Suicide Among Southeast Asian Youth

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Consuelo C. Cagande and Kalvin Foo

Case

Sue was a 17-year-old Filipino senior high school student who immigrated with her mother when she was 5 years old. The past year had been a struggle for Sue with a slight decline in grades and more participation in partying. Her friends noticed her Facebook postings were "always sad" and "dark" and pictures on Snapchat were not her usual "upbeat" pictures, with comments about being alone. Despite this, she joked around with them about it and they did not think of it as a concern. One of her friends mentioned that she would drink to feel relaxed and to be happy around her friends. Another friend recalled she once talked about dying, "What would it be like to be dead?" but ignored it because Sue was laughing when she said it. On the day of her suicide, her mother confronted her about her declining grades and increased partying. She warned Sue that her father knew about these and was angry. He told her that he would not support her pursuit of nursing school if she continued the behavior. Her mother was a nurse, but Sue was never sure she wanted to be a nurse. Sue was afraid to face her father. He was considered strict and education was always priority in order to get a good job. Fearing her father's reaction and scolding, hours later Sue went to the bathroom and took 20 pills of acetaminophen. She was admitted to pediatric intensive care unit.

Sue has no prior history of psychiatric illness but was described as a perfectionist and anxious about her academic performance as well as getting into a top nursing school. When she immigrated to the United States (USA), she was teased about her accent and did not make friends easily. Her father came to the USA 2 years after Sue and her mother did. He had difficulty acculturating to American culture given that he had to work in an under-qualified position. He was an engineer and managed a 20-person team in the Philippines; meanwhile in the USA, he was a restaurant manager. She has one older brother and one older sister who came to the USA with her father. The sister had recently been accepted to one of

C.C. Cagande, MD (✉) • K. Foo, MD
Department of Psychiatry, Cooper Medical School of Rowan University and Cooper Health System, 401 Haddon Avenue, Camden, NJ 08103, USA
e-mail: cagande-consuelo@cooperhealth.edu; fooka@rowan.edu

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the best nursing schools in the area. In terms of relationships and support system, Sue was closest to her mother since they immigrated together. But now, her mother "always took my father's side."

Introduction

Since the turn of the millennium, suicide among Southeast Asian diverse youth has increased. It has become one of the leading causes of mortality in young people globally. Therefore, it has become a public health concern in developing countries such as those in Southeast Asia (SEA). . Suicide was identified to be one of the five leading causes of death in people aged 15–29 years [1]. There appears to be specific predisposing and risk factors, psychiatric diagnoses, and access to means of self-harm among youth who either thought of suicide, attempt suicide, or complete suicide in the majority of these countries. Fortunately, some countries have taken steps towards prevention and intervention. In other countries the stigma of mental illness is still profound. This stigma can translate into their adopted countries such as the USA, where there are profound differences in Asian-American mental healthcare utilization [2]. In the past decades, suicide has become one of the leading causes of mortality in young people globally and thus a major focus of research. It is the third leading cause of death among adolescents and youth in the USA [4]. In the USA, SEAs were found to have a higher prevalence of overall psychiatric disorders compared to East Asians and South Asians, mostly due to a high prevalence of drug use disorder (16.7%) which is a risk factor for suicide [5].

Some SEA countries underwent hardship or suffering due to suppressive leadership. There were some studies on Cambodian refugees in the USA who were young during the Khmer Rouge regime. They experienced and survived extreme conditions of death and destruction such as deprivation, physical injury or torture, incarceration or reeducation camps, and witnessing killing or torture brought about by the Khmer Rouge regime from 1975 to 1979 [6]. These youth are parents now and their experiences as refugees may affect their parenting style.

Alliances among Asian countries with Western countries had major impact on acculturation and discrimination against immigrants in the USA. For example, until recent years where most Asian countries have a respectable relationship with the western world, the Philippines had a stronger relationship with the USA than Vietnam did, especially during the war [3]. Western culture was evident in many areas of the Philippines, especially in urban cities. In addition to being under the US, the presence of the US military bases in the Philippines strengthened the relationship, providing jobs for the local people. Therefore, Filipino immigrants, especially those immigrating at a younger age, may have a better understanding and acceptance of American culture and can easily identify with certain attitudes and behaviors such as autonomy than other countries. The parents on the other hand may have more challenging experiences acculturating. This challenge can prove to be too stressful for their children also.

There has been a paucity of research on suicide in many Asian countries such as those in the Southeast Asian region, but since the turn of the century, it has become a public health concern among countries such as Cambodia, Malaysia, the Philippines, Thailand, and Vietnam. We found minimal literature, but it provided important data on predisposing and risk factors and cultural aspects and insights on suicidal behavior among youth from these countries and cultures in the USA.

