Special Populations

Goal 9: Staff members are aware of the risk and protective factors for individuals within special populations and are competent at engaging and supporting the unique needs of individuals within the community they serve.

Rationale

An individual's beliefs, values, and culture can play an important role in the factors that contribute to suicidal risk, as well as those serving as potential protective factors. The relationship between an individual's beliefs, values, and culture and their risk for suicide is frequently a unique one, requiring competent exploration in a trusting therapeutic relationship. It is critical for the workforce striving to screen, assess, engage, treat, and support individuals at risk of suicide to have a strong understanding of the potential impact that these factors may have on the individual and the treatment process. Additionally, some special populations of individuals have been found to have unique risk and protective factors and the culturally competent provider should be aware of the unique factors that may impact individuals from the specialized populations.

Understanding the Impact of Beliefs, Values, and Culture

All individuals have personal beliefs, values, and cultural norms that impact their thoughts, emotions, and behaviors. Suicide experts have identified several core areas that are theorized to be related to suicide risk and protective factors for some individuals, especially those from minority populations. These core areas represent possible issues that behavioral health providers may want to explore when understanding an individual's unique beliefs, values, and culture. These core areas include:

- Acculturation and cultural mistrust
- Perceptions of family and community responsibility
- Beliefs about suicide and death
- Beliefs about mental health and help-seeking.

Although there may be similarities in some of these core areas among individuals within a similar cultural group, providers should assess the relevance to the individuals in their care.

Some possible questions that a provider may want to explore with individuals related to their beliefs and values include:

- Who do you talk with when you are feeling upset or distressed? What types of responses help you feel better or less upset?
- What do you think mental health treatment will be like? What do you hope to get out of it? Do you have any concerns or worries about treatment?
- How do your friends and family feel about mental health treatment?

- How has your family/friends responded to your suicide attempt (feeling suicidal)? How do you wish they would respond?
- People have different ways that they think about death or what happens to us after death. What does death mean to you? How do you understand it?
- Are there any things that might keep you from wanting to die? Do you have reasons to live?

Suicide Risk in Young People Identifying as Lesbian, Gay, Bisexual, and Transgender

Individuals who identify as lesbian, gay, bisexual, or transgender (LBGT) represent a very heterogeneous group of people as it relates to their gender identity, sexual orientation, race/ethnicity, and socioeconomic status (Royal College of Nursing, 2015). Recent research has documented that adolescent sexual minorities are at increased risk for suicidal behaviors when compared to their heterosexual peers (Kann, Olsen, McManus, Kinchen, Chyen, et al., 2011, Mustanski & Liu, 2013). A number of studies have reported the prevalence of suicide attempts for youth within the LGBT community to be between 20 and 53% (Haas, Eliason, Mays, Mathy, Cochran, et al., 2011; McDaniel, Purcell, & D'Augelli, 2001; Savin-Williams, 2001). Although attempt rates are high, LGBT youth have not been found to comprise a disproportionately large percentage of completed suicides (Renaud, Berlim, Begolli, McGirr, & Turecki, 2010; Mustanski & Liu, 2013).

Research underscores the toll that discrimination experienced in every day life (e.g., workplace, school, or in their own family) takes on LGBT youth. Within this population, it appears that this increase in the incidence of suicidal behavior may be due, in part, to "societal anti-LGBT opinions, internalized homophobia, stigma, rejection, and discrimination" (Moody & Smith, 2013, pp. 739). Furthermore, this discrimination and stigma can inhibit individuals from accessing or getting help when it is needed. Stigma and lack of comfort can also prevent those in helping positions from asking questions regarding an individual's sexual orientation/identity, potentially leading to further isolation and stress in the youth's relationships with family, peers, and the community as a whole (Royal College of Nursing, 2015).

Risk and Protective Factors. Research has identified specific suicide risk factors unique to sexual minority youth (Haas et al., 2011). It should be noted however, that many general risk factors, such as previous suicidal behaviors, symptoms of depression, and hopelessness, remain some of the most critical risk factors for this population (Mustanski & Liu, 2013).

