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Impact of Suicide Literacy in Hispanic/Latinx Communities

Denisse Centeno Lamas
Walden University

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Walden University

College of Social and Behavioral Health

This is to certify that the doctoral study by

Denisse Centeno Lamas

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University
2026

Abstract

Impact of Suicide Literacy in Hispanic/Latinx Communities

by

Denisse Centeno Lamas

MS, University of Central Florida, 2001

BS, University of Central Florida, 2000

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Social Work

Walden University

February 2026

Abstract

Suicide prevention is a critical public health priority, often hindered by cultural stigma, misinformation, and barriers, particularly within the Hispanic/Latinx community. The effectiveness of American Foundation for Suicide Prevention's Talk Saves Lives™ suicide prevention program in enhancing suicide literacy within this population was measured in this study. Although research emphasizes cultural stigma and the need for culturally responsive interventions, little is known about their specific impact on suicide literacy. Guided by social cognitive theory, the impact of two versions of the Talk Saves Lives™ program: Version 1, a direct Spanish translation, and Version 2, a culturally adapted version for the Hispanic/Latinx population were assessed. One hundred and fifteen Spanish-speaking Hispanic participants from Central Florida were recruited and divided between the two program versions. Pre- and posttests using the Literacy of Suicide Scale (LOSS) measured changes in suicide literacy, and *t-tests* were used to analyze the data and evaluate the relative effectiveness of the two versions. The findings revealed statistically significant gains in suicide literacy for both versions of the program. Specifically, participants in the culturally adapted program demonstrated a 48.6% greater mean score increase on the LOSS compared to participants in the translated version. These results underscore the importance of cultural adaptation in suicide prevention, demonstrating that culturally responsive education effectively enhances knowledge, reduces stigma, and ultimately saves lives. These findings also provide guidance to social workers and policymakers on developing culturally responsive strategies to reduce disparities and strengthen community-based prevention initiatives.

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Dedication

I dedicate this project to the American Foundation for Suicide Prevention (AFSP) for its ongoing commitment to saving lives and bringing hope to those affected by suicide. Thank you for your continued efforts to advance diversity, equity, and inclusion, and for going beyond language to reach and protect my community. Your work continues to make a profound difference.

I also dedicate this work to my Hispanic community; your strength, faith, and resilience inspire others every day. Keep fighting, keep breathing, and stay here. Your life has value, your voice matters, and your presence brings HOPE. ¡Que nada nos detenga, adelante!

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Section 1: Foundation of the Study and Literature Review

Introduction

Suicide is a public global health challenge that significantly contributes to mortality rates worldwide. While vast materials are available on the topic of suicide prevention, there is a lack of culturally sensitive educational programs catering to the needs of the Hispanic/Latinx Community. Misra et al. (2021) identified a direct correlation between stigma and the increased risk of suicidal behavior. They also found that people internalizing stigma are more prone to suicide attempts, and minority groups and communities have higher suicide rates.

The program Talk Saves Lives™ (TSL), developed by the American Foundation for Suicide Prevention (AFSP), aims to educate the community about warning signs of suicide and basic tools to assist someone in need. In 2022, TSL for the Hispanic/Latinx community was introduced. The program was customized to address the specific cultural factors affecting suicide prevention within this group.

Given its recent release, its implementation is relatively new and has not undergone formal evaluation. I sought to fill the gap in assessing the efficacy of the program within the Hispanic/Latinx community, not only due to the significant impact of cultural dynamics in this issue, but also given the concerning increase in suicide rates among Hispanic/Latinx. These rates rose by 4.3% from 2021 to 2022, reaching a rate of 7.9 per 100,000 in 2021 and continuing to show upward trends in recent years in the United States (Centers for Disease Control and Prevention [CDC], 2023a).

I intended to measure whether there was an increase in suicide literacy after participating in the TSL training. Suicide literacy is defined as the knowledge and comprehension a person has related to suicide, including the recognition of warning signs, awareness of risk and protective factors, and knowledge of available resources (Jorm et al., 1997). Consistent with this definition, the TSL program focuses on increasing awareness of suicide warning signs, reducing misinformation, and improving knowledge of available supports and resources (AFSP, n.d.-a). Higher levels of suicide literacy enable individuals to recognize suicide risk in themselves and others, understand the role of stigma, and take the necessary measures to prevent suicide (Deweke & Bridges, 2017). This understanding encompasses more than identifying signs of depression but also tackles how to support someone with suicidal ideation. By improving suicide literacy, programs like TSL aim to reduce misinformation, increase awareness of suicide warning signs, and strengthen participants' capacity to respond appropriately to suicide risk within their communities (AFSP, n.d.-a).

Section 1: Foundation of the Study and Literature Review

In this section, I provide a general description of suicide, the research questions, and the purpose of this study. I also include a detailed literature review that explains mental health problems, the increased risk of suicide among those with mental health problems, and different programs to mitigate suicide. I also explore suicide within the Hispanic/Latinx community and how cultural considerations are important when addressing suicide prevention.

Section 2: Research Design and Data Collection

In this section, I outline the research design and data collection process. I address challenges encountered, outline the study's limitations, and discuss the implications of the findings for the practice of social work.

Section 3: Presentation of the findings

In the third section of the research, I present the study's findings, including a detailed description of the data collection process, limitations encountered during the study, a summary of the data analysis, and implications for social work practice.

Section 4: Application of professional practice and implications for social change

In the final section of the study, I reiterate the study's purpose and nature and explain how the findings extend knowledge within the profession. I also explain the principles of the social work code of ethics and the impact of the findings on social work practice.