It is important to understand suicide in these specific ethnic populations in their native country as well as in their adopted country such as the USA. This chapter will focus on looking into SEA-American youth who struggle with suicide and mental health in the USA.

Epidemiology

Asian-Americans are the fastest growing minority population in the USA. Among the diverse groups in the USA, a study on ethnic identity and major depression (MDD) in Asian-American subgroups (Chinese, Filipinos, Vietnamese) found that Filipinos (4.33%) and Vietnamese (3.27%) subgroups were among the top three after Chinese subgroups to most likely suffer from MDD [3]. As prior research has shown cultural attitudes to affect immigrants and first-generation attitudes toward mental health and subsequent utilization, cultural attitudes in mother countries bear weight in Asian-American populations in America [5]. Epidemiologic findings can be used to formulate a comprehensive understanding of SEA immigrants and/or descents in America.

A study on Asian-American college students and adolescents showed that this population was most likely to seriously consider suicide in the previous year compared to European-Americans. Furthermore, in this study, SEA (e.g., Hmong, Cambodia, Laotian) who are more likely to be mixed in the pan-ethnically Asian population were more likely to report suicidal thoughts in the previous 30 days and SEA older adolescent boys were more likely to attempt suicide than girls. Interestingly, the gender generalization of suicide attempts where girls are reportedly to attempt more than boys does not necessarily translate across ethnic groups [7]. The gender difference was also not the same in their country of origin.

Historically, suicide was very rare in the SEA region relative to other regions, and subsequently, SEA-Americans were thought of as a low-risk population for mental illness and suicide. To the contrary, World Health Organization (WHO) Health Statistics 2016 data reported the SEA region as having the highest suicide rate (17.1/100,000) compared to the rest of the world (11.4) [8]. It is the leading cause of death for 15–19-year-old males and females in the Southeast Asia Region, the rates being slightly higher for females than males (28 and 21 per 100,000 population, respectively) [9].

Outside of SEA, descendants of emigrants of this population have also been found to have increased rates of suicidal thoughts. The SEA region ranks third after the African and Eastern Mediterranean Regions in disability-adjusted life years (DALYs), with an indication that affective disorders are the highest-ranked causes of years lost. Trending between 2010 and 2012 has shown a 21% decrease in DALYs potentially because of recent public health focus [10]. Additionally, a significant focus is placed on school-aged students as a focal population for suicide, but this does not capture the full scope of youth. To appreciate a more comprehensive perspective, cultural epidemiology that may impact these youth immigrants must be assessed.

In terms of Southeast Asian factors that may compound Southeast Asian-American youth's emotional state, studies involving Cambodia, Malaysia, the Philippines, and Vietnam reported the most vulnerable age group for suicidal behavior was between 15 and 24 years old [11–14]. This is consistent with the systematic analysis of population health data on global patterns of mortality in young people which showed suicide increase in both sexes in people aged 15–24 years and was overall the second most common cause of death [1]. Our case subject, Sue, falls into this age group.

Brunei seemed to have the lowest suicide rate among youth ages 10–19 years [15]. However, this Brunei study did not specify the factors that protect this age group from suicide risk.

In Cambodia, youth who had conflicts in their academic or filial lives are at risk for suicide. A youth risk behavior survey revealed 19% of 11–18 years old expressed suicidal thoughts and 14% made suicidal plans. Among those who had suicidal thoughts, 39.5% had attempted suicide once and 12.4% more than three times [13].

Data that may help clinicians with Vietnamese-Americans is that overall prevalence of suicidal ideation in the last 12 months was lowest in Hanoi (2.3%) compared to 8.1% in Shanghai and 17% in Taipei. Consistent with most countries females were more likely to report suicidal ideation and attempt. A 1998 data from the Ministry of Health estimated the national prevalence in Vietnam to be 0.98 per 100, 000 [12].

In Thailand, a survey of the transgender youth population revealed that 49% had attempted suicide in the past. In another study of 55 Thai transgender youth aged 15–21, 45% had seriously consider suicide and 26% had suicidal behavior [16]. In another Thai study on fatal firearm injuries, autopsy reports found suicide as the second most common manner of death, consisting of 29 males and 3 females [17]. This gender difference in lethal means is consistent with the US means of suicide.

