is a mixed method design (Greene, 2007; Johnson & Onwuegbuzie, 2004). This dissertation study builds off pragmatism and uses such a design (Johnson & Onwuegbuzie, 2007; Teddlie & Tashakkori, 2006). Specifically, this dissertation follows an *integrated development* mixed method study design employing a mixed method *sequential* data collection process (Greene, 2007). I describe each of the mixed method components — integrated, development, and sequential — along with their selection rationale in this section.

For decades, social scientists have used mixed method designs with the broad purpose of developing a better understanding of the phenomenon of interest (Greene, 2007). Researchers have described the purpose for conducting a mixed method study into five categories: triangulation, complementarity, development, initiation, and expansion (Greene, 2007). The study purpose defines these categories. As I designed the study, the purpose was to understand SPC among Latino caregivers better and thus identify ways to propel their engagement in this phenomenon. To do this, I needed to get a baseline of their SPC and explore possible factors that could increase or decrease this phenomenon. Given that Latino caregivers seldomly are included in the research process, it was imperative to design a study that explored factors that could increase SPC noted in the literature and those directly identified by Latino caregivers. Thus, the purpose of the mixing methodology was to use the results from a scoping study identifying family-related factors to inform the instrumentation development for a survey examining SPC and its possible correlates among Latino caregivers, which was then used to inform the development of an interview protocol that was conducted with a sub-set of Latino caregivers who completed a survey exploring their suicide-related prevention perceptions and program recommendation for increasing their SPC. Ultimately, I wanted to capitalize on the inherent strengths of quantitative and qualitative methods to understand SPC among Latino caregivers better, thus designing a mixed method development study.

By default, given the mixed method development design, the methods in the study were implemented sequentially. First, I collected and analyzed qualitative data from the literature on Latino adolescent suicide. Second, I collected and analyzed quantitative survey data from a sample of Latino adult caregivers living in Georgia, a “new destination state” for Latino immigrants with a growing Latino population that is underrepresented in research (Flores et al.,

2017). Lastly, I collected and analyzed qualitative interview data from a subsample of those Latino adult caregivers. Ultimately, I employed what is described in the literature as a mixed method sequential data collection process for the qualitative study (study #3) depended on that of the quantitative studies (Greene, 2007; Teddlie & Yu, 2007). I describe the data collection process for each objective in detail under the methods section of its corresponding manuscript.

As there are distinct purposes for mixed method designs, there are different mixed method typologies. When choosing the mixed method typology, some authors emphasize the status given to the methods being used (e.g., Creswell et al., 2011), while others focus on the number of methodological approaches used (Teddlie & Tashakkori, 2006). Expanding on the ideas of these prominent authors, Greene (2007) goes beyond focusing on one single aspect of design to create more complex and encompassing mixed methods design typologies (Greene, 2007). Specifically, Greene includes a more robust set of elements when outlining mixed method typologies. These elements include paradigms, phenomena, methods, status, independence, timing, and study. Based on the elements, Greene classifies mixed method research into two broad clusters: component or integrated. This dissertation study's mixed method development design falls under the latter, which is used when the researcher needs the methods (quantitative and qualitative) to intentionally interact with each other throughout the study to assess different facets of the same phenomenon and to inform the development of one another (Greene, 2007).

Regardless of the mixed method conceptualization one uses to design, describe, and define the study, there is an agreement that for research to be considered mixed method, it must mix qualitative and quantitative approaches into one study (Johnson et al., 2007). This dissertation mixed quantitative and qualitative methodologies. The mixing of these

methodologies occurred during the data collection, analysis, and interpretation phases (Greene, 2007).

## Dissertation Structure

This dissertation is organized into six chapters: (1) introduction; (2) conceptual framework; (3) manuscript 1; (4) manuscript 2; (5) manuscript 3; and (6) summary, implications, and conclusion. References are presented at the end of each chapter. Appendices are presented at the end of the dissertation. The following is an overview of the three manuscripts presented in chapters 3, 4, and 5.

### Abstracts

#### *(Manuscript 1) Where are Latino Families in Adolescent Suicide Prevention? A Scoping Study*

As suicidality continues to increase among U.S. adolescents, there is a move towards more family-oriented prevention efforts. Such a move is especially significant for Latino communities due to their family values. **Objective**. The purpose of this scoping review was to systematically map out the contours of the current empirical literature on Latino families' role and involvement in Latino adolescent suicide prevention. Three research questions guided the review: (1) What is the extent of research available on Latino adolescent suicide that mentions family? (2) Based on that literature, what is the family's role in the development of suicide-related phenomena? (3) How are Latino family members included in suicide-related prevention efforts? **Design**. Four online databases were selected to identify peer-reviewed papers written in English and published between January 2000 and January 2020. The selection criteria were as follows: articles had to (a) focus on suicidal behavior(s) among Latino adolescents living in the mainland United States and (b) mention family in the results or discussion section. Data were

analyzed using a template analysis approach. **Results**. Seventy-five publications were analyzed. The majority were published in the last decade, focused on the etiology of suicide among Latino adolescents, used a cross-sectional design, and excluded family members in their data collection. Nineteen family factors were identified. **Conclusions**. Strategies involving Latino families in suicide prevention are only beginning to be discussed in the literature and require more research. While most publications acknowledge the importance of families, few include complex family-related factors, such as familial communication and familism, and fewer actively involve family members. Implications for research and practice are discussed.

***(Manuscript 2) Latino Caregiver's Suicide-Related Prevention Communication Literacy, Involvement, and Self-Efficacy***

As suicide continues to be a leading cause of death for Latino adolescents in the US, their caregivers are strategically positioned to be leaders in its prevention. However, little is known regarding Latino caregivers' suicide-related literacy and suicide prevention communication (SPC) self-efficacy. **Aim**. The purpose of this study was to describe Latino caregivers' knowledge, engagement, and self-efficacy beliefs about Latino adolescent suicide and its prevention. **Methods**. A cross-sectional online survey design was used. Participants ($N$ = 133) were first-generation Latino caregivers living in Georgia (United States), and most were females in their early 40s. Descriptive statistics were used to report participants' suicide-related literacy, concern, desire, reinforcement, and prevention strategies. A multiple regression examined the Latino caregiver's suicide prevention-related factors (suicide literacy and suicide prevention reinforcement), family and cultural factors (familism, caregiver-adolescent communication, and acculturation), and sociodemographic (income and years in the United States) variables' associations to their SPC self-efficacy. **Results**. Nearly all the participants reported being

concerned about suicide among adolescents, but only 23% had heard of a suicide prevention program (i.e., reinforcement). Most participants scored well below average on suicide literacy and reported moderate-to-high SPC self-efficacy. The multiple regression revealed that suicide prevention reinforcement, familism, and income were significantly associated with the Latino caregiver's SPC self-efficacy. **Conclusions**. The findings begin to provide a baseline of Latino caregivers' SPC, paving multiple avenues for practice and future research. Most importantly, the results suggest that Latino caregivers want to be involved in preventing suicide among their adolescents but lack the support and knowledge to do so.

***(Manuscript 3) Adolescent Suicide Prevention Program Recommendations from Latina Immigrant Mothers: "Starting with the Word"***

As suicide and suicidality continue to rise among Latino adolescents in the US, their caregivers yearn for more support. **Aim.** The purpose of this study was to understand what Latino immigrant caregivers believe an effective suicide prevention program would look like for them — specifically, giving voice to Latina immigrant mothers' suicide prevention program recommendations. **Methods.** A total of 22 Latina immigrant mothers from a new destination state participated in semi-structured interviews via Zoom. Structural and inductive coding assisted in identifying three themes related to a culturally-tailored suicide prevention program that would target caregivers as agents of change. **Results.** The three essential themes for a Latino caregiver-targeted culturally-tailored adolescent suicide prevention program identified from the mother's recommendations and expressed preferences were: (1) engagement via a multi-step effort in culturally relevant spaces; (2) providing psychoeducation in culturally meaningful ways; and (3) offering tangible takeaways. **Conclusions.** The mother's recommendations provide practitioners and researchers with a sketch for developing a culturally-tailored suicide prevention

program that places Latino caregivers as agents of change in the fight against adolescent suicide within their communities.

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# CHAPTER 2

# A CONCEPTUAL FRAMEWORK FOR SUICIDE-RELATED PREVENTION RESEARCH WITH LATINO CAREGIVERS

In the United States, suicide takes more lives than homicide, natural disasters, and war combined (Ertl et al., 2019). For every death by suicide, more than 25 individuals contemplate taking their lives (Crosby et al., 2011). Families with adolescents are disproportionally affected by this devastating phenomenon, as suicide is the second leading cause of death in the United States for the adolescent population (Center for Disease Control and Prevention, 2018). Adolescent suicidality (i.e., thinking, planning, or attempting to kill oneself) and death by suicide impact families emotionally, financially, and socially. Similarly, a combination of copious system-level factors such as socioeconomic strains, discrimination, familial discord, interpersonal conflict, isolation, mental health disorders, feelings of hopelessness and burdensomeness, and violence-related experiences influence the development and trajectory of these phenomena (Chu et al., 2010; Villarreal-Otálora et al., 2020).

Due to Latinos' vulnerable position in the United States, Latino families with adolescent children are even more susceptible to experience the devastating effects of suicidality and suicide. For example, many Latino families experience the adverse indirect and direct effects of anti-immigrant policies and discrimination on their mental health (Hatzenbuehler et al., 2017; Zayas, 2018). Latino families also face multiple financial hardships (Flores et al., 2017) that strain family members' coping skills and interpersonal interactions. Furthermore, Latino families experience unique stressors related to ethnicity, culture, and immigration status associated with

suicidality (Cervantes et al., 2014; Gulbas et al., 2018; Piña-Watson et al., 2015; Zayas et al., 2015). Some of these stressors include bicultural stress (Piña-Watson et al., 2015); acculturation gaps between caregivers and adolescents (Gulbas et al., 2018; Gulbas & Zayas, 2015); and fear of family separation (Hatzenbuehler et al., 2017).

Despite the vulnerability and impact of suicidality and suicide on Latino families, the research surrounding suicide-related prevention communication (SPC) is predominantly based on U.S. Caucasian samples (Frey & Hunt, 2018). The research is also limited in scope, as most takes place in educational and healthcare settings focusing on school or medical personnel (Mo et al., 2018; Zalsman et al., 2016). With the omission of research involving Latino caregivers, there are significant gaps in knowledge hindering the effectiveness of suicide prevention for Latino communities. For example, there is limited information on the relationship between Latino caregivers' suicide prevention self-efficacy and engagement in specific suicide prevention strategies — much less information on their perceptions of suicidality, suicide, and SPC. Thus, this mixed method dissertation is designed to fill this gap.

**The Mixed Method Dissertation Study**

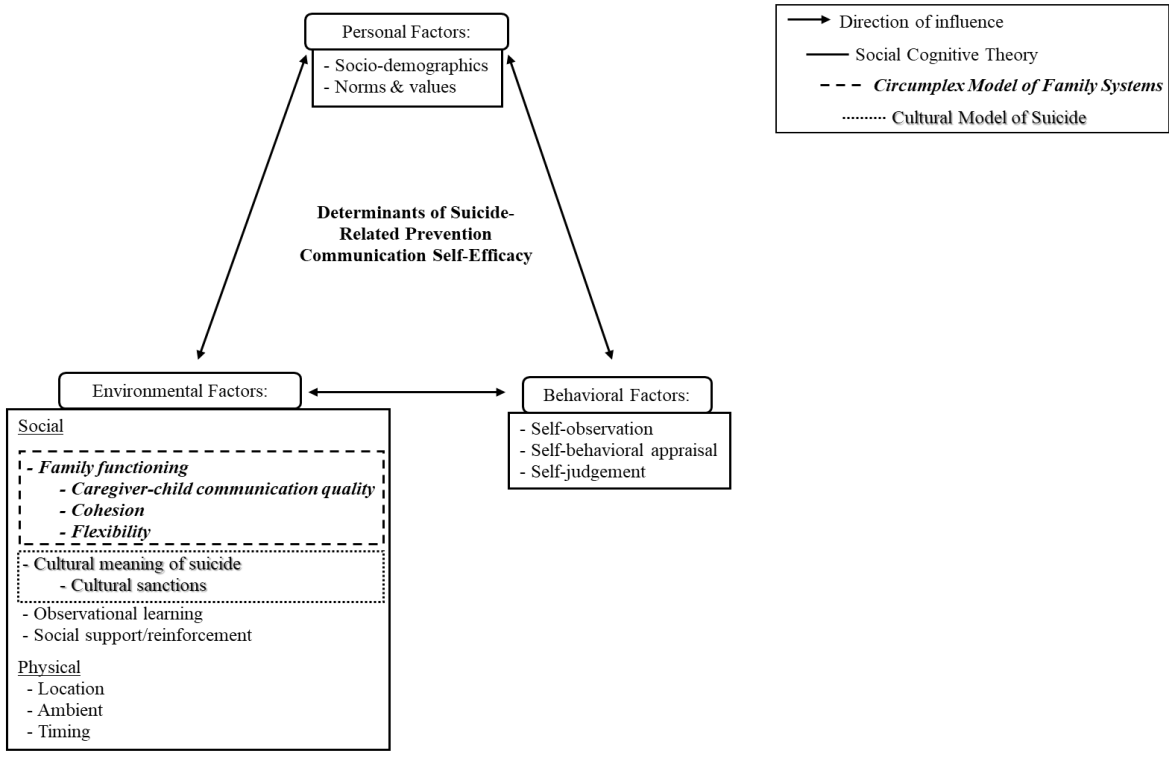
This mixed method dissertation study is a cross-sectional multi-mode data collection project aimed at exploring, describing, and extending our understanding of the factors associated with caregivers' self-efficacy and engagement in Latino adolescent SPC among a sample of Latino caregivers living in the state of Georgia. The specific objectives are to move the knowledge forward by (1) exploring Latino caregivers' role in suicide prevention; (2) extending our understanding of Latino caregivers' engagement, knowledge, and self-efficacy in Latino adolescent SPC; and (3) obtaining a deeper understanding of what Latino caregiver's believe propels or would propel their SPC. These objectives were informed by several theoretical models

relevant to individual and family behavior, suicide risk applicable to ethnic minority groups, and sources of influence specific to Latino families living in the United States. It is important to note that the objectives were further informed, revised, and finetuned throughout the data collection and analysis phases.

In this chapter, I describe the three theoretical models that guided the objectives: (a) the social cognitive theory (SCT); (b) the circumplex model of family systems (CMFS); and (c) the cultural model of suicide (CMS; see Figure 2). Also, I describe how the conceptual framework guided the selection of measurements (see Table 2). Lastly, I describe the model's implications for future research.

**Figure 2**

*Conceptual Framework for this Dissertation Study*



## Theoretical Frameworks' Relevant to Suicide-Related Prevention Communication

The mixed method dissertation is informed predominantly by the SCT and the CMFS and influenced by the CMS. Figure 1 portrays how these three theoretical models create the conceptual framework for the study. These three models were developed with the underlying goal of supporting and propelling change. Bandura (1977) developed the SCT hoping that professionals could use it to affect and promote psychological and behavioral change. Per Olson et al. (1983), they developed the CMFS intending to bridge the gap between research and professionals by providing a framework that could be used in diagnosis assessments, clinical interventions, prevention efforts, and education programs for families. Chu and colleagues (2010) developed the CMS to provide a more in-depth, culturally inclusive explanation of suicide risk to serve as a guide for conducting culturally competent suicide-related research. Thus, these three models align with this dissertation study's pragmatism theoretical approach, which is beneficial for prevention research, as discussed in chapter 1. The following sections describe these three models' fundamental tenets, empirical research, their relationship to suicide-related prevention research, and their use in this study's conceptual framework.

### The Social Cognitive Theory

Findings continually highlight familial-related factors — such as caregiver-adolescent communication, cohesion, and involvement — as essential components of efficacious prevention interventions (e.g., Czyz et al., 2018; Rotheram-Borus et al., 1996, 2000; Singh et al., 2011). These findings support the need for caregivers in the development and implementation of SPC. Multiple reviews echo this need, concluding that familial involvement is critical in SPC (Frey & Hunt, 2018; Ougrin et al., 2015). To involve caregivers in adolescent SPC, we first must understand the personal and environmental factors that influence their perceived ability and

engagement with such sensitive phenomena. The SCT (Bandura, 1977a, 1977b, 1982) is useful for analyzing and predicting an individual's functioning in situations that tend to induce fearful and avoidant behaviors, such as a caregiver talking to an adolescent child about suicide or responding to their child's suicidality.

The SCT emphasizes that individuals are shaped through a continuous reciprocal interaction between the behavior, the person, and the environments in which those behaviors occur (Bandura, 1977a, 1977b, 1982). Behavioral factors refer to a person's self-regulation related to a behavioral task. Specifically, the SCT delineates three behavioral components: self-observation (i.e., awareness of self and monitoring of behaviors to increase positive outcomes); self-behavioral appraisal (i.e., behavior perceived as good or bad); and self-reaction (i.e., negative, or positive reinforcements the person gives). Ultimately, the SCT hypothesizes that these behavioral factors are influenced and influence environmental and personal factors.

Environmental factors in the theory are divided into two: social and physical. The former delineates reinforcement and observational learning as influencers of human behavior. For example, reinforcements to engage in SPC for a caregiver may be having a balanced level of communication with their adolescent or having social support (e.g., mental health professional or family) who encourage such behaviors. They also include the caregiver's perceived consequence of engaging in SPC with their adolescent. Reinforcement can also stem from seeing others engage in SPC. For example, a caregiver may observe a school counselor talking to their adolescent about suicidality or connecting them to needed mental health services. Also, the caregiver may participate or merely hear about suicide prevention programs. In a non-professional setting, a caregiver may also observe how a family friend can prevent an adolescent from attempting suicide during a suicidal crisis. The physical environmental factors in the model

represent the situational circumstances (e.g., location, ambiance, timing) during which a caregiver is expected to engage in suicide-related prevention strategies — for example, the circumstances during which a caregiver is confronted with a suicidal comment by their adolescent.

At the core, the SCT assumes that individuals are not the sole agents of change, but neither is their environment. Deriving from this assumption is the SCT's practical concept of perceived *self-efficacy* (Bandura, 1977a), which stems from the personal factors component of the theory and is impacted by the other two factors — environmental and behavioral. A person's self-efficacy, values, norms, and other factors that may influence these make up the model's personal component. As asserted by the SCT, self-efficacy is the magnitude, generality, and strength in an individual's "conviction that one can successfully execute the behaviors required to produce the outcomes" (Bandura, 1977a, p. 193). Ultimately, SCT hypothesizes that self-efficacy expectations are a significant determinant of an individual's allocation of length, extent, and maintenance of behavioral efforts in stressful situations. Keeping with SCT's assumptions, self-efficacy is a producer, a mediator, and a result of an individual's behavior (Bandura, 1977b). For this dissertation, I focus on self-efficacy as an outcome, thus assuming that caregivers with high self-efficacy would be more likely to utilize actions to prevent and help their adolescents manage suicidal crises (Bandura, 1977b).

Four principles guide this cognitive mechanism: (1) performance attainment, (2) vicarious experiences, (3) verbal persuasion, and (4) physical state. Performance attainment is the total pattern of individual perceived mastery experiences and is hypothesized to be the most influential on self-efficacy. The other most substantial influence is the vicarious experience, which is seeing others perform the behavior. Verbal persuasion is not as strong as the previous

two mentioned and refers to the verbal suggestions the individual receives regarding their capability to execute and master the behavior. This principle is not as strong as it is dependent on the environment, the relationship the individual has with the person providing the verbal persuasion, and the perceived creditability of that person. The physical state is hypothesized to be the least influential on self-efficacy. This principle refers to the state of heightened physiological activity that partly assists an individual in judging their anxiety and vulnerability to stress.

As stated above, the strength of influence these four dimensions have on an individual's self-efficacy is drawn from a Western-individualistic perspective. However, self-efficacy development is shaped by the individual's cultural embedment (Bandura, 2001). For example, the strength of performance attainment, vicarious experiences, verbal persuasion, and physical state on the development of self-efficacy varies when comparing people embedded within individualistic cultures versus those in collectivistic cultures (Jurecska et al., 2011; Klassen, 2004). Also, the definition and evaluation of performance attainment, vicarious experiences, verbal persuasion, and physical state may vary along several socio-cultural dimensions. For example, for Latino immigrants, entertainment-education telenovelas may be more influential in increasing their self-efficacy than seeing a neighbor engage in the desired behavior. Despite self-efficacy's operational differences, research supports that cross-culturally it continues to be highly predictive of performance (Jones & Prinz, 2015; Jurecska et al., 2011; Klassen, 2004).

Across the literature, this self-efficacy is broken down into three categories: general, task-related, or narrow-domain (Jones & Prinz, 2015). Studies have found that caregiver self-efficacy is associated with multiple behaviors, such as caregiver-adolescent communication and caregiver's response to their adolescent suicidal crisis (Czyz et al., 2018; Jones & Prinz, 2005).

Congruent with the SCT, research findings suggest that environmental factors also play a substantial role in an individual's self-efficacy. Some environmental factors include the availability of supports (e.g., extended family) and neighborhood characteristics (Jones & Prinz, 2005).

To date, most of the studies examining caregiver self-efficacy do not account for culture, and when they do, culture tends to be equated to ethnicity or race tends. Similarly, there is also a lack of attention to the familial environmental influence on caregiver self-efficacy. An explanation for this omission in the literature may derive from the construct's origin, which is theoretically located within a Western-individualist context. Performance attainment, vicarious experiences, verbal persuasion, and physical state are all factors that are somewhat determined by an individual's culture, as it is the mechanism setting forth their evaluative criteria. These omissions are related to the SCT's weakness: its heavy reliance on an individualistic sociocognitive perspective and not as much on a collectivistic systems perspective, thus inadvertently minimizing the influence of culture and the family system on behavior.

**The Circumplex Model of Family Systems**

Similar to the SCT, the CMFS (Olson et al., 1983) supports the concept of continuous reciprocal interaction but focuses on the relationship between familial interactions and family members' behavioral outcomes and stems from a systems perspective. Rooted in the family systems theory, the CMFS is an analytical typology depicting the intersection of two major family interactions — cohesion and flexibility — with the facilitating interaction of *communication* (Olson, 1993; Olson et al., 2019). Following a family systems theory assumption, the CMFS assumes that individuals within a family unit are simultaneously influencing one another and influenced by the environment produced by these interactions (Frey

et al., 2016). Findings from the existing suicide prevention interventions that target families support this assumption (Frey & Hunt, 2018).

The CMFS posits that balanced levels of cohesion (i.e., the emotional bonding between family members) and flexibility (i.e., the degree of change in its power structure, role relationships, and relationship rules) in family members are optimal for family functioning (Olson, 1993). Balanced levels of cohesion and flexibility are operationalized as the two midranges between extremes on a four-point range. Both cohesion and flexibility have four anchor points. Cohesion ranges from disengaged to separated to connected to enmeshed, and flexibility ranges from rigid to structured to flexible to chaotic. Responding to criticism regarding the universalistic standpoint taken by the model, Olson and colleagues (1983) added a caveat to the hypothesis that families will function best if they are in the midranges. Specifically, the CMFS hypothesizes that "if the normative expectations of a couple or family support behaviors extreme on one or both of the circumplex dimensions, they will function well as long as all family members accept these expectations" (Olson et al., 1983, p. 72). Nonetheless, there is a lack of attunement to cultural factors that influence family members' behaviors, and thus, functioning continues to be a weakness of the model.

Cohesion includes emotional bonding, boundaries, coalitions, time, space, friends, decision-making and interests, and recreation (Olson, 1999). This dimension goes well with SCT's assertion that environmental factors influence an individual's behavior as the CMFS asserts that the relations people have with one another influence family members' behavior and overall family functioning. Flexibility focuses on how the family systems balance change versus stability and includes negotiation styles, leadership (i.e., discipline and control), role relationships, and relationship rules (Olson, 1999).

Communication plays a critical role in the CMFS. As defined in the CMFS, communication is the mechanism families use to share their needs, feelings, and preferences. When examining communication, the model looks at several factors: listening skills (i.e., empathy and active listening); speaking skills (i.e., I-statements); self-disclosure (i.e., feelings about self and relationship); clarity; continuity-tracking (i.e., staying on topic); and respect and regard (Olson, 1999). The CMFS hypothesizes that positive communication skills enable change within family members (Olson et al., 2019). In sum, communication is critical as it is directly related to cohesion and flexibility while facilitating family movement within the two (Olson, 1993). Ultimately, the CMFS views communication as the protective factor that facilitates and fosters movement within and across the cohesion and flexibility dimensions.

Researchers have extensively examined and validated the utility of the CMFS on a wide variety of topics. These topics are directly and indirectly associated with the prevention of suicide and include family assessment, families with unique problems, family dynamics, conflict and development, and sexuality (as cited in Olson et al., 2019). Unfortunately, most of the research using this model is predominantly based on Caucasians, middle-class Christian families. Limited sample diversity is a common problem within medicine, psychology, and family science, which host most of the research using the CMFS (Olson et al., 2019). Nonetheless, the findings of one study examining the model's utility in preventing trauma within Mexican immigrant families in the United States suggest that positive caregiver-adolescent communication plays a protective role in prevention among that population (Singh et al., 2011).

Moreover, the few studies that have applied the model to suicide-related prevention research note promising findings. One such study's findings come from Rotheram-Borus and colleagues' (1999, 2000) suicide prevention program primarily targeting Latina adolescent

suicide attempters. By increasing family cohesion and adaptability, the pilot program decreased depressive symptomatology and re-attempt and increased attendance to therapy. Given the association between these two dimensions and communication, research can extrapolate their findings to communication and postulate that communication may significantly prevent re-attempts and increase therapy adherence.

Unfortunately, the research thus far mainly focuses on the cohesion and adaptability dimensions and thus pays less attention to the facilitating dimension of communication (Olson et al., 2019). Nonetheless, based on the model's hypothesis, similar assertions can be deduced regarding the protective influence that caregiver-adolescent communication may have on the prevention of adolescent suicide. Additionally, findings from a parent-centered prevention program for Latino adolescent behavioral issues continuously suggest that caregiver-adolescent communication is associated with the intervention's efficacy on adolescent internalizing symptoms (e.g., Patinin et al., 2009; Perrino et al., 2014; Vidot et al., 2016). Given previous study findings on the applicability, validity, and utility of the CMFS, suicide prevention research that involves ethnic minority caregivers could draw on this theory. However, such research needs to incorporate the CMFS with a model that attunes more to cultural factors.

**The Cultural Model of Suicide**

Engaging in suicide-related prevention is futile without a deep understanding of the fundamental processes that cause its development. Thus, suicide research must be rooted in a theoretical perspective that expands this understanding, such as an ideation-to-action framework, and in one that accounts explicitly for cultural factors. One such framework that compliments SCT and CMFS is the CMS (Chu et al., 2010). The CMS uses an ideation-to-action framework

and provides a more in-depth, culturally inclusive explanation of suicide that can serve as a guide for conducting culturally competent suicide-related research (Chu et al., 2010).