Problem Statement

Suicide remains one of the top ten leading causes of death in the United States (CDC, 2023c). It is also considered a public health concern, but one that is preventable. Therefore, education about suicide signs and symptoms, as well as knowledge of professionals and places where people with suicidal ideations could go to seek help, are essential to assist someone with suicidal thoughts effectively.

After 13 straight years of an increase in deaths by suicide, the national suicide rate declined in 2019 by 2.1% (CDC, 2021). However, not all racial or ethnic groups experienced this decline. Unfortunately, for the Hispanic/Latinx population, suicide

trends moved upward, with an increase of nearly 7% in suicide rates from 2018 to 2021 (AFSP, 2023a). These statistics highlight the urgency for culturally tailored education efforts and justify evaluating TSL's impact on the Hispanic/Latinx community. It is important to emphasize that mental health conditions that contribute to suicide are treatable, and recognizing people at risk through conversations is possible with the correct training and education in place (CDC, 2023b).

In the Hispanic/Latinx communities, religious beliefs and cultural stigma may be significant factors that make conversation about mental health and suicide prevention taboo (Fortuna et al., 2007). Therefore, understanding the Hispanic/Latinx culture to provide culturally sensitive suicide prevention training is of utmost importance to decrease the stigma related to suicide, increase knowledge about suicide signs and symptoms, and ultimately, prevent suicide among Hispanic/Latinx individuals (Martínez et al., 2025).

This AFSP training is a program designed to educate participants about general concepts of suicide, the latest research on suicide, suicide prevention, and steps people can take to reduce suicide in their communities (AFSP, n.d.-a). As the program expanded to reach diverse populations, it was translated into Spanish several years ago. However, language translation alone was insufficient to fully address the cultural factors influencing suicide within Hispanic/Latinx communities; therefore, AFSP collaborated with the National Latino Behavioral Health Association (NLBHA) to develop a culturally adapted version for the Hispanic/Latinx community (AFSP, n.d.-b). In 2022, the culturally adapted version was introduced. The implementation of this culturally adapted

version has been supported through a Substance Abuse and Mental Health Services Administration (SAMHSA)–funded Mental Health Awareness Collaborative awarded to the National Latino Behavioral Health Association (NLBHA; Award No. U79SP023012). The primary focus is to enlighten individuals to identify signs of suicide and equip them with intervention strategies to assist those in need. Despite developing TSL for the Hispanic/Latinx community, its effectiveness has not been thoroughly evaluated.

In Central Florida, the suicide rate has been a significant health problem. In 2022, the overall suicide rate per age in Florida was 14.1 per 100,000 people, with some of the Central Florida counties showing a slightly higher rate. For example, Orange County has a similar rate to the state average. In contrast, other close counties have rates that fluctuate between 12 and 16 per 100,000, depending on the year (Florida Department of Health, 2024).

With the Hispanic/Latinx community, the suicide rate has increased, reflecting broader national trends. Historically, the Hispanic/Latinx community has displayed lower suicide rates when compared with other ethnicities. Unfortunately, recent data show their rates have increased, particularly within the younger Hispanic/Latinx population. This increase shows the urgent need for suicide prevention programs that are culturally adapted, as is this initiative, which is now adapted to better serve the needs of the Hispanic/Latinx community in Central Florida (AFSP, 2024a).

I aimed to assess the efficacy of the translated program and culturally adapted version of the program in enhancing suicide literacy within the Hispanic/Latinx community and evaluate if either of the programs has a better outcome in increasing

literacy towards suicide. Employing a pre- and posttest design, used the Literacy of Suicide Scale (LOSS; see Appendix) as the outcome measure. The specific goal is to identify potential disparities in effectiveness between both versions of the program. Ultimately, I intended to gain valuable insights and validate the programs' ability to improve suicide literacy within the Hispanic/Latinx community.

In 2025, TSL was added to the Best Practice Registry (BPR) maintained by the Suicide Prevention Resource Center (SPRC), recognizing it as a program that meets national standards for effectiveness and evidence-based design in suicide prevention (SPRC, 2025). This designation further validates its credibility as a community education tool. It underscores the importance of evaluating its cultural adaptations for the Hispanic/Latinx community.

Purpose Statement and Research Question(s)

Social cognitive theory (Bandura, 2001) provides a foundation for evaluating program effectiveness by examining how participants' attitudes and behaviors change through modeling, reinforcement, and the development of self-efficacy related to suicide prevention. Therefore, the social cognitive theory was used to evaluate the translated version of TSL. Specifically, I measured how the program incorporates principles to influence a social change in the understanding and actions of the participants regarding suicide and mental health. I aimed to assess whether the translated program and its culturally adapted version for the Hispanic/Latinx community effectively increase suicide literacy.

RQ: Does the culturally adapted version of the program improve suicide literacy more effectively than the translated version within the Hispanic/Latinx Community?

There are three specific sets of hypotheses for this research. Two were designed to assess the individual impact of each of the two programs being evaluated, and the third one is to compare the two programs against each other. The three hypotheses are as follows.

H_01 : There is no significant increase in knowledge after completing the TSL translated program.

H_a1 : There is a significant increase in knowledge after completing the TSL translated program.

H_02 : There is no significant increase in knowledge after completing the TSL culturally adapted for the Hispanic/Latinx Community.

H_a2 : There is a significant increase in knowledge after completing the TSL culturally adapted for the Hispanic/Latinx Community.

