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RESEARCH PAPER

A qualitative examination of the impact of suicidal thoughts and behavior on help-seeking among university students in Colombia and Mexico

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Abstract
This study examined descriptions of suicidal thoughts and behavior (STB) to identify risk and protective factors that may present in clinical settings among university students from Latin America. Our focus was on answering the following key questions: *How are suicidal thoughts and behavior described? What are reasons for wanting to die and for living? What impact do STBs have on motivations to seek or avoid psychological treatment?* To this end, 55 qualitative interviews were completed with university students from Colombia and Mexico who recently endorsed emotional difficulties in the World Mental Health International College Student (WMH-ICS) surveys. Interviews were coded to identify themes specific to STBs. Findings

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revealed insight on symptom presentations and consequences of STBs. Participants described uncontrollable somatic symptoms during periods of high suicide risk, which serves as a relevant clinical marker for health providers. An important reason for living was to avoid suffering for family, which was protective against suicide and motivates familial involvement in treatment planning. Participants sought solutions to emotional problems after experiencing STBs, including psychological treatment. Cultural stigma of mental illness induced feelings of shame and burden, which led to avolition, avoidance, and nondisclosure of symptom severity. This study provides insight into the utility of evaluating cultural context in (a) detecting antecedents to STBs frequently reported as somatic symptoms, (b) identifying protective factors against suicide, and (c) recognizing how stigma of mental illness and suicide, shame avoidance, and familism might influence personal motivations to seek or avoid help for emotional distress.

Introduction

Suicide is the second leading cause of death among university students (Owusu-Ansah, Addae, Peasah, Oppong Asante, & Osafo, 2020; dos Santos, Marcon, Espinosa, Baptista, & de Paulo, 2017). Across several continents students commonly endorse suicidal thoughts and behavior (STB); with past-year estimates of 17.2% for suicidal thoughts, 8.8% for suicide plans, and 1% for suicide attempts (Benjet et al., 2019; Mortier et al., 2018). Suicide is of particular concern among students due to the high incidence (Benjet et al., 2016; Sood & Linker, 2017) and steep increase in suicide deaths (Cha et al., 2018; World Health Organization (2021), 2021) during the transition from adolescence to young adulthood. Changes in social and academic experiences are unique stressors during this period (Crispim et al., 2021; dos Santos et al., 2017) that can exacerbate suicide risk (Wilcox et al., 2010; Wilkinson et al., 2022). As such, college is a critical target for intervention.

University-based interventions have beneficial mental-health effects (Black et al., 2021; Cecchin, Murta, de Macedo, & Moore, 2022; Robinson, Calear, & Bailey, 2018; Wolitzky-Taylor, LeBeau, Perez, Gong-Guy, & Fong, 2020). In particular, university-based mindfulness and cognitive behavioral interventions have been shown to decrease stress (Amanvermez et al., 2022; Harith, Backhaus, Mohbin, Ngo, & Khoo, 2022) as well as improve symptoms of depression and anxiety (Davies, Morriss, & Glazebrook, 2014; Harrer et al., 2019; Lattie et al., 2019; Worsley, Pennington, & Corcoran, 2022). However, even with effective interventions available, most students at risk for suicide do not initiate treatment (Bruffaerts et al., 2019; Cuijpers et al., 2013; Mortier et al., 2018).

Based on evidence from the World Mental Health International College Student (WMH-ICS) surveys, most students cite barriers such as embarrassment and a desire to resolve problems on their own as reasons they did not seek treatment for STBs (Ebert et al., 2019). Attitudinal barriers are common throughout Latin America and even remain salient among Latin*e* students in the U.S., who report feeling embarrassment, shame, and pressure to keep emotional problems concealed or only known to those within their families (Goldstein & Wilson, 2022; Valdivieso-Mora, Peet, Garnier-Villarreal, Salazar-Villanea, & Johnson, 2016). The stigmatization of help-seeking for emotional problems and STBs among Latin*e*s as well as strong preferences for avoiding shame for their families are attitudinal barriers that are exacerbated by systemic issues such as lack of access to mental health services and economic constraints. Given these longstanding systemic and attitudinal barriers to treatment utilization among Latin*e*s, more culturally informed knowledge is important when providing care, such as in assessing the way psychological symptoms are perceived, acknowledged, and communicated (i.e., the language and phrases used to articulate distress or impairment)(Alegría, Pescosolido, Williams, & Canino, 2011; Yasui, Pottick, & Chen, 2017).

Prior studies have focused on barriers and facilitators to help-seeking for general symptoms of mental illness including depression, anxiety, emotional distress, and suicidal thoughts and behavior (Aguirre Velasco, Cruz, Billings, Jimenez, & Rowe, 2020; Czyz, Horwitz, Eisenberg, Kramer, & King, 2013; Ebert et al., 2019). Such studies have assessed intentions to seek treatment, which may not lead to treatment-initiation, or provide insight into treatment-seeking decision processes. One recent WMH-ICS study assessed readiness to seek help for emotional or substance use problems (Ebert et al., 2019). The authors acknowledged that use of a single-item assessment limited the ability to: (a) distinguish among many emotional problems or (b) identify the most salient problem that motivated treatment-seeking and (c) assess interactions between personal/cultural characteristics in predicting treatment-initiation. As such, these issues inspire further inquiry.