Developed in 2010 via a systematic literature review on suicide, the CMS asserts that culturally specific risk factors can explain a phenomenon's occurrence. Per the model, the culturally relevant risk factors bearing influence on suicidal behaviors include: (a) *cultural meaning* (i.e., cultural sanctions and messages); (b) *minority stress* (i.e., stresses experienced by cultural minorities due to their social position or identity); (c) *social discord* (i.e., conflict, discord, lack of integration, or alienation from or between social networks); and (d) *idioms of distress* (i.e., expression of suicide). The cultural meaning of suicide is the "culturally normative beliefs about the acceptability of suicide, and what a cultural context deems appropriate to motivate suicide" (Chu et al., 2017, p. 1345).

Similar to SCT, CMS has an interactive component assuming that the environment influences perceptions, norms, and values. Where it differs is in its directionality. The CMS proposes a linear relationship and overlooks the reciprocal influence of those ascribed perceptions, norms, and values on the environment. Specifically, the CMS depicts a one-way relationship asserting that cultural sanctions (i.e., approval and acceptability) and cultural messages influence the beliefs and interpretation ascribed to a stressful life event and suicide, influencing whether an individual will engage in suicidal behaviors (Chu et al., 2010). While the directionality of the influence is questionable, the hypothesis that there is a relationship between the individual's cultural meaning of suicide and the development of suicidality is useful for suicide-related prevention communication.

At its center, the CMS contains the core belief that culture permeates all social phenomenon. Following this belief, the caregiver's cultural views of suicide may also affect their

engagement in suicide prevention strategies. Indirectly this may affect the development of suicidality in their children. For example, a Latino caregiver's effective transmission of the cultural value of familism (i.e., a focus on family cohesion; Calzada et al., 2012) could reduce their adolescent's risk for suicide (Valdivieso-Mora et al., 2016). Transmission of familism could reduce suicidality by reinforcing strong bonds of attachment to the family, reliable family support during a crisis or psychological distress, and providing a reason to live (Valdivieso-Mora et al., 2016). The caregiver's cultural view of suicide may also influence their communication with their adolescent about the topic. For example, the caregiver may hold very negative views of mental health issues. Thus, when their adolescent brings up the subject of suicide, the caregiver may dismiss it missing the opportunity to engage in suicide prevention and intervention strategies (Frey et al., 2016).

### Application to Suicide-Related Prevention Communication Research

The conceptual framework described above assisted as a guide for the selection of study measurements. See Table 2 for the measurement items used in the study dissertation organized by the conceptual framework. I describe each of the measurements in their corresponding manuscript(s). For example, manuscript 2 (i.e., chapter 4) describes constructs examined using a survey measurement approach.

## Limitations

Before concluding with the importance of this dissertation study's conceptual framework and its implications for future research, it is important to note a limitation concerning its influence on the measurement selection. Apart from the Cultural Assessment of Risk for Suicide (CARS; Chu et al. 2013), the measurements selected were predominantly developed with non-ethnic minorities in mind. Such constraint reflects the limitations presented in most grand

theories and family systems theories. Due to this limitation, I had to adapt most of the measurement scales for the study context. After I adapted, they then had to be translated to Spanish using a back-translation method. The translation process is described in detail in manuscript 2 (chapter 4).

**Conclusion**

I hope that the conceptual framework described in this chapter can assist with Latino caregiver suicide-related prevention communication research. Via the development of this conceptual framework, two innovative features arose (1) the collection of data from caregivers and (2) multiple operationalizations of suicide prevention strategies, cultural, and caregiver influences.

A limitation of the research on suicide-related prevention communication is the omission of caregivers, especially Latinos. Thus, by integrating aspects of the SCT with the CMFS, a valuable aspect of this dissertation study is the focus on Latino caregivers' suicide-related prevention communication as a behavior influenced by multiple personal, familial, behavioral, and environmental factors. Via drawing both on the CMFS and the CMS, this study also expands on the operationalization of suicide prevention strategies and cultural and familial influences. Specifically, by including various measurement approaches, the study provides space for varying definitions of these variables and their dimensions, which I hope can assist in developing future research protocols.

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**Table 2**

*Measurement items organized by the conceptual framework*

| Constructs | Measurement (scale) | Measurement approach |
|---|---|---|
| Personal Factors | | |
| Caregiver suicide prevention self-efficacy | | Survey/Interview |
| | • Performance attainments (Parent Self-Efficacy)<br>• Vicarious experiences with suicide prevention and/or mental health<br>• Verbal persuasion related to suicide prevention and/or mental health<br>• Physical state related to suicide prevention and/or mental health | |
| Socio-Demographic | Caregiver<br>• Gender<br>• Age<br>• Marital status<br>• Nativity<br>• Length of time in the United States & Georgia<br>• Highest level of education<br>• Annual household income<br>• Number of adolescent children | Survey |
| | Caregiver's adolescent(s)<br>• Gender<br>• Age<br>• Nativity<br>• Immigration status | Survey |
| Norms & Values | Suicide Concern | Survey |
| | Perceived Cause of Suicide | Survey |
| | Suicide literacy (LOSS) | Survey |
| | Religiosity | Survey |
| | Cultural meaning of suicide (CARS - cultural sanctions) | Survey/Interview |
| | Familism (5-item PFS) | Survey |
| | Acculturation | Survey |
| Behavioral Factors | Self-appraisal of suicide prevention efforts | Interview |
| | Experience with adolescent suicidality | Survey/Interview |

| Constructs | Measurement (scale) | Measurement approach |
|---|---|---|
| Environmental Factors | | |
| | Physical: Suicide prevention efforts'… | Interview |
| | • Timing | |
| | • Location | |
| | • Ambient | |
| | Social: | |
| | • Caregiver-adolescent communication (PA-OCF) | Survey |
| | • Caregiver report on family cohesion | Interview |
| | • Caregiver report on family flexibility | Interview |
| | • Exposure to suicide prevention efforts | Survey |
| | • Social supports | Interview |

# CHAPTER 3

# WHERE ARE LATINO FAMILIES IN ADOLESCENT SUICIDE PREVENTION? A SCOPING STUDY [1]

[1] Villarreal-Otálora, T. To be submitted to *Archives of Suicide.* (Other contributors to this article, such as dissertation committee members, are to be added at a later date).

## Abstract

As suicidality continues to increase among U.S. adolescents, there is a move towards more family-oriented prevention efforts. Such a move is especially significant for Latino communities due to their family values. **Objective**. The purpose of this scoping review was to systematically map out the contours of the current empirical literature on Latino families' role and involvement in Latino adolescent suicide prevention. Three research questions guided the review: (1) What is the extent of research available on Latino adolescent suicide that mentions family? (2) Based on that literature, what is the family's role in the development of suicide-related phenomena? (3) How are Latino family members included in suicide-related prevention efforts? **Design**. Four online databases were selected to identify peer-reviewed papers written in English and published between January 2000 and January 2020. Selection criteria were as follows: articles had to (a) focus on suicidal behavior(s) among Latino adolescents living in mainland United States and (b) mention family in the results or discussion section. Data were analyzed using a template analysis approach. **Results**. Seventy-five publications were analyzed. Most were in the last decade, focused on the etiology of suicide among Latino adolescents, used a cross-sectional design, and excluded family members in their data collection. Nineteen family factors were identified. **Conclusions**. Strategies involving Latino families in suicide prevention are only beginning to be discussed in the literature and require more research. While most publications acknowledge families' importance, few include complex family-related factors, such as familial communication and familism, and fewer actively involve family members. Implications for research and practice are discussed.


**Keywords:** Latino, adolescent, suicide, prevention, family, scoping review.

## Introduction

By 2060 the United States will be home to 111.2 million Latino individuals, making up nearly 30% of the overall U.S. population (U.S. Census Bureau, 2018). Many of these individuals are part of a family with children between 13 and 18 (U.S. Census Bureau, 2018). Quite a few of them will have experienced suicidality. According to the most recent Youth Risk Behavioral Survey, in 2018, 17.2% of Latino adolescents seriously considered attempting suicide, 14.7% planned how they would attempt suicide, and 8.9% attempted suicide at least once in 12-months (Ivey-Stephenson et al., 2020). Suicide death rates for Latino adolescents are two times higher in the United States than those in most Latin American countries (Borges et al., 2008; World Health Organization [WHO], 2014). Thus, compared to non-Latino parents, Latino parents may be quite perplexed and at a loss if their adolescent struggles with suicidality. Many Latino parents may not know where to turn. They may resort to cultural scripts of silence or shaming behaviors to cope with the situation — two coping skills that may exacerbate mental health issues (Gulbas & Zayas, 2017; Szlyk et al., 2019).

As the largest ethnic minority group in the United States, Latino families face significant system stressors that heighten their risk for suicide (Hatzenbuehler et al., 2017; Semega et al., 2019; Wildsmith et al., 2018) and decrease formal help-seeking (Toomey et al., 2014). Poverty, lack of access to health care, discrimination, and family separation are all stressors correlated with suicidality common in Latino communities in the United States (see Semega et al., 2019, & Wildsmith et al., 2018). Thanks to an increase in Latino adolescent suicidality research, this information is well known.

The early literature on Latino adolescent suicide in the United States — which began in the late 20th century — has established the epidemiology of suicidal behaviors among these

communities (Canino & Roberts, 2001). As epidemiological data continued to show increasing suicidality rates among Latino adolescents, scholars began to explore possible cultural factors and system stressors related to suicidal behaviors among Latinos in the United States. Among those examined, the family became a focal point. No study has outlined how Latino families are — or can be — involved in suicide prevention efforts. As part of a more extensive mixed method study related to Latino caregivers as a locus of suicide prevention in the state of Georgia, this scoping study addresses the knowledge gap by scoping the body of literature and investigating the current research related to the Latino family's role in the development and prevention of Latino adolescent suicide.

**Previous Reviews on the Subject**

Although there is robust literature synthesizing research on the prevention of suicide among adolescents (e.g., Brent et al., 2012; Ougring et al., 2015; Wodarski & Harries, 1987; Zalsman et al., 2016), only a few studies explore the role of family, particularly caregivers, in these phenomena (e.g., Calear et al., 2016; Frey & Cerel, 2015; Frey & Hunt, 2018). There are two common findings: (1) Caregivers tend to be discussed in terms of risk, and (2) there are few suicide prevention efforts that include caregivers (Calear et al., 2016). These currently available reviews do not focus on Latino populations.

As of writing this article, three reviews outline the literature related to Latino adolescent suicide (i.e., Canino & Roberts, 2001; Duarté-Vélez & Bernal, 2007; Villarreal-Otálora et al., 2019). Two of these reviews were conducted more than a decade ago, and none of them focuses on the family's role in suicide-related prevention. Instead, these reviews direct their attention to summarizing the breadth of literature on Latino adolescent suicide in general and its etiology.

## Study Objectives

This scoping study's primary goal was to summarize the existing literature on Latino families — especially caregivers — within the Latino adolescent suicide research. The following research questions guided the scoping study:

(1) What is the extent of research available on Latino adolescent suicide that mentions family?

(2) Based on Latino adolescent suicide literature that mentions family, what is the family's role in the development of suicide-related phenomena?

(3) In the identified literature, how are Latino family members included in suicide-related prevention efforts?

## Methods

Given the interest in identifying specific characteristics of the research and mapping them out, coupled with the fact that there is no systematic review of the topic, a scoping study design was most suitable (Munn et al., 2018). Levac et al.'s (2010) delineation of Arksey and O'Malley's (2005) five-stage scoping review methodological framework was used. The article follows the Preferred Reporting of Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews to describe the study's methodology and results (Tricco et al., 2018).

### Eligibility Criteria

To be included in this study, papers needed to focus on suicidality (i.e., suicide ideation, planning, or attempt) or suicide (i.e., fatal suicide attempt) among U.S. Latino adolescents that reside in mainland United States and mention family in the results or discussion section. The articles were geographically bounded to the mainland United States because suicide rates are nearly two times higher for Latino adolescents living in the United States than in Latin America

(Borges et al., 2008; WHO, 2014). Peer-reviewed journal articles were included if they were: published between 2000 and January 2020 (early access papers included), written in English, involved human participants, and contained suicidality or suicide as one of their outcome measures or as the primary focus of the study.

Papers were excluded if they focused on a cross-national sample and had less than 15% Latino individuals. Two key statistics facilitated the 15% threshold decision: (1) approximately 16% of the U.S. mainland population is of Latino descent (U.S. Census Bureau, 2019) and (2), at the time of embarking on the study, estimates reported that 15% of Georgia's population below the age of 18 was of Latino descent (Kids Count, 2018). If the study had an adolescent sample with an age range outside of 13 to 18, the sample's mean was used to determine eligibility.

**Information Sources and Search Strategy**

The following databases were selected to identify potentially relevant papers: PsychoInfo, Web of Science, SocINDEX, and Medline. These four databases are sufficient to cover the major fields and journals that publish research on suicide. In collaboration with an experienced librarian, the author drafted a search strategy. The search terms — Latino, adolescent, suicide, intervention, and family and variant relating terms (e.g., Hispanic, youth, suicidality) — were combined to create the search strategy (see Appendix B) and entered into each database. Papers' bibliographies were reviewed to supplement the search.

**Selection of Sources of Evidence**

To identify sources of evidence, the author evaluated all the article titles and abstracts for relevance to the topic area. After removing duplicates and extracting irrelevant articles, the researcher evaluated all the remaining publications' full text. Full-text publications that met inclusion criteria were extracted for key study characteristics and detailed information on the

article's discussion of family in the development and prevention of suicide. Key study characteristics included the following: author and year of publication, study design, sample characteristics, and the type of prevention efforts mentioned. NVivo 12 assisted with data management, charting, and analysis.

## Data Analysis and Charting

Full-text articles were analyzed thematically. While thematic analysis is commonly used for analysis scoping study data (Arksey & O'Malley, 2005; Munn et al., 2018), many different coding procedures fall under this analytic umbrella. This study used the template analysis procedure (see King, 2012). The template analysis procedure is practical for analyzing scoping study data because of its emphasis on abductive and hierarchical coding to develop and stabilize a coding template.

After exploring 12 articles that meet inclusion and exclusion criterion, an initial coding template was created that included inductive codes from the articles and deductive codes from the study's research questions and theories relevant to Latino families and suicide-related prevention. For example, drawing from the systems circumplex model (Olson et al., 1983), the coding template included familial-related codes such as family cohesion, parent-adolescent communication, and family flexibility. Stemming from the cultural model for suicide risk (Chu et al., 2010), familism and minority-related stress were used as codes. The template also included codes related to suicide-related prevention communication, suicide, suicidality, and types of prevention efforts.

### *Conceptual Perspective, Definitions, and Terminology*

This study used Leavell and Clark’s (1965) conceptual model for preventive efforts to define suicide-related communication prevention and the Center for Disease Control and

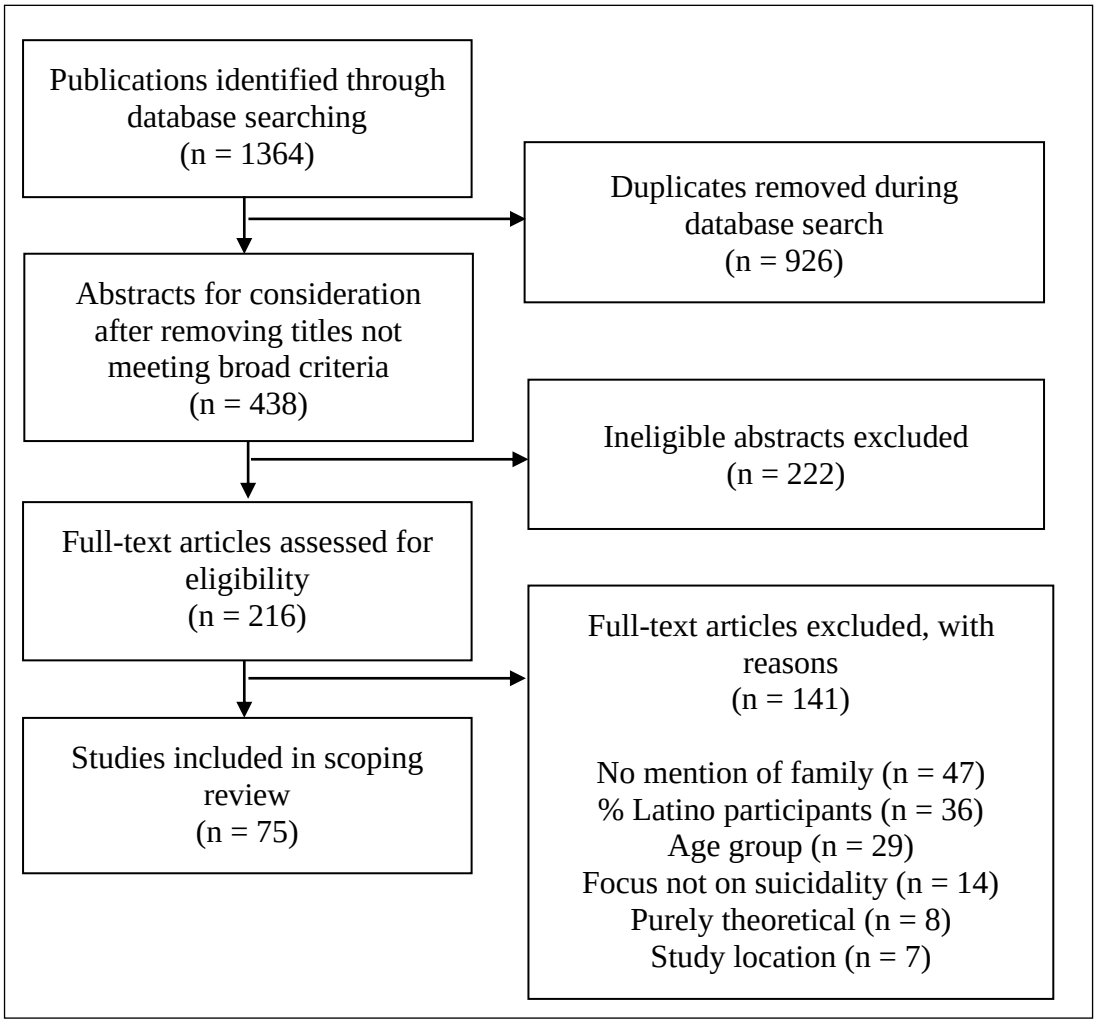
Prevention's ([CDC] 2015) suicide terminology. Per the CDC, suicidal behaviors range from (1) a desire to kill oneself (i.e., suicide ideation) to (2) preparing to take one's life (i.e., suicide planning) to (3) engaging in a non-fatal suicide attempt to (4) death by suicide. Leavell and Clark's (1965) conceptual model distinguishes prevention efforts into three categories: (1) primary (i.e., initiatives aimed at all individuals regardless of risk level); (2) secondary (i.e., programs targeting specific subgroups that are at risk); and (3) tertiary (i.e., programs for individuals who are already struggling with the problem). Suicide prevention efforts were classified as tertiary if they focused on reducing the occurrence of suicidal behaviors. An example of such an effort is Life is Precious; an intervention developed to reduce suicidality among Latina adolescents (Humensky et al., 2013, 2017a). Suicide prevention efforts aiming to prevent the onset of suicidal behaviors via detecting and reducing suicide risk factors (e.g., depressive symptomology and family conflict) were classified as secondary. These efforts may include brief suicide safety assessments or programs that equip gatekeepers to identify those at risk. Lastly, efforts concentrating on raising awareness were classified as primary.

## Results

A total of 1,364 articles were screened, and 926 duplicates were removed (see Figure 3). This process left 216 full-text articles for the primary researcher to assess for study eligibility. Of these articles, 141 did not meet the eligibility criteria leaving 75 papers for study inclusion.

**Figure 3**

*Flow diagram of study selection*




## Extent of the Literature

The majority of the literature identified for inclusion ($N$ = 75) was published between 2010 and 2020 (83%; $n$ = 62) and focused on the etiology of suicide among Latino adolescents (79%; $n$ = 59). Of the identified publications, there were seven intervention studies (Adrian et al., 2019; Humensky et al., 2013, 2017a, 2017b; Reyes-Portillo et al., 2017; Rotheram-Borus et al., 2000; Vidot et al., 2016) and two program development studies (Ford et al., 2013; Morgan

Consoli et al., 2012). More than half (81%; *n* = 61) used a cross-sectional design; excluded family members in the sample (69%; *n* = 52); and had study sample that consisted of 50% or more Latino individuals (65%; *n* = 49). Nearly half of the studies (49%; *n* = 37) centered on nonfatal suicide attempts. Study settings ranged from clinical healthcare institutions to schools, the former being the most common (40%; *n* = 30). See Table 3.1 for a description of the data.

**Family in the Context of Latino Adolescent Suicidality and Suicide**

Most of the publications (81%; *n* = 61) included a family-related variable in their data analysis, with a minority limiting the family's mention to solely the discussion or conclusion sections (17%; *n* = 13). The analysis distinguished a total of 19 family-related variables mentioned by the articles. See Table 3.2 for a list of the variables and their definitions.

The family-related variables varied in their complexity and detail, with a few studies (*n* = 7; see Table 3.1) accounting only for family demographic factors — such as family structure and socioeconomic status — in their analysis. In contrast, others included broader concepts, such as family cohesion and familism. Of the 61 articles that included a family-related variable, the most commonly explored variable was family cohesion (66%; *n* = 40; see Table 3.1), and the three least were familism (15%; *n* = 9; see Table 3.1), family communication (13%; *n* = 8; see Table 3.1), and perceptions of suicide (13%; *n* = 8; see Table 3.1).

When the studies discussed their selection rationale for family-related variables, more than half of them presented their choice in the context of risk (*n* = 33; see Table 3.1). These publications made statements such as “tumultuous relationships with parents are a suicide risk factor for Hispanic youth” (Hall et al., 2018, p. 233). Nearly a third of them conceptualized family-related variables as having the potential to both protect and propel suicide (*n* = 18; see Table 3.1). For example, as Rapp et al. (2017) set up their study rationale, the authors

highlighted that familial relationships, depending on the level of conflict and connection, may precipitate or protect against suicide attempts. Few studies (*n* = 9; see Table 3.1) solely discussed family-related variables as potentially protective factors in developing and preventing suicidality. A slightly different pattern emerged within the 15 articles that solely mentioned family in their discussion or conclusion sections: 53% (*n* = 8; see Table 3.1) framed family-related variables as risk; 27% (*n* = 4; see Table 3.1) as protective; and 20% (*n* = 3; see Table 3.1) as both risk and protective.

More than 40% (*n* = 31) of the total sample explicitly called for scientists to involve the family in future Latino suicide-related research. Despite this call, 32% (*n* = 24) provided no ideas for promoting such involvement. Overall, 33% (*n* = 25) of the sample noted the lack of family member inclusion in their research as a significant study limitation.

## Inclusion of Latino Parents in Suicide Prevention

Forty-nine publications outlined specific suicide prevention strategies that include or could benefit from the inclusion of Latino families. Nearly half of those articles (43%; *n* = 21; see Table 3.1) advocated for multipronged efforts. For example, Zayas et al. (2009) encouraged that in addition to individual counseling for Latina adolescents, there be skill-building and psycho-educational groups for them and their parents to reduce suicide risk and re-attempts. The publications least advocated for primary efforts (*n* = 3; see Table 3.1).

### *Publications Directly Involving Latino Family Members*

Less than 30% of the total sample (*n* = 21) directly solicited family members' opinions or actively involved them in the research process (see Table 3.3). Parents were the family members that were most likely to be included (*n* = 17; see Table 3.3). Some articles (*n* = 7; see Table 3.3) focused exclusively on Latina mothers, none had a sample of solely Latino fathers, and four

articles included caregivers, siblings, and extended family members. Eight studies — six of which were based on the same two samples — explored family members' perceptions of adolescent suicidality in their data collection (see Table 3.3).

The family members' level of engagement in the studies ranged from very high to minimal. Two studies, Ford-Paz et al. (2013) and Morgan Cosoli et al. (2012), immersed family members as members of the research team who helped develop and implement prevention efforts. Both these studies described the development of multipronged suicide prevention efforts, which engaged family members' to use primary and secondary suicide prevention strategies.

Other publications directly involving the family were multi-informant projects (*n* = 12; see Table 3.3). Through standardized measurements or interviews, each of the projects collected data from at least one family member. Data commonly collected from the family members were in the form of demographic questionnaires, parent-child mutuality and adolescent-caregiver conflict measurements, family cohesion evaluation scales, and semi-structured parent in-depth interviews. Six of the 12 multi-informant projects called for tertiary prevention efforts. For example, they advocated for “educational and psychotherapeutic interventions” (Hausmann-Stabile et al., 2013, p. 403); utilizing interventions acknowledging that “the daughter who attempted suicide and the mother are both clients” (Szlyk et al., 2019, p. 787); and interventions that promote the participation of mothers in the adolescent's therapy through parenting support and addressing “their own histories of sexual violence” (Szlyk et al., 2019, p. 787). Five of the multi-informant projects drew on their results to advocate for multipronged prevention efforts that combine “individually targeted therapy with the at-risk adolescent with activities that foster positive communication dynamics within the family” (Gulbas et al., 2011, p. 322).

The remaining publications directly involving family members (*n* = 7) used a multi-informant approach, but their focus was on program evaluation. They examined various prevention efforts that involved a family member's participation, such as Life is Precious (Humensky et al., 2013, 2017b), interpersonal psychotherapy for depressed adolescents (Reyes-Portillo et al., 2017), and Familias Unidas (Vidot et al., 2016). The latter two are secondary — interpersonal psychotherapy for depressed adolescents and Familias Unidas — and Life is Precious is a multipronged effort.

## Discussion

Suicide-related research with Latino individuals has clearly expanded, with this review identifying triple the number of publications than Duarté-Vélez and Bernal's review in 2007. Similarly, this article reports on the increase in publications that focus exclusively on Latino adolescents. This study identified 36 such publications compared to the ten identified by Duarté-Vélez and Bernal. Despite this increase, the field continues to direct its attention to etiological studies and lacks with-in group diversity (e.g., gender, nativity, and participants other than the adolescent). Indeed, this scoping study finds that only a few studies (*n* = 8) ask Latino family members directly about suicide and suicidality. Thus, suicide-related prevention efforts involving Latino families remain an emerging field.

Most of the studies reviewed limit Latino family members' involvement to providing demographic information during the data collection phase. Such limited involvement is surprising, considering that most of the publications reviewed continuously note strong correlations between family-related variables and suicidality among Latino adolescents. For example, Adrian et al. (2019) found that as family conflict decreases, the odds of adolescent suicidality may decrease by more than 15%. Results from a sample of Latina adolescents suggest

a 5% and 28% reduction in suicidal ideation for every level of increase in father support and parental support, respectively (De Lucas et al., 2012). Additionally, not considering Latino families' perspective is detrimental as the families' reaction to suicide warning signs has a mediating effect on the individual's suicidality severity and behaviors (Frey & Fulginiti, 2017).