Malaysia has a heterogenous population of Malays, Chinese, Indians, and indigenous people. The Indian ethnic group has the highest attempt and completed suicide rates. It is thought that the Hindu faith appears to permit suicide for a noble cause. Malay Muslims, on the other hand, consider it to be a taboo. The Malaysian Psychiatric Association estimated that seven people, mostly comprised of youth and young adults, are killing themselves daily. According to the 2011 National Health and Morbidity Survey done by the Ministry of Health Malaysia, 6.3% reported having suicidal ideation. Females were found to have reported higher suicidal ideation. Unlike developing countries, there was no difference between urban and rural population [18]. The prevalence of suicidal *ideation* in 2012 seemed to increase to 7.9% which was higher compared to Cambodia (6.2%) but lower compared to that of Vietnam (16.9%), the Philippines (16.3%), and Thailand (8.8%) [14]. There did not seem to be a specific factor for this increase, but a heterogenous group can be a factor in terms of identity crisis or the stress of maintaining one's cultural values and challenges of acculturation. The past-year prevalence rate of suicidal ideation in a systematic review by Armitage et al. ranged between 6% and 8%, consistent with the other studies [19].

In the Philippines, a study using the Global School Health Surveys (GSHS) found 17.1% of students reporting seriously considering attempting suicide in the past 12 months. This is close to the US high school 2003 Youth Risk Behavior Survey (YRBS) of 16.9% and higher than China's GSHS result of 15.8%. Unfortunately, the GSHS did not inquire about suicide attempt [20]. Another study analyzed the suicide death trend from 1974 to 2005. It revealed an increased incidence of suicide in both males and females. Consistent with most countries, more women than men attempt suicide and case fatality is higher in males (3.3:1). Overall, the increases in incidence occurred in adolescents and young adults [11]. In a small and very rural island called Palawan, a survey was conducted due to an increase in suicide rates there. They found the suicide rate to be ten times more than in the USA, Canada, and many European countries. Similar to other studies, the suicide rate in ages between 15 and 24 years was high (56.25%) [21]. One theory for the high rate is limited access to modern technological support, higher education, and employment opportunities. But this is a theory that is not fully proven among most Asian-Americans like Sue, where social media via technology can be a vehicle to both more stress and a cry for help. Furthermore, Sue had access to higher education with nursing school and employment opportunities as a nurse. One would think these as protective.

Descendants from these countries in the USA are showing similar age patterns; therefore, screening is vital for prevention and intervention for Southeast Asian youth like our 17-year-old Sue. What are the other factors then that pushed Sue to take her own life?

Risk Factors/Culturally Specific Presentations and Symptoms/ Expressions

Experiencing developmental changes in the context of psychosocial struggles cause youth to be very vulnerable for high-risk behaviors such as suicide. It is well known that having a mental illness and history of prior suicide attempt are major risk factors for future suicide attempts. Asian-American youth with longer histories in the USA, i.e., Filipinos and Chinese, will have less stress than Koreans and Vietnamese, who would more likely to be recent immigrants and

refugees [22]. Integration and cultural assimilation of a particular Asian subgroup has thought to be an alleviating factor to the stresses of multiculturalism of Asian-American youth, in terms of adaptation to culture and American views of the subgroups. Compared to children of US-born non-Hispanic White families, American children of foreign-born Asian families were at greater risk of poor physical health, depression and anxiety (by parent report), and inadequate interpersonal relationships. Children of US-born Asian parents did not differ in physical health or internalizing problems. Physical and mental health was worse in SEAs, due to higher likelihood of disadvantaged living situations. Furthermore, Huang and his group reported the "model minority" concept of Asian-American children compared to other ethnic backgrounds seemed to have added perpetuating pressure of academic achievements in this age group [23]. Sue's parents like most Asian parents place a high value on educational achievement. Sue was described to be a perfectionist and seemed to value academic performance as expected of an Asian child.

Willgerodt reported that family bonds and peer behavior exert significant influences on psychological and behavioral outcomes in Asian-American youth, similar with White adolescents [24]. Social connection and support in the USA is vital for their mental health. Sue seemed to have friends, but social media has also substituted friendship in terms of posting vague or encrypted messages that seem to be a cry for help despite "sugarcoating it." Clinicians should take into consideration social media activity and value of friendship as part of their mental health assessment of all SEA youth.

There are other risk factors discussed below in individual SEA countries that can impact their mental well-being when attempting to acculturate in the USA. They can also directly and indirectly impact mental health and risk for suicide in these youth. Clinical implications of the following factors and findings from studies are important for a culturally informed mental illness assessment of SEA-American youth.