Understanding barriers to treatment is particularly important for cultures with highly stigmatized beliefs about suicide and psychopathology. Students in Latin America face unique culturally-specific challenges also held by students in the US who immigrate from Latin America or identify as Latin*e* ethnic minorities in academia. That is, attitudinal barriers keep Latin*e* students in need of care from seeking and initiating psychological treatment (Hampton & Sharp, 2014; Mendoza, Masuda, & Swartout, 2015).

Promising new approaches that may reduce health disparities in Latin America include internet-based electronic health (eHealth) interventions, for which university students with depression in Mexico report a preference (Benjet et al., 2020). For example, smartphone-delivered interventions can improve accessibility to evidence-based

psychological treatment and may serve as a means by which to scale up suicide prevention efforts across low-resource settings. As such, there is a growing body of research on the use of digital technologies for mental health in Latin America (Carter, Araya, Anjur, Deng, & Naslund, 2021; Escobar-Viera et al., 2021; Naslund et al., 2017) with mounting evidence of effectiveness of these interventions (Fu, Burger, Arjadi, & Bockting, 2020). Expanding our understanding of attitudinal barriers and facilitators to treatment among students in Latin America may lead to more effective interventions focused on increasing engagement with available interventions such as eHealth.

The current study employed qualitative inquiry to explore STBs among university students from Mexico and Colombia. We focused on students in Mexico and Colombia because they share language, cultural values, and similar highly stigmatized attitudes toward suicide and treatment-seeking for mental health problems (Mascayano et al., 2016; Sapag et al., 2018). We aimed to answer the following key questions: *How are suicidal thoughts, plans, and attempts described? What are reasons for wanting to die and for living? What impact do STBs have on motivations to seek or avoid psychological treatment?* We identified participants from the WMH-ICS surveys conducted in Mexico and Colombia, and reached out to students to conduct qualitative interviews aimed at collecting detailed accounts of their STBs.

Methods

Sample

Participants (n = 55; female = 67.9%; M_{age} = 21.8 years, range = 18—26, SD = 1.8) who completed the DSM-5 WMH-ICS Surveys were recruited from four universities in Mexico and Colombia (1-private, 1-public per site). A total 156 students met inclusion criteria (106 from Mexico, 50 from Colombia) and were contacted via email/WhatsApp and invited to participate. Those that responded to outreach attempts (n = 56; 30 from Mexico, 26 from Colombia) were screened to confirm their responses to the WMH-ICS surveys, before completing qualitative interviews. One interview was incomplete and therefore excluded. Although participants included in the current study (n = 55) tended to be slightly older, they did not differ across gender and parental education compared to the larger pool of potentially eligible participants who were contacted (see Table 1a).

Inclusion criteria

All participants met diagnostic criteria for major depressive disorder, generalized anxiety disorder, and/or indicated past-year STBs. This current qualitative study is adjunct to a clinical trial to evaluate digital mental health interventions designed for students in Latin American universities. The aim of the current project is to assess *stages-of-change* identified via responses to an item in the WMH-ICS survey, ''*How would you rate your readiness or willingness to change any emotional or substance use problems you are experiencing at this time?*" Each participant was categorized into the following response profiles: 1-Denied problem, denied need for help, and not treatment-seeking; 2-Acknowledged problem, unsure about need for help, and not treatment-seeking; 3-Acknowledged problem, confirmed need for help, didn't have access; 4-Acknowledged problem, confirmed need for help, and were treatment-seeking or had done so and resolved their problems; and 5-Acknowledged problem, confirmed need for help, and accepted electronic cognitive behavioral therapy (e-CBT) offered as part of a separate ongoing clinical trial. Individual stage-of-change profiles were assigned distinct questions for the qualitative interview. All participants were assessed for current/past-year STBs and received core questions focused on the identification of symptoms, recognition that symptoms create problems, consideration of help-seeking options, and experiences with accessing and receiving psychological treatment. We restricted the current qualitative analysis to participants who endorsed past-year STBs.