Before discussing the study's implications for future research, it is important to note some limitations. First, no attempt was made to include unpublished work or "gray literature." Therefore, prevention efforts from grassroots and non-for-profit organizations may have been excluded. Many organizations are working towards expanding suicide prevention efforts' reach to Latino communities. The American Foundation for Suicide Prevention is an example of this, as they have begun to translate much of their suicide prevention curriculum and materials into Spanish. Researchers may want to review this gray literature for its efficacy and cultural responsiveness for Latino families and include Spanish literature. Second, the publications were coded by one researcher, thus limiting the ability to compare coding. The author paid careful attention to this and took steps to increase study legitimization, such as continuous consultation with colleagues regarding the codes' definitions and applications and recoding sample subsets to audit their internal coding agreement and refine the coding template.

With these limitations in mind, this study paves important avenues for future research. First, we need to start assessing and asking Latino family members about their suicide literacy and overall perspectives of suicide-related phenomena. Many of the studies reviewed here only ask for the adolescent's viewpoints.

Secondly, we need to pay more attention to the various dimensions of familism and family communication as few publications considered them. While diverse among themselves, Latino populations in the United States tend to emphasize this social structure of family well-

being and cohesion (Sabogal et al., 1987). Regarding familism's relationship to suicide, Valdivieso-Mora et al.'s (2016) study results assert that familism is a mediating factor. Familism reinforces strong bonds of attachment to the family, reliable family support during a crisis or psychological distress, and provides a reason to live, all of which may directly impact Latino adolescents' suicidality.

Along with familism, the family members' cultural views, especially the caregivers' perspectives, related to suicide and mental health may advance or deter their adolescent's suicide-related communication (Frey et al. 2020). For example, if the caregiver holds negative views of mental health issues, they may dismiss it when their adolescent brings up the subject of suicide. This dismissal can create a negative feedback loop of communication and is a missed opportunity to engage in suicide prevention and intervention strategies (Frey et al., 2016). Family members are strategically positioned to provide more emotional support and coping skills than a clinician alone; thus, involving them in suicide-related prevention communication can have a more powerful result in reducing suicidality (Prabhu et al., 2010; Frey & Hunt, 2018).

Thirdly, research needs to move away from focusing on family-related variables in terms of risk. Instead, researchers should acknowledge both their dual roles in the development of suicide. The publications reviewed tended to focus on the former. Perhaps unintentionally, aspects of Latino family dynamics and caregivers were pathologized to establish risk and protective factors. This focus on risk and protective factors may have overlooked Latino families as a locus of suicide prevention.

Nonetheless, the research thus far does acknowledge Latino families' importance in the development and prevention of suicide. Future research can move past mere rhetoric and involve Latino families in suicide-related prevention communication research. Indeed, due to study

limitations such as ethical considerations, time, and setting, it can be challenging to embark on research that involves Latino families. Starting with the problems related to stigma attached to suicide within Latino communities, to the mistrust Latino communities have towards government-affiliated systems, it can seem quite daunting for researchers to design a study with them in mind.

Nevertheless, if scholars in the field of Latino suicide want to move forward, it is our responsibility to find creative ways to engage Latino communities in research. A place to start is primary prevention efforts, which are nearly absent within the literature. These prevention efforts can be standalone or integrated into more extensive multiprong prevention efforts. Nestor et al. (2016) suggest that primary standalone efforts can be large-scale educational campaigns to diffuse cultural stigma regarding suicide and treatment targeting parents. Primary efforts to start the conversation within Latino communities are crucial in increasing service utilization, decreasing stigma, and ultimately preventing suicide (Nestor et al., 2016). Multiprong efforts that include a primary component can follow Weinberger et al.'s (2001) vision of a psycho-educational program for caregivers focusing on suicide warning signs, lethal means restriction, and promoting advocacy work for policies that reduce adolescent suicide risk, all in conjunction with therapeutic support groups.

**Concluding Remarks**

As reflected by the publications reviewed, there is no doubt that Latino families are an untouched potential in our fight against Latino adolescent suicide. Indeed, various limitations and considerations prevent researchers from involving family members — study setting, time, feasibility. Nonetheless, to move the field forward and ethically work with Latino communities, we must try to involve them.

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**Table 3.1**

*Descriptives of Articles Included in the Final Scoping Study Analysis (N = 75)*

| Author | Design | Latino Sample % | Suicidal behavior | Family-related variable [a] | Development [b] | Involvement [c] | Prevention effort [d] |
|---|---|---|---|---|---|---|---|
| Adrian et al. (2019) | Longitudinal | 28% Adolescent & caregiver | A | Yes | Risk | Active | Tertiary |
| Baumann et al. (2010) | Cross-sectional | 80% Female adolescent & mother | A | Yes | Both | Active | Secondary |
| Behnken et al. (2010) | Cross-sectional | 30% Female adolescent | I | No | Risk | None | None |
| Bennett & Joe (2015) | Cross-sectional | 58% Adolescent | A | Yes | Protective | None | None |
| Borges et al. (2013) | Cross-sectional | 32% Adolescent | I | Yes | Risk | None | None |
| Boyas et al. (2019a) | Cross-sectional | 100% Adolescent | I | Yes | Protective | Passive | Multipronged |
| Boyas et al. (2019b) | Cross-sectional | 100% Adolescent | I & A | No | Risk | Passive | Multipronged |
| Cervantes et al. (2014) | Cross-sectional | 100% Adolescent | I | Yes | Risk | None | Tertiary |
| Chang et al. (2020) | Cross-sectional | 100% Adolescent & caregiver | I | Yes | Both | Active | Tertiary |
| Choi et al. (2006) | Cross-sectional | 25% Adolescent | I | Yes | Risk | None | None |
| Craig & McInray (2013) | Cross-sectional | 59% Adolescent | R | Yes | Risk | Passive | Primary |
| Cuellar & Curry (2007) | Cross-sectional | 100% Female adolescent | A | Yes | Risk | None | None |
| De Luca & Wyman (2012) | Cross-sectional | 16% Adolescent | I | No | Protective | Passive | Multipronged |
| De Luca et al. (2012) | Cross-sectional | 100% Adolescent | I | Yes | Both | Passive | Multipronged |
| Eaton et al. (2011) | Cross-sectional | 18% Female adolescent | I | No | Risk | Passive | Secondary |
| Ford-Paz et al. (2013) | Cross-sectional | 100% Adolescent, caregiver, & other adults | R | Yes | Risk | Active | Multipronged |
| Garcia et al. (2008) | Cross-sectional | 100% Adolescent | I | Yes | Protective | Passive | Secondary |
| Garnett et al. (2014) | Cross-sectional | 29% Adolescent | I | Yes | Risk | None | None |
| Gattamorta et al. (2019) | Cross-sectional | 38% Adolescent | I | No | Both | None | None |
| Gulbas & Zayas (2015) | Cross-sectional | 100% Female adolescent & caregiver | A | Yes | Both | Active | Multipronged |
| Gulbas et al. (2011) | Cross-sectional | 100% Female adolescent & caregiver | A | Yes | Both | Active | Multipronged |
| Gulbas et al. (2015) | Cross-sectional | 100% Female adolescent | A | Yes | Risk | None | None |
| Gulbas et al. (2019) | Cross-sectional | 100% Female adolescent | A | Yes | Risk | None | None |
| Hall et al. (2018) | Cross-sectional | 100% Adolescent | A | Yes | Risk | Passive | Multipronged |

| Author | Design | Latino Sample % | Suicidal behavior | Family-related variable [a] | Development [b] | Involvement [c] | Prevention effort [d] |
|---|---|---|---|---|---|---|---|
| Hausmann-Stabile et al. (2012) | Cross-sectional | 100% Female adolescent | A | Yes | Risk | None | None |
| Hausmann-Stabile et al. (2013) | Cross-sectional | 100% Adolescent & caregiver | A | Yes | Risk | Active | Tertiary |
| Hausmann-Stabile et al. (2018) | Cross-sectional | 100% Female adolescent | A | Yes | Protective | Passive | Tertiary |
| Henry et al. (2014) | Cross-sectional | 36% Adolescent | I | No | Both | Passive | Tertiary |
| Hill et al. (2018) | Cross-sectional | 52% Adolescent | I | Yes | Risk | Passive | Tertiary |
| Hill et al. (2019) | Cross-sectional | 38% Adolescent | I | Yes | Risk | Passive | Secondary |
| Humensky et al. (2013) | Longitudinal | 100% Female adolescent & mother | A | Yes | Risk | Active | Multipronged |
| Humensky et al. (2017a) | Cross-sectional | 100% Female adolescent & mother | R | Yes | Risk | Active | Multipronged |
| Humensky et al. (2017b) | Longitudinal | 100% Female adolescent & mother | I | Yes | Risk | Active | Multipronged |
| Kaminiski et al. (2010) | Cross-sectional | 44% Adolescent | I | Yes | Protective | Passive | Secondary |
| Kuhlberg et al. (2010) | Cross-sectional | 100% Female adolescent | A | Yes | Both | Passive | Multipronged |
| Lardier et al. (2017) | Cross-sectional | 100% Adolescent | I | Yes | Protective | Passive | Secondary |
| Lensch et al. (2019) | Longitudinal | 29% Adolescent | I | Yes | Protective | Passive | Secondary |
| LeVasseur et al. (2013) | Cross-sectional | 34% Adolescent | A | No | Protective | None | None |
| Li & Shi (2018) | Cross-sectional | 29% Adolescent | I & A | No | Protective | Passive | None |
| Morgan Consoli et al. (2012) | Longitudinal | 100% Adolescent & caregiver | R | Yes | Protective | Active | Multipronged |
| Nestor et al. (2016) | Cross-sectional | 21% Adolescent | I & A | Yes | Both | Passive | Primary |
| Nolle et al. (2012) | Cross-sectional | 100% Female adolescent & caregiver | A | Yes | Both | Active | Tertiary |
| O'Donnell et al. (2003) | Cross-sectional | 23% Adolescent | I | Yes | Both | Passive | Multipronged |
| O'Donnell et al. (2004) | Cross-sectional | 17% Adolescent | I | Yes | Both | Passive | Multipronged |
| Olvera (2001) | Cross-sectional | 56% Adolescent | I | Yes | Risk | Passive | Tertiary |
| Ortin et al. (2018) | Cross-sectional | 67% Adolescent & caregiver | I | Yes | Risk | Active | Tertiary |
| Peña et al. (2008) | Cross-sectional | 100% Adolescent & caregiver | A | Yes | Both | None | None |
| Peña et al. (2011) | Cross-sectional | 100% Adolescent | A | Yes | Both | Passive | Tertiary |
| Perez et al. (2016) | Longitudinal | 15% Adolescent | A | Yes | Risk | Passive | Secondary |

| Author | Design | Latino Sample % | Suicidal behavior | Family-related variable [a] | Development [b] | Involvement [c] | Prevention effort [d] |
|---|---|---|---|---|---|---|---|
| Piña-Watson et al. (2014) | Cross-sectional | 100% Female adolescent | I | Yes | Both | Passive | Multipronged |
| Piña-Watson et al. (2015) | Cross-sectional | 100% Adolescent | I | Yes | Risk | None | None |
| Piña-Watson et al. (2019) | Cross-sectional | 100% Adolescent | I & A | Yes | Protective | Passive | Secondary |
| Price & Khubchandani (2017) | Cross-sectional | 100% Female adolescent | I & A | No | Risk | Passive | Primary |
| Rapp et al. (2017) | Cross-sectional | 26% Adolescent | I | Yes | Both | Passive | Multipronged |
| Rew et al. (2016) | Longitudinal | 51% Adolescent | I | No | Risk | None | None |
| Reyes-Portillo et al. | Longitudinal | 100% Adolescent & caregiver | I | Yes | Risk | Active | Secondary |
| Roberts et al. (2007) | Cross-sectional | 28% Adolescent & caregiver | A | Yes | Risk | None | None |
| Romero et al. (2013) | Cross-sectional | 100% Female adolescent | I & A | No | Risk | None | None |
| Rotheram-Borus et al. (2000) | Longitudinal | 89% Female adolescent & mother | I & A | Yes | Risk | Active | Tertiary |
| Sheftall et al. (2013) | Cross-sectional | 68% Adolescent & caregiver | A | Yes | Risk | Active | Tertiary |
| Szlyk et al. (2019) | Cross-sectional | 100% Female adolescent & mother | A | Yes | Risk | Active | Tertiary |
| Tapia et al. (2016) | Longitudinal | 75% Adolescent | I | No | Risk | None | None |
| Thompson & Swartout (2018) | Longitudinal | 17% Adolescent | A | Yes | Risk | None | None |
| Tobler et al. (2013) | Longitudinal | 32% Adolescent | I | Yes | Risk | None | None |
| Turner et al. (2002) | Cross-sectional | 100% Female adolescent | A | Yes | Both | Passive | Multipronged |
| Vidot et al. (2016) | Longitudinal | 100% Adolescent & caregiver | I & A | Yes | Both | Active | Secondary |
| Weignberger et al. (2001) | Cross-sectional | 39% Adolescent, caregiver, & other adults | D | Yes | Risk | Active | Multipronged |
| Werenko et al. (2000) | Cross-sectional | 45% Adolescent, caregiver, & other adults | D | Yes | Risk | Active | Multipronged |
| Whaling & Sharkey (2019) | Cross-sectional | 50% Adolescent | I | Yes | Risk | Passive | Secondary |
| Winterrowd & Canetto (2013) | Longitudinal | 59% Adolescent | I & A | Yes | Risk | None | Secondary |
| Winterrowd et al. (2010) | Cross-sectional | 100% Adolescent | I & A | Yes | Both | None | None |

| Author | Design | Latino Sample % | Suicidal behavior | Family-related variable [a] | Development [b] | Involvement [c] | Prevention effort [d] |
|---|---|---|---|---|---|---|---|
| Winterrowd et al. (2011) | Cross-sectional | 52% Adolescent | I & A | Yes | Protective | None | None |
| Yen-Chi et al. (2011) | Cross-sectional | 33% Female adolescent | I | No | Both | None | None |
| Zayas et al. (2009) | Cross-sectional | 100% Female adolescent & mother | A | Yes | Both | Active | Multipronged |
| Zayas et al. (2010) | Cross-sectional | 100% Female adolescent | A | Yes | Risk | None | None |

*Note.* A = Suicide attempt was measured; I = Suicide ideation was measured; D = Suicide death was measured; R = Suicide risk was measured.
[a] Refers to whether the article includes a family-related variable in their analysis. [b] Refers to how the article depicts the family in the development of suicide and suicidality. Options include risk, protective, or both risk and protective. [c] Refers to how the article involves the family in its study design. Options include active, passive, and both active and passive. [d] Is based on Leavell and Clark's prevention classification levels and refers to the prevention level at which the family could be engaged at as suggested by the article. Options include tertiary, secondary, primary, and multipronged.

**Table 3.2**

*Family-Related Variables Identified in the Scoping Study Analysis*

| Family-related variable | Description |
|---|---|
| Caregiver(s): | |
| Nativity | The country where the adolescent's caregiver was born. |
| Language | The primary language spoken by the adolescent's caregiver. |
| Religion | The religion reported by the adolescent's caregiver. |
| Highest level of education | The highest educational grade or degree obtained by the adolescent's caregiver. |
| Acculturation / Acculturation gap | The differences between adolescent and caregivers' level of adaptation and involvement in the culture of origin compared to the new host culture. |
| Psychopathology | Whether the adolescent's caregiver is diagnosed with a mental health disorder or endorsement of psychiatric symptoms that meet criterion for a mental health disorder. |
| Family: | |
| Flexibility | How the family members experience and cope with changes includes negotiation styles, leadership (i.e., discipline and control), role relationships, and relationship rules. |
| Cohesion | The emotional bonding between family members includes the expression of support, caring, belonging, and acceptance within the family. |
| Communication | The extent to which family members can share their needs, feelings, concerns, and preferences with each other. |
| Structure | The caregivers that the adolescent lives with, (e.g., mother, stepmother, father, stepfather, another relative) and these adults relationship status (e.g., married, cohabitating). |
| Violence | Exposure (witness or recipient) to violence (verbal, physical, or sexual) within the home. |
| Attachment | The type of attachment (secure versus insecure) the adolescent has with their caregiver. |
| Socioeconomic status | The family's economic position can be based on their household income, government assistance received, or neighborhood poverty level. |
| Caregiver-child relationship | How connected and attune the adolescent and their caregiver(s) feel with each other. |
| Familism | The values that place a high emphasis on the family unit and familial support by prioritizing a strong alliance and obligation to the family. |

| Family-related variable | Description |
|---|---|
| Immigration stress | Stress felt by an adolescent due to immigration-related disruptions in family, issues related to family member's immigration-status, or immigration-based discrimination. |
| Parental monitoring | The extent to which the caregivers monitor the adolescents' daily behaviors (e.g., whereabouts, friends, and activities). |
| Mental health stigma | A families cultural context where the expression of emotions and professional help seeking for distress is frowned upon. |
| Perceptions of suicide | The family members beliefs and attitudes related to suicide and its prevention. |

**Table 3.3**

*Summary of Articles Directly Involving the Family (n = 21)*

| Author | Family member | Family-related variable | Research process involvement [a] |
|---|---|---|---|
| Adrian et al. (2019) | P | Caregiver psychopathology; Family cohesion | Intervention & data collection |
| Baumann et al. (2010) | M | Acculturation gap; Mother-daughter relationship; Familism | Data collection |
| Chang et al. (2020) | C | Family cohesion | Data collection |
| Ford-Paz et al. (2013) | C | Socio-demographics; Acculturation gap; Family cohesion; Familism; Mental health stigma; Perception of suicide | All aspects |
| Gulbas & Zayas (2015) | P | Acculturation gap; Family cohesion, flexibility, & communication; Family violence; Perceptions of suicide | Data collection |
| Gulbas et al. (2011) | P | Family cohesion, flexibility, & communication; Familism; Perception of suicide | Data collection |
| Hausmann-Stabile et al. (2013) | P | Socio-demographics; Family flexibility; Familism; Family violence | Data collection |
| Humensky et al. (2013) | M | Socio-demographics; Acculturation gap; Family flexibility & communication; Mother-daughter relationship; Familism; Perception of suicide | Intervention & data collection |
| Humensky et al. (2017a) | M | Family cohesion; Mother-daughter relationship; Perception of suicide | Intervention & data collection |
| Humensky et al. (2017b) | M | Acculturation gap; Family cohesion & flexibility; Mother-daughter relationship: Immigration stress; Perception of suicide | Intervention & data collection |
| Morgan Consoli et al. (2012) | P | Socio-demographics; Family communication; Parent-child relationship | All aspects |
| Nolle et al. (2012) | P | Family flexibility; Familism; Perceptions of suicide | Data collection |
| Ortin et al. (2018) | P | Socio-demographics; Acculturation gap | Data collection |
| Reyes-Portillo et al. (2017) | P | Family cohesion | Intervention & data collection |
| Rotheram-Borus et al. (2000) | M | Socio-demographics; Caregiver psychopathology; Family cohesion & flexibility | Intervention & data collection |
| Sheftall et al. (2013) | P | Family cohesion & flexibility; Familial attachment | Data collection |
| Szlyk et al. (2019) | M | Family cohesion; Mother-daughter relationship; Perception of suicide | Data collection |
| Vidot et al. (2016) | P | Family cohesion, flexibility, & communication | Intervention & data collection |
| Weignberger et al. (2001) | C | Family cohesion | Data collection |
| Werenko et al. (2000) | C | Family cohesion & flexibility | Data collection |
| Zayas et al. (2009) | M | Socio-demographics; Acculturation gap; Family cohesion, flexibility, & communication; Familism | Data collection |

*Note.* P = Parent; M = Mother; C = Caregiver.

[a] Refers to the part of the research process that the study engaged and involved the family members.

# CHAPTER 4

# LATINO CAREGIVER'S SUICIDE-RELATED PREVENTION COMMUNICATION LITERACY, INVOLVEMENT, AND SELF-EFFICACY [1]

[1] Villarreal-Otálora, T. This chapter will be divided into two articles: (1) "Latino caregiver's suicide-related prevention communication literacy, concern, and involvement" to be submitted to *Death Studies;* and (2) "Correlates of Latino caregiver suicide prevention communication self-efficacy with their adolescents" to be submitted to *Suicide and Life-Threating Behavior.* (Other contributors to this article, such as dissertation committee members, are to be added at a later date).

## Abstract

As suicide continues to be a leading cause of death for Latino adolescents in the United States, their caregivers are strategically positioned to be leaders in its prevention. However, little is known regarding Latino caregivers' suicide literacy and suicide-related prevention communication (SPC) self-efficacy. **Aim**. The purpose of this study was to describe Latino caregivers' knowledge, engagement, and self-efficacy beliefs about Latino adolescent suicide and its prevention. **Methods**. A cross-sectional online survey designed was used ($N$ = 133). Participants were first-generation Latino caregivers living in a new destination state, and most were females in their early 40s. Descriptive statistics were used to report participants' suicide literacy, concern, desire, reinforcement, and prevention strategies. A multiple regression examined the Latino caregiver's suicide prevention-related factors (suicide literacy and suicide prevention reinforcement), family and cultural factors (familism, caregiver-adolescent communication, and acculturation), and socio-demographic (income and years in the United States) variables' associations to their SPC self-efficacy. **Results**. Nearly all the participants reported being concerned about suicide among adolescents, but only 23% had heard of a suicide prevention program (i.e., reinforcement). Most participants scored well below average on suicide literacy and reported moderate-to-high SPC self-efficacy. The multiple regression revealed that suicide prevention reinforcement, familism, and income were significantly associated with the Latino caregiver's SPC self-efficacy. **Conclusions**. The findings begin to provide a baseline of Latino caregivers' SPC, paving multiple avenues for practice and future research. Most importantly, the results suggest that Latino caregivers want to be involved in preventing suicide among their adolescents but lack the support and knowledge to do so.


**Keywords:** Latino, caregivers, adolescent, suicide, prevention, self-efficacy.

## Introduction

Two decades have passed since the Surgeon General's Call to Action to Prevent Suicide (Office of the Surgeon General, 2021). While the research field now knows more about this complex phenomenon's etiology and prevention, suicidality and suicide remain severe and growing problems among adolescents. Given these problems, it is no surprise that the most recent Surgeon General's Call to Action identified the empowering of families and communities as a vital tool for the direction of suicide prevention. Such empowerment is crucial as most suicide deaths among adolescents occur in or around their homes (Weinberger et al., 2001). Nearly 20% of adolescents who die by suicide express suicide warning signs such as isolating or talking about killing oneself to family members before the fatal attempt (Weinberger et al., 2001). Thus, families are strategically positioned to address all suicide prevention levels, ranging from primary to tertiary (Leavell & Clark, 1965). So much so that a standard component of successful suicide prevention programs among adolescents, while varying in modality and level, includes family (Brent, 2013). For example, brief interventions that focus on enhancing family engagement and behavioral changes through increasing suicide literacy (i.e., knowledge and beliefs about suicide) and family support are associated with reducing suicide risk across adolescence and well into early adulthood (Connell et al., 2016). Other study findings suggest that caregivers can assist with removing or withholding access to lethal means, responding to suicide warning signs, engaging in risk monitoring, connecting their adolescent to services, and providing emotional support to their adolescent (Dueweke & Bridges, 2016; King et al., 2013).

All the efforts mentioned above are critical suicide-related prevention strategies contingent on the caregiver's suicide literacy, suicide perceptions, and suicide-related prevention communication (SPC) self-efficacy (Czyz et al., 2018). Currently, only one study by Czyz et al.

(2018) focuses on exploring SPC self-efficacy among caregivers. That study explored SPC self-efficacy based on life experiences (or lack thereof) among, predominantly, Caucasian adolescents suicide attempters and their parents in an emergency room setting. As of this writing, no studies focus on examining SPC self-efficacy among Latino caregivers and much less on the factors that may drive it. Thus, this quantitative portion of a more extensive mixed method study draws on a Latino caregiver sample to explore their knowledge, engagement, and self-efficacy beliefs about Latino adolescent suicide and its prevention.

**Literature Review**

Infusing caregivers in SPC has long-lasting effects on decreasing suicide risk (Brent, 2016). This infusion is especially salient for Latino individuals (Villarreal-Otálora et al., 2019; Vidot et al., 2016) as familism (i.e., focusing on family cohesion; Calzada et al., 2012) tends to be a core value guiding caregiver's decisions and behaviors. This value is also a protective factor against suicide, reinforcing strong family attachment bonds, providing reliable family support during a crisis or psychological distress, and offering a reason to live for Latino adolescents (see Chapter 3; Valdivieso-Mora et al., 2016). Inversely familism has been linked to an increase in suicide risk (see Chapter 3). For example, Latino caregivers may suggest that their Latino adolescent's mental health issues burden the family, inadvertently propelling adolescents to attempt suicide to relieve that burden. Additionally, familism may reinforce a script of silence among family members. For example, Latino caregivers may avoid this taboo subject with their adolescents and ignore warning signs to maintain family cohesion and balance.

The relationship quality that Latino caregivers have with their adolescents is also an influential factor in SPC (see Chapter 3). Specifically, family dynamics, such as communication level, cohesion, and flexibility, influence family members' behaviors (Olson et al., 1983). Also,

research findings suggest that caregiver-adolescent dynamics mediate suicide risk (Piña-Watson et al., 2019). Thus, whether a Latino caregiver feels and can respond effectively to suicide warning signs with their adolescent may be related to the level of communication with that child.

In addition to their relationship with their adolescent, knowledge may also influence Latino caregivers' SPC. For example, studies suggest that the knowledge and perceptions about emotional and psychological problems of Latino caregivers significantly impact whether their Latino adolescent seeks, accesses, and receives help for suicidality (Dueweke & Bridges, 2016; Martinez Tyson et al., 2016). If caregivers are unaware of the problem, they will be unlikely to acknowledge the need to engage in suicide prevention strategies, such as providing emotional support or connecting them to mental health services (Alegría et al., 2004).

Nevertheless, knowledge, by itself, may not translate into action. Even when a caregiver cognitively knows the warning signs for an emotional and behavioral problem, such as suicidality, they may lack a belief in their capabilities to engage in prevention strategies and believe those strategies to be ineffective (i.e., SPC self-efficacy; Czyz et al., 2018). For Latino caregivers, their SPC self-efficacy may be especially vulnerable due to negative cultural meanings relating to suicide and multiple stressors — such as poverty and immigration stress — impacting their daily lives and behaviors. These factors may decrease the caregiver's SPC self-efficacy and engagement.

**The Social Cognitive Theory and Suicide-Related Prevention Communication**

The social cognitive theory (SCT; Bandura, 1977) asserts that individuals are more likely to engage in the desired behavior if they have a firm conviction that they can successfully execute the behaviors required to reach it. This conviction is referred to as self-efficacy, which is shaped by a combination of (1) personal (i.e., socio-demographics, previous experiences, and

norms and values); (2) environmental (i.e., the social and physical environment, observational learning, and social support and reinforcements); and (3) behaviors factors (i.e., self-observation, self-behavioral appraisal, and self-judgment). Applying this theory to Latino caregivers, the cultural value of familism, cultural meanings of suicide, and socio-demographics (e.g., religion and acculturation) may influence their SPC self-efficacy. Environmental factors that may influence a Latino caregiver's SPC may include suicide prevention reinforcements such as previous exposure to suicide prevention programs and family communication. For example, the findings of Czyz et al. (2018) suggest that caregivers whose adolescents had attempted suicide felt more confident directly asking their child about suicidal thoughts after receiving professional help. Lastly, behavioral factors could include appraising SPC as desirable behaviors and previous experience with suicidality or the mental health system.