Malaysia

In Malaysia, it was found that the commonly reported suicide attempts were due to personal illness issues, family illness, bereavement issues, interpersonal issues, work issues, and other life event issues in descending order. Base on a review of psychological autopsies, interpersonal issues contributed to 94% of total cases of suicide attempts. Malaysian-American youth may struggle themselves with interpersonal relationships.

The presence of generalized anxiety disorder (GAD), major depressive disorder (MDD), and a past lifetime history of major depressive disorder greatly increased the risk. One study found depression as the only predictor for suicidal ideation which is consistent with other countries. Other precipitating factors found among Malaysian adolescents were being bullied and being abused at home, either physically or verbally. Sue was bullied for her accent as a child. There seemed to be no other form of abuse which is protective. Consistent with other countries, alcohol dependence was associated with suicide risk [14, 18, 19].

Understanding how faith is valued among youth can help mental health providers formulate religion as precipitating or protective factor. The Hindu faith reportedly has less deterrents with respect to suicidal behavior. General attitude though varies with some Hindu scriptures condemning it and others condoning it. Researcher Adityanjee in India reported that "Hindu religion has given sanction to altruistic suicides." In contrast, Malay Muslims endorse it as taboo. In fact, attempting suicide is a crime in Malaysian law which might explain the low rate of reported suicidal ideation in one study [25].

Means of suicide is also important to explore in this population. Hanging was the most common means of suicide in the urban regions, while ingestion of agricultural poisons was more common on rural areas. Though, more recently, there have been increasing reports of jumping from tall buildings. This can be attributed to Kuala Lumpur's boom in high-rise constructions [15, 19]. Having

close friends and married parents were strongly protective against suicidal ideation [19, 25].

Cambodia

There is a paucity of studies involving Cambodian youth in the USA, but more recent articles have studied refugees who were young during the Khmer Rouge regime. In addition to experiencing extreme conditions of death and destruction, the Cambodian refugees in the USA also endured racial discrimination and "severe antagonism." Shirley McSharry and Robert Blair studied a cohort of Cambodian refugees in Utah, where the largest number of Cambodians settled. Their findings resulted similar findings with earlier studies where post-traumatic stress disorder (PTSD) and major depressive disorder (MDD) were ubiquitous among this population. Risk factors included greater number of war traumas experienced (average of 20.1), greater number of resettlement stressors, loss of more immediate family members, and financial stress. Given there were more men killed during the Khmer Rouge regime, there were more women among the refugees. A protective factor was living with immediate family or extended family while in the camps [6].

Thailand

Thailand ranks the highest rate of civilian gun possession among regional countries. Access to a lethal weapon is a well-known risk factor for suicide. In Thailand, suicide is the second most common manner of death (21.5%) using a firearm. Men are more likely to commit suicide, consistent with global data trend [17]. In the USA, gun control may have more restrictions than Thailand. Therefore, suicide by guns may occur depending on the availability of guns.

A report on Thai transgender youth identified depression, substance abuse, underage sexual activities, feelings of insecurity at school, cigarette smoking, and a lack of social support as the most common risk factors affecting LGBT and non-LGBT population. It also observed that loneliness was a high-risk factor and predictor for depression, suicidal behavior, and sexual risk behavior among Thai transgender youth. Furthermore, those with higher level of education reported greater loneliness (feeling isolated from the general population), contrary to most literature reporting lower levels of education are more frequently to report loneliness. Using the Positive and Negative Suicide Ideation Inventory (PANSI), Yadegarfard et al. found Thai transgender adolescents aged 15–19 years to have higher suicidal ideation than non-transgender adolescents [16]. The outward appearance and higher visibility of transgender people are more evident in Thailand than in most Asian countries, but there is still high prevalence of hostility and prejudice toward LGBT people, as well as institutional discrimination [26]. Thai transgender youth in the USA would have similar factors mentioned earlier in addition to the stigma of being transgender and being in the minority population. These are factors that can lead to suicide. It is possible that stigma of being trans in the Thai community can isolate the youth from his family and community, thus, potentially stripping him/her of a support system.

Vietnam

Like the Cambodian immigrants, earlier Vietnamese settlers arrived as refugees. They also left their homeland under frequently violent and traumatic circumstances of the Vietnam War. Fifty two percent of Vietnamese-American children who were US born were under 18 years as of 1990. Although they may have not experienced the trauma of war, they were still deeply affected by family histories and quasi-mythical accounts of life in the host country [27]. The study on ethnic identity in Asian-American subgroups by Amy Ai et al. reported that racial and ethnic identity and level of acculturation stress were the highest in the Vietnamese subgroup [3]. This stress can impact the youth of refugees.