H_03 : There is no significant difference between TSL translated program when compared to TSL culturally adapted for the Hispanic/Latinx community program with respect to increasing suicide knowledge.

H_a3 : There is a significant difference between TSL translated program when compared to the TSL culturally adapted for the Hispanic/Latinx community program with respect to increasing suicide knowledge.

Nature of the Doctoral Project

This quantitative study was an observational evaluation using survey research (QN) to assess two existing versions of the TLS program, each aimed at enhancing suicide literacy within the Hispanic/Latinx community. I did not introduce a new intervention nor impact the fidelity of the program content. Instead, I evaluated the impact of the Spanish translation and the culturally sensitive adaptation.

I used a pre- and posttest design to gather data on the effectiveness of the program in improving suicide literacy among Spanish-speaking Hispanic/Latinx adults. This approach allowed for the measurement of knowledge gain and changes in attitudes following participation in the program without direct interference or modification of the intervention. By comparing outcomes across versions, the study examined whether cultural adaptations in the programs benefited the Hispanic/Latinx community. The evaluation compared pre- and posttests using the LOSS instrument.

The training sessions were provided in various communities, using the translated version and comparing its impact with that designed and culturally adapted specifically for the Hispanic/Latinx community. Before the program, participants completed the LOSS. The same LOSS scale was administered to participants at the end of the program to assess any changes in their scores. The resulting LOSS scores for the translated version of TSL were then statistically compared with those for the TSL program tailored for the Hispanic/Latinx community. This comparative analysis was used to determine the effectiveness of both programs in increasing knowledge and provide insight into which program is more impactful within the Hispanic/Latinx community on a broader scale.

These trainings were provided to the Central Florida community, Spanish-speaking immigrants, where 34.8% of the population is Hispanic/Latinx (see United States Census Bureau [USCB], 2023). Several training courses were conducted in Orange, Osceola, and Seminole counties. The goal was to recruit an even or similar number of participants taking the TSL translated version and TSL for the Hispanic/Latinx community. Unfortunately, the data was not even, as not everyone completed the pre- and the posttest; therefore, the translated version had fewer participants than the culturally adapted version. I aimed to include a sample of over 100 participants across the three counties. The training was offered in Spanish and promoted in Spanish-speaking church communities, Spanish supermarkets, Hispanic/Latinx events, and social media to attract a large number of participants. Once participants signed up for the training, they were assigned to a group – the goal was to match similar characteristics, such as age, race, ethnicity, sex, and highest level of study, across both groups.

Significance of the Study

This study is significant because it provides empirical evidence that culturally adapted suicide prevention education enhances suicide literacy more effectively than direct translation, offering a model for equitable culturally responsive interventions that advance social justice, which aligns with the core values of social work.

The significance of this study lies in the potential to fill a gap in suicide prevention, particularly within the Hispanic/Latinx community. Suicide rates among this demographic group have increased, a new trend given the historical context of lower suicide rates among Hispanics/Latinx when compared with other ethnicities (CDC,

2023a). This increase is a testament to the urgent need for effective, culturally relevant interventions that address the social, cultural, and linguistic needs unique to this population.

This study is particularly important as it evaluates the effectiveness of a culturally adapted suicide prevention program specifically designed for the Hispanic/Latinx community and compares it with its directly translated version. Although there are several suicide prevention programs available, many fail to resonate with minority populations due to the lack of cultural sensitivity. By comparing the results of the translated version with the culturally adapted version, this study aimed to determine which approach was more effective in increasing suicide literacy and consequently reducing suicide among the Hispanic/Latinx community.

The findings of this study have substantial implications for the profession of social work. Demonstrating that culturally adapted versions of TSL are more effective in increasing suicide literacy directly supports the social work core values of service, social justice, dignity and worth of the person, and competence (National Association of Social Workers [NASW], 2024). This research promotes equitable access to prevention resources, advocates for interventions that respect cultural identity, and models competent, evidence-based practice that can be replicated among other underserved communities.

As the NASW (2021) states,

“The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention

to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty” (p.1).

This research directly contributes to that mission by advancing culturally responsive prevention strategies and promoting equitable access to mental health knowledge and resources for the underserved population.

Moreover, this study reflects the social work profession’s commitment to enhancing human well-being and addressing social determinants of mental health. The focus within the Hispanic/Latinx community in central Florida, a region with a significant Hispanic/Latinx population, adds a geographic dimension to its significance and aligns with the value of human relationships, as it creates stronger community partnerships and local capacity for suicide prevention.

Finally, this study contributes to a broader academic literature by filling the gap about the effectiveness of suicide prevention programs that are translated, as well as the effectiveness of suicide prevention programs that are culturally adapted to the Hispanic/Latinx community. Despite the increased understanding of the need for culturally adapted interventions in mental health, there is still a lack of empirical evidence that supports the effectiveness of these approaches. By rigorously evaluating this community-based training in a specific cultural context, this study provides valuable data that could guide social workers, mental health professionals, and policymakers in advancing responsive public health strategies, informing future research, and developing effective programs in suicide prevention.

In summary, this study reflects the mission and core values of social work, promoting justice, dignity, and equity while addressing a concerning public health issue. It has the potential to influence practice as well as politics in the area of suicide prevention, particularly within the Hispanic/Latinx community. Its findings could lead to culturally competent interventions, improve mental health outcomes for underserved populations, and contribute to the ongoing discourse on the importance of culturally adapted public health initiatives. Ultimately, this study demonstrates how culturally responsive education aligns with the NASW mission by promoting equity, dignity, and evidence-based practice for vulnerable populations.