It is important to note that self-efficacy's development and operation are also influenced by various socio-cultural dimensions, such as socioeconomic status (SES) and cultural embedment (Bandura, 2001; Jones & Prinz, 2015; Jurecska et al., 2011; Klassen, 2004). For example, for individuals who assert a more collectivistic viewpoint, family and group-related factors tend to increase their self-efficacy. For caregivers, many times, their self-efficacy is influenced by SES as economic hardship and instability may lead to feelings of helplessness that may serve to decrease their self-efficacy (Jones & Prinz, 2015).

**Lack of Suicide Prevention Research Involving Latino Caregivers**

Despite Latino caregivers' potential role in preventing suicide, Latino families are underrepresented in suicide prevention research (see Chapter 3). Historically, they are thought of as a "hard-to-reach" population, and because of this, they are often under-sampled or excluded altogether from the research. When included, they tend to be from states that traditionally host

Latino immigrants, such as New York or Southwestern border states. Suicide prevention research with Latino families residing in new destination states is anemic. This absence is alarming as Latino families in new destination states have limited access to support systems, networks, and resources (Terrazas, 2011). Moreover, due to the increase in Latinos many new destination states have implemented exclusionary immigration-policies. These policies create an environment where Latino families are faced even higher mental and economic stress than those living in more inclusive immigration-policy climates (Hatzenbuehler et al., 2017).

**Study Context**

This manuscript reports on the survey portion of a larger mixed method development study conducted in the new destination state of Georgia (United States). This state has seen a significant increase in both its Latino population and deaths by suicide (Flores et al., 2017; Georgia Suicide Death Statistics, 2021). For example, since 2000, Georgia has seen an increase in its Latino populations by more than 100%, an extension projected to continue (Flores, 2017). In terms of suicide within the state, Georgia has seen a significant increase in suicide deaths since the mid-90s (Georgia Suicide Death Statistics, 2021). Moreover, it is ranked sixth for child suicide deaths in mainland United States (Price & Khubchandani, 2021).

**Study Purpose**

The absence and exclusion of Latino families from suicide prevention research, especially in new destination states, leaves many questions regarding their suicide literacy, suicide perceptions, and SPC self-efficacy. This study aims to address those questions by exploring literacy, desire, and self-efficacy beliefs about Latino adolescent suicide and its prevention among Latino caregivers. Based on this aim, the following research questions guided the study:

1. What do Latino caregivers know about suicide and its prevention?
2. To what extent do Latino caregivers perceive themselves as being able to engage in SPC?
3. How does SPC self-efficacy vary by socio-demographics, familism, caregiver-adolescent communication, cultural sanctions around suicide, exposure to suicide prevention programs, and experience with adolescent suicidal behaviors and the mental health system among Latino caregivers?

## Methods

This study was part of a more extensive integrated mixed method development project that the Institutional Review Board approved at the researcher's home university. The more extensive study sequentially employed quantitative and qualitative data collection strategies to explore, describe, and extend our understanding of the factors associated with caregiver's self-efficacy and engagement in Latino adolescent SPC among a sample of Latino caregivers living in Georgia — a new destination state with an exclusionary immigration-policy climate. This manuscript reports on the quantitative portion of the project, which utilized a cross-sectional online survey design.

The sample for this manuscript consisted of 133 Latino immigrant caregivers. To be eligible for the study, caregivers had to: (a) self-identify as Hispanic or Latino, (b) live in the state of Georgia (United States), and (c) have an adolescent between the ages of 13 to 18 living in Georgia. Potential participants were excluded if they reported having had a child die by suicide as the survey questions could induce guilt and unnecessary emotional distress

### Procedures

Using a non-probability snowball sampling method, over ten weeks, the author recruited participants for the survey through a multi-strategy three-phase process: (1) community

gatekeeper recruitment; (2) responsive-driven advertisement; and (3) flyers at Latino public-serving sites. Multi-strategy recruitment is an effective strategy to recruit harder to reach, vulnerable, and otherwise underserved populations (Delgado-Romero et al., 2018; Haack et al., 2014; Kayrouz et al., 2016). Dividing the strategy into three phases allowed the author to assess which strategies yielded more participation systematically.

In phase one, the author invited gatekeepers in frequent contact with Latino families via emails and SMSs, to assist with study recruitment. These gatekeepers included directors and staff members at primarily Latino serving agencies and institutions, church leaders, and Latino individuals actively involved within the community. Gatekeepers that agreed to participate were provided with a unique eligibility survey link to pass on to possible participants, a recruitment script, and study flyers. The author sent gatekeepers a study email update in the form of a flyer. The flyer included a thank you, encouragement to continue disseminating the study, and an update on the overall number of completed study surveys gathered thus far. After four weeks, the author launched phase two, recruiting through Facebook and WhatsApp groups for Latino individuals and suicide prevention. The posts were uploaded three times a week and had a unique eligibility survey link, the sample size thus far, and encouragement for further participation. One month before the survey's closing, the author launched phase three: posting study flyers in Latino public-serving sites with a unique eligibility survey link.

The eligibility survey contained an embedded video of the researcher introducing themselves and briefly describing the purpose of the eligibility survey, the study, and confidentiality. Potential participants had the opportunity to enroll in a raffle to win one of four $15 Amazon e-gift cards for completing the eligibility survey. Within 24 hours of completing the eligibility survey, participants who met eligibility criteria were sent the study survey link via

email and short message services (SMS). Study purpose, risk, benefits, and confidentiality were described on the study survey's first page. Participants could watch a video or read the informed consent information. They consented to participate by selecting “I agree to participate” on the forced response question and clicking next to proceed to the survey. For completing the study survey, individuals were provided with a $15 Amazon e-gift card.

Following the above-stated procedures, 746 potential participants were reached, of whom 318 met eligibility criteria. The final sample consisted of 133 participants, all of whom opted to take the survey in Spanish. Nearly half (47%; $n = 63$) heard from friends or family members about the study. Phase two of the three recruitment phases — Facebook and WhatsApp groups — yielded the most participants (50%; $n = 67$). Onsite flyers, phase three, yielded the least (3%; $n = 4$). There were no statistically significant differences in socio-demographic characteristics of participants between those recruited via the three phases.

**Measures**

All study material was translated to Spanish using a conceptual translation approach and verified using a back-translation process (Knight et al., 2009). Discrepancies were resolved by adjusting the original English-language measurement. Both the eligibility and study surveys were piloted among 12 Latino caregivers living in the United States. Feedback from the pilot was used to assess the survey questions' content clarity and face validity. Cronbach’s alpha values were calculated to determine measurements’ reliability (Bland & Altman, 1997; see Table 4.1). General acceptance for the alpha value is a minimum of .70 (Nunnally, 1978).

The study survey had a Flesch-Kincaid Grade Level Readability of 6.3, meaning that the survey read at a sixth-grade reading level (Kincaid et al., 1988). It included several family-related factors identified in the literature as having the potential to prevent suicide among Latino

adolescents (see Chapter 3), as well as factors that may promote and deter caregiver self-efficacy. See Appendix C for the Spanish and English versions of the survey. The survey also included security measurements to prevent fraudulent responses: reCAPTCHA and unique survey link manually sent to the phone number or email address provided on the eligibility screener. To assist with identifying possible fraudulent responses that got past the security measurements, embedded within the survey were several quality checks — IP addresses, survey time, asking questions twice using different language, and option choices.

Before describing the study measures in more detail, it is essential to note that the author collapsed all response categories with less than 10% to address low cell distributions within all nominal and ordinal variables and ensure participants' confidentiality (NCHS, 1997; Tabachnick & Fidell, 2001). For example, response categories for the nativity variable originally were divided into each of the Latin American countries, but take the case of Chile, only two participants selected it. Thus, during data analysis, the nativity categories were collapsed into South America, Central America, and Mexico.

***Dependent Variable: Suicide-Related Prevention Communication Self-Efficacy***

Research findings suggest that a caregiver's SPC self-efficacy may influence their use of specific SPC strategies (Czyz et al., 2018). The survey adapted Czyz and colleagues' (2018) Parent Self-Efficacy Scale, a nine-item 11-point Likert scale (0 = not at all confident to 10 = completely confident) to measure this construct. The original scale was validated within a sample of 129 caregivers ($\alpha = .87$), most of whom were non-Hispanic Caucasians. To fit the context of the study, the word "child" was changed to "adolescent" on the scale items. Since the original scale omitted empirically supported statements regarding the caregiver's self-efficacy with lethal means restriction (Zalsman et al., 2016), the researcher added two items to the scale. These items

asked about a caregiver's self-efficacy with lethal means restriction. The modified scale demonstrated a high internal consistency ($\alpha = .89$) among this study's sample.

### *Independent Variables*

**Suicide Prevention Independent Variables.** Three suicide prevention independent variables were measured: (1) **literacy**, (2) **observational learning**, and (3) **reinforcement**. Suicide **literacy** refers to knowledge regarding suicide risk factors, causes, warning signs, coping skills, and prevention. Previous research findings suggest that an individual's suicide literacy influences their engagement in SPC (Dueweke & Bridges, 2017; Gryglewicz et al., 2018). Thus, the researcher modified Batterham et al.'s (2013) Literacy of Suicide Scale (LOSS) short version to measure this construct. The LOSS scale covers four suicide-related literacy themes: (1) treatment and prevention, (2) cause and nature of suicide, and (3) signs and symptoms of suicidality. It is validated for use among various ethnic adult populations and has demonstrated high internal consistency (Dueweke & Bridges, 2017; Han et al., 2017). The researcher adapted the scale to focus on literacy regarding suicide among Latino adolescent populations. First, the word "people" on the scale items was changed to "adolescents." For example, instead of the question being "people who talk about suicide rarely kill themselves," it was changed to "adolescents who talk about suicide rarely kill themselves." During the piloting of the survey, individuals stated that the following question, "a suicidal person will always be suicidal and entertain thoughts of suicide," was too difficult to comprehend and suggested the item be changed to "adolescent suicide is preventable." The adapted scale contains eight true/false items and provides a total literacy score, the percentage correct (0 to 100), with higher scores indicating higher suicide literacy (Calear et al., 2021).

Per the SCT, in addition to knowledge, there are environmental factors that shape desired behaviors. Two of these factors are observing others engage in the desired behavior (i.e., **observational learning**) and having social reinforcements (i.e., **reinforcement**). Adolescent suicidality was used as a proxy for observational learning. Specifically, the survey asked caregivers if their adolescents ever struggled with suicidality. For the analysis, the categories were dichotomized as 1 = yes and 0 = no and not sure. To examine reinforcement, the author also used a dichotomized item: "Have you heard about any suicide prevention programs in your community?" Answer choices were 1 = yes and 0 = no.

**Additional Independent Variables.** Consistent with the SCT, the research looked at the family environment, specifically caregiver-adolescent communication, related to SPC self-efficacy. **Caregiver-adolescent communication** refers to the quality of communication as reported by the caregiver. Research indicates that caregiver-adolescent communication is strongly related to suicidality among Latina teenagers (Gulbas et al., 2011) and impacts various mental health outcomes among adolescents (Kuhlber et al., 2010). Most importantly, the communication patterns between adolescents and caregivers may impact the caregivers' engagement in specific SPC strategies. To measure caregiver-adolescent communication, the researcher included Barnes and Olson's (1985) Parent-Adolescent's Open Family Communication scale (PA-OCF) in the survey. PA-OCF consists of ten Likert items (1 = strongly disagree to 5 = strongly agree) that measure the level of open expression and understanding in caregiver-adolescent interaction. Previous studies have used the scale with various Latino populations and reported strong coefficient alphas around .82 (Rotheram-Borus et al., 2000; Vidot et al., 2016). The PA-OCF exhibited good internal reliability in the present sample ($\alpha = .83$).

The author also included cultural sanctions, which may influence the caregiver's SPC self-efficacy. Specifically, the Cultural Assessment of Risk for Suicide's **Cultural Sanctions** subscale was used to explore the participant's familial and cultural views about the acceptability of suicide. This subscale includes four Likert style questions (1 = strongly disagree to 7 = strongly agree). The subscale was developed and tested with minoritized adults (Chu et al., 2013). In this study's sample, the subscale demonstrated a lower Cronbach's alpha value of .59 than the original subscale (α = .65; Chu et al., 2013). Upon further investigation, the researcher found that the subscale's internal consistency within this study's sample drastically varied by nativity: Mexico α = .60; Central America α = .44; and South America α = .46. Moreover, when examining each item, one item's low correlations (.23, .11, and .07) stood out. This item read as follows, "Suicide would bring shame to my family." When that item was dropped, the subscale's internal consistency continued below a .60; thus, the item was retained.

Lastly, the author included **familism** as a personal factor that may influence a Latino caregiver's SPC self-efficacy. The researcher included the Spanish version of Villarreal et al. (2005) 5-item Pan-Hispanic Familism Scale in the survey to measure attitudinal familism. This 5-point Likert scale was validated in Spanish with Latino adults across various nativities living in the United States (α = .82; Villarreal et al., 2005). Per the coefficient alpha, the internal consistency for this sample was strong (α = .88).

***Descriptive Variables***

**Socio-Demographic Variables.** The sociodemographic questionnaire gathered information on participants: gender (0 = male, 1 = female); age; nativity (0 = Mexico, 1 = Central America, 2 = South America); marital status (0 = single, 1 = living with spouse or partner); education (0 = elementary or middle school, 1 = high school degree/ some college, 2 =

post-secondary/ vocational degree); household income (0 = less than 15000, 1 = 15000–35000, 2 = 35001–55000, 3 = more than 55001, 4 = preferred not to answer); years in the United States; religious orientation (0 = none, 1 = Catholic, 2 = other Christian or non-Christian denomination); religiosity; and acculturation. Language preference was used as a proxy for acculturation (Marin et al., 1987). Specifically, caregivers were asked to indicate what language they preferred to read and speak. The response choices were rated on a 5-point scale ranging from 1 = only Spanish to 5 = only English. Two items were averaged — (1) how important their religious beliefs are in their life and (2) how often they participate in religious activities — to create the religiosity measure. Caregivers answered both items using a 5-point Likert scale with higher values indicating more importance and more participation. The overall Cronbach's alpha for this variable was .77 in the present study. Also, the questionnaire asked caregivers to report their adolescent(s)' age, gender, and nativity.

**Suicide Concern and Desire to Participate in Prevention.** The researcher created a single-item question to gauge the caregiver's level of **concern** regarding Latino adolescent suicide. This question read as follows: "Are you worried about suicide among Hispanic/Latino adolescents in the United States?" Caregivers' answered the question on a 4-point Likert scale (No, not at all; Yes, a little; Yes, somewhat; Yes, a lot). Similar to the concern variable, **desire** was assessed using a single-item measure as well. The survey asked caregivers if they would participate in a suicide prevention program if presented with the chance. The response categories for desire were dichotomized to 1 = yes and 0 = no/maybe for the analysis.

**Perceived Cause of Suicide.** Caregivers were provided with a multiple-choice item to gauge their perceptions of what causes suicide within Latino adolescents. The item asked caregivers to select all the reasons why a Latino adolescent may take their own life. This item's

response options were based on previous literature regarding family's role in the development of suicide and their perceptions of suicide (see Chapter 3; Schwartz et al., 2010): (a) depression; (b) a family death; (c) to get attention; and (d) multiple reasons that converge.

**Suicide Prevention Strategies.** A multiple-choice item was used to obtain a baseline regarding the suicide prevention strategies a caregiver would use. Specifically, caregivers were asked, "If a Hispanic/Latino adolescent is thinking about suicide, what can you do to help them?" They were instructed to select all that they would do. Possible selections included: (a) seek help; (b) talk to the adolescent; (c) if not my child, talk to the adolescent's parent(s); (d) be on the lookout for suicide warning signs; and (e) ask the adolescent if they are having thoughts about suicide.

## Data Analysis

Stata version 17 (StataCorp, 2017) assisted in the data cleaning and analysis. After importing the data into Stata, the researcher examined the participants' IP addresses, emails, phone numbers, survey completion time, and responses to repeated and attention-getting questions to identify and remove fraudulent responses. Once the data was clean, frequencies and descriptive statistics were calculated for study variables. Missingness was less than 5% for each variable; because of this, it was handled using Stata's default setting of pair-wise deletion (Tabachnick & Fidell, 2001). Summary statistics were used to report on Latino caregivers' socio-demographic, concern, desire, perceived cause of suicide, prevention strategies, and SPC self-efficacy.

Analysis of variance, correlations, or t-test were used to examine each independent variable's relationships to the dependent variable at the bivariate level. Only the socio-demographic and independent variables that showed an alpha level of .25 or less at the bivariate

level were included in the final multivariate analysis for parsimony and to avoid spurious relationships (Bursac et al., 2008). Due to the study's sensitive nature and the limited information on the target population, it was difficult to estimate the number of needed participants at the onset of the study. Thus, a power analysis using G-power 3.1 was conducted after completing the bivariate analyses (Faul et al., 2009). Based on the results, a sample of 73 participants was suggested for a multiple regression analysis that includes the seven independent variables with an alpha level set to .05, effect size ($f2$) of .15 (medium), and power of .90 (Cohen, 1988; Rubin, 2013).

The final analysis consisted of a multiple regression to predict the correlates of SPC self-efficacy among Latino caregivers. Before running the regression analysis, all assumptions were tested. Outliers and linearity were established by visual inspection of scatterplots. The independence of residuals was assessed and confirmed by a Durbin-Watson statistic of 1.79. To test for the assumption of homoscedasticity, the author ran one visual and two statistical diagnostics, which suggested that the assumption of homoscedasticity was met. The variance inflation factors ($M$ = 1.43) were less than four, indicating no multicollinearity issue. After running the model, a post-hoc power analysis using G-power 3.1 was conducted, which suggested the model had power of .93.

## Results

### Sample Characteristics

Table 4.2 displays the socio-demographic characteristics of the study sample. The total sample size for this study included 133 first-generation Latino caregivers living in the state of Georgia. Most of the participants were females (82%; $n$ = 109), in their early 40s ($SD$ = 7.49; range 28 to 71), and lived with a spouse or partner (71%; $n$ = 96). The participant’s nativity varied among the sample (65% from Mexico, 32% from South America, and 12% from Central

America). There were no participants from Cuba, Dominican Republic, and Puerto Rico. The majority of the participants had: one adolescent child between 13 to 16 years of age (*M* = 15) born in the United States (81%; *n* = 108). Regarding their adolescent's gender, 69% (*n* = 92) of the participants had at least one female child, and 54% (*n* = 72) had at least one male child.

The descriptive statistics for participants' suicide prevention variables are in Tables 4.3 and 4.4. Most participants scored 58 (out of 100) on suicide literacy and reported no previous reinforcement (77%; *n* = 102). Nearly all the participants (89%; *n* = 122) endorsed being concerned about suicide among adolescents, with 41% of the sample rating their concern as "a lot." However, if given the opportunity, a little more than half of the sample (60%; *n* = 80) desired to participate in a suicide prevention program.

In terms of suicide causes, the most endorsed was depression (88%; *n* = 117), and the least was attention-seeking (29%; *n* = 39). If caregivers suspected an adolescent was struggling with suicidal thoughts, most (86%; *n* = 114) endorsed that they would seek help. Less than half of them (40%; *n* = 53) would directly ask the adolescent about their suspicion.

**Bivariate Findings: Latino Caregivers' SPC Self-Efficacy**

On average, participants' SPC self-efficacy was 8.09 (*SD* = 2.87). See Table 4.4 for an item breakdown. The highest ratings were indicated for offering emotional support (*M* = 10.03, *SD* = 2.13) and for assisting their adolescent in accessing treatment (*M* = 9.12, *SD* = 3.20). Alternatively, caregivers' reported relatively low confidence in their ability to respond in a helpful manner if their adolescent disclosed suicidal ideation to them (*M* = 6.37; *SD* = 2.38) and in identifying suicide warning signs in their adolescent (*M* = 6.42, *SD* = 2.99).

**Multivariate Analysis: Correlates of SPC Self-Efficacy**

Table 4.5 presents the results of the final multivariate analysis. This final analysis consisted of a multiple regression model examining SPC self-efficacy among Latino caregivers. The regression included the seven variables that meet the .25 and below threshold at the bivariate level: income, years in the United States, acculturation, suicide literacy, suicide prevention reinforcement, familism, and caregiver-adolescent communication. That model was statistically significant and explained 33% of the variance in SPC self-efficacy among Latino caregivers, $F(11, 113) = 5.07$, $p < .0005$, $R^2 = .3304$. Per Cohen's (1988) standards, the model demonstrated a large effect size ($f^2 = 0.361$).

Of the seven variables included in the model, three added significance: suicide prevention reinforcement ($p < .01$), familism ($p < .01$), and income ($p < .05$). Latino caregivers exposed to a suicide prevention reinforcement and those who endorsed more familism had higher SPC self-efficacy than their counterparts. There was also higher SPC self-efficacy among Latino caregivers whose annual income was between 15,000 to 35,000 compared to those below 14,999.

## Discussion

This study exploring the correlations of SPC self-efficacy among a sample of first-generation Latino immigrant caregivers in a new destination state is the first of its kind, obtaining the perspectives of individuals that have historically been underrepresented in the field of suicide prevention. The findings begin to provide a baseline of Latino caregivers' SPC, ultimately paving multiple avenues for practice implications and future research. Most importantly, the results demonstrate that Latino caregivers are willing to be involved in preventing suicide among their adolescents but lack the support and knowledge to do so. Thus, the findings can guide service providers to deliver that needed support. By obtaining buy-in and

support from those in constant contact with the adolescent client, service providers can collaborate with the caregivers to help prevent suicide among their clients. Lastly, the findings can assist organizations and researchers in developing suicide prevention efforts that empower, involve, and strengthen Latino caregivers' engagement.

Beyond being the first to start measuring SPC among Latino caregivers, this study adds to the existing literature on SPC self-efficacy. As expected, the study finds present similarities and divergences from the few previous related works that focus on caregiver SPC self-efficacy because of the sample's uniqueness. Specifically, similarities emerged in terms of levels of SPC self-efficacy and suicide literacy. Divergences centered around observational learning and caregiver-adolescent communication's relationship with SPC self-efficacy at the multivariate level. Additionally, new insights emerged regarding the strength of influence of cultural and socio-economic factors – such as familism, income, years in the United States, and acculturation – on Latino immigrant caregivers' SPC self-efficacy. The following sections discuss the key findings and their implications for program development and social work practice in more detail.

**Suicide Literacy and Prevention Among Latino Caregivers**

Similar to previous findings with Latino adults and Caucasian populations, this Latino immigrant caregiver sample exhibited alarmingly low levels of suicide literacy (Calear et al., 2021; Dueweke & Bridges, 2016). Most Latino caregivers struggled with suicide literacy related to warning signs or risk factors instead of those related to help-seeking behaviors. Insufficient knowledge regarding suicide warning signs is alarming as some adolescents demonstrate such signs before a suicide attempt (Weinberger et al., 2001); thus, recognizing them could save lives.

To propel learning regarding common suicide warning signs, we must first tackle suicide and mental health stigma. Despite previous research showing the stigmatization of suicidality

among Latino immigrants and underutilization of mental health services (Batterham et al., 2013; Dueweke & Bridges, 2016; Martinez Tyson et al., 2016), our findings suggest a desire to learn more about suicide prevention. Primary and secondary prevention efforts such as psychoeducation in the form of videos that have shown significant effects on raising suicide literacy (Connell et al., 2016; Dueweke & Bridges, 2016) could tap into this populations' desire and start the conversation.

Knowledge as a standalone variable did increase SPC self-efficacy among the sample. However, consistent with SCT (Bandura, 1977), when additional environmental factors were considered, knowledge lost its strength and no longer translated to increase SPC self-efficacy. Thus, prevention efforts should extend past a mere focus on increasing suicide literacy. For example, primary prevention could include messages emphasizing family connectedness or fair employment to increase economic stability among Latino immigrant caregivers. Such efforts are crucial as those Latino caregivers exposed to a reinforcer in the form of hearing about suicide prevention in their community had significantly higher SPC self-efficacy. While evolving with changing migration patterns, for most first-generation Latino immigrant caregivers in the United States, the information provided within their community is particularly salient in their decision-making process and their sense of self-efficacy to carry out that decision (Nielsen Diverse Intelligence Series, 2021). The multiple regression findings reinforce this notion that social reinforcement for Latino immigrant caregivers has a stronger influence on their self-efficacy than personal factors, such as time in the United States.

**Latino Caregiver Suicide-Related Prevention Communication Self-Efficacy**

While most of the Latino caregiver's SPC self-efficacy scores were moderately-high as found among Caucasian caregiver samples (Czyz et al., 2018), they are likely lower. Caregivers

may have inflated their reported self-efficacy to conform in a socially desirable way given that the survey was not anonymous and that self-efficacy tends to be exaggerated on self-report assessments (Jones & Prinz, 2005). With that caveat in mind, following similar patterns from Caucasian caregivers (Czyz et al., 2018), Latino caregivers reported high SPC self-efficacy to provide general emotional support and connect their adolescents to treatment. They reported low SPC self-efficacy in engaging in more direct prevention strategies, such as asking about suicide, identifying suicide warning signs, and responding helpfully to a suicide ideation disclosure. Alarmingly, these are the three prevention strategies that protect against suicidal crisis becoming a fatal attempt (Czyz et al., 2018; King et al., 2013). A unique contribution of this study is that it added a question on lethal means restriction to the SPC self-efficacy scale. Examining caregivers' responses with this critical component of suicide prevention showed lower self-efficacy, similarly to the previously mentioned direct prevention strategies. Thus, future secondary and tertiary prevention programs for Latino caregivers should focus on increasing SPC self-efficacy with these four strategies.

Previous research suggests that a Latino caregiver's lack of confidence in employing direct suicide prevention strategies may be explained by caregiver-adolescent communication (Piña-Watson et al., 2019). However, this study's final statistical model suggests that something else may be at play as caregiver-adolescent communication lost statistical significance at the multivariate level in the model. Instead, two variables — familism and income — maintained significance at the multivariate level with Latino caregiver SPC self-efficacy. As mentioned earlier, Latino immigrant caregivers continue to lean towards a more collectivistic orientation (Neilson Intelligence Diversity Series, 2021). Thus, it may be that even when communication with their adolescent is closed, the importance of caring for their family's well-being and an

existing agency in being able to do so may trigger an increase in SPC self-efficacy. This assertation is supported by previous research findings stating that family and group-related factors tend to increase their self-efficacy for individuals with a collectivistic viewpoint (Jurecska et al., 2011; Klassen, 2004). Most of the Latino caregivers in our study were native-born, and most migrated to the United States as adults during a developmental stage where our values and worldviews have become an integral and subconscious part of our person, which would explain why their SPC self-efficacy was influenced mainly by familism not acculturation and years in the United States.