Like most Asian countries, Vietnam has experienced an economic transformation and increas-

ing influence of more developed countries that challenge their traditional values. These can have an impact on Vietnamese-American youth. Blum studied the impact of this influence of social change on the rates of adolescent suicide and risk factors among youth in Hanoi. Younger age groups, female gender, family structure (i.e., single parent), immigrant status, family history of suicide, adverse relationships with mother and father, and alcohol use were all associated with suicidal ideation. Smoking cigarettes in the past month appeared to be almost two times at risk for suicidal ideation. Migrants from rural to urban had almost twice the likelihood of suicidal ideation compared to their urban native peers. These youth were the least likely to seek help if they were experiencing suicidal thoughts compared to youth in Shanghai and Taipei, but they are most likely to turn to peers, followed by partners and, then, parents. Interestingly, males were more likely to turn to parents. Comparatively, females were more likely to turn to health professionals and peers. A higher positive maternal relationship was a protective factor for youth in Hanoi [12]. Religious involvement and social support supplied protection of mental health in Vietnamese subgroup as well as having the highest level of racial and ethnic identity [3]. Immigrant parents with these behavioral patterns can also have an impact on Vietnamese-American youth.

The relationship between length of residence in America and depression in Vietnamese-Americans was reported to be significant. The first decade of resettlement had higher levels of psychiatric problems. However, after approximately 12.5 years, depression levels decrease. Age, family income, and gender had no effect. Protective factors included being married, higher education, employment, and good health [28].

Parenting style seemed to be a significant risk factor for Vietnamese-American youth mental health issues that can lead to suicide. Vietnamese-American adolescent immigrants who perceived their fathers as using the authoritarian parenting style reported lower levels of self-esteem and higher depression scores when compared with those who perceived their fathers as using the authoritative parenting style [29]. A limitation of this study is that it did not explore suicide. It would enhance a clinician's knowledge about Sue's relationship with her father and her perception of her father's parenting style. Sue seemed to be closer with her mother but at the same time felt betrayed. "My mother always took my father's side." The mother herself seems to be caught in the middle.

The Philippines

Factors that impact Filipino-American youth tend to be rooted from their country of origin. In the Philippines, the most commonly used methods of suicide were hanging, shooting, and organophosphate ingestion. Common precipitants were family and relationship problems. The most common diagnosis was adjustment disorder. In an indigenous tribal group in Palawan, poisoning by a plant *Derris elliptica* (tuba) followed by hanging were the most common means. In this group, called Kulbi, reasons for suicide among the younger and middle-aged adults were anger, jealousy, "love problems," and grief over the death of a loved one. Other characteristics such as impulsivity, violence, childhood abuse, and substance use are risk factors as well [11, 21].

In a study by Page et al., suicide ideation was associated with substance use, physical activity, feelings of loneliness, hopelessness/sadness, and worrying. Sadness or hopelessness almost every day for 2 weeks or more consecutively that limits functioning was the overall strongest predictor of suicide ideation. Interestingly, this study found that obesity and sedentary lifestyle (sitting activities more than or equal to 3 h per day) was protective for Philippine adolescents compared to Chinese adolescents. The explanatory theory was that the overweight Philippine adolescents who have access to electronic devices represent those with adequate family income. Therefore, the economic advantage is indicative of emotional well-being in this population. Filipino-American youth of immigrant parents may not have this economic advantage in the USA, thus it can have a psychosocial impact.

In terms of economy and financial factors, for Sue's case, it seems the family income may have decreased. The father achieved higher status in the Philippines but forced to acquire a more middle socioeconomic status in America. Furthermore, he was not employed for what he studied for, an engineer. There are many SEA families with similar situations. This can have an impact on SEA youth. They may feel the pressure of achieving higher education. Their parents only "want the best" for their children, not necessarily what the children may aspire for themselves. They want for their children what they never had in their country of origin or even in their adopted country.

Alcohol use, ever being drunk, using drugs, current smoking behavior, being in a physical fight, having no close friends, and been bullied were other risk factors for suicidal behaviors. Page also identified that there was higher risk for suicide in the least populated and more rural regions [20]. Living in an urban community where there are other similar ethnic groups tends to be psychologically protective among Filipino-Americans. Major cities such as Honolulu and in the west and east coasts such as Los Angeles, San Francisco, New York, and Jersey City/Newark areas have large Filipino communities among other Asian cultures.