LGBT-specific Suicide Risk Factors	LGBT-specific Protective Factors
Disclosure/coming out	LGBT Peer Support: -Having LGBT friends -Presence of school-based Gay-Straight Alliance Club
Gender non-conformity	Other LGBT- related social support

LGBT-based discrimination/victimization	Family support or connectedness
Homophobic bullying	Perception of school safety
Parental rejection/abuse	Affirmative counseling
Condemnation by religious communities	
Diagnosis of HIV/AIDS	

Family Acceptance and Suicide Risk. LGBT youth experience an increase in suicide attempts and ideation near the time of disclosure (Suicide Prevention Resource Center, 2008; D'Augelli & Hershberger, 1993; Igartua, Gill, & Montoro, 2003; Remafedi, Farrow, & Deisher, 1991). It is theorized that this is due to "stress caused by coming out and fear of – or actual – rejection by members of their family" (Suicide Prevention Resource Center, 2008, pp. 23).

LGBT young adults who reported high levels of family rejection compared to those who reported no or low levels of family rejection during adolescence were:

- 8.4 times more likely to report having attempted suicide
- 5.9 times more likely to report high levels of depression
- 3.4 times more likely to use illegal drugs
- 3.4 times more likely to report having engaged in unprotected sexual intercourse (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010).

Additionally, abuse within the family (e.g., psychological, verbal, physical, etc.) further elevates the risk of suicidal behavior in LGBT youth (Suicide Prevention Resource Center, 2008). LGBT youth who experience rejection from their family of origin are also at risk for homelessness, foster care and/or placement in juvenile justice facilities. On the other hand, family and parental support serve as notable protective factors against suicidality for LGBT youth (Kidd, Henrich, Brookmeyer, Davidson, King, et al., 2006; Suicide Prevention Resource Center, 2008). One study found that youth in families with high levels of family support were half as likely to exhibit suicidal ideation when compared to youth who had low family support (Eisenberg and Resnick, 2006).

The Family Acceptance Project has conducted research to identify both helpful and unhelpful behaviors of family members to lead to perceived rejection or acceptance by LGBT youth. Researchers have found that when families understand the negative impact of behaviors perceived by youth as rejecting, most are open to striving to increase the number of helpful or supportive behaviors.

Helpful Family Behaviors	Unhelpful Family Behaviors
• Talk with your child about their LGBT identity	• Hitting, slapping or physically hurting the child because of the LGBT identity
• Express affection when you child tells you or when you learn that your child is gay or transgender	• Verbal harassment or name-calling because of the child's LGBT identify

• Support your child's LGBT identity even though you may feel uncomfortable	• Excluding LGBT youth from family or family activities
• Advocate for your child when he or she is mistreated because of their LGBT identity	• Blocking access to LGBT friends, events, resources
• Require that other family members respect your LGBT child	• Blaming the child when they are discriminated against because of their LGBT identify
• Bring your child to LGBT organizations or events	• Pressuring the child to be more (or less) masculine or feminine
• Welcome your child's LGBT friends and partners to your home	• Telling your child the God will punish them because they are gay
• Believe your child can have a happy future as an LGBT adult	• Telling your child that you are ashamed of them or that how they look or act will shame the family
• Connect your child with an LGBT adult role model to show them options for the future	• Making the child keep their LGBT identity a secret in the family and not letting them talk about it.

For parents and caregivers, encouraging a reduction in rejecting behaviors and increasing or enhancing accepting behaviors within the family can make an important difference in reducing a young person's risk for serious physical and mental health problems, including suicide. Families often feel that they are protecting their child or helping them fit in to the normative culture, without understanding their child may perceive their actions as rejecting. Access to accurate information has been shown to be helpful in increasing parent and family supportive responses their LGBT child.

Resources for Behavioral Health Providers. Several guidelines and training resources have been developed to support behavioral health providers working with youth, young adults, or adults identifying as LGBT. The following list identifies some important resources for further training and support:

- A Practitioner's Resource Guide: Helping Families to Support their LGBT Children (Caitlyn Ryan; SAMHSA)
- Best Practice Family Guides: Supportive Families, Health Children (Family Acceptance Project; in English, Spanish & Chinese)
- American Psychological Association Practice Guidelines for LGB Clients
- A Guide for Understanding, Supporting, and Affirming LGBTQI2-S Children, Youth, and Families (American Institutes for Research)
- Video: 10 Standards of Care: Improving Services for LGBT Young People (American Institutes for Research)
- No Longer Alone: A Resource Manual for Rural Sexual Minority Youth and the Adults Who Serve Them (Christopher Stapel)