Given familism's relationship and previous research showing attitudinal familism indirectly reduces suicidality among Latino adolescents (e.g., Valdivieso-Mora et al., 2016; Vidot et al., 2016), suicide prevention efforts focusing on familism may propel both youth and their caregivers to engage in SPC. Some tertiary and secondary programs to increase SPC self-efficacy among Latino caregivers that embed familism include clinical family-oriented interventions and programs like Familias Unidas (Vidot et al., 2016) or Strengthening Families. In addition to utilizing programs that include a family orientation, providers should also ensure that their suicide prevention efforts incorporate behavioral components that influence self-efficacy (Bandura, 1977). Based on this study findings, providers may want to engage Latino caregivers in role-plays where they are asking about suicide, provide them with practical trainings on how to respond when their child(ren) discloses thoughts of suicide, and psychoeducation on how to identify suicide warning signs.

Providers working with Latino immigrant families around suicide prevention must engage in holistic service delivery, branching out to more macro-level efforts. For example, to decrease suicide risk among adolescent clients and obtain the needed support from the client's

caregiver, providers should connect caregivers to resources that will increase their income and decrease financial stress. Advocacy around fair housing and against anti-immigration policies that block caregivers from obtaining needed income are also crucial suicide prevention strategies that service providers, especially social workers, should employ.

Keeping with the need to branch out towards macro-level efforts, using primary suicide prevention campaigns, like the American Foundation for Suicide Prevention's Seize the Awkward, as inspiration, researchers could develop short social media video clips highlighting Latino families. Ideally, these clips would showcase Latino families using various suicide prevention strategies. Written psycho-educational resources that have shown to be valuable and motivational, such as It's Time to Talk About It (Gryglewicz et al., 2018), could also be revamped towards a more familistic framework. Even better, since SPC self-efficacy and familism were positively correlated in this sample, printable resources could be adapted to be more family-oriented and converted into audio clips. These efforts could utilize focus groups to pilot them among Latino caregivers.

While all the ideas presented above are based on this study's findings and prevention literature, they do not account for the perspectives of Latino caregivers. Therefore, before entertaining any of the ideas stated above, future research needs to understand further how Latino caregivers envision effective adolescent suicide prevention programming in their communities.

**Limitations**

First, although one of the significant strengths of this study was sampling a traditionally understudied population, it should be noted that there were some limitations in the methodology and approach. Due to a recruitment site's unforeseen withdrawal from the study right before

launching, the sample was relatively small and included few Latino caregivers whose adolescents' struggled with suicidality, ultimately limiting the generalizability of the study. The sample also had a small number of caregivers from Central America, which could be related to the survey delivery format that required participants to be somewhat technology proficient and have at least a middle school reading level in Spanish. Compared to immigrant adults from South America, those individuals from Guatemala, El Salvador, Honduras, and Nicaragua tend to have a lower Spanish reading proficiency rate (Central Intelligence Agency, 2020). Also, because the sample included only foreign-born Latino caregivers coupled with the study findings suggesting a strong correlation between SPC self-efficacy and familism and given that the former varies by generation status (Calzada et al., 2012), future research may want to explore SPC self-efficacy and familisms relationship further among second and third-generation Latino immigrant caregivers. Such a study may also want to expand and examine behavioral and structural aspects of familisms' relationship to SPC self-efficacy. It is also essential to consider that the sample came from a new destination, southeastern state, where support for Latino communities is just beginning. Future research could expand its data collection to other states, allowing comparisons across states and other socio-demographic variables, such as generation and nativity.

Another limitation of this study was related to the low alphas of some scales. The cultural sanctions alpha was below a .70. Given the low alpha, future studies may want to investigate further the mechanisms by which cultural sanctions may be related to Latino caregivers' use of SPC through a qualitative methodology. As conceptualized by the study, SPC self-efficacy drew primarily from a theory developed from an individualist and Western non-Latino Caucasian perspective (Bandura, 1977). Future studies should use a qualitative methodology to critically examine and expand vicarious experiences that may influence SPC self-efficacy among Latino

immigrant caregivers. Such a study could also examine unique environmental and behavioral components influencing SPC self-efficacy (e.g., social persuasion and self-regulation; Bandura, 1977) among Latino immigrant caregivers. Notwithstanding these limitations, essential information was gathered regarding SPC among Latino immigrant caregivers that can aid in developing future prevention efforts for this community.

## Conclusion

In conclusion, this study highlights Latino caregiver's desire to be involved in its prevention despite the stigma associated with suicide in the Latino community. Notwithstanding Latino caregiver's moderately high sense of self-efficacy for most suicide prevention strategies, the majority do not have sufficient knowledge regarding how to prevent suicide among their adolescents. This combination of moderately high SPC self-efficacy and limited knowledge, with a strong desire, is an opportunity for the research and prevention field to work with Latino caregivers to end adolescent suicide.

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**Table 4.1**

*Reliability of Measures Used in the Study*

| Scale | *M* | *SD* | Range | Cronbach's α |
|---|---|---|---|---|
| Perceptions and attitude toward suicide and its prevention questionnaire | | | | |
| Parent self-efficacy regarding suicide prevention (adapted) | 8.09 | 2.87 | 1-11 | 0.893 |
| Literacy of suicide scale-short version (adapted) | 57.71 | 22.39 | 12.5-100 | 0.643 |
| Cultural assessment of risk for suicide cultural sanctions subscale | 12.14 | 5.96 | 0-24 | 0.579 |
| Caregiver-adolescent communication, familism, and religiosity questionnaire | | | | |
| Parent-adolescent open family communication scale | 37.16 | 6.63 | 10-46 | 0.831 |
| 5-item pan-Hispanic familism scale | 22.10 | 3.59 | 5-25 | 0.869 |
| Religiosity | 2.23 | 1.09 | 0-4 | 0.774 |

**Table 4.2**

*Socio-demographic Characteristics of Participants and Distribution of Study Variables*

| Variable | | | | | Suicide prevention self-efficacy |
|---|---|---|---|---|---|
| | *n* | % | *M* | *SD* | ANOVA/*r* |
| Gender | | | | | 0.01 |
| Female | 109 | 82 | | | |
| Male | 24 | 18 | | | |
| Nativity | | | | | 0.70 |
| Mexico | 74 | 56 | | | |
| Central America | 16 | 12 | | | |
| South America | 43 | 32 | | | |
| Marital Status | | | | | 0.92 |
| Single | 37 | 28 | | | |
| Living with spouse or partner [a] | 96 | 71 | | | |
| Highest educational level | | | | | 0.02 |
| Elementary or middle school | 45 | 36 | | | |
| High school degree/ some college | 42 | 32 | | | |
| Post-secondary/ vocational degree | 44 | 33 | | | |
| Household income | | | | | 1.66 * |
| Less than 15000 | 33 | 25 | | | |
| 15000–35000 | 39 | 29 | | | |
| 35001–55000 | 20 | 15 | | | |
| More than 55001 | 26 | 20 | | | |
| Preferred not to answer | 15 | 11 | | | |
| Years in the US | | | | | 1.49 * |
| 1–10 | 22 | 17 | | | |
| 11–20 | 64 | 48 | | | |
| More than 21 | 47 | 35 | | | |
| Acculturation | | | 1.04 | 0.83 | 0.11 * |
| Religious orientation | | | | | 0.06 |
| None | 13 | 10 | | | |
| Catholic | 76 | 57 | | | |
| Other Christian/ Non-Christian | 44 | 33 | | | |
| Religiosity | | | 2.23 | 1.09 | 0.04 |
| Cultural sanctions | | | 12.14 | 5.96 | -003 |
| Familism | | | 22.09 | 3.59 | 0.43 *** |
| Caregiver-adolescent communication | | | 37.16 | 6.63 | 0.45 *** |

| Variable | | | | | Suicide prevention self-efficacy |
|---|---|---|---|---|---|
| | *n* | % | *M* | *SD* | ANOVA/*r* |
| Number of children | | | | | 0.01 |
| 1 | 86 | 65 | | | |
| 2 or more | 48 | 35 | | | |
| Age of adolescent children | | | 14.79 | 1.63 | -0.08 |
| Adolescent suicidality (Observational learning) [b] | | | | | 0.21 |
| No/ Don't know/ Prefer not to answer | 101 | 76 | | | |
| Yes | 32 | 24 | | | |

*Note.* $N = 133$. ANOVA= analysis of variance; $r$ = Pearson's correlation. Participants were on average 41.79 years old ($SD = 7.49$), and their suicide prevention self-efficacy was not statistically significant to age.

[a] Includes the married and nonmarried participants who reported living with their partner/spouse. [b] Refers to whether the participants' adolescents ever struggled with suicidality.

* $p < .25$. ** $p < .05$. *** $p < .001$.

**Table 4.3**

*Participants' Suicide-Related Literacy, Concern, Desire, Reinforcement, and Prevention Strategies*

| Variable/ Item | *n* | % |
|---|---|---|
| Concern | | |
| None | 15 | 11 |
| A little | 21 | 16 |
| Somewhat | 43 | 32 |
| A lot | 54 | 41 |
| Desire | | |
| No/ Maybe | 53 | 40 |
| Yes | 80 | 60 |
| Reinforcement | | |
| No | 102 | 77 |
| Yes | 31 | 23 |
| Suicide literacy | | |
| Seeing a psychiatrist or psychologist can help prevent an adolescent from suicide. [a] | 116 | 87 |
| Suicide is preventable. [a] | 111 | 83 |
| There is a strong relationship between drug use and suicide. [a] | 87 | 65 |
| Talking about suicide always increases the risk of suicide. [a] | 84 | 63 |
| Not all adolescents who attempt suicide plan their attempt in advance. [a] | 64 | 48 |
| Very few Latino adolescents have thoughts about suicide. [a] | 59 | 44 |
| Adolescents who want to attempt suicide can change their mind quickly. [a] | 48 | 36 |
| Adolescents who talk about suicide rarely kill themselves. [a] | 47 | 35 |
| Perceived cause of suicide | | |
| Depression [b] | 117 | 88 |
| Multiple reasons [b] | 106 | 80 |
| Family death [b] | 58 | 44 |
| Attention seeking [b] | 39 | 29 |
| Prevention strategies | | |
| Seek help. [b] | 114 | 86 |
| Talk to the adolescent. [b] | 107 | 80 |
| Talk to the adolescent's parent(s). [b] | 100 | 75 |
| Be on the lookout for suicide warning signs. [b] | 96 | 72 |
| Ask the adolescent if they are having thoughts about suicide. [b] | 53 | 40 |

*Note*. $N = 133$. On average, participants' suicide literacy was 57.71 ($SD = 22.39$).

[a] Reflects the number and percentage of participants who answered the item correctly.

[b] Represents the number and percentage of the participants endorsing this variable.

**Table 4.4**

*Caregivers' Self-Efficacy Regarding Suicide Prevention*

| Item | *M* | *SD* |
|---|---|---|
| Offer emotional support to your adolescent (such as listen to them, tell them they are important to you, give them a hug). | 10.03 | 2.13 |
| Assist your adolescent in accessing treatment services for their difficulties. | 9.12 | 3.20 |
| Ask your adolescent about their mood. | 8.97 | 3.10 |
| Encourage your adolescent to cope with their difficulties in ways that have been helpful in the past. | 8.93 | 2.99 |
| Work with your adolescent on a plan for their safety. | 8.85 | 3.25 |
| Keep your adolescent from accessing lethal means if they were having thoughts of killing themselves in the future. | 8.08 | 2.99 |
| Obtain a commitment from your adolescent not to attempt suicide. | 7.55 | 3.97 |
| Put away all of the house knives, over-the-counter and prescribed medications, and firearms in a lockbox. | 7.25 | 2.2 |
| Ask your adolescent if they are experiencing thoughts of suicide. | 6.58 | 2.34 |
| Identify suicide indicators or warning signs in your adolescent. | 6.42 | 2.99 |
| Respond in a helpful manner if your adolescent discloses thoughts of suicide. | 6.37 | 2.38 |

*Note.* Items are displayed in terms of highest to lowest means (range = 1-11). The higher the mean, the more self-efficacy reported by the participants.

**Table 4.5**

*Regression Results for Suicide Prevention Self-Efficacy among Latino Caregivers*

| Variable | *B* | 95% CI for *B* | | *SE B* | *β* | *t* | *p* |
|---|---|---|---|---|---|---|---|
| | | *LL* | *UL* | | | | |
| Familism | 0.21 | 0.07 | 0.36 | 0.07 | 0.32 | 2.90 | 0.004 ** |
| Caregiver-adolescent communication | 0.06 | -0.02 | 0.14 | 0.04 | 0.16 | 1.48 | 0.143 |
| Reinforcement [a] | 1.18 | 0.26 | 2.09 | 0.46 | 0.21 | 2.56 | 0.012 ** |
| Literacy | 0.14 | -0.08 | 0.35 | 0.11 | 0.10 | 1.27 | 0.206 |
| Acculturation | -0.10 | -0.67 | 0.47 | 0.29 | -0.03 | 1.89 | 0.728 |
| Household income [b] | | | | | | | |
| 15000-35000 | 1.07 | 0.01 | 2.13 | 0.53 | 0.20 | 2.00 | 0.048 * |
| 35001-55000 | 0.08 | -1.23 | 1.39 | 0.66 | 0.01 | 0.12 | 0.907 |
| 55001 and more | 0.73 | -0.58 | 2.03 | 0.66 | 0.12 | 1.10 | 0.273 |
| Preferred not to answer | 0.75 | -0.82 | 2.33 | 0.79 | 0.09 | 0.95 | 0.345 |
| Years in United States [c] | | | | | | | |
| 11-20 | 0.32 | -0.79 | 1.44 | 0.06 | 0.07 | 0.57 | 0.570 |
| More than 21 | 1.11 | -0.06 | 2.28 | 0.59 | 0.22 | 1.89 | 0.062 |
| $R^2$ | 0.33 | | | | | | |
| $\Delta R^2$ | 0.27 | | | | | | |

*Note.* $N = 133$. *B* = unstandardized coefficient; β = standardized coefficient; *SE* = standard error; CI = confidence interval; *LL* = lower limit; *UL* = upper limit.

[a] Yes = 1, no = 0. [b] Preferred not to answer = 4; 55,001 plus = 3; 55,000-35,001 = 2; 35,000-15,001 = 1; Less than 15,000 = 0. [c] More than 21 = 2; 11-20 = 1; and 1-10 = 0.

* $p < .05$. ** $p < .01$.

# CHAPTER 5

# ADOLESCENT SUICIDE PREVENTION PROGRAM RECOMMENDATIONS FROM LATINA IMMIGRANT MOTHERS: "STARTING WITH THE WORD" [1]

[1] Villarreal-Otálora, T. To be submitted to *Qualitative Health Research* (Other contributors to this article, such as dissertation committee members, are to be added at a later date).

## Abstract

As suicide and suicidality continue to rise among Latino adolescents in the United States, their caregivers yearn for more support. **Aim.** The purpose of this study was to understand what Latino immigrant caregivers believe an effective suicide prevention program would look like for them — specifically, giving voice to Latina immigrant mothers' suicide prevention program recommendations. **Methods.** A total of 22 Latina immigrant mothers from a new destination state participated in semi-structured interviews via Zoom. Structural and inductive coding assisted in revealing three themes related to a culturally-tailored suicide prevention program that would target caregivers as agents of change. **Results.** The three essential themes for a Latino caregiver-targeted culturally-tailored adolescent suicide prevention program identified from the mother's recommendations and expressed preferences were: (1) engagement via a multi-step effort in culturally relevant spaces; providing psychoeducation in culturally meaningful ways; and (3) offering tangible takeaways. **Conclusions.** The mother's recommendations provide practitioners and researchers with a sketch for developing a culturally-tailored suicide prevention program that places Latino caregivers as agents of change in the fight against adolescent suicide within their communities.


**Keywords:** Latina, mothers, immigrants, parenting, suicide, prevention, culturally responsive, program recommendation

## Introduction

In spite of the increase in suicide prevention efforts, suicide is still a leading cause of death among adolescents in the United States (Center for Disease Control and Prevention, 2019). Suicide and suicidality rates in the United States continue to increase among ethnic minoritized youth, especially Latino adolescents (Ivey-Stephenson et al., 2020; Plemmons et al., 2018). A potential explanation for the scant progress in reducing these phenomena within the Latino community may be that most suicide literature is primarily based on and informed by Caucasian European-American culture with very few culturally-tailored prevention programs (Leong & Leach, 2010; Villarreal-Otálora et al., 2019). For example, within the Latino community, the family may be a great resource in the fight against suicide as it can be a protective factor (Boyas et al., 2019; Garcia et al., 2008; Gulbas & Zayas, 2015; see Chapter 3). However, Latino family members' opinions about adolescent suicide and their inclusion in prevention efforts are anemic in the suicide literature (see Chapter 3). A recent scoping study (see Chapter 3) only identified eight peer-reviewed articles between 2000 and 2020 that asked Latino family members directly about suicide, and none of those studies asked the caregivers for their perspectives regarding prevention. Such omission may lead to the development of suicide prevention programs that are culturally inappropriate, overlooking the contextual factors that increase Latino adolescents' vulnerability and their caregivers' potential sources of wisdom and prevention intervention. Additionally, a successful suicide prevention program should reflect the attitudes and beliefs of the targeted community (Gryglewicz et al., 2018).

While Latino caregivers' involvement in suicide prevention research is limited, the literature emphasizes their protective role (see Chapter 3). For example, in the context of suicidality among Latina adolescents, having meaningful, supportive mother-daughter

relationships have been reported to promote healthy adolescent coping and feelings of belonging, both of which deter suicidal behaviors (Gulbas & Zayas, 2019). Given the caregivers' role as a protective factor against suicide, the need to engage and involve them in Latino adolescent suicide prevention programming design is warranted.

To promote the development of culturally-relevant suicide programming, scholars recommend that researchers engage in qualitative inquiry with the communities of interest (Boden et al., 2016; Hjelmeland & Knizek, 2010; Gryglewicz et al., 2018). This manuscript reports on the qualitative portion of a mixed method study that sought to expand Latino caregivers' endorsed desire for a culturally specific suicide prevention program targeting them as agents of change. Following suicide-prevention and culturally-relevant scholarly recommendations (Boden et al., 2016; Hjelmeland & Knizek, 2010; Gryglewicz et al., 2018) and acknowledging Latino caregivers important role in adolescent suicide prevention and their desire to be involved (Jensen et al., 2014; Prado et al., 2019; see Chapter 4; Vidot et al., 2016), this study is the first to describe Latino caregivers' recommendations for engaging them in a suicide prevention program.

**Literature Review**

Latino caregivers' express a need and desire to engage in Latino-specific suicide prevention programs (see Chapter 4). A recent survey of Latino adults ($N$ = 133) living in Georgia (United States) found that nearly 90% of Latino immigrant caregivers are concerned about adolescent suicide in their communities. This concern is consistent with epidemiological findings on suicide rates among Latino adolescents: every year, approximately 3,000 Latino adolescents in the United States seriously consider ending their lives by suicide (Ivey-Stephenson et al., 2020).

Not only is there a concern within Latino caregivers regarding adolescent suicide, but there is also a thirst for involvement. For example, the same survey of Georgia Latino caregivers found that more than 60% of respondents were eager to engage in a suicide prevention program (see Chapter 4). Unfortunately, 77% of them had never heard of such programming in their communities. Given that exposure to suicide prevention techniques (e.g., connecting people to professional help, securing access to lethal means) increases a person's self-efficacy to engage in life-saving behaviors (see Chapter 4; Bandura, 1977; Czyz et al., 2018), Latino caregivers' lack of exposure is concerning. Certainly, the caregivers' reported lack of access to prevention resources is unsurprising given the few Latino-specific suicide prevention programs that exist.

### *Latino Suicide Prevention Programs*

Although there are a few evidence-based prevention programs for Latino adolescent suicide (Villarreal-Otálora et al., 2019), they tend to be gender-specific efforts focusing on adolescents who have already exhibited suicidal behaviors. In prevention science, efforts focusing on those already affected by the problem are considered "tertiary prevention" (Leavell & Clark, 1965). An example of one such program is Life is Precious, which draws on the multiple Latino cultural values — familism, individualism, and gender roles — to decrease suicide among Latina adolescents while involving their mothers in the process (Humensky et al., 2017). Life is Precious is one of the few tertiary programs that, along with adolescents, also work with their caregivers to be change agents.

Unfortunately, no primary — efforts aimed at preventing suicide in completely unaffected populations — nor secondary — efforts aimed at slowing the development of suicide for those at risk — suicide prevention efforts (Leavell & Clark, 1965) focus on Latino caregivers. Nonetheless, non-suicide-specific primary and secondary prevention programs

targeting Latino family members have continuously shown promise in deterring other unhealthy risky behaviors, such as drug use and unsafe driving (Jensen et al., 2014; Prado et al., 2019; Vidot et al., 2016). Most of these programs were developed and tested in well-established Latino immigrant communities. Familias Unidas is an example of one such program. By targeting family processes and working closely with caregivers to further develop positive parenting and communication skills, the Familias Unidas curriculum reduces and prevents risky sexual behaviors and drug use among Latino youth (Vidot et al., 2016). This program has even shown a small indirect impact on reducing suicide attempts among Latino adolescents with low levels of caregiver-child communication (Vidot et al., 2016). Scholars suggest that this family-based program might have a greater impact on preventing suicide attempts if it included suicide-specific information (Vidot et al., 2016). Further, the program's limited impact on suicidality may also be related to its development, which was completed without seeking caregivers' views (Coatsworth et al., 2002; Vidot et al., 2016). Thus, the program could be missing critical elements that caregivers want and need in a prevention program, especially among Latino caregivers living in states with limited resources and anti-immigrant sentiments and policies (Hatzenbuehler et al., 2017; Terrazas, 2011)

**Latina Immigrant Mothers and Caregiver Roles.** While evolving with changing migration and settlement patterns in the United States, the responsibility of childrearing for most Latino immigrant families lies heavily with the mother (Garcia-Huidobro et al., 2016; Kramer et al., 2021). For example, compared to first-generation Latino immigrant fathers, mothers tend to be more involved in the childcare routines, such as making sure children get ready in the morning for school (Kramer et al., 2021). Latina mothers also tend to be the ones who take

adolescents to school and other educational or mental-health-related activities (Kramer et al., 2021).

Given the importance of Latina immigrant mothers' involvement in the routine care of children within the family and the scant suicide prevention programming developed with their perspectives in mind, there lies the question of how they envision its design, implementation, and their involvement. Thus, this study sought to understand what Latino immigrant caregivers believe an effective suicide prevention program would look like for them — specifically, giving voice to Latina immigrant mothers' suicide prevention program recommendations.

## Methods

In this manuscript, I analyze qualitative data collected from a larger mixed method project approved by the University Institute Review Board in the Fall of 2020. The qualitative portion of the project aimed to expand our knowledge regarding Latino immigrant caregivers' perceptions of suicide prevention, factors that promote and deterrent their suicide-related prevention communication (SPC) self-efficacy, and their recommendation for a SPC program that places them as the change agents. This manuscript focuses on the latter part of the qualitative data collected. Specifically, this manuscript aims to expand our knowledge on what Latina immigrant mothers want and believe would be effective in a prevention program to reduce Latino adolescent suicide. Towards this aim, thematic analysis captured Latina immigrant mothers' descriptions of an ideal suicide prevention program involving them.

The sampling frame for the qualitative portion of the mixed method project consisted of 133 Latino immigrant caregivers who participated in the study's quantitative part by completing an online survey (see Chapter 4) that asked about their suicide-related literacy and SPC self-efficacy. Recruitment for participants occurred in the Fall of 2020 and followed a purposive

sampling approach with the goal of reaching a sample size of 18 to 24 interviews. Before starting recruitment, several parameters — the study's purpose, complexity and focus, population, and types of codes — guided the sample size estimate decision (Hennink et al., 2016).

First, a criterion sampling approach was employed to identify all Latino immigrant caregivers who had completed the online survey and had not heard of a suicide prevention program in their community. The primary investigator approached the possible participants who met the previously stated criteria via telephone and invited them to participate in the qualitative portion of the study. Forty-eight Latino immigrant caregivers' expressed a willingness to participate, of which two were males. Thus, the decision was made to only include females in the second phase of sampling. A maximum variation approach was used in the second phase of sampling to iteratively select a sample of participants from those identified in phase one that varied in years in the United States, nativity, education, SPC self-efficacy, annual household income, level of familism, mental health involvement, and experience with their adolescents struggling with suicidality. During the interview scheduling process, 18 Latina immigrant mothers did not respond to the researcher's follow-up outreach efforts, and six of them dropped out after scheduling the interview. Thus, leaving a total of 22 Latina immigrant mothers who participated in the qualitative interviews and varied on several dimensions of interest.

**Study Setting and Participants**

All participants ($N$ = 22) identified as females born outside of the United States and reported their primary language as Spanish. The Latina immigrant mothers were on average 42 years old and reported having between one to five children, with the majority of the sample currently raising two adolescent children. Most of them were born in Mexico ($n$ = 15), followed by Colombia ($n$ = 4), Peru ($n$ = 2), and one in El Salvador. At the time of the interviews, most ($n$

= 14) had been in the United States for 11 to 20 years, four had been in the United States for more than 21 years, and four had lived in the United States less than ten years. None of the participants had seen or participated in a suicide prevention program. See Table 5.1 for a breakdown of participants' socio-demographic characteristics.

**Qualitative Interview**

The author — a bilingual-bicultural female clinical social worker and researcher — conducted all interviews via Zoom. Participants were assigned pseudonyms and received compensation in the form of a 25-dollar e-gift card for their participation before the interview started. On average, interviews were about 75 minutes long, ranging from one hour to two hours and a half. All interviews were conducted in Spanish, with a couple of participants switching to English at various points throughout the interview. When participants would switch languages, the interviewer would follow suit. Field notes were made after each interview.

A semi-structured interview protocol was used, which was developed and informed by the results of the quantitative analysis of the mixed method project (see Chapter 4). The interview protocol (see Appendix D) included three sections that queried on the various quantitative findings: (I) perceptions of suicide and suicide prevention; (II) promotion and deterrents of SPC self-efficacy; and (III) culturally relevant prevention programming. Using a semi-structured interview protocol allows for flexibility and rapport-building with participants while also ensuring fruitful data collection quality and, if done thoughtfully, can aid in data analysis (Guest et al., 2012; Saldaña, 2013).

To capture the interview audio, the interviewer used Zoom's built-in recording tool. The audio was then imported into NVivo Transcription, which created automated transcriptions of the interviews in their original language. The researcher then carefully reviewed and edited them

for accuracy to develop clean transcriptions. After that, the author imported the clean transcriptions into NVivo16. This process enabled the author to familiarize herself with the data further.