Procedure

The Research Ethics Committee of the National Institute of Psychiatry in Mexico and the Committee on the Use of Human Subjects at Harvard University approved all study procedures for data collection at both Mexico and Colombia sites. Informed consent was acquired online. All interviews were conducted in Spanish by researchers in Colombia and Mexico. After each interview, risk assessments and safety plans were conducted as-needed and all participants were provided a list of available university resources specific to each site. All interviews were audio recorded using Zoom or Microsoft Teams. Recordings were transcribed verbatim using speech-to-text in AdobePremierePro or MicrosoftAzure and independently assessed for quality by researchers on-site. Transcribers were trained psychologists and post-baccalaureate research assistants. Transcription instructions were created and reviewed by a team of six Harvard researchers to ensure accuracy and consistency across interviews. All text data were reviewed, thematically coded, and indexed by researchers on site in Mexico and Colombia as well as by native Spanish speaking researchers at Harvard. The final themes and sample quotes were translated to English for this manuscript first using OpenAI Translator and subsequently reviewed by two bilingual native Spanish speaking Harvard researchers. All participant quotes found in Table 3 were directly translated. The final English translation of idioms and themes presented in Table 3 as well as in the results (below) were interpreted for categorization by the first, second, and senior authors, Castro-Ramirez (bilingual native Spanish), Paz-Pérez (native Spanish), and Benjet (bilingual native English).

Interviews

The interview began with a broad exploration of perceived emotional problems/symptoms then progressed to questions about STBs. The current study draws from participants' responses to seven questions focused specifically on STBs from a sub-section of the larger qualitative interview (see Table 2a). The overall interview aimed to capture participant insights to inform our understanding of stages-of-

Table 1a Sample Characteristics: Participants Recruited *The sample recruited did not differ in any general demographic characteristic compared to the larger pool of potentially eligible participants for the current study.*

	Students Recruited		*t*	$\chi^2_{(2,55)}$	*p*
	% Interviewed (n = 55)	% Not Interviewed[†] (n = 100)			
Demographic information					
Age (mean)	21.78	20.82	2.64		0.01*
[‡]Gender (female)	69.10	81.00		2.82	0.09
[§]First-generation status	47.30	43.00		0.26	0.07
History of suicidal thoughts & behavior					
Passive suicidal thoughts	70.90	67.00		0.73	0.69
Active suicidal thoughts	50.90	52.00		0.10	0.95
Lifetime suicide attempts	14.50	17.00		0.16	0.69
History of help-seeking for psychological problems					
Counseling	40.00	39.00		0.15	0.93
Medication	10.90	13.00		0.22	0.90
Anything else	7.30	11.00		0.62	0.73

* $p < 0.05$.
† Participants that were unresponsive to outreach attempts for study participation.
‡ All students reported the same gender identity as their gender at birth except for two; Both were interviewed, they indicated option ''other" and in the open text one wrote ''gender fluid" and the other left it blank.
§ Parent(s) did not attend or complete a 4-year college/university degree.

change to help-seeking and treatment-initiation for mental health problems among college students, whereas the current study focused only on participants' description of their experiences with STBs. A semi-structured interview design was used in which participants were asked a set of predetermined open-ended questions that were followed by probe questions to further explore their response on the subject of interest. Interviewers were also psychologists and post-baccalaureate research assistants–all trained by the first and second author, who oversaw interviewing, implementation, and suicide risk procedures. Participants that endorsed STBs during the interview: (a) underwent suicide risk assessment with trained interviewers in which they indicated current STBs, (b) completed suicide safety plans in which trained interviewers discussed healthy alternative behaviors for the next time they experienced STBs, and (c) were encouraged to use resources provided in the form of site-specific university mental health services.

Coding and analysis

We employed a framework analysis approach, a technique that typically falls into a broad range of thematic and content analysis methodologies (Gale, Heath, Cameron, Rashid, & Redwood, 2013), and that is often used in applied qualitative and policy research studies aimed at addressing pre-specified research questions (in our case the questions focused on individuals' experiences with STBs) to inform tangible solutions, and increasingly used in qualitative research focused on mental health and psychology (Ritchie & Spencer, 1994; Ward, Furber, Tierney, & Swallow, 2013). We selected this qualitative methodology because our primary aim was to understand participant descriptions of their STBs, and to accommodate the relatively large number of interviews and broad range in participant characteristics (Parkinson, Eatough, Holmes, Stapley, & Midgley, 2016). Specifically, framework analysis offers a transparent and flexible approach for organizing a large amount of data according to main themes, which are ordered in a tabular format with representative data from each study participant (Ritchie, Spencer, & O'Connor, 2003). The framework analysis methodology contrasts other forms of thematic analysis by generating highly structured output that is particularly useful when working as part of a larger team across multiple countries (Gale et al., 2013). The main themes were identified through coding the qualitative interview transcripts.

