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Original article

Mental health, migration stressors and suicidal ideation among Latino immigrants in Spain and the United States

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ABSTRACT

Background: Immigration stress appears to augment the risk for suicide behaviors for Latinos. Yet, specific risk factors that contribute to suicidal ideation (SI) among diverse Latino immigrant populations are not well established.
Methods: Data were collected in Boston, Madrid and Barcelona using a screening battery assessing mental health, substance abuse risk, trauma exposure, demographics, and sociocultural factors. Prevalence rates of lifetime and 30-day SI were compared across sites. Logistic regression modeling was used to identify sociodemographic, clinical, and sociocultural-contextual factors associated with 30-day SI.
Results: Five hundred and sixty-seven Latino patients from primary care, behavioral health and HIV clinics and community agencies participated. Rates of lifetime SI ranged from 29–35%; rates for 30-day SI were 21–23%. Rates of SI were not statistically different between sites. Factors associated with SI included exposure to discrimination, lower ethnic identity, elevated family conflict, and low sense of belonging ($P < 0.01$). In the adjusted model, higher scores on depression, posttraumatic stress disorder, and trauma exposure were significantly associated with 30-day SI (OR = 1.14, 1.04, and 7.76, respectively). Greater number of years living in the host country was significantly associated with increased odds of having SI (OR = 2.22) while having citizenship status was associated with lower odds (OR = 0.45).
Conclusion: Latinos suffering depression, trauma exposure, and immigration stressors are more likely to experience SI. Despite differences in country of origin, education, and other demographic factors between countries, rates of SI did not differ. Recommendations for prevention and clinical practice for addressing suicidal ideation risk among Latino immigrants are discussed.

1. Introduction

Immigration from Latin America and the Caribbean over the last three decades has transformed the ethnic composition of the United States and many European countries [1]. Latinos are the largest ethnic minority population in the U.S. and the second largest in Spain [2,3]; however, research on suicidality (suicidal ideation, planning, and attempts) among Latino immigrants in Spain is limited in comparison to the U.S. Past epidemiological studies of U.S. Latinos show that lifetime prevalence of suicidal ideation (SI) and suicide attempts is 10.1% and 4.4%, respectively, with higher rates of each among U.S. born Latinos compared to foreign-born [4]. Although studies have reported important risk factors for SI and attempts among the general population [5], there is no consensus regarding the most prominent risk factors among Latino immigrants. International studies have found that across ethnic groups, current symptoms of mental distress are the most important risk factor for suicide [6]. U.S. and Spanish studies have identified that both passive SI (thoughts of wanting to be dead) and active SI (thoughts of planning to kill oneself) increase lifetime risk for suicide attempts [7,8].

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The risk for suicidality among immigrants is multifactorial, and includes sociocultural and migration/acculturative stressors as well as mental health status. Generation and time in the U.S. appear to influence the risk for suicidality among Latinos [9–11], with SI highest in US-born Latinos, followed by immigrants who migrated as children (< = 12 years) [4,12]. This posits an association of acculturation and time in the US with suicidality [13]. Mexicans who have never migrated to the U.S. and lack family living there have lower rates of suicidal behavior compared to those who have migrated or have family in the U.S. [13]. Endorsement of acculturative stress has been associated with over three times increased odds of suicide attempts among Latino emerging adults in the U.S. [14]. A study of immigrants in European countries showed that 27 out of 56 groups studied had higher rates of suicide attempts when compared to the host population and to their counterparts who had not migrated [9]. In a separate study in the Netherlands, living in a neighborhood with high minority density was associated with lower rates of suicide among non-Western immigrants when compared to native Dutch residents [15]. While relative risk for suicidality for immigrants varies by country and context within country, immigrants may experience specific risk and protective factors associated with the migration experience and status in the host country. Furthermore, the recent worldwide economic downturn and high unemployment rates have contributed to significant stress on immigrants in the U.S. and Spain [11]. SI can be an important symptom of distress in the context of poverty, oppression and racism, and acculturative stressors can be particularly salient for marginalized Latino immigrants [14,16]. Undocumented status likely exacerbates this risk; however, few studies specifically link citizenship status to suicidality. Barriers to mental health care, including linguistic and socioeconomic barriers, may especially be a challenge for noncitizens [17].