Theoretical Framework

The theoretical framework for this study was the SCT. SCT emphasizes that individuals learn from observing and interacting with others within their social context, and the ability to apply the concepts learned through observation and social interaction (Bandura, 2001). In addition, SCT suggests that individuals' prior experiences may influence future behavior (Bandura, 2001). This study drew on the SCT principles of modeling, reinforcement, and self-efficacy to evaluate the TSL program. Through modeling, participants were exposed to examples of effective ways to address suicide and mental health concerns, including how to ask someone if they are suicidal in a supportive manner. Reinforcement was reflected in the structured learning environment, which encouraged positive attitudes toward discussing mental health and increased the likelihood that participants would imitate these behaviors in real-life situations (Bandura, 2001). In addition, the program was designed to support increases in participants' self-

efficacy and confidence to identify warning signs and take appropriate action when someone may be at risk for suicide. Grounding the study in SCT frames suicide prevention education as not only information transfer but also as a social learning process that supports participants in observing, internalizing, and modeling life-saving behaviors. These principles were later reflected in participants' reported comfort discussing suicide and in the observed gains in suicide literacy.

The AFSP training is a suicide prevention intervention intended to increase suicide literacy among communities (AFSP, n.d.-a). Suicide literacy involves individuals' attitudes and understanding of topics related to suicide, like warning signs, risk factors, protective factors, and available resources. Dueweke & Bridges (2017) stated that even using passive psychoeducational material in the form of a brochure or a flyer was found to be effective at increasing suicide literacy among the Hispanic/Latinx population. However, it was not enough to prove whether it changes people's attitudes toward suicide.

Using SCT (Bandura, 2001), I evaluated how this educational initiative influences suicide literacy by applying the following:

Modeling and imitating: SCT emphasizes that individuals can learn by observing others (Bandura, 2001). In the context of TSL, many exercises involve modeling appropriate (or inappropriate) techniques that participants later imitate. The study identified whether the exercises in the training related to modeling and imitating do indeed provide positive or improved tools. For example, participants learned that it is more effective to inquire if someone is suicidal by directly asking: "Are you suicidal?"

rather than, for instance, “You are not thinking about committing suicide, are you?” – The latter incorporates a negative connotation and could prevent the person in need from opening up about suicidal tendencies. Moreover, “committing” reinforces the stigma of suicide as it implies a connection to criminal acts.

Reinforcement: People can learn by observing the consequences of other people’s actions (Clarke et al., 2015). In contrast, *reinforcement* brings a positive angle. That is, it emphasizes that positive behavior is more likely to repeat itself when it is reinforced. The evaluation of the program TSL can reinforce positive mental health behaviors by helping participants actively listen and enabling open, honest conversations about mental health.

Self-efficacy: Self-efficacy is a key component of effective suicide prevention, as increased confidence in recognizing warning signs and engaging in supportive communication is associated with greater willingness to intervene (Bandura, 2001). The program aimed to increase participants’ self-efficacy by training them to unequivocally identify warning signs, to initiate a conversation with someone in crisis, and to communicate about mental illness effectively.

Values and Ethics

This study was guided by the principles and values outlined in the NASW Code of Ethics. The primary mission of social work as a profession is “to enhance the well-being of all people, especially those who are vulnerable, oppressed, and living in poverty, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty” (NASW, 2024, p.1).

This is particularly important for Hispanic/Latinx individuals for several reasons. First, there are many significant disadvantages for Hispanic/Latinx individuals when immigrating to the United States, primarily due to language barriers and the lack of recognition of their educational credentials (Pew Research Center, 2023). Limitations in effectively communicating and advocating for their rights make them vulnerable. Consequently, many Hispanic/Latinx individuals end up accepting low-income jobs, often requiring them to work multiple jobs to provide for their families (Laurito et al., 2023, para. 4). Second, Hispanic/Latinx workers are highly underrepresented in higher-paying jobs and are often segregated into low-wage occupations and industries such as construction, food services, and maintenance (Washington Center for Equitable Growth, 2023). These factors contribute to a significant number of Hispanic/Latinx individuals living in poverty, placing members of the Hispanic/Latinx community among those who most need the support and services that the social work profession is committed to providing (National Alliance on Mental Illness, n.d.).

NASW has also identified six core values that serve as the foundation of social work's unique calling. These are the service, dignity, and worth of the person; the importance of human relationships; social justice; integrity; and competence. This project addressed most of them in one way or another. However, four were particularly evident in this work: the importance of human relationships, social justice, the dignity and worth of a person, and, ultimately, competence.

SCT aligns with the NASW value of competence, as it emphasizes modeling and practicing evidence-based behaviors, such as directly asking, "Are you thinking about

suicide?” A skill that reflects professional proficiency and promotes ethical, effective intervention.

Social workers understand that relationships are the key to change. They collaborate closely with individuals, families, and the community, providing them with tools to help them grow and heal. A critical goal is empowering people to strengthen their relationships to promote their overall well-being. (NASW, 2024). The TSL program is designed to build a community where open conversations about mental health and suicide are encouraged. That is, creating a culture where individuals feel heard, understood, and supported (AFSP, 2024b).