The initial coding framework was developed in collaboration with Harvard researchers and on-site researchers in Mexico and Colombia. Pre-existing (deductive, *a priori*) themes were created using the Self-Injurious Thoughts and Behaviors Interview (SITBI; Nock, Wedig, Janis, & Deliberto, 2008) and emergent (inductive) themes were generated iteratively in the course of the analysis and expanded on the initial framework (see Table 2b). The SITBI was used to define the framework's key areas of exploration (*a priori* themes based on our research questions) prior to reviewing each transcript and to further expand the framework. Researchers on-site reviewed each interview in its entirety to identify and label preliminary categories and discussion points related to participants' responses that align with the SITBI embedded throughout the transcript. The initial framework was tested against a subset of 10 interviews by four coders–clinical science doctoral students, trained psychologists, and post-baccalaureate research assistants. Coders met regularly to compare all codes applied to case examples, disagreements were discussed, and joint decisions were made about the set of codes to apply to all

remaining transcripts. All transcripts were then independently coded by trained coders prior to refining our framework using inductive themes. Study data was indexed by seven coders on the framework as well as emergent codes that were iteratively derived. Code matrices and other data were reviewed and condensed to make them more concise for interpretation as indicated by the study aims, available interviews, and significant patterns/themes. Final consensus was determined in discussions with coauthors Nock, Naslund, and Benjet–leading experts in suicide, qualitative data analysis, and WMH studies in Mexico and Colombia, respectively.

Results

Overview

A total of 55 participants were interviewed. Among those, 17 participants did not endorse past-year STB and so were excluded from the results described below. The current study is based on qualitative interviews collected from 38 participants with past-year STB. Our initial coding analysis revealed that 10 participants endorsed so-called passive suicidal thoughts (e.g., a desire to die or simply not exist) while the remaining 28 participants endorsed past-month/past-year STB–self-injury with intent to die, preparatory actions in anticipation of killing oneself, and/or thoughts that they should kill themself. Additionally, 17 participants endorsed both passive and active suicidal thoughts, 9 participants indicated methods they had considered, and 10 participants described a suicide attempt in the past year. Sample demographic characteristics are summarized in Table 1b.

Experiences with suicidal thoughts and behavior

Findings from the framework analysis are summarized below according to the five main themes that emerged from the data: 1-active suicidal thoughts; 2-passive suicidal thoughts; 3-reasons for wanting to die; 4-reasons for living; and 5-impact of STBs. Table 3 provides a summary of these overarching themes, along with illustrative quotes.

Active suicidal thoughts

Participants endorsing thoughts of or desire to kill themself (n = 28, 73.7%) described suicide as an escape from distressing psychological states while also expressing apprehension over experiencing physical pain (from a suicide attempt) and fear of the unknown (regarding what happens after death). For example, a 22 year old woman (female-22yo) described researching methods such as a drug overdose to avoid feeling physical pain. Another (female-23yo) shared, ''At first I started with small deep cuts on the wrists, the normal thing, what you see in the movies. Later I went with pills and it scared me. I thought, what is going to happen to me after I die?" Participants shared details of what they were experiencing shortly prior to a recent suicide attempt and what they believed contributed to their urge to die. For example, (female-22yo) explained, ''I felt so sad that I actually lasted three weeks sick... and I took an overdose of medicine." Participants also described methods they considered and gestures to lead others to believe they tried to kill themself. For example, (female-21yo) indicated, ''I am saying make it easy, with pills" Another participant (male-25yo) described planning a car accident that was serious enough to require hospitalization in order to lead someone to believe he wanted to die.

Table 1b Sample Characteristics: Participants Interviewed *Those that endorsed past-year STBs did not differ in any general demographic characteristic compared to participants who did not endorse past-year STBs for the current study.*

	Students Interviewed		*t*	$\chi^2_{(2,38)}$	*p*
	% Past-year STB (n = 38)	% No past-year STB (n = 17)			
Demographic information					
Age (mean)	21.84	21.65	0.332		0.20
‡Gender (female)	71.10	64.70		0.22	0.64
§First-generation status	52.60	35.30		1.42	0.23
Lifetime suicidal thoughts & behavior					
Passive suicidal thoughts	86.80	35.30		24.54	0.00*
Active suicidal thoughts	68.40	11.80		18.31	0.00*
Suicide attempt(s)	21.10	0.00		11.62	0.00*
History of help-seeking for psychological problems					
Counseling	47.40	23.50		3.27	0.20
Medication	13.20	5.90		0.70	0.70
Anything else	10.50	0.00		2.02	0.37

* $p < 0.05$.
‡ All students reported the same gender identity as their gender at birth except for two; Both were interviewed, they indicated option ''other" and in the open text one wrote ''gender fluid" and the other left it blank.
§ Parent(s) did not attend or complete a 4-year college/university degree.

Table 2a Stages-of-change interview questions about experiences with suicidal thoughts and behavior.

Thoughts	Please describe any thoughts you may have had about dying or killing yourself.
Method/Means	Please describe any ways that you might choose to die. (explore plans, means, and intent)
Attempts	How close have you come to doing something like this? How was that?
Danger-Seeking	Please describe any reckless things you may have done to 'tempt fate' or because you didn't care about your safety?
Protective Factors	What stopped you? What factors have helped you not to do it?
Impact	How did these thoughts impact how and whether you sought help or support?
Self-Help	What have you done to try to address these thoughts and urges? What has helped you?

Table 2b *A priori* (deductive) and emergent (inductive) themes were generated from qualitative interviews.