In contrast, self-identification as Latino may be associated with cultural values that protect against suicidal behavior even when mental health problems and significant socioeconomic stressors are present. One study [18] found that Latinos report higher rates of survival and coping beliefs, including responsibility to family and moral objections to suicide. Highly acculturated immigrants may be more socially integrated into the host country and at decreased risk for suicidality [19], but greater acculturation may imply the emergence of risk factors, such as a loss in traditional cultural values (i.e. familismo, ethnic identity, religiosity), and the loss of family structure and supports [4,12,20–25].

Mental health diagnoses and posttraumatic stress, depression and substance abuse symptoms are significant risk factors for suicide across populations, including Latinos [4,22,26–28]. Approximately 60% of people in the U.S. who report SI and 80% who report suicide attempts have a prior mental health disorder, with greater numbers of comorbid disorders increasing the risk [29]. Meeting criteria for any psychiatric disorder, including alcohol and substance use disorders, was highly correlated with lifetime SI and attempts in a national sample of U.S. Latinos, even after adjusting for age, gender, language, and nativity [4]. Experiencing traumatic events has also been associated with increased risk for SI and suicide attempts in cross-national studies [30], with presence of posttraumatic stress symptoms as an important risk factor for attempted suicide among individuals with depression [31].

Given differences between the U.S. and Spain in the national origins of the Latino immigrant population, circumstances of migration, and healthcare systems, this study offers a unique opportunity to examine risk for suicide behaviors for Latino immigrants in the two countries. We hypothesize that relevant risk factors for SI in immigrant Latino populations include depressive disorders, trauma and other mental health problems [32]; substance abuse; immigration-related stressors such as discrimination, poverty and non-citizen status; and related stressors linked to leaving one's home and adjusting to a new context [33]. We hypothesize that immigrants in Spain will experience lower rates of SI, given a lower threshold in the healthcare system to access behavioral health services and presumed fewer barriers to integration in a Spanish-speaking country. We present findings regarding SI in an international sample of first and second-generation Latino immigrants in Spain (Barcelona and Madrid) and the U.S. (Boston, Massachusetts). We focus on three aims: to describe the prevalence of SI and attempts in a largely clinical sample of Latino immigrants residing in these two countries; identify any differences in SI rates between the two countries/three cities represented; and establish which sociodemographic, clinical and sociocultural factors are associated with SI.

2. Methods

2.1. Procedure

Data were derived from a mental health and substance abuse screening interview conducted between July 2013 and August 2014 as part of the International Latino Research Partnership (ILRP; NIDA R01DA034952). The ILRP unites research institutions and community clinics in the U.S. and Spain to conduct cross-national comparative research investigating Latino migrants' behavioral health service needs. Participants (n = 567) were recruited in waiting rooms from mental health, substance use, primary care and HIV clinics and from community agencies serving Latino immigrants in Boston, Massachusetts, and Madrid and Barcelona, Spain. Approximately 25% of people approached declined to complete the interview. The study was approved by the institutional review boards of the participating institutions.

First-generation Latino immigrants (born in a country other than the interview site) comprised 100% of the Spain sample and 78% of the Massachusetts sample. Boston participants were born in Central America (40%), continental U.S. (22%), Puerto Rico (16%), the Caribbean (11%), South America (10%), and Spain (1%). The majority of participants in Spain were of South American origin (86% in Madrid and 80% in Barcelona), followed by Caribbean (12%) in Madrid and Central American (10%) in Barcelona. The percentage of participants speaking Spanish as a first language was 82% in Boston, 95% in Madrid, and 96% in Barcelona.

3. Measures

3.1. Sociodemographics

Self-report demographic information was coded as binary variables: economic status (i.e., live very well or comfortably; live check-to-check or poor), highest level of education (i.e., less than high school; completed high school/GED, or vocational school), and having a primary sexual partner.

3.2. Clinical profile

Depression symptoms were measured using the Patient Health Questionnaire (PHQ-9) [34,35] using 8 items, dropping the SI item since this was an outcome variable (Cronbach's α = .89). We selected the PHQ-9 given its use in primary care and effectiveness in detection of depression symptoms among Latinos. Anxiety symptoms were measured with the General Anxiety Disorder screener (GAD-7) (Cronbach's α = .90) [36]. PTSD symptoms were measured using the Posttraumatic Stress Disorder Checklist, Civilian (PCL-C) [37,38], a self-report measure of DSM-IV symptoms of PTSD (Cronbach's α = .96). Trauma exposure was assessed with the Brief Trauma Questionnaire, a 10-item self-report measure that includes participant perception of risk of