Social justice is another NASW value that I aimed to impact. Social workers are expected to ensure access to adequate information, facilitate services, provide resources, and promote opportunities for participation in decision-making for all people (NASW, 2024). The suicide prevention program directly addresses this issue by making the training accessible in Spanish, thereby removing language barriers that often prevent Hispanic/Latinx communities from receiving vital mental health education. This approach promotes inclusivity and broadens the mission of social justice by providing Spanish-speaking individuals with the tools and knowledge needed for their own well-being and that of their communities.

The value of dignity and worth of the person emphasizes that every person deserves to be treated with respect and compassion regardless of their race, ethnicity, gender, or beliefs (NASW, 2024). This study reflected that principle by adapting educational materials to honor Hispanic/Latinx cultural values, beliefs, and lived

experiences. Recognizing that participants' backgrounds shape how they understand and engage with information, the culturally adapted program sought to affirm each person's identity and worldview. By integrating familiar language and culturally relevant examples, this research helped reduce language barriers and fostered an inclusive learning environment where participants felt seen, valued, and understood.

The value of competence emphasizes the need for social workers to enhance their professional knowledge and skills continuously, ensuring they provide the highest quality of service to clients (NASW 2024). I aimed to enhance understanding of suicide prevention within the Hispanic/Latinx community by increasing suicide literacy. The findings are intended to be shared with the social work profession to illustrate how the program enhances suicide literacy and to inform best practices when working with Hispanic/Latinx populations, thereby contributing to the profession's broader knowledge base.

Finally, it is important to highlight that the AFSP (2024b) is committed to saving lives and bringing hope to those affected by suicide through education, advocacy, research, and support. Their mission aligns closely with NASW's core values, particularly those highlighted by this work. Through this study, I strived to honor those values not only by adhering to ethical research standards but also by ensuring that the work itself promotes inclusion, cultural responsiveness, and respect for human dignity, especially during a time when members of the Hispanic/Latinx community have faced increased marginalization. The outcome of this study further affirms these values by demonstrating how culturally grounded education enhances inclusion and competence.

Literature Review

The literature review for this project examined suicide within the Hispanic/Latinx community, with a focus on cultural, social, and religious factors that affect mental health and influence suicide prevention. The review was conducted using the Walden University Library (EBSCO) and Google Scholar as primary databases. There was a range of keywords used, including *suicide prevention*, *suicide stigma*, *the Hispanic/Latinx community*, *statistics in suicide*, *suicide*, and *mental health*, *suicide taboo*, *suicide education*, *depression*, *faith and suicide*, *religion within the Hispanic/Latinx community*, *culture*, *suicide prevention programs*, *TSL*, and *grief after a suicide*, to capture relevant research.

Through this review, my aim was to identify and understand research related to the areas of stigma, suicide, and cultural beliefs, as well as highlight the effectiveness of educational programs available for this population. Moreover, it identified gaps between knowledge and practice, particularly when it comes to suicide prevention programs that are culturally adapted to the Hispanic/Latinx community, as it is TSL for the Hispanic/Latinx community.

The following sections are organized to specifically discuss literature findings related to suicide rates and risk factors within the Hispanic/Latinx community, cultural influences on suicide and mental health, and cultural considerations in suicide prevention. Additionally, it reviewed relevant literature on cultural barriers, cultural competency in mental health interventions, and suicide prevention/intervention programs targeting the

Hispanic/Latinx community. Finally, the impact of stigma on mental health in Hispanic/Latinx communities was examined.

Suicide Rates and Risk Factors in the Hispanic/Latinx Community

According to the CDC (2021), suicide rates among the Hispanic/Latinx community have been rising, particularly among youths and Hispanic/Latinx individuals born in the United States. Although the Hispanic/Latinx community has historically had lower rates of suicide compared to other ethnicities, researchers, including Silva and Van Orden (2018), highlighted an upward trend, especially among Hispanic/Latinx females and young adults. This increase may be attributed to factors such as acculturation stress, family conflict, and financial stressors, which contribute to the erosion of important cultural values such as familism, religion, and community support, leading to an increase in suicidal ideation. Understanding these risk factors is critical for developing effective interventions to address the specific needs of this community. Therefore, it is crucial to encourage conversations about mental health conditions that contribute to suicidality and explain how those conditions can be manageable and treatable. Fostering open discussions can promote seeking help when necessary.

Cultural Influences on Suicide and Mental Health

Cultural norms within the Hispanic/Latinx community highly influence the attitude toward mental health and suicide. Many believe that seeking help is a sign of weakness or failure, thereby contributing to greater stigma and reluctance to seek professional support (Fortuna et al., 2016). Studies show that familism and community support play a key role in mental health outcomes and often provide emotional support

and essential financial assistance (Villatoro et al., 2018). However, the expectations from family members can also increase stress, resulting in additional mental health problems. Addressing these cultural influences through initiatives such as TSL can encourage open conversations and promote help-seeking behaviors.

Each culture has a unique perspective regarding beliefs in mental health and suicide. Wong et al. (2017) noted that within many Asian cultures, mental health concerns are often viewed as a sign of weakness or personal failure, which generates greater stigma. Perceptions like this one have vulnerable people internalize their issues, avoiding help-seeking for fear of exclusion or being labeled. In contrast, some Western cultures encourage people to talk openly about mental health, which generally increases acceptance and understanding (Hwang et al., 2008). This action significantly impacts how mental health is perceived and how people with suicidal ideation may look for help when facing mental health challenges.