A priori Themes[a]		Emergent Themes[b]
SITBI	Stages-of-Change	Main themes
Active suicidal Thoughts	Suicidal thoughts	**Suicidal Thoughts**
Passive suicidal thoughts		Active
Methods/Plans	Method/Means	Passive
Suicide attempts	Suicide attempts	Reasons for wanting to die
Non-suicidal self Injury	Danger-Seeking	**Reason for Living**
	Protective Factors	Guilt
	Impact	Fear
	Self-Help	Purpose
		Support
		Response to Suicidal Thoughts
		Motivation to explore solutions
		Negative emotional responses

Note, emergent themes do not deviate substantially from the apriori themes used to develop the initial framework.
[a] Apriori (deductive) themes created using the Self-Injurious Thoughts and Behaviors Interview (SITBI) and Stages-of-Change Interview.
[b] Emergent (inductive) themes generated iteratively in the course of thematic analysis.

Passive suicidal thoughts

Participants endorsing passive thoughts of wanting to die (n = 17, 44.7%) described ways to die without negatively impacting loved ones. For example, (male-25yo) explained, ''I have thought about how to die without it affecting my mother so much." Some indicated simply not wanting to exist. For example, (male-25yo) described hoping he had never been born. Participants also described actions they take to put themself in harm's way. For example, (female-20yo) explained how she sought dangerous situations hoping something happened and she died as a result. Others indicated that they did not care whether they lived or died. For example, (male-20yo) explained that his life was inconsequential and he did not seek nor avoid death.

Reasons for wanting to die

Participants cited reasons they perceived contributed to their STBs, including adversity and seeking respite from what they perceived was an ongoing struggle. Participants described experiencing intense physical sensations such as anxious agitation with panic symptoms. For example, (female-21yo) indicated experiencing chest pain coinciding with feelings of hopelessness and anxiety as she described injuring herself in an attempt to feel different pain (see Table 3). Participants also reported psychological states such as desperation and loneliness, as though they had no support, and expressed a somber outlook of their future.

Reasons for living

Participants indicated they had not yet killed themselves due to feelings of guilt, fear, a sense of purpose, and being well-supported. Those that expressed guilt indicated that they did not want to cause their parents to suffer or leave their siblings behind. Participants that expressed fear indicated that they were religious and feared god, they were afraid of attempting suicide and failing, and they feared what might happen or what people might think of them and their family after they died. Among those that indicated having a deep sense of purpose that kept them from acting on their suicidal thoughts, personal goals and responsibility to their family were the most commonly reported. Lastly, participants described being well-supported as their reason to live and family, friends, and professional help from mental-health providers were the most endorsed sources of support.

Impact of suicidal thoughts

Participants indicated that experiencing STB motivated them to explore ways to improve emotional problems. In fact, most participants that endorsed active suicidal

thoughts during the qualitative interview also indicated that they were in need of help for emotional or substance use problems in the WMH-ICS survey (n = 21, 75%). Participants reported that as a result of experiencing STB they got professional help, pursued social contact, engaged in spiritual practices, tried to resolve things on their own by using mind-altering substances, sought companionship from pets, engaged in goal-oriented career-focused activities, and engaged more intensely with religious activities. Importantly, spiritual practices and religious activities are not diametrically opposed but differ in two key ways. First, religion in our study was primarily tied to Christianity and participants endorsed activities such as attending church services. Second, spirituality was referenced in connection to the use of crystals, magnets, and *Limpiezas* (or spiritual cleanses).

Most participants were motivated to improve their mental-health as a result of experiencing STB, yet some reported symptoms that severely impaired their functioning and served as a barrier to their seeking help of any kind. These individuals described feeling unmotivated to try anything that might improve their mood. While all participants who endorsed STB indicated feeling shame at some point, for some, shame and experiential avoidance prevented them from exploring treatment options.

Discussion

There were three key findings in this qualitative study, each of which provide clinical insight and point toward understudied topics in existing quantitative studies on STB. First, suicide attempts were a means to escape, with common drivers being psychological states of desperation and somatic symptoms of anxious-agitation. Second, many provided descriptions of their reason for living in tandem with STB, such as not wanting to cause their family to suffer. Third, STB often motivated treatment-seeking, with some attempting to resolve their issues by seeking alternatives to traditional psychological treatment. Each of these findings warrants additional comment.