Military Personnel, Veterans, and their Families

Suicide is the second most common cause of death in the U.S. Armed Forces (Bryan, Bryan, Etienne, Morrow, & Ray-Sannerud, 2014). Historically, the suicide rate in military personnel has been below that of civilians, but in recent years it has increased to a point in 2008 where it exceeded the civilian rate. (Keuhn, 2009; Lineberry & O'Connor, 2012). During this time period, suicide rates increased for individuals currently deployed, previously deployed, and never deployed, painting a complicated picture that is not fully explained by the military operations occurring during the period (Schoenbaum, Kessler, Gilman, Colpe, Heeringa, et al., 2014).

The issue is also significant for veterans, with a recent study finding rates of suicide increasing in recent years. A recent study found an estimated 22 veterans die by suicide every day, based on rates available from 2010 (Kemp & Bossarte, 2014). Young male veterans under the age of 30 are three times more likely to commit suicide than civilians in the same age bracket. The impact also impacts families, with increases in family discord, decreased satisfaction with marital relationships, and increased psychological distress of children in military families (Waliska, 2013). It is important that behavioral health providers working with individuals with current or past military experience or their family members are aware of the potential risk factors for suicide within these groups.

Risk Factors for Military and Veteran Populations. The risk and protective factors identified for suicide in the general population are relevant for military populations as well. However, some research has begun to identify risk factors unique to this special population. Two recent studies (Bush, Reger, Luxton, Skopp, Kinn, et al., 2013; Schoenbaum, et al., 2014) examined the Department of Defense Suicide Event Report and other relevant data to identify unique risk factors (see table below). Bush et al. (2013) found that 61% of suicides involved the use of a firearm; however these were rarely military-issue weapons. Although still common, females were less likely to use a firearm than males (41% versus 62%). Additionally, the researchers found elevated rates of health care utilization by military members in the thirty days prior to the suicide event. Schoenbaum and colleagues (2014) found suicide risk to be highest during deployment and for risk factors to vary during this period. Another study that examined the risk associated with a history of deployment (combat experience, days deployed, numbers of deployments); however, failed to find increased risk for suicide when psychiatric and substance-abuse risk factors were accounted for statistically (LeardMann, Powell, Smith, Bell, Smith, et al., 2013).

Suicide Risk Factors Specific to Military Personnel
Under the age of 25 years old
Junior rank in military
High school diploma or less education
Member of active component of military (not Guard or Reserves)
Demotion during the past 2 years
History of anxiety or PTSD disorders
Less than 2 years of military service

Less information is available about the specific risk factors for military veterans. This is largely due to the limited information available in existing surveillance systems to identify previous military experience. The Department of Veterans Affairs has been striving to improve existing surveillance systems through partnerships with states. An early study examined a population-based health survey matched with a cause of death database, focusing on individuals with and without military involvement (Kaplan, Huguet, McFarland, Newsom, 2007). A more recent report (Kemp & Bossarte, 2014) reviewed suicide death reporting from multiple states that were able to include information on military service. Results were generally consistent across both studies, with risk factors listed in the table below.

Suicide Risk Factors Specific to Veterans
Over the age of 50 years old (males)
Married or previously married
Greater than high school education
Evidence of activity limitations

Suicidal risk in the families of military service member or veterans has not been specifically studied; however, the spouses and children of service members may be at elevated risk. Research has demonstrated an increased risk of mental health disorders and significant stressors, which can in turn lead to elevated suicide risk. Families of service members or veterans who have engaged in suicidal behaviors may be at particular risk, and outreach, screening, and education of family members should be considered when a service member or veteran engages in suicidal behaviors.