Family roles and community vary significantly across cultures, which can significantly influence seeking mental health assistance. Family and community support are fundamental in collective communities, such as Asian or Hispanic/Latinx communities (Caplan, 2019). Families serve as the primary source of emotional and financial support, which can be both beneficial and problematic. On one hand, close family ties can provide essential assistance and emotional support. On the other hand, however, family expectations and obligations can contribute to stress and psychological distress, particularly within the Hispanic/Latinx families where familism plays a central cultural role (Cahill et al., 2021). In contrast, cultures emphasizing individual autonomy

and responsibility can influence how people manage their mental health (Valdivieso-Mora et al., 2016).

Cultural Considerations in Suicide Prevention

Culturally adapted interventions are mental health and educational programs tailored to meet a specific community's unique cultural values, beliefs, and contextual needs. These adaptations go beyond language translation, incorporating relevant cultural examples that address unique cultural barriers, thereby improving engagement and effectiveness across diverse groups (Parra-Cardona et al., 2022). For example, within the Hispanic/Latinx community, culturally adapted programs often incorporate family participation (familism), respect for the elderly, and community support, as these are fundamental cultural values that can influence attitudes and mental health behaviors (Ayón et al., 2010). By addressing specific cultural risk factors, such as stigma around mental health and acculturation stress, these adaptations aim to make interventions more accessible and impactful, fostering a sense of cultural belonging, trust, and relevance for the Hispanic/Latinx populations. Research has shown that culturally responsive programs yield better outcomes by promoting acceptance, reducing stigma, and strengthening trust surrounding mental health within Hispanic/Latinx communities (Alegría et al., 2015).

Addressing disparities in mental and psychiatric care requires a comprehensive understanding of the cultural factors influencing help-seeking behaviors and treatment preferences among diverse populations (Ruiz & Primm, 2010). Unfortunately, mental health and suicidality are stigmatized among the Hispanic/Latinx community, and looking for help can be perceived as a sign of weakness or even as a failure; therefore,

people tend to avoid looking for help or getting treatment. To provide effective suicide prevention techniques within the Hispanic/Latinx community, cultural factors must be considered. Some cultural and social factors to consider include familism, acculturation, access to education, language barriers, access to mental health care, and religion.

Familism is a core cultural value in many Hispanic/Latinx communities, emphasizing strong family interconnectedness, loyalty, and collective responsibility. Hispanic/Latinx individuals may face unique challenges related to acculturation stress, family conflict, and cultural norms, which might contribute to their risk for suicidal ideation (Smokowski et al., 2009). Educating the family, providing resources, and training them on recognizing the signs and symptoms of someone with suicidal ideation can provide support and assistance to the person who is in need. On the contrary, if the family is not involved, they might discourage the individual from seeking or obtaining help.

Cook et al. (2014) highlighted persistent racial and ethnic disparities in access to mental health care, underscoring the importance of addressing such barriers as language, insurance coverage, and transportation among Hispanic/Latinx populations. Language barriers and access to care can be obstacles for those who are seeking mental health services. Lack of health insurance, transportation, and immigration concerns can add to the mental health stressors, increasing the risk of suicide that many Hispanic/Latinx families encounter.

Religion plays a significant role in Hispanic/Latinx culture, influencing attitudes toward mental health and suicide in various ways (Caplan, 2019). It provides a strong

sense of community and support, serving as a coping mechanism during difficult times. However, religious beliefs can also contribute to the stigma and silence surrounding mental health issues, discouraging individuals from seeking professional help. Teachings that condemn suicide may deter suicidal behavior but can also instill shame and prevent open discussions.

Cultural Barriers

Culture can exert both positive and negative influences on perceptions of, and acceptance toward, mental health conditions. Examining the historical and cultural diversity of Hispanic/Latinx subgroups enhances understanding of the factors that shape mental health experiences (SAMHSA, 2023). Cultural barriers significantly affect the capacity and willingness of self-seeking when it comes to mental health. Stigma, shame, religion, and language are some of the barriers that prevent people from looking for mental health services (Mental Health America, n.d.). In many cultures, the main barrier to mental health is the stigma associated with it. For some communities, having a mental health problem is shameful for the individual and for the family (Abdullah & Brown, 2011), particularly in cultures where it is emphasized to maintain a positive public image. In many Middle Eastern and Asian cultures, mental health problems are not discussed in public, and looking for help is a sign of failure and family dishonor (Al-Krenawi and Graham, 2000). The stigma associated with Hispanic/Latinx communities is an important barrier when it comes to mental health since mental illness is often considered a personal or family failure, which discourages people from looking for help (Fortuna et al., 2016). Cultural stigma affects more than the willingness of a person to look for help; it is also a

contributing factor in delaying intervention with worsened mental health results (Alegria et al., 2017).

Effective communication is critical when seeking mental health services, as language barriers can hinder this process. Access to services can be challenging for people who do not speak English in the United States (Sentell et al., 2007). This can be critical to the individual as it can result in misunderstandings, wrongful diagnoses, and inadequate treatment. Providing services in different languages and having translators available can decrease these barriers (Flores, 2006). Language barriers make access to services more challenging for Spanish speakers, often leading to miscommunication, misunderstandings, incorrect diagnoses, and inadequate treatment, which discourages help-seeking behavior (Sentell et al., 2007). Addressing these barriers by offering services in Spanish is critical in developing accessible mental health care.

Religion and spirituality can influence positively or negatively when it comes to seeking mental health services. In some cultures, mental health issues can be attributed to spiritual issues or be taken as a faith test (Loewenthal, 2007). This causes people to look for help from faith leaders instead of going to a mental health professional. In some African and Caribbean cultures, mental health problems are seen as spiritual afflictions that lead people to seek help and healing through prayer and traditional rituals (Dein et al., 2010). These practices can bring comfort and support but also impede people from seeking professional mental health treatment, resulting in treatment delays.