Filipino culture is predominantly Roman Catholic. Religion has been found to be protective when suicides were barred from receiving religious burial sites. In 1983 this ban was removed from the canon law and seems to correlate with the increase in reported mortality rates in the Philippines and other predominantly Catholic countries. Nevertheless, the strong Roman Catholic culture could also be protective, which is consistent with low suicide rates in other predominantly Catholic countries [11].

Unlike with Vietnamese-American, ethnic identity and level of acculturation stress were lowest in Filipinos. The Filipino subgroup reportedly experienced the highest level of discrimination, but it also reported the highest levels of social support. Social identity theory may explain this discrepancy since "when facing collective stressors, the targeted group can rally around its identity to collectively resist adversity." In the same study, although immigration and cultural experiences were different from Chinese and Filipinos (they experienced more overt racism and discrimination early in their immigration status), the acculturation stress experienced by Vietnamese was found to be related to elevated diagnosis of MDD. The Philippines' alliance with the USA against North Vietnam may have contributed to a low level of perceived discrimination. Furthermore, Filipinos may be more acculturated because of their exposure to Western culture through the three-century colonization by Spain and the USA [3].

Although Sue was not a refugee and did not seem to experience physical or sexual abuse, being teased for her accent and not having friends during her early childhood may be traumatic enough as an immigrant child. Her onset of depressive episode was during her adolescent years which can portray resiliency until internal conflict develops. The nature of the parent-child relationship must be explored. She wants to be successful and make her parents proud but at the same time she wants to be independent, making her own career choice instead of what her parents want, with the risk of losing their support. Filipino-American students were less willing to openly disagree with their parents [24].

In summary, a good support system and faith appear to be the most common protective factor among Malaysian, Cambodian, Vietnamese, and Filipino-American youth. The degree or perception of the support system should be explored, though a SEA-American youth may vary based on their own personal family history, coping mechanism, and economic status like Sue.

Diagnostic Considerations

Asians are likely to be more comfortable talking about somatic as opposed to psychological complaints. Internalizing symptoms and depressive symptoms were related to an elevated risk for suicidal presentation among Asian-American youth [30]. The *model minority* myth that depicts Asian-Americans in better psychological health than the general population has been refuted. In

one study, ethnicity was not significantly associated with somatic symptoms. But other studies on Asian-American college students consistently revealed more somatic complaints, isolation, and anxiety. Another study reported Asian-American adolescents aged 12–17 to score lower on depressed mood scales compared to Latinos, Euro-Americans, and African-Americans. In a nationally representative study of immigrant youth, it was found that Filipino and other Asian adolescents were more likely to report depressive symptoms compared to non-Hispanic Whites [31]. Hopelessness was a major psychological symptom that preceded suicidal thoughts among Asian-American adolescents in general [30]. Sue had signs and symptoms of depression with suicidal behavior. She seemed to internalize symptoms compounded by her ambivalence about becoming a nurse but at the same time displaying signs of depression through social media.

Using the DSM-IV criteria among Asian-American adults compared to European-Americans, which may also reflect youth, a study reported that there was no overreport of somatic symptoms (i.e., appetite changes, sleep disturbances, loss of energy). This is contrary to what is more widely known of people of Asian descent reporting primarily somatic symptoms and endorsing affective symptoms (i.e., sad mood, anhedonia) more rarely, which may explain the low rates of depression reported in some Asian countries. But the study did reflect a high rate of a variety of depressive symptoms, including depressed mood, discouragement, insomnia, loss of energy, trouble concentrating, loss of self-confidence, and decreased talkativeness. Asian-Americans endorsed feeling worthless and appetite disturbances more easily [32]. Psychological autopsy of Sue's suicide attempt and the emotions and events leading to it would reveal many of these symptoms, including discouragement. She may be discouraged by her mother who she perceived to be close to her or discouraged about herself not being able to disagree with her parent's aspiration of her.

SEA-American engaged in substance use may also be a risk factor to suicidal behavior. For example, cigarette smoking was related to depression among Chinese, Korean, and Filipino females [30]. Another study found substance use to be the highest prevalence rate (16.7%) among SEA-Americans compared to other Asian-Americans in the study (East Asians 13.1%, South Asians 11.1%). In the same study, SEA-Americans had a higher prevalence of any DSM-IV psychiatric disorders (34.6%) compared to East Asians (22.5%) and South Asians (24.5%). Furthermore, SEA-Americans were found to have the highest point prevalence of any mood disorder and any anxiety disorder. Although the latter finding was not found to be statistically significant [5], psychiatric disorders among SEA-Americans play a major role in suicide. Another study reported that Filipino-American adolescents engaged more in delinquent acts that moderately correlated with substance use compared to Euro-American adolescents. The reason was unclear [31]. Sue's substance use seemed to spiral and seems to impact her academic performance. This can further impact her status for nursing school. She may have been self-medicating herself. It is well studied that substances altering the mind predisposes a person to suicide. Sue may have not been using drugs at the time of her suicide, but the chronicity of use has a major impact on the mood, impulse control, and judgment.