Resources for Behavioral Health Providers. Approximately half of all veterans who have been discharged from service are utilizing services provided by the Veterans Administration; the remainder seek mental health services in the private sector. An even greater proportion of family members rely on private sector services, which highlights the importance of mental health providers being knowledgeable about military life, deployment, and challenges associated with these issues with respect to individuals and their families (Waliski, 2013). Several resources have been developed to support behavioral health providers working with military personnel, veterans, or their families. The following list identifies some important resources for further training and support:

- Veterans Administration Community Provider Toolkit
- Resource Guide for Family Members of Veterans Who are Coping with Suicidality (Department of Veterans Affairs); Spanish version
- How to Talk to a Child about a Suicide Attempt in Your Family (Department of Veteran's Affairs)
    - 4-8 year olds: English version; Spanish version
    - 9-13 year olds: English version; Spanish version
    - 14-18 year olds: English version; Spanish version
- Center for Deployment Psychology

Suicide Risk in Racial and Ethnic Groups

Racial and ethnic groups differ in the epidemiology of suicide, risk and protective factors, and patterns of help seeking (Goldston, Molock, Whitbeck, Murakami, Zayas, et al., 2008). Providers should be aware of these group differences when working with individuals from a specific racial or ethnic group, while recognizing that each individual is unique in their beliefs, values, and cultural identity. Racial and ethnic differences in suicide rates are presented in the table below.

Suicide Rates in the U.S. and Texas by Race/Ethnicity – 2011-2013

	United States		Texas	
Sub-populations	Number of Deaths	Rate per 100,000	Number of Deaths	Rate per 100,000
White, non-Hispanic	101,011	16.8	6,660	18.9
White, Hispanic	8,125	5.7	1,576	5.5
Black, non-Hispanic	6,789	5.6	512	5.5
Black, Hispanic	127	1.5	11	Unreliable
Asian or Pacific Islander	3,222	6.3	193	5.7
American Indian/Alaskan Native	1,362	17.3	11	Unreliable

As illustrated in the table, individuals who identify as White or Caucasian and non-Hispanic have the highest rate of suicides followed closely by individuals who identify as American Indian or Alaskan Native. Fact sheets summarizing research on epidemiology, protective and risk factors developed by the Suicide Prevention Resource Center are provided in the appendix.

Hispanic Populations. While Hispanic populations have a lower overall suicide rate than other populations, some unique cultural factors have been suggested to result in increased risk for Hispanics. Adolescents may experience stress due to the differences between family expectations of behavior (e.g., *marianismo* or *machismo*) and expectations from the majority culture regarding independence, autonomy, and individuality (Goldston, et al., 2008). The experience of trauma during immigration, including leaving family and loved ones behind, may contribute to risk for suicide. Strain related to acculturation to the mainstream culture, especially when younger generations acculturate at a faster rate than older family members, may also serve as a risk factor for Hispanic populations (Zayas, Lester, Cabassa, & Fortuna, 2005).

Positive familial closeness and good relationships with parents have been found to be a protective factor for suicidality for Hispanic individuals (Zayas, et. al., 2005; Locke & Newcomb, 2005). One study showed that a perception of caring teachers reduced suicide risk for Latina adolescents (De Luca, Wyman, & Warren, 2012). In addition, individuals who are Hispanic are more likely to identify with religious beliefs that prohibit suicidal thoughts and behaviors and are more likely to report moral objections to suicide than non-Hispanics (Oquendo, Dragstsi, Harkavy-Friedman, Zervic, Currier, et al., 2005).

Blacks or African Americans. Racism and discrimination, while not unique to African Americans, have been associated with depression, increased substance use, and hopelessness (Goldston, 2004; Goldston, et al., 2008). Additional factors such as economic and social disadvantage, poverty, lack of educational and employment opportunity, feelings of hopelessness and alienation, violence, and fewer social supports have all been documented as risk factors for suicidal risk in African Americans (Kubrin, Wadsworth, & DiPietro, 2006). Black men of Caribbean descent tended to have higher rates of suicide attempts than those of African descent; Black adults in the southern region had lower rates of suicide attempts (Joe, Baser, Breeden, Neighbors, & Jackson, 2006).

One possible protective factor that has been theorized to be behind lower suicide rates is religiosity. African Americans tend to report more religious activities when compared to other cultural groups. However, research has shown mixed findings, suggesting that some religious beliefs, such as God grants individuals freedom to resolve their own problems, may increase risk while others protect against suicide risk. Further, the importance of social support and the role of extended family have been theorized to mitigate the risk of suicidal behaviors among African Americans (Goldston, et al., 2008). Having a strong ethnic identity has also been shown to serves as a protective factor against suicide for African American women (Perry, Stevens-Watkins, & Oser, 2013).