Suicide as escape

Participants described suicide as a form of relief from ongoing adversity and related feelings of desperation for an end to somatic symptoms. This finding is consistent with theories of the function of suicide as escape from emotional pain (Baumeister, 1990; Shneidman, 1993) and/or a solution (Clum, Patsiokas, & Luscomb, 1979; Priester & Clum, 1993) when healthy regulatory options are unknown or inaccessible. Although psychopathology, sociodemographic factors, and life-stressors are the most often-studied risk factors for suicide (Franklin et al., 2017), students in this study reported escape from specific and relatively understudied psychological states. For instance, desperation and anxious agitation emerged as critical states that led students to want to escape and in some cases co-ocurred with self-injurious behavior. These findings are consistent with earlier work suggesting desperation is among the most important factors increasing suicide risk (Garlow et al., 2008; Hendin, Maltsberger, & Szanto, 2007) and death (Hendin, Maltsberger, Haas, Szanto, & Rabinowicz, 2004). Earlier work also indicates that anxious-agitation increases acute suicide risk. In fact, severe anxiety and agitation co-occur with depression and can yield more immediate suicide risk (Fawcett, 1997, 2001; Fawcett, Busch, Jacobs, Kravitz, & Fogg, 1997). For example, among suicide deaths occurring in the hospital or shortly after discharge, most (79% in one study, see Busch, Fawcett, & Jacobs, 2003) meet criteria for severe anxiety and agitation as defined by the Hamilton Depression Rating Scale, HDRS (Hamilton, 1960) and/or the Schedule for Affective Disorders and Schizophrenia, SADS (Endicott & Spitzer, 1978). Anxious-agitation therefore manifests as anxiety and panic symptoms with physical restlessness. Importantly, Latin*e* patients are consistently found to report greater levels of somatic symptoms of anxiety and depression than Black and non-Latin*e* patients in the U.S. (Dunlop et al., 2020). These findings highlight the need for more research focused on desperation, anxious agitation, and the efficacy of interventions focused on urgent recognition of immediate suicide risk in Latin*e* patients.

Specific stressful experiences increased desires to escape. Participants reported experiencing ongoing adversity such as poverty, first-generation status[1], migration stress, and the psychological impact of past trauma–all of which exacerbated feelings of shame and somatic mood symptoms. This finding is consistent with prior work on the accumulation of traumatic experiences contributing to the accumulation of psychological disorders and increased suicide risk (Nock et al., 2008; Nock & Kessler, 2006). Reported STBs often followed recent adverse interpersonal experiences when participants felt isolated and unsupported. In particular, conflicts with family, friends, or romantic partners were described as the most distressing experiences, eliciting shame, limiting their disclosure of symptoms, and thereby reducing opportunities for intervention. These findings are consistent with prior work demonstrating how family conflict (Baumann, Kuhlberg, & Zayas, 2010; Peña et al., 2011; Perez-Rodriguez et al., 2014; Villarreal-Otálora, McPherson, & Garcia-Magaña, 2023) and low family connectedness (Garcia, Skay, Sieving, Naughton, & Bearinger, 2008; Valdivieso-Mora et al., 2016) appear to increase suicide risk among young people from Latin America. Cultural factors such as existing mental health stigma can dictate the level of support individuals receive from their families–parents, siblings, and partners may lack knowledge about and invalidate mental illness, thereby contributing to the worsening of mood symptoms and increased suicide risk.

Taken together, these findings add to prior studies on psychological treatment use among university students in which attitudinal barriers such as reported embarrassment were linked to lower reported intentions to seek help (Andrade et al., 2014; Ebert et al., 2019; Gulliver, Griffiths, & Christensen, 2010; Vidourek, King, Nabors, & Merianos, 2014). Prior work has focused on structural barriers to psychological treatment engagement, used quantitative means to measure attitudinal barriers, and applied findings to cross-national samples of university students (Auerbach et al., 2018; Ebert et al., 2019; Eisenberg,

[1] Parent(s) did not complete a 4-year college or university degree.

Downs, Golberstein, & Zivin, 2009; Evans-Lacko & Thornicroft, 2019; Janota, Kovess-Masfety, Gobin-Bourdet, & Husky, 2022; Orozco et al., 2022). The current study findings also offer unique perspectives about STBs from students in Mexico and Colombia, and underscore the need for considering cultural factors that may help mental health providers better detect and treat STBs. For instance, culture can influence how students describe and disclose their symptoms–they may perceive and discuss only somatic symptoms while presenting to primary healthcare providers. Furthermore, students from cultures that highly stigmatize mental illness may benefit from family involvement in psychoeducation during clinical decision making. Further qualitative exploration of beliefs about and motivations to die by suicide is warranted, with consideration of whether the perspectives from students in Latin America may differ from the perspectives of students in other countries or settings.

Reasons for living were protective against suicide

Participants commented on reasons for living and that these reasons had deterred them from going through with suicide plans and methods they had considered. They expressed fear of physical pain from an uncompleted suicide attempt or during the process of dying and fear of not knowing what happens after death. Most indicated their reasons for living were primarily due to their strong relationships with their families. In fact, the most frequently reported reason for living was experiencing guilt over their parents and siblings suffering if they were to die by suicide. Importantly, some reported that related feelings of shame and burdensomeness led them to conceal mood symptoms and avoid seeking help. This finding is consistent with prior work on mental-health behavior and familism. In particular, Latin American cultures[2] value familism and tend toward strong preferences for the well-being of family over one's own interest. Experiencing emotional distress may therefore elicit feelings of shame and burden since any mental-health stigma also reflects on one's family (Brenes, 2019; Caplan, 2019). As such, familism in Latin American culture often promotes reliance on the family for support and could result in unwillingness to disclose (Mendoza et al., 2015; Senft, Campos, Shiota, & Chentsova-Dutton, 2021) or seek help for psychological problems (Chang & Biegel, 2018).