For the Hispanic/Latinx community, language, stigma, religion, and migration status represent significant barriers to accessing mental health services (Banda et al.,

2025). Language barriers impede clear communication, often leading to misunderstandings and even wrongful diagnoses. The stigma associated with mental illness within the Hispanic/Latinx community emphasized the importance of maintaining a positive public image, discouraging individuals from seeking help. In addition, religious beliefs might frame illness as a “spiritual issue,” prompting individuals to seek guidance from religious leaders instead of mental health professionals. Migration status can add to these challenges, as fear of legal consequences, misinformation, or lack of knowledge about available resources often prevents people from seeking the care they need. The culturally adapted version of the program aims to address these gaps by integrating cultural and religious considerations into its educational content. They encourage open conversations that decrease the stigma and promote seeking help.

Cultural barriers require a multifaceted approach, including cultural competency, community involvement, and education to reduce the stigma and promote understanding. By recognizing and respecting cultural differences, mental health providers help people from diverse communities to access the help they need.

Cultural Competency in Mental Health Interventions

Cultural competency in mental health interventions is crucial for effectively addressing the diverse needs of patients. Research has consistently shown that culturally sensitive mental health professionals are better equipped to understand and respect their clients' values and beliefs. This understanding leads to better communication between patient and provider, increased trust, and consequently, a more effective treatment (Sue, 2006).

Studies have shown that culturally adapted interventions have a better outcome when it comes to client involvement in treatment and help reduce disparities in mental health results. For example, a systematic review by Griner and Smith (2006) found that culturally adapted programs are more effective than traditional interventions for ethnic minorities as they align more closely with their values and beliefs. In addition, training in cultural competency for medical personnel improves their ability to recognize and address cultural differences, resulting in higher patient satisfaction and greater compliance with treatment (Bhui et al., 2007). The TSL Program incorporates culturally sensitive training and materials to better resonate with the values of the Hispanic/Latinx community, thereby enhancing program effectiveness and increasing participant involvement.

A 2011 study by Benish et al. found that culturally adapted interventions were significantly more effective in dealing with depression and anxiety when compared to other minority groups with standard interventions. It is important to incorporate values, beliefs, and cultural traditions into the therapeutic process to ensure treatment is relevant and respectful within the client's cultural context. (Benish, et al., 2011). Moreover, a systematic review by Chu et al. (2022) showed that training in cultural competency among mental health professionals leads to improved diagnosis accuracy and higher client satisfaction. These outcomes underscore the need for mental health professionals to develop and improve their cultural competency skills to close the gap in mental health disparities, providing equitable care for everyone (Chu et al., 2022).

Suicide Prevention/Intervention Programs Targeting the Hispanic/Latinx

Community

When evaluating suicide prevention and intervention programs, it is fundamental to recognize the unique cultural, socioeconomic, and linguistic factors that influence both the risks and the intervention's effectiveness. Hispanic/Latinx communities are constantly overcoming barriers to accessing mental health services, including stigma, lack of cultural competency by providers, and limited access to resources (Lee et al., 2014). These barriers contribute to the underutilization of mental health services, increasing the suicide risk within this population. Effective programs must adapt to include specific challenges by incorporating a unique approach that is culturally relevant and that resonates with Hispanic/Latinx values, such as familism (importance of the family) and respect (caring for the elders and authority figures) (Villatoro et al. 2018).

To effectively serve Hispanic/Latinx individuals, it is crucial to engage bilingual and/or bicultural mental health professionals who can navigate the linguistic and cultural variations within the community. Adaptable, culturally responsive, community-engaged mental health interventions, particularly those that incorporate family and community contexts, have been identified as essential for increasing participation, reducing stigma, and improving reach among historically underserved populations (Alvarez et al., 2022). By integrating evidence-based suicide prevention strategies with culturally tailored approaches that reflect community values, suicide prevention programs provide more culturally relevant support and directly address culturally specific risk factors among Hispanic/Latinx individuals (Querdasi & Bacio, 2021).

According to the 2022 US Census, Hispanic/Latinx individuals constitute about 19% of the population, making them one of the fastest-growing groups in the country. This growth impacts economics, as well as cultural and social norms. Research over the past two decades consistently demonstrates that language translation alone is insufficient when interventions fail to incorporate culturally relevant values and contextual factors, limiting engagement and effectiveness among Hispanic/Latinx populations (Bernal & Domenech Rodríguez, 2012; Alegría et al., 2016; Alvarez et al., 2022).

Three well-known programs that aim to prevent suicide are the QPR (Question, Persuade, Refer) Institute, ASIST (Applied Suicide Intervention Skills Training), and Mental Health First Aid (MHFA). These programs collectively contribute to a more inclusive approach to suicide prevention, addressing the linguistic needs of the Hispanic/Latinx community and promoting mental health awareness and support within this population.

QPR has been translated into Spanish; it focuses on training community members to identify the signs and symptoms of someone who is suicidal, how to start a conversation about mental health, and how to refer the person to the appropriate resource within the community (QPR Institute, n.d.). ASIST focuses on training people to recognize someone with suicidal ideation and to work with them in developing a safety plan. The Spanish version of ASIST includes education on how family and community can create a safe place for at-risk people, which is particularly needed within the Hispanic/Latinx culture (Living Works, n.d.). The MHFA program is tailored to assist someone who is having a mental health crisis (Mental Health First Aid, n.d.).