American Indian or Alaskan Natives. American Indians and Alaskan Natives generally have been found to have the highest suicide rates of all racial or ethnic groups. The majority of research on risk factors has been centered on individuals who reside on reservations; therefore risks associated with American Indians who reside in urban regions is lacking. For individuals living on reservations geographic isolation, economic deprivation, lack of education, and poor employment opportunities have been identified as risk factors for suicide. Additionally, elevated substance abuse rates for American Indian populations, frequently beginning in adolescence, has been associated with increased risk of suicidality (Goldston, 2004). A high percentage of American Indians who die by suicide, and the majority of youth and young adults, were found to be legally intoxicated at the time of death. American Indians also potentially experience increased risk of suicide stemming from intergenerational trauma related to the forced relocation onto restrictive reservations, demoralization, and hopelessness (Whitbeck, Adams, Hoyt, & Chen, 2004). American Indian populations have been shown to have more exposure to suicide deaths and youth may be particularly vulnerable to suicide contagions (Wissow, Walkup, Barlow, Reid & Kane, 2001).

Enculturation or the degree to which an individual is engaged in cultural traditions (e.g., traditional practices, languages, identity) represents a notable protective factor against suicide risk. A cultural spiritual orientation has also been shown to be related to reduced risk of suicide (Garroutte, Goldberg, Beals, Herrell, Manson, 2003). A strong relationship with family and discussing problems with family and friends has also been shown to be a protective factor for American Indian youth (Borowsky, Resnick, Ireland, & Blum, 1999). Studies based in Canada have also shown that the community's control (e.g., sovereignty,

self-government, provision of services within the community) was associated with tribal communities with no suicides (Chandler & Lalonde, 2008).

Asian Americans or Pacific Islanders. Although there is significant diversity in the various cultures represented within this group, interdependence and group harmony is generally a high value. Disrupting this harmony can result in shame or "loss of face". When this shame is perceived as intolerable, it may be a precipitant of suicidal behavior. Beliefs about whether suicide is an honorable or dishonorable strategy for dealing with difficulties varies across cultural groups, and can either increase or decrease suicide risk. Asian American beliefs about group harmony may also reduce the likelihood that individuals will recognize and express their problems, leading to decreased recognition of suicidal risk. As with Hispanic groups, issues of acculturation and recency of immigration may also impact suicidality in Asian Americans and Pacific Islanders (Goldston, et al., 2008).

A high level of identification with one's cultural group was found to be a protective factor for Asian Americans (Cheng, Fancher, Ratanansen, Connor, Duberstein, et al., 2010). Family cohesion and family support have also been shown to reduce suicide risk in Asian Americans and Pacific Islanders (Wong, Uhm, & Li, 2012). It has also been hypothesized that language proficiency, social support from community members protect against depression and significant emotional distress, thereby reducing suicide risk (Hsu, Davies, & Hansen, 2004).

Resources for Behavioral Health Providers. Numerous resources are available to support providers in increasing their cultural competence. The resources identified here focus on those specific to Texas or suicide prevention as it relates to racial and ethnic populations.

- Advancing Health Equity in Texas through Culturally Responsive Care (Texas Health Steps)
- Diversity and Suicidal Behaviors (American Psychological Association, Division 12)
- Podcast: Understanding Latinas' Suicidal Behaviors and Implications for Practice (Suicide Prevention Resource Center)
- Culture Card: A Guide to Build Cultural Awareness American Indian and Alaskan Natives (Substance Abuse and Mental Health Services Administration)

Moving Beyond: Community Outreach

To ensure that effective and engaging suicide prevention services and supports are available to individuals from special populations, it is essential to engage members of these community groups in planning for and evaluating these programs. The behavioral health organization can also partner with faith leaders, community cultural leaders, and cultural organizations to ensure that cultural brokers have the skills needed for identifying individuals in their community who are at risk for suicide and making appropriate referrals. Sponsoring gatekeeper trainings targeting individuals within these organizations can build partnerships. Examples of local community groups that may be a target for such partnerships include faith leaders from various denominations, traditional or Native

healers (e.g. curanderos, faith healers, tribal healers), community health workers/ *promotoras*, and culturally-specific non-profits (e.g. refugee services, agencies supporting LGBT youth). These community partnerships can assist the behavioral health organization in understanding the needs of the individuals they represent.

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