Evidence on Intervention Approaches

On a regional level, Suicide Prevention International's (SPI) Strategies to Prevent Suicide (STOPS) project approaches suicide prevention through increasing public awareness and knowledge, educating gatekeepers, increasing identification of at-risk individuals, improving treatment for suicide-risk conditions, reducing access to lethal means of self-harm, and protecting survivors of suicide [33]. The overlapping countries between this project and countries of focus in this chapter include Malaysia, Thailand, and Vietnam. While it employed novel strategies and examples of implementation in the countries, the report acknowledges the infeasibility of finding statistical significant

reduction of suicide and evaluates programs through changes in identification of at-risk individuals and ability to provide help to them.

In terms of improving public awareness and improving media portrayal, the Malaysian Ministry of Health, in conjunction with the Malaysian Psychiatric Association and the Befrienders Worldwide organizations, has released posters and radio and television broadcasts and run public forums. Furthermore, they released national guidelines for media presentation of suicide, leading to news frequently detailing the method of death and acknowledging related mental disorders. On the other hand, the Ministry of Public Health in Thailand has held multiple seminars on how to sensitively present suicide news, and strong public efforts have not been made in Vietnam. With regard to awareness and portrayal, there is frequent failure to acknowledge mental disorders related to suicides and little exposure of suicide-related stories. Unfortunately, there has been weak evaluation for these programs.

Gatekeepers are nonmedical workers who have regular and widespread contact with individual in distress and have been a target by the STOPS project to better identify and facilitate guidance to mental healthcare. Teachers, social workers, religious leaders, and policemen are all examples of gatekeepers that participating countries have targeted. While there have been local efforts in all STOPs participants, only Thailand has nationally approached gatekeeper education, as the Ministry of Public Health has trained community leaders on how to recognize depression and developed referral networks. Utilizing a cultural resource, there has also been work with Buddhist monks to educate and counsel suicidal individuals using Buddhist dharma, although both programs have not been evaluated.

In a culture with limited help-seeking behavior, novel identification strategies of high-risk individuals have operated at the community level, through non-health sectors, and implementation of screening and detection. Examples in the region have enhanced screening for high schoolers, military personnel, gamblers, and welfare recipients, but multiple participants have reinforced suicide screening for people with existent mental health issues.

Restricting means of self-harm works through a multifactorial theory, one of which is by minimizing the role of impulsiveness in suicide due to access barriers. As such, members of the STOPs project have aimed at reducing access to poisons, restricting firearms, and securing jumping sites. Pesticides, as a primary means of poisoning in rural areas, have encountered provisions such as warning labels, lockboxes, and other small-scale projects pending evaluation. This may hold true still in youth living in rural areas where migrant Asian families are. Finally, the STOPs notes a lack of support for survivors of suicide, as support groups, professional support, and psychiatric consultation were not readily accessible for these individuals. For the support services that were found, they were noted to be isolated major urban areas. This was found to be an area that is a culmination of social and political factors that have been strongly affected, and that with the existing knowledge of increased risk of suicide for individuals with prior attempts, it needs to be properly addressed.

While the STOPs program has been a collaborative international effort, there have been concurrent studies and interventions at different, nongovernmental levels. For example, in studies targeted at school-aged and university-aged youth in Cambodia and Malaysia, respectively, deficit in life skills and problem-solving schools have been linked to suicidal ideation [9]. School-based interventions to build psychological hardiness have been employed in an effort to improve mental health profiles.

Asian-Americans have a low rate of help-seeking behavior [2]. They are among the least to utilize mental health services. Stigma, cultural beliefs and practices, and barriers to services may affect their motivation to stay in treatment. Studies have shown that patients who engage in treatment have better health outcomes than those who dropped out of treatment [34].

A culturally sensitive school-based mental health program seems to be an important model for early detection, intervention, and preventive strategy for SEA youth. A study looked at the

effectiveness of such a program for SEA refugee children. The program included a collaboration among bilingual/bicultural teachers and nurses in schools implementing a cognitive-behavioral school-based program. The cognitive-behavioral interaction emphasized coping skills building and homework assignments. The latter were designed to foster parent-child interaction. The Children's Depression Inventory was used 1 month prior the intervention, at 4 weeks and 8 weeks and 1 month following the intervention. This may improve and meet the needs of the youth. The study demonstrated a successful decrease in depressive symptoms among these children. It also reportedly diminished any social stigmas that may have been associated with attending an after-school activity [35].