Participants also indicated that their reasons for living included feeling grateful for the sacrifices their family had made for them and a sense of responsibility to "*echarle ganas*[3]", which they felt compelled them to resolve emotional problems on their own. This finding is supported by prior work on social support as a fundamental component of Latin American cultural values of connectedness and emphasis on familial relationships. In fact, social support can be a source of resilience as it is a well-established protective factor against loneliness that can moderate the negative impact of stress and depression (Chen, Alston, & Guo, 2019). These findings highlight the importance of culture on personal motivations to improve emotional wellbeing. While understanding cultural norms around familism is key for guiding clinical practice in Latin American cultures, further qualitative inquiry is needed to investigate ways to promote the protective benefits of family while overcoming any potential challenges that family can play in limiting help-seeking and self-disclosure of STBs, and whether this may differ across cultures and contexts.

Suicide & help-seeking decisions

The current study also explored the impact of STBs on the decision to seek or avoid treatment. A novel finding was that experiencing suicidal thoughts often motivated participants to explore solutions for emotional problems, including psychological treatment when it was available. Unfortunately, access to evidence-based care is limited and there are often waitlists for these services even for those who seek and can afford them. There are significant gaps in access to mental health services in Latin American countries, particularly among socioeconomically disadvantaged groups (Araya, Zitko, & Markkula, 2018; Araya, Zitko, Markkula, Rai, & Jones, 2018; The Burden of Mental Disorders in the Region of the Americas, 2018 - PAHO/WHO | Pan American Health Organization, 2018). As such, there is a critical need for more accessible, cost-effective options for psychological treatment. Participants described strategies they tried on their own in order to keep themselves from feeling suicidal, including passive social contact in public spaces and seeking positive distractions with pets. Some also reported that they relied on institutions such as religion, alternative healing such as with crystals or magnets, and traditional spiritual practices recommended by family. Empirical evidence for religion as protective against STBs is conflicting. Consistent associations between attending religious services and lower suicide risk are highly reliant on culture and have been credited in large part to cultural preferences for social support (Hoffman & Marsiglia, 2014; Lawrence, Oquendo, & Stanley, 2016). The current findings warrant further research on how experiencing suicidal thoughts among college students can act as motivators for seeking help with emotional problems. This suggests that early identification of suicidal thoughts, and creating an environment where students can openly share their challenges with trusted individuals, could encourage help-seeking and ultimately prevent suicide deaths. This could be further complemented by the support of community-based efforts to use accessible avenues for social support such as religion to promote mental healthcare and help-seeking (Ali, Mahmood, McBryde-Redzovic, Humam, & Awaad, 2022; Breland-Noble et al., 2020).

Those with preferences to resolve their own problems also endorsed self-medicating with drugs and alcohol as a means of coping with emotional problems. One participant also described their use of psychedelics as a tool for introspection. Importantly, many university students who feel suicidal do not seek treatment or social support and may engage in substance use in order to help regulate difficult emotions (Weiss et al., 2022; Wolitzky-Taylor et al., 2020). Alcohol consumption, in particular, should be monitored carefully as dependence is linked to increased suicidal thoughts and acute alcohol intoxication with increased suicide attempts (Borges et al., 2017). Stigma toward people

[2] Predominantly (non-European) Spanish, Portuguese, and French-speaking nations in the Americas and the Caribbean.

[3] To make a good effort, apply oneself, and hustle.

with mental illness and addiction problems has been found to lead to worse prognosis by limiting disclosure and help-seeking, which enables shame avoidance and isolation (Sapag et al., 2018). Taken together, our findings underscore the need for strategies to identify behavior indicative of high suicide risk without depending on self-disclosure or help-seeking. These findings also highlight the need to support personal efforts to resolve emotional problems by providing accessible interventions that are culturally informed and culturally collaborative, such as effective community-based suicide prevention (Alonzo, Popescu, & Zubaroglu-Ioannides, 2021; Farahbakhsh et al., 2022; Fountoulakis, Gonda, & Rihmer, 2011).