**Data Analysis**

The semi-structured interviews were examined using thematic analysis. Specifically, the author used structural coding and then an inductive coding approach. The structural coding approach was guided by the interview protocol and the mixed method project's conceptual lens (see Chapter 2). Structural coding uses segments of the interview protocol as the basis for code development (Guest et al., 2012). This coding approach is particularly appropriate for research with large datasets when the researchers are interested in focusing on a particular aspect of data collected through semi-structured interviews (Guest et al., 2012; Saldaña, 2013).

Following the structural coding approach, the author developed a structural codebook. The initial codebook was composed of various deductive codes from the questions in the third section of the interview protocol — culturally relevant prevention programming — and the conceptual framework. For example, based on the interview question "¿En qué lugar debe ocurrir?" [Where should the program take place?] the preliminary code *location* was created. Once the initial codebook was developed, the author systematically reviewed a subset of the data, six interviews, and assigned structural codes. After this, another subsection of the data, six additional interviews, was examined to revise the codebook again and begin inductive coding. This revision process was repeated until data saturation was reached. Guest and colleagues' (2006) data saturation definition, meaning that no more changes to the codebook are made, was employed.

The researcher reviewed the codes for patterns and commonalities to organize, manage, and make sense of them. Moreover, to enhance the legitimation (also referred to as trustworthiness or validity, depending on the theoretical perspective; Onwuegbuzie & Johnson, 2006) of the study, the researcher coded the data in its original language, self-audit their rater agreement on 50% of the codes, and revised the codebook multiple times because of coding checks (Guest et al., 2012). Memos were used throughout the data analysis process to flesh out the codes' interconnections and create an audit trail. From this process, the author developed three themes.

## Results

The data produced three overarching themes essential for a Latino caregiver-targeted culturally-tailored adolescent suicide prevention program: (1) engagement via a multi-step effort in culturally relevant spaces; (2) providing psychoeducation in culturally meaningful ways; and (3) offering tangible takeaways. The following sections describe each theme outlining its major components and topics. Before describing the themes, the reader should keep in mind that the data was coded in Spanish then translated to English for the write-up of this manuscript. Thus, to promote the transparency of the translations, the Spanish version of the participants' quotes is presented, and the English translations are included in brackets. Participants' pseudonyms are used to present the data.

### Engagement via a Multi-Step Effort in Culturally Relevant Spaces

When participants were asked for their program recommendations, most responded by taking a step back. Instead of answering the question directly, they described a multi-step effort, including primary and secondary prevention elements. More specifically, participants expressed a need to be approached passively at the primary level through social media awareness-raising

campaigns relating to adolescent well-being and then a more centered secondary prevention program focusing on suicide literacy and family processes. Emma describes this multi-step approach in detail:

> Pues me gustaría que furea un programa educativo … y me gustaría ver *primero* anuncios en las redes sociales, hablando del tema primero y decir cosas impactantes. Como decir qué harías si te enteraras que a tu hijo lo bulín en la escuela y tú no tienes ni idea. ¿Qué harías? Entonces, cómo abordar el tema desde otros puntos para luego centrar en el suicidio en un programa. [Well, I would like it to be an educational program … and I would like to see *first* ads on social media, talking about the topic first and saying shocking things. Like saying, what would you do if you found out that your child was bullied at school, and you have no idea. What would you do? So, like approach the issue from other points then center it on suicide in a program.] (Emma)

Many mothers cautioned against using the word suicide in this first step. For example, as Yuly provided her primary program recommendations, she stopped midway and stated, "y la palabra 'suicidio,' yo creo que asusta a muchos. Habría que tener cuidado con esa palabra" [and the word 'suicide,' I think that it scares many. You would have to be careful with that word]. Multiple mothers echoed this sentiment, with a few recommending that the word suicide be omitted entirely. Some suggested that instead of omitting the word, because as mentioned by Laura, "es importante ser claros" [it is important to be clear], "suicide" would be best included as a small bullet point or a subheading.

While disagreeing on the use of the word, most participants reported that they want the campaigns to provoke reflection and curiosity, preferable via passively phrased questions. Paola hones in on the importance of using questions to engage mothers like herself:

> Si a mí me vienen con un mensaje tan directo. A decirme, ¿su hijo se piensa suicidar? Venga, venga, le ayudamos. De una, mi negación total. No, mi hijo no piensa eso. Mi hija no piensa en eso. Es la manera como lo redacten. Como que me deben crear esa duda, pero como que me hagan sentir que mira, ¿por qué no vas? ¿Por qué no te involucras? [If they come to me with a very direct message, to say your child is thinking of committing suicide? Come, come, we will help you. Immediately, my total denial. No, my son does not think that. My daughter does not think about that. It is the way they write it. Like they should spark a doubt, but make me feel like, look, why don't you go? Why don't you get involved?]

Ultimately, mothers hoped to see such thought-provoking campaigns in culturally relevant spaces placed at "el mero corazón de nuestra comunidad" [the very heart of our community" (Martha). These spaces can be virtual, such as Facebook and WhatsApp, or in-person. The participants articulated a complex preference around the ideal location: it should be connected to the community, but at the same time, it must be seen as neutral enough to promote privacy. Examples of appropriate places mentioned by the mothers included Hispanic shopping plazas, medical offices, Latin American associations, and consulates. None-neutral sites were described as mental health and behavioral health facilities.

Beyond seeing the prevention campaign in their communities, participants would like to be personally invited to a suicide prevention program. More specifically, the social media awareness-raising campaigns should be run for some weeks. Then, be adapted to include an invitation to participate in a secondary suicide-specific prevention effort.

**Providing Psychoeducation in Culturally Meaningful Ways**

Table 5.2 describes participants' recommendations for a suicide prevention program targeting Latino caregivers as the agent of change. This secondary prevention effort was described by most as educational or informative meetings. Like the primary effort, Latina mothers recommend that these meetings be held at a culturally relevant location that is neutral within the Latino community. Cindi, a recent immigrant, summarizes this recommendation:

> Yo iría fácilmente a cualquier centro comunal, al consulado, o incluso una iglesia, aunque no sea mi iglesia, a una de estas escuelas donde enseñan idiomas. Pues pienso que lo relaciono mucho en sitios neutros. Que no tenga mucho como que ver con los valores o con la salud mental. O sea, como en un sitio, así como que uno va a ver que aprendo. Eso me daría confianza. [I would easily go to any community center, the consulate, or even a church, even if it is not my church, to one of these schools where they teach languages. I think I relate it a lot to neutral places that do not have much to do with values or with mental health. Like, in a place where one goes to see what one can learn. That would give me confidence [to go].]

Other recommended locations for the secondary program included: middle and high schools, universities, local event halls, food pantries, health fairs, and even worksites such as restaurants. Many participants recommended that the program be held in a synchronous hybrid format. Specifically, participants want the ability to attend in person or via a video conference platform, such as zoom or WhatsApp, as transportation issues are common among Latina immigrant caregivers.

Extending on this theme of cultural relevancy, all participants mentioned the need for the program's facilitators to be Spanish-speaking Hispanic/Latinos. Debra emphasizes the importance of this, stating:

> El hecho de que hayan vivido cinco años, ocho años en alguno de nuestros países Hispanos o en España no quiere decir que sean Hispanos o que coman aroz cón habichuela; no quiere decir que son Hispanos. Entonces no sienten, no conocen 100% nuestra cultura, y eso choca. Aunque no lo crean, choca. Entonces la persona que esté ahí al frente tiene que ser un Hispano Latino y si es venido de allá, mejor. [The fact that they've lived five years, eight years in one of our Hispanic countries or in Spain doesn't mean they're Hispanic or that they eat Arroz con Habichuelas; it doesn't mean they're Hispanic. So, they do not feel, they do not know 100% of our culture, and that clashes. Even if they don't believe it, it collides. So, the person who is there in front has to be a Hispanic/Latino, and if they are coming from there, all the better.]

In addition to language and ethnicity attributes, participants discussed the need for facilitators to be personable and humble above all, regardless of other characteristics. Participants also mentioned the need for facilitators to use jargon-free language, especially when providing suicide-related content to be relatable and personable.

Moreover, following the importance of embedding personalism into the program, 60% of the participants ($n$ = 13) wanted a team of facilitators composed of experts in mental health and adolescent development and a parent. Valeria described this team as a panel composed of "una trabajadora social, un terapeuta que trabaja padre-a-padre or padre-a-hijo, el psiquiatra que es el que está más calificado y habria el padre que está que está pasando por eso" [a social worker, a therapist who works parent-to-parent or parent-to-child, the psychiatrist who is the one who is

most qualified, and there would be the parent who is going through it.]" Ideally, the parent facilitator would be able to tug at their hearts, sharing their experience of caring for an adolescent struggling with suicidality while highlighting the practical solution-focused steps they took to help their child. One participant suggested that along with a parent's testimony, there could also be an adolescent's testimony. The purpose of such testimony is to help caregivers understand why adolescents may think about suicide. Thus, educating them on suicide-related risks. Overall, this idea of testimonies was accentuated by participants as an effective way to personalize, destigmatize, and open the topic of suicide and its prevention. After the testimonies, per the participants, the program could then focus on providing suicide-specific information via a panel-style format.

There were 11 specific informational categories that participants believed should make up the content of the secondary prevention program. The first being "empezando por la palabra" [starting with the word] because, as explained by Lilith, "[Yo] nunca tuve esa palabra [suicidio] en mi cabeza" [[I] never had that word [suicide] in my head]. Interestingly, unlike the primary prevention effort, nearly all participants stated that "suicide" needs to be directly stated, addressed, and discussed head-on in this educational program. They discussed this in terms of destigmatizing the word for Latino caregivers and providing an opportunity for them to engage in affect regulation. An overwhelming majority of the participants mentioned wanting help managing their emotions and physical discomfort associated with the mere mention of the topic. Some participants also mentioned wanting statistics on the prevalence of suicide and suicidality among Latino adolescents, but not in graphs. Participants also recommended that the program include information to help them understand the stressors Latino adolescents face in the United States that may cause suicide.

The topics that most participants suggested, aside from the affect regulation, were education on suicide warning signs, how to intervene, and techniques to enhance caregiver-child communication. Participants were very adamant about including warning signs, which was directly connected to what steps to take if present. For participants, including specific information on what to do when noticing warning signs and steps during a crisis would help them better understand their role in prevention. Additionally, it would help them get past their apprehension to intervene.

Given the sensitive nature of intervening and communicating with adolescents around suicide, participants suggested providing breakout groups after each topic is covered. Emma describes this recommendation in detail:

> Grupos donde los padres puedan hablar y yo pienso que a lo mejor tal vez algo educativo, un segmento. Digamos, los tienes ahí cautivos por dos horas, una hora, o veinte minutos. Hablarles de un tema en particular, como comunicación, estos recursos, y otro momento donde ellos puedan expresar sus inquietudes, donde puedan hacer preguntas, donde simplemente puedan desahogarse la realidad que viven porque a veces eso es lo que necesitan para empezar a escuchar. [Groups where parents can talk, and I think maybe something educational, a segment. You have them there captive for two hours, an hour, or twenty minutes. Talk about a particular topic, such as communication, resources, and another time where they can express their concerns, where they can ask questions, where they can simply vent about the reality they live because sometimes that's what they need to start listening.]

Jenny suggested something similar, explicitly recommending small breakout groups to feel "más comodos hablando y posiblemente acceptando [la información]" [more comfortable talking and

possibly accepting [the information]. In general, other participants also echoed the idea of caregiver breakout groups to enhance open discussion, get feedback from other caregivers, and possibly practice skills learned. Lastly, given the sensitive nature of the issue, participants also recommended an incentive to attend — primarily centering around food to create a more personal, communal, and comfortable space.

### Offering Tangible Takeaways

All the participants mentioned that for the educational program to be successful, it would have to include tangible takeaways: family activities, resources, and an audio, visual, or video hand-out with the programs' content. A couple of participants mentioned wanting to leave the program with specific assigned tasks to complete. Some suggestions included contacting the adolescent's school, enrolling the adolescent in an extracurricular activity, or starting a small conversation with their adolescent. These tasks would promote caregiver involvement in the adolescent's world and thus channels for more communication. The following takeaways participants mentioned were resources, specifically a resource list. Participants mentioned that the list should include suicide prevention hotline numbers, recreational centers in the community for adolescents, local mental health agencies, and a bilingual-bicultural contact person for those resources. Lastly, participants recommended that they be given a visual, audio, or video format of the program to take home, reference when needed, and pass on to their networks.

## Discussion

Caregivers are critical in suicide prevention, especially for Latino adolescents in the United States (Boyas et al., 2019; Garcia et al., 2008; Gulbas & Zayas, 2015; Jensen et al., 2014; O'Gara et al., 2021; see Chapter 3). However, few suicide prevention efforts target Latino caregivers, and even fewer consider their needs and preferences when developing those

programs (Leong & Leach, 2010; see Chapter 3; Villarreal-Otálora et al., 2019). This study is unique in that it solicited Latino caregivers' input and recommendations about what they want in a culturally-specific suicide prevention program. Thus, by examining and organizing Latino caregivers' voices surrounding suicide prevention programming, this study takes an essential first step towards developing interventions that place caregivers as agents of change and recognize their role, in a non-pathologizing manner, in the fight against adolescent suicide within their communities. Overall, the study results identify essential characteristics for program and curriculum development.

This study has caveats and strengths, which need to be considered before discussing the study's implications for program development, future research, and practice. Constraints with time and resources led to sampling and data analysis limitations. Specifically, population transferability is limited. Of the larger quantitative sample, only mothers opted into this qualitative portion of the study. Future studies should recruit Latino immigrant fathers to inquire about their program recommendations, as they also play an essential role in the development and prevention of suicide (Garcia et al., 2008; Leong & Leach, 2010; O'Gara et al., 2021). Moreover, most of the participants had been in the United States for more than ten years. Newly immigrant caregivers tend to be more vulnerable (Terrazas, 2011) and thus may be in further need of suicide prevention. Obtaining more of their perspectives and recommendations is need. Lastly, due to time limitation, the analysis could not explore specific nuances in Latino immigrant caregivers' interview responses. For example, the analysis did not examine the emotional responses to the topic, which may impact a Latino caregiver's overall engagement in suicide prevention, and further inform what they meant when recommending program content regarding affect regulation.

Despite the limitations, from the synthesis of the overarching themes emerges the idea of a multi-step, culturally-tailored caregiver-focused support program that introduces the topic of suicide, provides participants with concrete prevention steps, and leaves them with tangible skills and resources to take back to their community. This idea encompasses several strategies described in the suicide prevention literature, including mental health literacy campaigns and family-focused support (Calear et al., 2016; Ford et al., 2015; Villarreal-Otálora et al., 2019). A new finding was the participants' emphasis on primary efforts. Latino immigrant caregivers in this study made it very clear that before they would involve themselves in a suicide prevention program, even if it incorporated all their recommendations, they needed researchers and clinicians to meet them where they are at — at the beginning.

First, there needs to be a gentle introduction to the topic via social media and community campaigns that focus on adolescent well-being and the destigmatization of mental health. Preferably these campaigns would ask thought-provoking questions and possibly include testimonies or short informational videos related to overall adolescent well-being and mental health. These suggestions provide researchers with an excellent opportunity to collaborate with Latino caregivers in designing such campaigns. For example, researchers could use focus groups to obtain direct feedback from caregivers and launch a truly culturally relevant prevention campaign. The primary prevention effort recommendations made by the mothers reiterates the continued need to destigmatize mental health among Latinos in the United States (Batterham et al., 2013; Dueweke & Bridges, 2016; Martinez Tyson et al., 2016). For example, many mothers recommended that the word suicide be used cautiously and be introduced gently to them, which could reflect the stigma that that word carries among their communities (Dueweke & Bridges, 2016).

After the primary effort should come the secondary program, in the form of synchronous hybrid educational meetings. Throughout the interviews, Latino immigrant caregivers verbalized a yearning for overall knowledge regarding this phenomenon. Their yearning supports previous studies noting the overall low levels of suicide literacy among communities in the United States, especially minoritized individuals (Calear et al., 2021; Dueweke & Bridges, 2016; see Chapter 4). They also asked for practical, direct suicide prevention skills, which they can role-play within a program. Some asked for what to say when noticing suicide warning signs and how to connect an adolescent to services. These petitions make sense, as quantitative findings suggest that caregivers lack confidence when engaging in those direct skills (Czyz et al., 2018; see Chapter 4). As a needed component of suicide prevention programming, Latino immigrant caregivers also focused on communication and affect regulation skills to strengthen familism within the family unit.

Sadly, as mentioned earlier in the manuscript, no primary nor secondary suicide-specific prevention programs currently target Latino caregivers as the agents of change. Nonetheless, many of the secondary program recommendations made by Latino immigrant caregivers closely aligns with Familias Unidas' curriculum (Prado et al., 2019). That program targets Latinx adolescent drug use and risky sexual behavior. Future studies may investigate the feasibility of adapting Familias Unidas to incorporate suicide-specific information and other program recommendations mentioned by the mothers in this sample.

## Conclusion

Latino caregivers need to be at the forefront of suicide prevention if society aims to reduce suicide among Latino adolescents in the United States. This aim is imperative given the continued rise in suicidality and suicide among ethnic minoritized youth. Latino caregiver's

experiences, wisdom, and perspectives are crucial in developing programs that will have long-lasting effects and be well received within the community. Thus, as researchers, we must inquire and listen to their voices and collaborate with them in developing suicide prevention programs that target them as agents of change.

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**Table 5.1**

*Participants' sociodemographic characteristics.* (*N* = 22)

| Pseudonym | Age | Nativity | Years in the United States | Highest level of education | Number of adolescent children |
|---|---|---|---|---|---|
| Marcela | 40s | Mexico | 11-20 | University | 1 - 2 |
| Marlel | 30s | Mexico | 11-20 | Middle | 3 + |
| Graciela | 30s | Mexico | 11-20 | Middle | 3 + |
| Yuly | 40s | Peru | 11-20 | Technical | 1 - 2 |
| Martha | 30s | Mexico | 11-20 | High | 1 - 2 |
| Pamela | 40s | Colombia | 11-20 | High | 1 - 2 |
| Lilith | 40s | Mexico | 11-20 | High | 1 - 2 |
| Maryem | 50s | Peru | 11-20 | Technical | 1 - 2 |
| Sabrina | 40s | Mexico | 11-20 | High | 1 - 2 |
| Mariela | 50s | Colombia | 11-20 | Masters | 1 - 2 |
| Paloma | 30s | El Salvador | 11-20 | High | 1 - 2 |
| Hanna | 40s | Mexico | 11-20 | Elementary | 3 + |
| Jenny | 30s | Mexico | 11-20 | High | 1 - 2 |
| Juliet | 30s | Mexico | 11-20 | Middle | 1 - 2 |
| Paola | 40s | Colombia | 21 + | University | 1 - 2 |
| Debra | 40s | Colombia | 21 + | University | 1 - 2 |
| Laura | 40s | Mexico | 21 + | High | 3 + |
| Valeria | 40s | Mexico | 21 + | University | 1 - 2 |
| Cindi | 40s | Mexico | ≤ 10 | Masters | 1 - 2 |
| Emma | 40s | Mexico | ≤ 10 | University | 3 + |
| Sofi | 40s | Mexico | ≤ 10 | University | 1 - 2 |
| Rosaria | 40s | Mexico | ≤ 10 | Masters | 1 - 2 |

**Table 5.2**

*Participants' recommendations for a suicide prevention program targeting Latino caregivers at the secondary level.*

| Topic | Recommendations |
|---|---|
| *Location* | Culturally relevant venues |
| *Ideal start time/days* | Monday – Thursday after 6 pm |
| | Saturday or Sunday after 10 am |
| *Duration and frequency* | No more than 60 minutes once a week |
| | One to four sessions |
| *Format* | Synchronous hybrid |
| *Facilitators' characteristics* | Latino |
| | Both gender |
| | Spanish primary language |
| | Expert |
| | Parent with experience |
| | Personable and humble |
| *Activities* | Sharing of food |
| | Listening to testimonies |
| | Panel style Q&A |
| | Caregiver-led breakout groups |
| | Videos with vignettes |
| *Information* | Starting with the word |
| | Affect regulation skills |
| | Prevalence of suicide among Latino adolescents |
| | Stressors related to suicide specific to Latino adolescents |
| | Warning signs of suicide |
| | Intervening & lethal means safety |
| | Techniques to enhance caregiver-child communication |

| Topic | Recommendations |
|---|---|
| | Opportunities to increase parental involvement |
| | How to broker the subject of emotions, mental health, and suicide with an adolescent |
| | Steps to follow if adolescent discloses or attempts suicide |
| | Resources in the community |
| *Takeaway* | Audio or written guide |

# CHAPTER 6

## SUMMARY, IMPLICATIONS AND CONCLUSIONS

For most families, the topic of suicide is frightening. It may be even more frightening for vulnerable families whose survival and cohesion are daily struggles. This vulnerability may be especially relevant for Latino families in the United States, many of whom continue to live in poverty, suffer food insecurity, lack access to health services, struggle with the English language, navigate complex intergenerational migration stories and statuses, and experience multiple forms of discrimination. Furthermore, all of these vulnerabilities are contributing factors in suicide risk (Terrazas et al., 2011; Semega et al., 2019).

The suicide prevention community recognizes the significant threat that suicide poses to the U.S. population as a whole and to minoritized communities, in particular. The most recent Surgeon General's call explicitly urges more research to better understand and prevent suicide, especially among vulnerable populations (Office of the Surgeon General, 2021). Noting the limited progress that has been made in U.S. suicide prevention overall, the Surgeon General and other experts in the field have also called for more research that focuses on family-based prevention efforts (Calear et al., 2016; Frey et al., 2016; Office of the Surgeon General, 2021; Stone et al., 2017).

For Latino adolescents in the United States, caregivers are a missing component in suicide prevention. Suicide risk is significantly decreased in Latino youth with higher levels of attitudinal familism and whose caregivers enact behaviors that align with a sense of obligation to the family, of providing familial support, and of placing the family's well-being at the center

of their decision making (i.e., behavioral familism; Kuhlber et al., 2010; Sabogal et al., 1987; Valdivieso-Mora et al., 2016). Additionally, parental monitoring is negatively correlated with suicidal behaviors among Latino adolescents (Boyas et al., 2019; Frey & Hunt, 2018). Parental monitoring is even more crucial when considering suicide as caregivers are uniquely positioned to promote coping skills, identify warning signs, and connect adolescents to mental health services. However, for caregivers to engage in these and other lifesaving behaviors, they need to feel confident in doing them (i.e., suicide prevention communication [SPC] self-efficacy; Bandura, 1982).

Unfortunately, prior to the work reported here, no studies have examined Latino caregivers' SPC self-efficacy, and very few have explored their perspectives and recommendations for suicide prevention. Thus, this three-paper mixed method dissertation aims to explore, extend, and promote Latino caregivers' involvement in the prevention of suicide among Latino adolescents. Using a mixed methods design beginning with a scoping review, followed by quantitative data collection, and ending with additional qualitative interviews, I am able to flesh out the role of Latino caregivers in SPC, obtain a baseline of their concern, confidence, and desire for involvement in preventing adolescent suicide in their families; and gain a deeper understanding of what such involvement would entail. Most importantly, using data from multiple sources, quantitative and qualitative, allows me to unpack the construct of a "culturally-tailored prevention program" from Latino caregivers' point-of-view. In the following sections, I highlight the unique findings of each data collection component, describe some of the threats to validity discovered through the interviews and project limitations, and, lastly, I discuss the broader implications of this mixed method project for research, practice, and policy.

## Summary of Main Findings

### Chapter 3: Where are Latino Families in Adolescent Suicide Prevention? A Scoping Study

This chapter presents *Where are Latino Families in Adolescent Suicide Prevention? A Scoping Study*. The study provides an overview of Latino families' involvement in the etiology of suicide, their role in its prevention, and a discussion of how research has involved them in this phenomenon. More specifically, it explores the literature to answer the following research questions: (1) What is the extent of research available on Latino adolescent suicide that mentions family? (2) Based on Latino adolescent suicide literature that mentions family, what is the family's role in the development of suicide-related phenomena? (3) In the identified literature, how are Latino family members included in suicide-related prevention efforts?

Seventy-five peer-reviewed articles on Latino adolescent suicide mentioning the family between 2000 and 2020 were identified and included in the final analysis. The results demonstrate an increase in research around the topic compared to a similar review conducted in 2007 (Duarté-Vélez & Bernal, 2007). Most of the increase in the research focused on the causes of Latino adolescent suicide (79%; $n = 59$), with few studies directly soliciting family members' opinions or involving them in the research ($n = 21$).

Per the articles reviewed, Latino families have both a protective and a risk factor role in the development of Latino adolescent suicidality, with most of the literature emphasizing how families can create risk ($n = 33$). Still, although most research highlighted factors that possibly pathologize Latino families, a few focused on ways in which Latino family strengths may help prevent adolescent suicide. Family cohesion was one of the most significantly explored factors in the etiology of suicide among Latino adolescents. The findings suggest that there is a negative correlation between suicide and family cohesion. Attitudinal familism, family communication,

and the cultural meaning of suicide were the least explored by the literature and received mixed findings in the studies examined. Some suggested negative correlations with suicide, and others noted positive correlations.

Forty percent ($n$ = 31) of the articles called for future studies to involve Latino family members in suicide prevention research. Few studies included a family member ($n$ = 21). Most of the family member's inclusion was providing demographic information or information on the parent-child relationship. A little more than ten percent of the sample ($n$ = 8) explored Latino family members' perceptions of adolescent suicidality. Ultimately, the study findings highlight a gap in Latino caregiver's involvement in suicide prevention research. Leaving the questions: What do families know about this phenomenon, and do they want to be engaged in its prevention?

**Chapter 4: Latino Caregiver's Suicide-Related Prevention Communication Literacy, Involvement, and Self-Efficacy**

Chapter 4 examines Latino caregiver's ($N$ = 133) literacy, desire, and self-efficacy beliefs about Latino adolescent suicide and its prevention. Three research questions guided the study, (1) What do Latino caregivers know about suicide and its prevention? (2) To what extent do Latino caregivers perceive themselves as being able to engage in SPC? And (3), How does Latino caregiver's SPC self-efficacy vary by socio-demographics, familism, caregiver-adolescent communication, cultural sanctions around suicide, exposure to suicide prevention programs (referred to as reinforcement), and experience with adolescent suicidal behaviors and the mental health system? Ultimately, the study begins to provide a baseline of Latino caregivers' SPC unearthing some of its correlates.

The study measured family factors identified by the scoping study findings that are also associated with caregiver self-efficacy. Study measures included: caregiver-adolescent communication; cultural sanctions of suicide; familism; suicide prevention variables—literacy; observational learning; reinforcement; concern; desire to participate in prevention; perceived cause of suicide; endorsed prevention strategies; several socio-demographic variables (e.g., age, income, time in the United States, acculturation, religiosity); and caregiver SPC self-efficacy.