Sue would benefit from psychopharmacology and psychotherapy given the severity of her depression. Careful dosing of psychotropic medications should be considered for SEA youth. Medications should start at a lower than recommended dose given Asians have reduced cytochrome P450 enzyme activity [36].

Psychotherapy should focus on improving her coping mechanisms, self-seeking behavior, and interpersonal skills. The parents will require a lot of psychoeducation about Sue's diagnosis, especially signs, symptoms, and course of depression. Specifically, highlighting that depression occurs insidiously, and that it is not a sign of weakness. Family therapy should also be considered since, for Filipino adolescents, family support was an important protective factor against academic, behavioral, and emotional difficulties [37]. The father may have difficulty accepting the mental illness and engage in family therapy. He may also have the burden of guilt which he may not endorse right away. Addressing expressed emotions may also be a good strategy. Although Sue is a Filipina, there was a study on the perceptions of Vietnamese fathers' acculturation level, parenting style, and mental health outcomes in Vietnamese-American adolescent immigrants. Results revealed most of the adolescents perceived that their fathers have not acculturated to the US culture and continue to practice the traditional authoritarian parenting style, regardless of the amount of time spent in the USA. Furthermore, the adolescents who perceived their fathers as using the authoritarian parenting style reported lower levels of self-esteem and higher depression scores when compared with those who perceived their fathers as using the authoritative parenting style [29].

In terms of psychotherapy, the idea of ethnic match between therapist and patient remains to be studied more as an effective treatment. A study did illustrate ethnic matching as a significant predictor for success of treatment [22]. It may help develop a stronger therapeutic alliance but more for the parents rather than the youth. The parents may expect the therapist and psychiatrist to be "on their side." Countertransference and transference issues need to be addressed if it will affect the alliance. Developing rapport involves a trusting, predictable relationship that often develops gradually [6]. A benefit for the youth may be that the therapist's and psychiatrist's recommendations will be taken seriously given their high professional status. Medical professionals are highly respected in Asia, especially in the Philippines. Engagement is key to success of treatment [35]. Good rapport always has an impact on outcome. The challenge is dissecting through the stigma and guilt a family member may be feeling and not being open to treatment. Given interpersonal issues are a major factor, starting with a focus on the positive aspects of the relationship and person may help as a start. The model of behavior therapy can be applied in the early psychotherapy stage.

Conclusion

There is a paucity of literature and studies on the increasing trend of suicide rates among SEA youth. But the literature we found and discussed in this chapter has data that provided insight and foundation to further researching the risk factors, prevention, and intervention in the SEA. There were a few studies done in Malaysia and the Philippines.

Hanging and ingestion of poisons were the most common means of method to suicide. In a

high firearm possession country or region, preventive measures must be implemented.

Psychological and interpersonal relationship problems were the most common predisposing factors. Religion seems to still have a protective purpose, but interestingly in certain religions such as Hindu and Catholic practices, it has allowed this population to accept suicide as a ways of coping with stress or as a "saving face" behavior. More research into religion as a protective versus precipitant factor should be done. Additionally, regional cultural beliefs and practices also need to be considered and explored more as risk factors as exemplified by the subgroup in a remote region in the Philippines.

Social media was not studied or mentioned in the literature we found for this specific region. Globally the Internet has brought youth closer across the oceans, and it should play a big factor especially when cyberbullying has been known to precipitate suicidal behavior. On the other hand, social media can act as a "big brother" that can help alert family and friends to intervene. In our case, social media did not protect Sue. Her friends did not alert her parents or other adults despite their perception that Sue was not serious.

The SEA region of the world should be able to collaborate and share data to better understand what the driving forces are that have propelled an increase in suicide rate in the youth. One of the goals should be to educate and destigmatize mental illness and suicide in this region which can be carried with those who immigrate to the USA. Furthermore, a level of support that is safe to talk about their feelings and not feel alone should be available to youth in this region. There are programs that have been implemented already, but more efforts should take place within the family unit as well. Preservation of family and social support appears to be a strong protective factor among SEA-American youth.

The content discussed in this chapter has valuable implications for mental health professionals and primary care physicians who provide care to SEA-American youth. The youth's cultural and ethnic background should be considered as part of the assessment, cultural formulation, and treatment plan for mental illness among SEA-American youth.

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