Limitations

These results should be interpreted in the context of important limitations. First, while a sizable number of participant interviews were analyzed in this exploratory qualitative study, there remain limitations to the generalizability of the findings. Participants were sampled from only two Spanish-speaking Latin American countries, which limits generalizability to other countries and university settings in Latin America. Second, the students who participated in this study were actively enrolled in urban university settings in Mexico and Colombia, and completed the interviews over a remote digital video-conferencing platform. Thus, our sample may not be representative of rural lower-income groups in either country, and other particularly vulnerable or at-risk population groups. Third, the findings presented in this study were extracted from a subset of items from longer interviews (about mental health-related topics other than STBs). While drawing from the larger WMH-ICS surveys and qualitative interviews is an important strength of the current methodology, this also limited the extent to which we could probe further about participants' experiences with STBs. As such, the current study focused only on participants' responses to questions about STBs, and therefore, did not cover additional aspects of risk/protective factors and barriers to treatment-initiation. Future studies could explore a broader range of topics related to STBs and their association with barriers and facilitators to seeking and engaging in treatment. Fourth, while our study offers important insights about various cultural factors that could influence STBs among college students from two countries in Latin America, our study does not provide an in-depth exploration of the role of culture in either study context. This highlights an important area to expand on our initial work, and to examine whether our findings here may differ among students from other countries and cultural backgrounds, and to consider how integrating culturally relevant content in the design of interventions and prevention strategies can impact outcomes. Despite these limitations, the current study provides valuable insight about symptom presentation and consequences of STBs among students from Latinoaméric.

Future directions

These results point toward next steps and considerations about student mental-health approaches. Periods of high suicide risk may emerge and amplify quickly (Kleiman et al., 2021), yielding highly distressing somatic symptoms (as observed among participants in this study) and likely interfere with cognitive processes needed to regulate emotions and physiological states or disclose symptom severity and ask for help. Effective treatments for reducing suicidal behavior such as dialectical behavior therapy (DBT; DeCou, Comtois, & Landes, 2019; McCauley et al., 2018) have been adapted for university students (Pistorello, Fruzzetti, MacLane, Gallop, & Iverson, 2012), with just a few adapted for Latin*e* adolescent young adults, or youth (Curcio, 2022; Germán et al., 2015; Morales et al., 2022). In fact, a web-based DBT skills-training session, with culturally informed examples for emotion regulation and distress tolerance skills, has been developed and delivered to DACA recipients and their families with beneficial results reported by participants (Morales et al., 2022). Additionally, courses of full-model DBT have been adapted for Latin*e* youth in which treatment targets included culturally specific dialectical dilemmas such as preferences for traditional vs modern social norms (Germán et al., 2015) and emotional invalidation due to generational trauma (Curcio, 2022). Lastly, our team has recently found that internet-delivered CBT–translated to deliver culturally relevant evidence-based skills training–improved symptoms of anxiety and depression among students from the same universities in Mexico and Colombia as the current study, results of which will be forthcoming.

While prior work suggests that psychological treatment is effective across a variety of cultures (Bolden, Gaona, McFarr, & Comtois, 2020; Griner & Smith, 2006; Haft, O'Grady, Shaller, & Liu, 2022), there is also strong evidence for greater improvement of symptoms when evidence-based treatments are culturally adapted as opposed to standard treatment protocols (Hall, Ibaraki, Huang, Marti, & Stice, 2016). Specifically, because patients may struggle to observe treatment goals that conflict with their cultural values. For example, being of service to one's family is a strong cultural value in Latin American culture and may supersede treatment seeking, treatment adherence, and treatment benefits. Studies on the effectiveness of cross-cultural dissemination of treatment modalities such as CBT and DBT also emphasize the significance of considering the impact of access to treatment, usage of treatment, and social stigma in order to increase treatment seeking and prevent instances of treatment not succeeding (Cardemil & Battle, 2003; Collins et al., 2011). Additional research focused on improving the delivery of more culturally responsive treatments is sorely needed. In particular, for the treatment of STBs for young people living in Latin America.

Even when effective, culturally-adapted care can be made available, a majority of students in need do not seek treatment. Furthermore, self-disclosure of suicide risk and adherence to multiple weekly sessions with a mental-health provider are not always accessible options. More research is needed that compares the effectiveness of personalized online interventions targeted to students at high suicide risk and adapted to disseminate culturally-adapted skills-training in stress management, DBT distress-tolerance with interpersonal-effectiveness skills, and CBT behavioral activation.

Recent digital innovations that include tracking people at high suicide risk–by using smartphones for just-in-time interventions (Coppersmith et al., 2022) deployable by text messages, emails, and phone calls–may also facilitate engagement with psychological treatment and help personalize the delivery of online interventions. Further research is needed to determine the clinical effectiveness, cost efficiency, sustainability and social impact of smartphone and online suicide prevention strategies across diverse settings.

Conclusion

This exploratory study offers insights about the personal experiences and details of the context in which suicidal thoughts, urges, and attempts occur for college students from two countries in Latin America. The use of qualitative interviewing yielded important culturally relevant information about how college students experience suicidal thoughts, what psychological states and factors they believe contributed to their urge to die, their urgency to escape distress, and about more positive experiences such as considered reasons for living and experienced desire to seek help for emotional problems. The current findings warrant social efforts to destigmatize psychological disorders as a public health crisis, provide psychoeducation and support to families, and improve public access to effective psychological interventions. More research is needed to explore reasons for living and the role of familism among university students from Latin American cultures in order to develop more culturally informed suicide safety planning as well as strategies to lower barriers to treatment initiation and engagement.

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Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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