The majority of the sample (89%; $n = 122$) reported being concerned about Latino adolescent suicide in their communities. Less than a quarter of the sample (23%; $n = 31$) had heard of a suicide prevention program in their community, but nearly half (60%; $n = 80$) would participate in one if given the opportunity. Moreover, similar to previous community-based samples (Calear et al., 2021; Czyz et al., 2018), the participants' suicide literacy was well below average ($M = 58$ out of 100), and their SPC self-efficacy ($M = 8.09$, $SD = 2.87$) was moderately high. Most participants struggled with knowledge related to warning signs and risk factors. Based on these levels, primary and secondary prevention that have shown significant effects on raising suicide literacy (Connell et al., 2016; Dueweke & Bridges, 2016) could be adapted to bridge their knowledge gaps.

Lastly, the multivariate analysis revealed that suicide prevention reinforcement ($p < .01$), familism ($p < .01$), and income ($p < .05$) had statistically significant positive correlations with Latino caregiver's SPC self-efficacy. These results provide support for the theory that behavioral, environmental, and personal factors influence an individual's self-efficacy (Bandura, 1977, 1982; Czyz et al., 2018). In sum, the study results show a desire and need for a culturally-tailored Latino adolescent suicide prevention program that targets their caregivers as agents of change. Such a program may build economic mobility, fortify familism, and increase Latino

caregivers' suicide literacy and SPC self-efficacy. The next question that arose was: How do Latino caregivers want such a program to look like and unfold?

## Chapter 5: Adolescent Suicide Prevention Program Recommendations from Latina Immigrant Mothers: "Starting with the Word"

Chapter 5 expands on the quantitative survey findings regarding Latino caregivers' endorsed desire to participate in a culturally specific suicide prevention program. The chapter explains the qualitative portion of the mixed method project, which seeks to understand and describe Latina immigrant mothers' ($n$ = 22) program recommendations for an effective suicide prevention program targeting caregivers as change agents. Semi-structured interviews were conducted via Zoom and primarily in Spanish. A structural and inductive coding was used to examine the subsection of the interviews where the participants were asked: How would you like an adolescent suicide prevention program aimed at Latino parents to be like? Then a thematic analysis was conducted.

From thematic analysis, three themes were identified: (1) engagement via a multi-step effort in culturally relevant spaces; (2) providing psychoeducation in culturally meaningful ways; and (3) offering tangible takeaways. Latina immigrant mothers described the need for a multi-step prevention effort that first engages them in culturally relevant spaces, such as their social media platforms, and a non-threatening manner. Instead of using the word suicide, the participants described a social media awareness campaign focusing on mental health and adolescent well-being. They mentioned wanting to be able to repost the campaign ads on their social media platforms and WhatsApp groups. The participants' desires to start with primary prevention efforts could be related to previous findings suggesting that suicide rates for Latino adolescents are two times higher in the United States than those in most Latin American

countries (Borges et al., 2008; World Health Organization, 2014). Thus, compared to non-Latino immigrant parents, Latina immigrant mothers may find the mere word or idea too stigmatizing and horrifying, and shut off if exposed to the subject too soon.

After being exposed to primary efforts, they reported a desire to participate in an educational meeting(s). These meetings would provide psychoeducation related to suicide and its prevention in culturally meaningful ways. In this second theme, the participants discussed aspects of the program related to logistics (e.g., time, location) and content. Latina mothers recommended that the meetings be at culturally relevant locations that are neutral within the community. Suggestions included: community centers, consulates, schools, and churches. They also discussed the need for a panel of facilitators who mirror themselves in acculturation, nativity, and language. More than half of the mothers recommended that the panel include a parent with lived experience caring for a suicidal adolescent. There were 11 specific informational categories that the mothers believed should make up the content of these educational meetings: (1) starting with the word suicide; (2) affect regulation skills; (3) prevalence of suicide among Latino adolescents; (4) stressors related to suicide specific to Latino adolescents; (5) warning signs of suicide; (6) intervening and lethal means safety; (7) techniques to enhance caregiver-child communication; (8) opportunities to increase parental involvement; (9) how to broker the subject of emotions, mental health, and suicide with an adolescent; (10) steps to follow if adolescent discloses or attempts suicide; and (11) resources in the community. This yearning for knowledge is unsurprising considering Latino caregivers' low suicide literacy levels (Calear et al., 2021; Dueweke & Bridges, 2016; see Chapter 4). Lastly, the mothers recommended that the program offer tangible takeaways. These takeaways included: family activities, resources, and an audio, visual, or video hand-out with the programs' content.

Overall, the importance of personalism and testimonies transcended throughout the themes, underlying many of the recommendations made by the mothers. This finding is consistent with research noting the importance of personalism and testimonies when working with Latino adults (Coatsworth et al., 2002; Delgado-Romero et al., 2018). Moreover, several of the recommendations made by the mothers contain strategies already depicted in the suicide prevention literature (Calear et al., 2016; Ford et al., 2015; Villarreal-Otálora et al., 2019). For example, many of the recommendations closely align with the curriculum of Familias Unidas — a prevention program targeting Latino adolescent drug use and risky sexual behaviors (Coatsworth et al., 2002). Future research may want to adapt the program to be suicide-specific and incorporate the primary prevention efforts suggested by the mothers.

## Limitations

It is important to note several limitations to this dissertation ranging from data collection to instrumentation to analysis. First, the sample was geographically constricted to Georgia, thus limiting the generalizability of the findings. Moreover, since the entire dissertation was conducted remotely through various online platforms, the sample may not reflect the Latino population's acculturation and nativity. For example, the sample included more caregivers from South America than Central America, which is not reflective of the Latino population breakdown in Georgia. This limitation could have been avoided if recruitment and data collection could have been conducted in person, but due to COVID-19 related research restrictions that was not possible. Only mothers agreed to participate in the qualitative portion of the study. Thus, the program recommendations outlined by the study may be missing components and content that appeal to Latino fathers.

Secondly, most of the measurements used and the quotes presented were translated, which always risks the loss of meaning. This limitation could explain why the scale of the cultural sanctions, which was developed and validated with U.S. minoritized populations in mind, performed poorly in the Latino caregiver sample. Secondly, the bias introduced by social desirability could have inflated the level of SPC self-efficacy reported by the participants as the survey was not anonymous. Moreover, the survey instrument did not include any attention checks to assess data quality. During the interviews, some qualitative participants mentioned not understanding or paying attention when taking the survey, thus selecting answers without understanding the question. Nonetheless, the survey instrument did include other types of quality checks — IP addresses, reCAPTCHA, survey time, asking questions twice using different language, and option choices — to assist with the removal of fraudulent responses and data cleansing. Lastly, due to limitations with time and resources, member checking was not possible for the thematic analysis, thus limiting the legitimation of the findings.

## Implications for Social Work

The dissertation's findings have several implications for social work practice, policy, and research despite the limitations stated above. Each of the studies' corresponding chapters describes in detail the implications of its findings. The following sections provide the reader with an overall summary of broader implications associated with the dissertation.

### Social Work Practice Implications

As the Latino population continues to grow in the United States (U.S. Census Bureau, 2019), social workers' interactions with Latino families and adolescents will increase. For many Latino families, their first encounter with a social worker is when their adolescent has reached a point of despair and hopelessness, two states that increase suicidal risk (Chu et al., 2010; Gulbas

et al., 2018; Van Orden et al., 2010). Thus, social workers must be prepared to assess suicide risk and engaged in evidence-based safety planning. Latino caregivers are central in caring for and monitoring Latino adolescents at risk for suicide. Social workers often rely on caregivers to engage in these activities as part of evidence-based safety planning (King et al., 2013). Indeed, by being aware of Latino caregivers' gaps in knowledge regarding suicide and its prevention, social workers can build better rapport, meet the caregiver where they are, and engage in more effective safety planning for an adolescent at risk; as well as for those who are in a crisis.

The findings from the survey highlight specific suicide prevention strategies Latino caregivers feel uncomfortable in engaging. Some include asking directly about suicide and lethal means restrictions. These strategies should be thoroughly discussed, outlined step-by-step, and role-played, if applicable, with the caregivers. The importance of this cannot be stressed enough as evidence consistently shows that reducing access to lethal means saves lives (Stone et al., 2017). To do this effectively, the provider most speak the language of the caregiver, which many times is not the case. There is an increased need for bilingual/bicultural providers who can assist caregivers in this effort to reduce suicidality among Latino children. Currently, there are very few bilingual/bicultural social workers so perhaps policies and programs can be developed to increase the number of mental health providers who can speak the language and can demonstrate cultural congruency with Latino immigrant families.

Latina immigrant mothers were very open in sharing their program recommendations, and the analysis yielded 11 suicide prevention-specific content areas. This information is precious given the few suicide prevention programs involving families (Frey & Hunt, 2018) and Latino caregivers (see Chapter 3; Villarreal-Otálora et al., 2019). Practitioners may utilize this knowledge in their clinical family sessions or as possible objectives for a suicide prevention

curriculum targeting Latino caregivers of adolescents. In sum, the findings from the dissertation study can inform, empower, and assist Latino caregiver's engagement in suicide prevention.

**Social Work Policy Implications**

By highlighting Latino caregivers' role in suicide prevention, the results from this study point towards a needed expansion of services that include more support for family members and assist with stabilizing the financial standing of Latino immigrant families. First, the findings from this study can assist in pushing insurances to cover family, family without sessions, and groups for caregivers as part of the adolescent's treatment plan. Second, based on the dissertation findings and consistent with previous research (Stone et al., 2017), micro policies need to be accompanied by macro policy changes that tackle barriers for Latino caregiver's economic stability. These policy implications are especially relevant for Latino families in new destination states with anti-immigrant policy climates. Latino caregivers in these states and hostile climates are excluded from employment due to immigration status and have fewer support systems, resources, and networks to turn to for assistance (Terrazas, 2011). All of which place significant stressors on them and, by extension, their adolescents, adding to an already challenging developmental period, possibly increasing their risk for adverse mental health outcomes (Hatzenbuehler et al., 2017).

**Research Implications**

The findings have significant implications for research, identifying multiple areas for further suicide prevention research and innovative recruitment and engagement methods with Latino caregivers. Additionally, since this dissertation study is the first to translate the SPC self-efficacy scale and use it with Latino adults, future studies can further test the reliability and

validity of the translated scale with this population. Such research can employ a similar mixed method design outlined in this dissertation.

The recommendations made by Latino caregivers and the knowledge and confidence gaps outlined in the survey results build a foundation for further prevention research. For example, the scoping study results found that primary prevention efforts were the least advocated for by the literature. However, during the interviews, Latina immigrant mothers described primary efforts as the most important. Thus, prevention research should pay special attention to primary level efforts that target Latino caregivers. Additionally, insights from the interview portion of the study can be used to inform program development or a protocol on engaging caregivers in suicide prevention if their adolescent is struggling with suicide.

In addition to laying the foundation for prevention research, by using a variety of data modes and analyses, the findings provide direction for future mixed method research with this population. Moreover, the findings add to previous insights from Zayas et al. (2009) and Haack et al. (2014) regarding retention and recruitment strategies with Latino individuals. In this dissertation, recruitment-driven advertisement (RDA) yielded more participants than the traditional recruitment methods used with minoritized populations of flyers and gatekeepers, suggesting RDA as a promising sampling tool with minoritized individuals. Another promising research area to explore is data collection through videoconference platforms with Latino adults. While most of the participants in this study mentioned preferring in-person interviews, they reported Zoom as a friendly and convenient alternative. Moreover, less than 5% of them had issues with the platform. Overall, it would be interesting to explore how generalizable the qualitative results are among a larger, population of Latino folks.

## Conclusion

For Latino adolescent suicide prevention to advance, the research community needs to involve and partner up with their caregivers. Taken together, this dissertation's findings offer insight into Latino immigrant caregiver's SPC and avenues in which they can be a locus for Latino adolescent suicide prevention. Ultimately, I hope that this dissertation propels more inclusive suicide prevention research among Latino communities.

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# APPENDIX A

## List of Key Terminology

- *Adolescent*: Is defined as an individual between the age of 13 to 18 because cross-sectional and longitudinal empirical research suggests that suicidal ideation and suicide attempt typically begin between the age of 13 and 15 (Hawton et al., 2012; Plener et al., 2015).
- *Caregiver*: encompasses a family member (e.g., parent, uncle, aunt, grandparent, sibling) who regularly looks after an adolescent and is responsible for managing the behavior and well-being of that minor.
- *Culture*: Is defined as a dynamic and polylithic concept referring to the attitudes, beliefs, standards of behaviors, and values that organize and influence a person's perceptions, psychological processes, actions, and social practices (Gulbas & Zayas, 2015). Culture, in this definition, is viewed as a plural concept encompassing a variety of evolving contexts. In these contexts, systems of interlocking beliefs and values interact and mutually influence an individual's actions, decisions, and life. Conceptualizing culture, in this manner, acknowledges the dynamic nature of culture and thus leans towards an anthropological view.
- *Latino adult*: Refers to those individuals 18 and older who trace their roots to Mexico, Puerto Rico, Dominican Republic, Cuba, and South America.

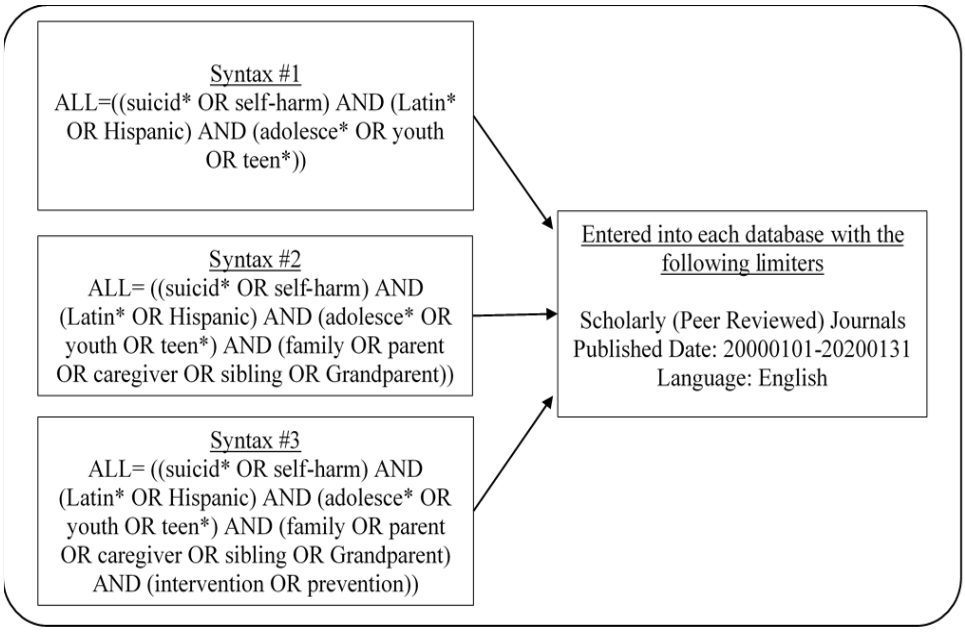
- *New destination state:* Geographic loctaions in the United States where few Latinos have previously settled. These are primary in the southern and central region of the United States. Some examples include, Georgia, North Carolina, South Carolina, and Tennessee.
- *Prevention:* Refers to systematic actions taken to reduce the occurrence of a behavioral problem (Leavell & Clark, 1965; Mrazek & Hoggarty, 1994). These actions can be directed towards general awareness-raising aimed at reducing the development of the behavioral problem (referred to as primary); target specific individuals known to be at risk for the behavioral problem or those individuals that frequently interact with them (referred to as secondary); or focus on specific individuals who have exhibited a clear manifestation of the problem or those individuals that frequently interact with them (tertiary).
- *Self-efficacy:* Refers to the magnitude, generality, and strength in an individual's conviction that they can successfully perform the behaviors required to produce a specific outcome (Bandura, 1977, 1982).
- *Suicide:* Is defined as a death caused by self-directed injurious behavior done with the intent to die (Centers for Disease Control and Prevention, 2019)
- *Suicide attempt:* Is defined as a non-fatal self-directed and potentially injurious behavior done with the intent to die as a result of the behavior (Centers for Disease Control and Prevention, 2019).
- *Suicidal ideation*: Is defined as thinking about, considering, or planning suicide (Centers for Disease Control and Prevention, 2019).
- *Suicidality:* Refers to both suicidal ideation and suicide attempt.

- *Suicide-related communication*: Describes “all forms of conveying information to another person about the prevention, intervention, and postvention of suicidal ideation or behavior, as well as one’s personal experiences with or exposure to suicidal ideation, intent, or behaviors” (Frey et al., 2019, p. 6).
- *Suicide-related prevention communication*: Refers to suicide-related communication that is not about ones-self and is done for advocacy, educational, outreach, or intervention purposes (Frey et al., 2019).
- *Suicide-related personal communication:* Refers to an individual’s act of conveying their suicidality to another person, such as an adolescent to a caregiver (Frey et al., 2019).

# APPENDIX B

## Database Search Strategy for Scoping Study (Chapter 3)

*Database Search Strategy*



# APPENDIX C

## Study Survey (Chapter 4)

**Spanish**

*Bienvenido! Sus respuestas son muy valiosas para nosotros. La información que usted nos da en esta encuesta es confidencial y no será compartida con nadie. Por favor conteste honestamente a todas las preguntas, ya que la información nos ayudara a proveer más apoyo a madres y padres Latinos/Hispanos en el estado de Georgia.*

*Usted recibirá su tarjeta de regalo electrónica de $15 en 24 a 48 horas de terminar esta encuesta.*

***Por favor conteste las siguientes preguntas acerca de su adolescente(s):***

1. ¿De cuántos adolescentes (de edad 13 a 18) es usted responsable?

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5 +
- ➔ ¿Cuáles son las edades de ellos/ellas? Elija todos los que apliquen
  - ☐ 13
  - ☐ 14
  - ☐ 15
  - ☐ 16
  - ☐ 17
  - ☐ 18
- ➔ Cuantos de ellos son…

  Femenino (mujer): _____ (dropdown box)

Masculino (hombre): _____ (dropdown box)

➔ ¿Alguno de esos adolescentes nació fuera de los Estados Unidos?

- ☐ Si
- ☐ No
- ☐ Prefiero no contestar

2. ¿Sus adolescentes (edad 13 a 18) viven con usted?

- ☐ Si, con todos
- ☐ Si, con algunos
- ☐ No, ningunos viven con migo

3. ¿Usted está preocupado/a por el suicidio entre los adolescentes Hispanos/Latinos?
   - ☐ Si, mucho
   - ☐ Si, algo
   - ☐ Si, poquito
   - ☐ No, para nada

4. ¿Usted ha oído hablar de algún programa de prevención del suicidio en su comunidad?
   - ☐ Si
   - ☐ No

5. Si se le presenta la oportunidad, ¿qué tan probable es que participe en un programa de prevención del suicidio?
   - ☐ Muy probable
   - ☐ Algo probable
   - ☐ Ni probable ni improbable
   - ☐ Algo improbable
   - ☐ Muy improbable

*Las siguientes frases se refieren a varios comportamientos.* ***Seleccione el puntaje que mejor refleje que tan seguro/a se siente de hacer lo que la frase dice.***

| ***0*** *1* *2* *3* *4* ***5*** *6* *7* *8* *9* *10* ***11*** |
|---|
| *Para nada seguro/a* — *Algo seguro/a* — *Completamente seguro/a* |

| **¿Qué tan seguro/a se siente en ...** | **0 1 2 3 4 5 6 7 8 9 10 11** |
|---|---|
| 6. Preguntarle a su adolescente de su estado de ánimo. …….... | 0 1 2 3 4 5 6 7 8 9 10 11 |
| 7. Preguntarle a su adolescente si está experimentando pensamientos de suicidio. …….... | 0 1 2 3 4 5 6 7 8 9 10 11 |
| 8. Responder de manera útil si su adolescente revela pensamientos de suicidio. …… | 0 1 2 3 4 5 6 7 8 9 10 11 |
| 9. Identificar indicadores de suicidio o señas de advertencia en su adolescente. ……. | 0 1 2 3 4 5 6 7 8 9 10 11 |
| 10. Obtener un compromiso de su adolescente a que no atente el suicidio. ….……..……..……..... | 0 1 2 3 4 5 6 7 8 9 10 11 |
| 11. Trabajar con su adolescente en un plan para mantener su seguridad. …..……..……..… | 0 1 2 3 4 5 6 7 8 9 10 11 |
| 12. Asistirle a su adolescente a conseguir tratamiento para sus dificultades. ……...……..……0 | 1 2 3 4 5 6 7 8 9 10 11 |
| 13. Animar a su adolescente a lidiar con sus dificultades de maneras que hayan sido útiles en el pasado. ...……..…… | 0 1 2 3 4 5 6 7 8 9 10 11 |

14. Ofrecer apoyo emocional (como escuchar los, decirles que son importantes para usted, abrazarlos) a su adolescente.
……..……..…. 0 1 2 3 4 5 6 7 8 9 10 11

15. Guardar en una caja de seguridad y caja fuerte todos los cuchillos de la casa, medicamentos recetados y sin receta, y pistolas.
……...…… 0 1 2 3 4 5 6 7 8 9 10 11

16. Que tan seguro/a esta usted que su adolescente le diga si tiene pensamientos de matarse.
.....…… 0 1 2 3 4 5 6 7 8 9 10 11

17. Que tan seguro/a se siente de poder mantener su adolescente a salvo si en un futuro tienen pensamientos de matarse.
……...…..0 1 2 3 4 5 6 7 8 9 10 11

18. Que tan seguro/a esta que su adolescente NO atentará al suicidio en un futuro.
…….…...….... 0 1 2 3 4 5 6 7 8 9 10 11

*Por favor lea las siguientes frases y* ***<u>seleccione si usted cree que la frase es verdadera, falsa o si no sabe</u>****.*

***Verdad Falso No sé***

19. El suicidio es prevenible.……...……..….... Verdad Falso No lo sé

20. Ver a un psicológico o psiquiatría puede ayudar a prevenir que un adolescente se suicide.
……...……..….... Verdad Falso No lo sé

21. Hablar acerca del suicidio siempre aumenta el riesgo al suicidio.
…….…….. Verdad Falso No lo sé

22. No todos los adolescentes que intentan suicidarse lo planean con anticipo.
…… Verdad Falso No lo sé

23. Muy pocos adolescentes tienen pensamientos sobre el suicidio.
…….…….. Verdad Falso No lo sé

24. Adolescentes que hablan del suicidio, rara vez lo hacen.
…….……..…Verdad Falso No lo sé

25. Los adolescentes que quieren suicidarse pueden cambiar de pensamiento rápidamente.
……..…….…… Verdad Falso No lo sé

26. Hay una relación fuerte entre el uso de drogas y el suicidio.
……..…….…..... Verdad Falso No lo sé

~~En los Estados Unidos, el problema del suicidio está creciendo entre los adolescentes Hispanos-as/Latinos-as. ……..…… Verdad Falso No lo sé~~

27. ¿Por qué las personas se quieren quitar la vida? Elija todos los que apliquen

- ☐ Depresión
- ☐ Están locas/locas
- ☐ Muerte de algún familiar
- ☐ Por llamar la atención
- ☐ Múltiples factores y/o razones

28. Si usted piensa que un adolescente Hispano/a esta pensando en suicidarse, ¿que puedes hacer para ayudarlo/a? Elija todos los que apliquen

- ☐ Nada
- ☐ Hablar con él adolescente
- ☐ Estar alerta a las señales de advertencia
- ☐ Preguntarle a el adolescente si está pensando en suicidarse
- ☐ Buscar ayuda

- ☐ Si, no es mi adolescente, decirles a los padres
- ☐ No se

*Las siguientes frases tienen 5 opciones de respuestas para elegir de.* ***Seleccione el puntaje que mejor refleje que tan de desacuerdo o acuerdo está usted con las siguientes frases.***

| |
|---|
| 1 = Muy en **desacuerdo** |
| 2 = En desacuerdo |
| 3 = Ni de acuerdo ni desacuerdo |
| 4 = De acuerdo |
| 5 = Muy de **acuerdo** |

| | ***Muy en desacuerdo*** | | | | ***Muy de acuerdo*** |
|---|---|---|---|---|---|
| 29. Mi adolescente y yo podemos hablar de casi todo. ..... | 1 | 2 | 3 | 4 | 5 |
| 30. Mi adolescente a veces no me escucha. ….....1 | 1 | 2 | 3 | 4 | 5 |
| 31. Yo puedo decirle a mi adolescente como me siente con respecto a cualquier cosa. ……..……..……..... | 1 | 2 | 3 | 4 | 5 |
| 32. Yo estoy satisfecho/a con la forma en que mi adolescente y yo hablamos. …… | 1 | 2 | 3 | 4 | 5 |
| 33. Yo soy cuidadoso/a con lo que le digo a mi adolescente. ……..... | 1 | 2 | 3 | 4 | 5 |
| 34. Cuando hago una pregunta, obtengo una respuesta honesta de mi adolescente. ……..... | 1 | 2 | 3 | 4 | 5 |

35. Hay temas que yo evito hablar con mi adolescente.
……. 1 2 3 4 5

36. Mi adolescente sabe cómo hablarme. …..... 1 2 3 4 5

37. Me resulta fácil hablar acerca de los problemas con mi adolescente.
……. 1 2 3 4 5

38. Es fácil para mi hablar acerca de todos mis sentimientos verdaderos con mi adolescente.
..... 1 2 3 4 5

39. Mi familia siempre está ahí cuando los necesito. ..... 1 2 3 4 5

40. Estoy orgulloso de mi familia. ..... 1 2 3 4 5

41. Valoro el tiempo que paso con mi familia. ..... 1 2 3 4 5

42. Sé que mi familia tiene en mente los mejores intereses para mí.
..... 1 2 3 4 5

43. Los miembros de mi familia y yo compartimos valores y creencias similares.
……..……1 2 3 4 5

*Las siguientes frases tienen 6 opciones de respuestas para elegir de.* ***Seleccione el puntaje que mejor refleja que tan en desacuerdo o acuerdo está usted con las siguientes frases.***

| |
|---|
| **0 =** Muy **desacuerdo** |
| 1 = Algo en desacuerdo |
| 2 = Poco en desacuerdo |
| 3 = Ni de desacuerdo ni de acuerdo |

| |
|---|
| 4 = Poco de acuerdo |
| 5 = Algo de acuerdo |
| **6 =** Muy de **acuerdo** |

| | ***Muy en desacuerdo*** | | | | | | ***Muy de acuerdo*** |
|---|---|---|---|---|---|---|---|
| 44. El suicidio le traería vergüenza a la familia. ….. | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 45. Las creencias familiares, culturales, o religiosas sobre el suicidio evitan que la gente considere suicidarse. ……... | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 46. Mi familia, cultura o religión está en contra la idea del suicidio. ……..…….. | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 47. Yo considero que el suicidio es moralmente incorrecto. ……..……..... | 0 | 1 | 2 | 3 | 4 | 5 | 6 |

*Antes de terminar, díganos sobre usted y su adolescente(s). Recuerde que todas sus respuestas son confidenciales.* ***<u>Para cada pregunta seleccione la respuesta que más le parezca.</u>***

48. ¿Usted con cuál religión se identifica?

- ☐ Católica
- ☐ Protestante: _____
- ☐ Testigo de Jehová
- ☐ Ortodoxa
- ☐ Ateo
- ☐ Ninguno
- ☐ Otro: _____

49. ¿Usted con qué frecuencia participa en actividades religiosas (como ir a misa o grupos de iglesia)?
    - ☐ Nunca
    - ☐ Algunas veces al año
    - ☐ Una vez al mes
    - ☐ Una vez a la semana
    - ☐ Casi todos los días de la semana

50. ¿Qué tan importante son sus creencias religiosas en su vida?
    - ☐ No son importantes
    - ☐ Algo importante
    - ☐ Moderadamente importante
    - ☐ Muy importante
    - ☐ Extremamente importante

51. ¿Alguno de sus hijos adolescentes han recibido o están recibiendo servicios de salud mental?
    - ☐ Si
    - ☐ No
    - ☐ Prefiero no contestar

52. Según su conocimiento, ¿alguno de sus adolescentes alguna vez ha <u>pensado</u> en suicidarse?
    - ☐ Si
    - ☐ No
    - ☐ No estoy seguro/a
    - ☐ Prefiero no contestar

53. Según su conocimiento, ¿alguno de sus hijos adolescentes alguna vez ha <u>intentado</u> suicidarse?
    - ☐ Sí
    - ☐ No
    - ☐ No estoy seguro/a

☐ Prefiero no contestar

54. ¿Usted ha intentado suicidarse alguna vez?

☐ Si

☐ No

☐ Prefiero no contestar

55. ¿Usted ha recibido o está recibiendo servicios de salud mental?

☐ Si

☐ No

☐ Prefiero no contestar

El número de Lifeline a continuación proporciona apoyo 24/7, gratuito y confidencial para personas que están sufriendo, prevención y recursos de crisis para usted o sus seres queridos:


Si usted o un ser querido necesita conectarse con servicios de salud mental en Georgia, llame a **la Línea de Acceso a Crisis y Acceso de Georgia al 1 (800) 715-4225**, disponible las 24 horas los 7 días de la semana:

***Por último, por favor proveer la siguiente información adicional.***

56. ¿En qué país naciste?

- Argentina
- Bolivia
- Brasil
- Chile
- Colombia
- Costa Rica
- Cuba
- Ecuador
- El Salvador
- Estados Unidos
- Guatemala
- Honduras
- México
- Nicaragua
- Panamá
- Paraguay
- Perú
- Puerto Rico
- República Dominicana
- Uruguay
- Venezuela

57. ¿Cuál es su género?

- ☐ Femenino
- ☐ Masculino
- ☐ Otro: _____

58. ¿Cuántos años tiene usted? _____ (dropdown box)

59. ¿Cuál es su estado civil actual?

- ☐ Soltero/a, nunca casado/a
- ☐ En una relación
- ☐ No casado/a, viviendo con pareja
- ☐ Casado/a, viviendo con pareja

- ☐ Casado/a, viviendo sin pareja
- ☐ Separado/a o Divorciado/a
- ☐ Viuda/o
- ☐ Otro: _____

60. Aproximadamente, ¿cuánto tiempo has vivido en los Estados Unidos?
    - ☐ _____ Años O_____ Meses
    - ☐ No estoy seguro/a
    - ☐ Prefiero no contestar

61. Aproximadamente, ¿cuántos años has vivido en el estado de Georgia?
    - ☐ _____ Años O_____ Meses
    - ☐ No estoy seguro/a
    - ☐ Prefiero no contestar

62. En general, ¿Usted que idioma(s) lee y habla?
    - ☐ Sólo español
    - ☐ Español mejor que inglés
    - ☐ Ambos igualmente
    - ☐ Inglés mejor que Español
    - ☐ Solo inglés

63. ¿Cuál es su nivel más alto de educación?
    - ☐ Primaria
    - ☐ Algo de secundaria
    - ☐ Secundaria
    - ☐ Algo de bachillerato/preparatoria
    - ☐ Bachillero/preparatoria
    - ☐ Algo de Superior/Universidad
    - ☐ Superior/Universidad
    - ☐ Posgrado/Maestría

- ☐ Técnica
- ☐ Otra: _____

64. ¿Cuál es su ingreso familiar anual?

- ☐ Ninguno
- ☐ Menos de $15,000
- ☐ $15,001 a $25,000
- ☐ $25,001 a $35,000
- ☐ $35,001 a $45,000
- ☐ $45,001 a $55,000
- ☐ $55,001 a $65,000
- ☐ $65,001 a $75,000
- ☐ $75,001 a $85,000
- ☐ $85,001 a $95,000
- ☐ $95,001 o más

65. ¿Cómo se enteró de este estudio? Seleccione todos los que apliquen.

- ☐ Amigo o miembro de familia
- ☐ La escuela de mi hijo/a (consejero escolar, profesor, etc.)
- ☐ Clínica de salud mental: _____
- ☐ Centro comunitario: _____
- ☐ Iglesia (volante en la iglesia, Sacerdote/Padre, personal o voluntario de la iglesia, etc.)
- ☐ Otro: _____

En caso de que no podamos comunicarnos con usted, por favor denos el nombre de una persona quien podamos llamar y que nos pueda ayudar a comunicarnos con usted (por ejemplo, un pariente o amigo cercano).

Nombre: _____

Teléfono: _____

66. ¿Cómo se enteró de este estudio?

- ☐ Familiar o amigo

- ☐ La escuela de mi hijo (consejero escolar, maestro, etc.)
- ☐ Centro de salud conductual de la comunidad: (especificar) _____
- ☐ Agencia de servicios comunitarios: (especificar) _____
- ☐ Iglesia (volante en la iglesia, sacerdote, personal de la iglesia, voluntarios de la iglesia, etc.)
- ☐ En línea: (especificar)_____
- ☐ Otro: (especificar) _____

**¡GRACIAS!**

Si usted completo la encuesta, **usted debe recibir su tarjeta de regalo electrónica de $15 en aproximadamente 24 a 48 horas.**

**Nosotros lo contactaremos por teléfono o correo electrónico en las próximas 24 a 48 horas.** Durante ese contacto le proveeremos con algunos recursos adicionales para la prevención del suicidio y nos aseguraremos de que haya recibido su tarjeta de regalo de $15 por haber completado la encuesta.

**English**

*Thank you for agreeing to participate in the study and complete this survey! Please answer honestly to all the questions as the information will help us provide more support for Latino/Hispanic parents in Georgia.*

*You will receive your $15 e-gift card within 24 to 48 hours of completing this survey.*

Please answer the following questions about your adolescent children.

1. How many adolescent (age 13 to 18) children are you responsible for?

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5 +
- ➔ What are their ages? Select all that apply
  - ☐ 13
  - ☐ 14
  - ☐ 15
  - ☐ 16
  - ☐ 17
  - ☐ 18
- ➔ How many of them are…

  Females: _____ (dropdown number box)

  Males: _____ (dropdown number box)
- ➔ Were any of them born outside of the United States?
  - ☐ Yes
  - ☐ No
  - ☐ Prefer not to answer

2. Do your adolescent (age 13 to 18) children live with you?

- ☐ Yes, all of them
- ☐ Yes, some of them
- ☐ No

67. Are you worried about suicide among Hispanic/Latino adolescents in the United States?
    - ☐ Yes, allot
    - ☐ Yes, somewhat
    - ☐ Yes, a little
    - ☐ No, not at all

68. Have you heard about any suicide prevention programs in your community?
    - ☐ Yes
    - ☐ No

69. If presented with the opportunity, how likely are you to participate in suicide prevention program?
    - ☐ Yes
    - ☐ No
    - ☐ Maybe
    - ☐ I do not know

*The following statements contain various behaviors.* ***Select the number that best reflects how confident you feel about doing what the statement says.***

| ***0*** *Not at all confident* | *1* | *2* | *3* | *4* | ***5*** *Some-what confident* | *6* | *7* | *8* | *9* | *10* | ***11*** *Completely confident* |
|---|---|---|---|---|---|---|---|---|---|---|---|

| **How confident are you to …** | **0 1 2 3 4 5 6 7 8 9 10 11** |
|---|---|

70. Ask your adolescent about their mood. ……..  0 1 2 3 4 5 6 7 8 9 10 11

71. Ask your adolescent if they are experiencing thoughts of suicide.
……..…… 0 1 2 3 4 5 6 7 8 9 10 11

72. Respond in a helpful manner if your adolescent discloses thoughts of suicide.
…… 0 1 2 3 4 5 6 7 8 9 10 11

73. Identify suicide indicators or warning signs in your adolescent.
……..... 0 1 2 3 4 5 6 7 8 9 10 11

74. Obtain a commitment from your adolescent not to attempt suicide.
……..……..…….…..... 0 1 2 3 4 5 6 7 8 9 10 11

75. Work with your adolescent on a plan for their safety.
……..……..…..… 0 1 2 3 4 5 6 7 8 9 10 11

76. Assist your adolescent in accessing treatment services for their difficulties.
…….…..……..…….. 0 1 2 3 4 5 6 7 8 9 10 11

77. Encourage your adolescent to cope with their difficulties in ways that have been helpful in the past. …… 0 1 2 3 4 5 6 7 8 9 10 11

78. Offer emotional support to your adolescent (such as listen to them, tell them they are important to you, give them a hug). ……..… 0 1 2 3 4 5 6 7 8 9 10 11

79. Put away all of the house knives, over-the-counter and prescribed medications, and firearms in a lockbox. ……...…… 0 1 2 3 4 5 6 7 8 9 10 11

80. If your adolescent has thoughts of killing themselves in the future, how confident are you that they will tell you? ……..…… 0 1 2 3 4 5 6 7 8 9 10 11

81. If your adolescent has thoughts of killing themselves in the future, how confident are you that you will be able to keep your adolescent safe?
……..……... 0 1 2 3 4 5 6 7 8 9 10 11

82. How confident are you that your adolescent will NOT attempt suicide in the future?
……... 0 1 2 3 4 5 6 7 8 9 10 11

*Please read the following statements carefully and* ***select whether you think that the statement is true, false, or you do not know.***

***True False I don't know***

83. Suicide is preventable. ……..……..….. True False I don't know

84. Seeing a psychiatrist or psychologist can help prevent an adolescent from suicide……...……..….. True False I don't know

85. Talking about suicide always increases the risk of suicide…….…... True False I don't know

86. Not all adolescents who attempt suicide plan their attempt in advance. ……..… True False I don't know

87. Very few Hispanic/Latino adolescents have thoughts about suicide. ……. True False I don't know

88. Adolescents who talk about suicide rarely kill themselves. ……. True False I don't know

89. Adolescents who want to attempt suicide can change their mind quickly. …… True False I don't know

90. There is a strong relationship between drug use and suicide. ……. True False I don't know

91. Why do adolescents want to take their own lives? Select all that you think apply.

- ☐ Depression
- ☐ They are crazy
- ☐ A family members death
- ☐ To get attention
- ☐ Multiple factors and reasons

29. If a Hispanic adolescent is thinking about suicide, what can you do to help them? Select all that you think apply.

- ☐ Nothing
- ☐ Talk to the adolescent
- ☐ Be on the look out for suicide warning signs
- ☐ Ask the adolescent if they are thinking about suicide
- ☐ Look for help
- ☐ If it is not my adolescent, tell their parents
- ☐ I do not know

*The following statements have 5 answer choices for you to choose from.* ***Select the number that best reflects your level of disagreement or agreement with the following statements.***

| 1 = Strongly disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly agree |
|---|

| | ***Strongly disagree*** | | | ***Strongly agree*** |
|---|---|---|---|---|

30. My adolescent and I can talk about almost anything. .... 1 2 3 4 5

31. My adolescent sometimes doesn't listen to me. …..... 1 2 3 4 5

32. I can tell my adolescent how I feel about everything. .... 1 2 3 4 5

33. I am satisfied with how my adolescent and I talk together.
……..…… 1 2 3 4 5

34. I am careful about what I say to my adolescent. ..... 1 2 3 4 5

35. When I ask a question, I get honest answers from my adolescent. ……..... 1 2 3 4 5

36. There are topics I avoid discussing with my adolescent. 1 2 3 4 5

37. My adolescent knows how to talk to me. ..... 1 2 3 4 5

38. I find it easy to discuss problems with my adolescent. .. 1 2 3 4 5

39. It is easy for me to discuss all my true feelings with my adolescent. ..... 1 2 3 4 5

**Familism scale**

40. My family is always there for me in times of need. ..... 1 2 3 4 5

41. I am proud of my family culture. ..... 1 2 3 4 5

42. I cherish the time I spend with my family. ..... 1 2 3 4 5

43. I know my family has my best interests in mind. ..... 1 2 3 4 5

44. My family members and I share similar values and beliefs.
……..…… 1 2 3 4 5

*The following statements have 6 answer choices for you to choose from.* ***Select the number that best reflects your level of disagreement or agreement with the following statements.***

| |
|---|
| 0 = Strongly disagree |
| 1 = Moderately disagree |
| 2 = Slightly disagree |
| 3 = Neither agree nor disagree |
| 4 = Slight agree |
| 5 = Moderate agree |
| 6 = Strongly agree |

| | ***Strongly disagree*** | | | | | | ***Strongly agree*** |
|---|---|---|---|---|---|---|---|
| 45. Suicide would bring shame to a family. ..... | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 46. Family, culture, or religious beliefs about suicide prevent people from considering killing themselves. ……. | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 47. My family, culture, or religion is against the idea of suicide. ……. | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 48. I consider suicide to be morally wrong. ..... | 0 | 1 | 2 | 3 | 4 | 5 | 6 |

*Before we finish up, tell us about yourself and your adolescent. Remember all your responses are confidential.* ***<u>For each question select the answer that best applies to you.</u>***

49. What religion do you identify with?

    Catholic

    Protestant: _____

    Jehovah's Witness

    Orthodox

    Atheist

    None

    Other: _____

50. How often do you participate in religious activities (like going to church, or church groups)?

    ☐ Never

    ☐ A few times per year

    ☐ Once a month

    ☐ Once a week

    ☐ Almost every day of the week

51. How important are your religious beliefs in your life?

    ☐ Not at all important

    ☐ Slightly important

    ☐ Moderately important

    ☐ Very Important

    ☐ Extremely important

52. Have any of your adolescent children received or are currently receiving mental health services?

    ☐ Yes

    ☐ No

    ☐ Prefer not to answer

53. To your knowledge, have any of your adolescents ever thought about killing themselves?

- ☐ Yes
- ☐ No
- ☐ I am not sure
- ☐ Prefer not to answer

54. To your knowledge, have any of your adolescent children ever attempted to kill themselves?

- ☐ Yes
- ☐ No
- ☐ I am not sure
- ☐ Prefer not to answer

55. Have you ever attempted to kill yourself?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

56. Have you received or are currently receiving mental health services?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

The Lifeline number below provides 24/7, free and confidential support for people in distress, prevention and crisis resources for you or your loved ones:


If you or a loved one needs to be connected to mental health services in Georgia, please call the **Georgia Crisis & Access Line at 1 (800) 715-4225**, available 24/7.



**You are almost done! Please provide us with some additional information about yourself.**

**What is your zip code?**

_____

**In what country were you born?**

- ☐ Argentina
- ☐ Bolivia
- ☐ Brazil
- ☐ Chile
- ☐ Colombia
- ☐ Costa Rica
- ☐ Cuba
- ☐ Dominican Republic
- ☐ Ecuador

- ☐ El Salvador
- ☐ Guatemala
- ☐ Honduras
- ☐ Mexico
- ☐ Nicaragua
- ☐ Panama
- ☐ Paraguay
- ☐ Peru
- ☐ Puerto Rico
- ☐ United States
- ☐ Uruguay
- ☐ Venezuela

**What is your gender?**

- ☐ Female
- ☐ Male
- ☐ Other: _____

**How old are you? _____** (dropdown box)

**Approximately, how long have you lived in the United States?** (dropdown box)

- ☐ Less than a year
- ☐ 1 - 2 years
- ☐ 3 - 5 years
- ☐ 6 - 10 years
- ☐ 11 - 15 years
- ☐ 15 - 20 years
- ☐ 20 - 25 years
- ☐ More than 25 years

**Approximately, how long have you lived in the state of Georgia?** (dropdown box)

Less than a year

- ☐ 1 - 2 years
- ☐ 3 - 5 years
- ☐ 6 - 10 years
- ☐ 11 - 15 years
- ☐ 15 - 20 years
- ☐ 20 - 25 years
- ☐ More than 25 years

**In general, what language(s) do you read and speak?**

- ☐ Only Spanish
- ☐ Spanish better than English
- ☐ Both equally
- ☐ English better than Spanish
- ☐ Only English

**In general, in what language does your adolescent respond to you?**

- ☐ Only Spanish
- ☐ Spanish better than English
- ☐ Both equally
- ☐ English better than Spanish
- ☐ Only English

**What is your current marital status?**

- ☐ Single, never married
- ☐ In a relationship
- ☐ Not married, living with a partner
- ☐ Married, living with a partner
- ☐ Married, living without a partner
- ☐ Separated or Divorced
- ☐ Widowed

- ☐ Other: _____

**What is your highest level of education?**

- ☐ Elementary school
- ☐ Some middle school
- ☐ Middle school
- ☐ Some high school
- ☐ High school
- ☐ Some college
- ☐ College
- ☐ Graduate / Professional school
- ☐ Trade / Vocational school
- ☐ Other: _____

**What is your annual household income?**

- ☐ None
- ☐ Less than $15,000
- ☐ $15,001 to $25,000
- ☐ $25,001 to $35,000
- ☐ $35,001 to $45,000
- ☐ $45,001 to $55,000
- ☐ $55,001 to $65,000
- ☐ $65,001 to $75,000
- ☐ $75,001 to $85,000
- ☐ $85,001 to $95,000
- ☐ More than $95,001

**How did you find out about this study?**

- ☐ Family member or friend
- ☐ My child's school (school counselor, teacher, etc.)
- ☐ Community behavioral health center: (specify) _____

- ☐ Community service agency: (specify) _____
- ☐ Church (flyer at church, priest, church staff, church volunteers, etc.)
- ☐ Online: (specify)_____

***[for remote date collection]*** In case we can't reach you, please provide us with a person that we can contact, and that would be able to help us reach you (e.g., a relative or close friend).

Name: _____

Phone: _____

**THANK YOU FOR COMPLETING THIS SURVEY!**

**We will follow-up with you via phone or email within 24 to 48 hours.**

During that contact we will provide you with some additional suicide prevention resources and provide you with the e-gift card for having completed the survey.

My email is tosudy@uga.edu and my work number is 770.609.4741.

If you or a loved one is in crisis or need to be connected to mental health services call


To be connected to mental health services in Georgia, call the **Georgia Crisis & Access Line at 1 (800) 715-4225**


A CRISIS HAS NO SCHEDULE
Georgia Crisis & Access Line
1-800-715-4225
GeorgiaCollaborative.com
Help is available 24/7 for problems with developmental disabilities, mental health, drugs, or alcohol.
Provided through the Georgia Collaborative ASO
UN CRISIS NO TIENE HORARIO
Georgia Crisis & Access Line
1-800-715-4225
Ayuda está disponible 24/7 para problemas con la salud mental, drogas, o alcohol.
The Georgia Collaborative ASO
www.GeorgiaCollaborative.com

# APPENDIX D

## Interview Protocol_ Spanish_ v3 (Chapter 5)

Study ID/Pseudonym: _____

Fecha:_____/_____/_____

## Part 1: Bienvenido

Gracias por aceptar reunirse conmigo. Recuerde, si algo de lo que hablamos le hace sentir incómodo o molesto, por favor avísame en cualquier momento. Podemos hablar de lo que le molesta, podemos tomar un descanso, podemos saltarnos ese tema, o incluso podemos detener la entrevista si siente que ya no puede seguir con la discusión. Su participación es completamente voluntaria. La entrevista debe tardar más o menos una hora en completarse.

[Envíe a los participantes la tarjeta de regalo electrónico.]

Estoy grabando la entrevista para poder volver a cualquiera de sus declaraciones que podrían ayudarnos a entender sus puntos de vista y posiblemente reproducir clips de sus respuestas para presentar resultados del estudio en conferencias académicas. Todo lo que usted diga será confidencial, y su nombre no estará vinculado a ningún comentario que haga.

****ESTOY ENCENDIENDO LA GRABADORA AHORA****

"Empecemos; hoy es_____ (fecha), y este es el participante (seudónimo) _____y esta entrevista se está llevando a cabo a través de _____ (modo) y se está llevando a cabo en _____ (idioma)."

“Para empezar, le voy a pedirle que confirme algunos de sus datos demográficos diciendo sí o no.”

Según la encuesta en línea que completo,

1. Usted tiene ____ años.
2. Usted nacio en _____.
3. Su adolescente ____ a pensado suicidarse.
4. Su adolescente ____ a intentado suicidarse.
5. Usted se identifica como (religión).
6. Usted o su adolescente (no/ sí) han estados involucrados con consejería o psiquiatría.

## Part 2: Qualitative Interview

**Prompts to keep in mind:**

- ¿Puede darme un ejemplo de lo que quiere decir?
- Por favor, cuénteme más sobre eso.
- Lo que está compartiendo (o ha dicho) es importante.
- ¿Puede decir más?
- ¿Cuéntame más sobre esa experiencia (o ese tiempo)?

**Remember to pause at least 5 seconds after posing a question**

### PART I: Perception of suicide

“Gracias por sus respuestas. Ahora, vamos a entablar una conversación más profunda con respecto al suicidio y su prevención desde su punto de vista.”

1. En la encuesta usted indico (estar/ no estar) preocupad@ por el suicidio entre adolescentes Latinos. Cuénteme más sobre eso.
2. Piense en su juventud, cuando usted estaba creciendo, ¿qué escuchaba acerca del suicidio adolescente?

   a. Y ahora, ¿qué piensas?

3. Cuando escuchas la frase suicidio adolescente, ¿qué le viene a la mente?
   a. ¿Que sentimos le produce escuchar esa frase?
   b. ¿Como se siente físicamente al escuchar esa frase?

**PART I.I: Factors influencing suicide**

1. ¿Qué nos puede señalar que un adolescente está en peligro del suicidio?
2. ¿Qué cree que lleva a adolescentes Latinos a pensar en el suicidio?
   a. ¿Qué los lleva a intentarlo?
   b. ¿Qué los puede detener?

**PART II: Suicide prevention self-efficacy**

1. Si un adulto está preocupado por un adolescente Latino que está pensando en el suicidio, ¿usted qué le diría a ese adulto?
   a. ¿Qué cree que ayudaría a un padre cuyo adolescente Latino está luchando con el suicidio?
      (1) ¿Qué tipo de… [doctor, especialista, terapia, apoyo…]?
   b. ¿Qué le diría a el adolescente?
2. ¿Usted ha visto o escuchado a otros adultos hablar acerca del suicidio con un adolescente?
   a. Por ejemplo, en televisión, en una novela, en consejería, en el medico, en la familia, como una hermana o hermano
   b. Cuénteme más acerca de eso.
   c. ¿Qué pensaste y que hiciste?
3. Si su adolescente le dijera a usted que está pensando en suicidarse, ¿Cuál cree que sería su reacción inicial?
   a. ¿Qué haría usted?

   b. ¿Qué le diría?
   c. ¿Qué cambiaría en su rutina doméstica o en su casa?
   d. ¿A quién le diría?

4. Hablar acerca del suicidio es difícil y especialmente con nuestros hijos. ¿Qué aumentaría su confianza en preguntarle a su adolescente directamente si está pensando en el suicidio?
   a. ¿Qué le ayudaria hacer esa pregunta?
   b. ¿Qué lo detiene?
5. ¿Hay unas circunstancias que usted estaría dispuesta a hablar del suicidio con su adolescente?
   a. ¿En qué lugar empezaría la conversación?
   b. ¿Quién involucraría en a la conversación?
   c. ¿En cuales circunstancias no estaría dispuesta a hablar con su adolescente del suicido?

**PART III: Culturally tailor suicide prevention**

1. Cuando escuchas la frase *prevención de suicidio adolescente*, ¿qué le viene a la mente?
   a. ¿Que sentimos le produce esa frase?
   b. ¿Como se siente físicamente al escuchar esa frase?
2. ¿Qué debemos hacer para prevenir el suicidio adolescente dentro de nuestra comunidad Latina?
3. En la encuesta usted indico que si se le presenta la oportunidad participaría en un programa de prevención del suicidio usted (si/ no/ de pronto/ no sabe si) lo haría. Cuénteme más sobre su eso.
4. ¿Qué necesitamos hacer para involucrar a padres Latinos en la prevención del suicidio?
   a. ¿Cuáles son algunas razones por las que padres tal vez no quieren involucrarse?

i. ¿por las cuelas no puedan?

5. Opción 1: [Usted menciono, que había oído hablar de programas de prevención del suicidio en la comunidad, deme un ejemplo de algunos de ellos]
    a. ¿Qué le gustó de ellos?
    b. ¿Qué no le gustó?
    c. ¿Qué desearía que hubieran añadido? y echo diferente?]

**O**

Opción 2: [¿Cómo le gustaría que sea un programa de prevención del suicidio dirigido a padres Latinos?

a. ¿Qué información cree que debe incluir para nuestra comunidad?
    a. ¿Qué palabras debe de incluir? ¿Cuelas no?
b. ¿Cómo debe ser el formato? (en persona, lectura, por video, en un libro, etc.)
c. ¿Cómo cree que debe a involucrar a padres?
    a. ¿dinámicas, actividades, practicas, preguntas?
d. ¿Quién lo debe dirigir?
e. ¿Cuándo debe ocurrir? (que horarios/ días?)
f. ¿En qué lugar debe ocurrir?

Voy a compartir mi pantalla y mostrarle como suele ser un programa de prevención del suicidio. [muestra “More Than Sad” has las preguntas y repite con “It’s time to talk”]

a. ¿ Ahora, cuál es su reacción inicial?
b. ¿Escoja tres palabras para describir cómo le pareció?
c. ¿ Específicamente que le gusto? ¿Qué no le gusto?]

**Wrapping up**

Nuestro tiempo de entrevista está llegando a su fin.

1. ¿Hay algo de lo que no hemos hablado de que cree que es importante que sepa para entender mejor la prevención del suicidio de adolescentes Latinos desde la perspectiva de padres?
2. ¿De qué más debemos hablar con respecto a este tema?

Gracias por participar.

**Zoom related questions**

¿Cómo fue hacer la entrevista a través del zoom?

Por favor califique lo siguiente, 1 (nada) a 5 (todo el tiempo)

1. ¿Con qué frecuencia tuvo problemas para conectarse?
2. ¿Con qué frecuencia tuvo problemas al verme?
3. ¿Con qué frecuencia tuvo problemas para oírme?

Voy a apagar la grabadora, así que, si tiene alguna pregunta sobre el estudio o si quiere seguir hablando, podemos seguir, pero la entrevista ya está oficialmente hecha.

*** * * APAGA LA GRABADORA * * ***

Recuérdele que, si tienen alguna pregunta con respecto al estudio, que no dude en comunicarse conmigo.