Although these three programs have taken steps to make their content accessible to the Hispanic/Latinx community through translation, there is still a need for stronger cultural adaptation across all programs. While translation helps reduce language barriers, it does not fully address the cultural differences that influence how interventions are understood, accepted, and used within Latinx communities (Bernal & Domenech Rodríguez, 2012). This highlights the need for interventions that are more intentionally tailored to the cultural and socioeconomic factors that affect Hispanic/Latinx youth, who continue to be at increased risk for suicide (Alvarez et al., 2022). Moreover, there remains a gap and an opportunity to develop more robust tools to evaluate the effectiveness of these programs after they are implemented.

In response to these challenges, some programs have emerged. For example, the NLBHA offers initiatives to reduce stigma and increase awareness within the Hispanic/Latinx community through culturally relevant training and resources (NLBHA, n.d.). The program “La Cultura Cura” (Culture Heals) promotes pride in cultural identity within the Hispanic/Latinx youth, taking advantage of the cultural heritage as a protective factor for mental health problems and suicidal behavior. However, it is not a suicide prevention program specifically (National Compadres Network, n.d.). Similarly, the community program “Mano a Mano” (Hand to Hand) offers linguistically and culturally adapted outreach services, education, and support to Hispanic/Latinx families, including workshops, peer support groups, and training focused on the overall well-being rather than a direct suicide prevention training (Mano a Mano Family Center, n.d.). The program “Juntos” (Together), developed by North Carolina State University, has as a

primary goal to increase a sense of belonging among Hispanic/Latinx students and families in their schools and community by promoting resilience and strengthening family bonds, which are important for academic success and overall mental health (NCSU, n.d.). In contrast, the AFSP offers the program TSL for the Hispanic/Latinx community, specifically addressing cultural factors that influence suicidal risk and providing strategies to prevent suicide within the Hispanic/Latinx community (AFSP, n.d.-b).

These programs underscore the importance of culturally adapted programs to mental health, highlighting the need for ongoing evaluation and research to ensure the effectiveness in fulfilling the needs of the Hispanic/Latinx Community, specifically in the context of suicide prevention.

Impact of Stigma on Mental Health in Hispanic/Latinx Communities

The stigma associated with mental illness continues to be an essential barrier for Hispanic/Latinx individuals to access care. In many Hispanic/Latinx cultures, mental health is stigmatized; therefore, people avoid getting help for fear of being seen as “crazy” or “weak” (Cabassa et al., 2007). The stigma can lead to resistance to openly discussing mental health, which results in delays in getting treatment or, worse, completely evading getting help.

The lack of cultural competency aggravates the stigma associated with mental health in the Hispanic/Latinx community. Many mental health professionals do not understand or respect the cultural nuances of Hispanic/Latinx patients, which further discourages people from getting treatment (Cabassa et al., 2007). According to Alegría et

al. (2017), the lack of cultural competency can result in wrongful diagnosis and inadequate treatment plans and ultimately worsen the mental health outcome for Hispanic/Latinx individuals. Additionally, the fear of being judged by providers as well as by the community increases isolation and feelings of hopelessness, contributing as a factor to depression and suicide.

The intersection between immigration status and the stigma about mental health can further complicate the willingness of Hispanic/Latinx individuals to obtain treatment. Undocumented immigrants experience higher levels of stress and anxiety due to their legal status. They may avoid looking for mental health services due to fear of deportation or other legal repercussions, discrimination, and systemic barriers. This fear, in combination with the already existing stigma associated with mental illness, can lead to a significant underutilization of mental health resources within the Hispanic/Latinx community (Espinoza-Kulick et al., 2022).

The impact of the mental health stigma within the Hispanic/Latinx community underscores the urgent need for mental health services that are culturally sensitive. Programs that understand and decrease the stigma while incorporating values and cultural norms are essential to promote mental health and encourage help-seeking behavior among the Hispanic/Latinx community. By integrating community approaches that involve the family and trusted members in the community, mental health interventions can become more effective in the Hispanic/Latinx community, reducing the stigma and ultimately improving mental health results (Pérez-Flores et al., 2025).

The Role of Community in Mental Health Interventions

Community plays a critical role in the success of mental health interventions, especially within marginalized groups, as the Hispanic/Latinx community. Research indicates that community-based approaches are more effective than traditional clinical models because they are grounded in cultural values, trust, and shared experiences within those communities (Baskin et al., 2021). Taking advantage of the strength of community engagement, mental health interventions can become accessible, culturally relevant, and sustainable through partnerships that center community priorities and knowledge (Michener et al., 2025). The collective support of community members fosters a sense of belonging and acceptance, thereby facilitating engagement with mental health services and promoting participation and continuity in treatment (Banda et al., 2025).

Community leaders, religious institutions, and local organizations are often trusted sources for sharing information and offering support, serving as a bridge between mental health services and individuals in need. However, stigma, language barriers, and fears about being perceived as weak or not knowing where to find help discourage many Hispanic/Latinx individuals from engaging with formal mental health care (Newberry et al., 2024). The integration of education and mental health resources into familiar community events can significantly improve the reach and effectiveness of interventions (Santiago-Rivera et al., 2002).

Community participation in mental health interventions leads to the development of personalized programs that reflect the unique needs of that population. For example, incorporating the community can lead to the creation of culturally sensitive materials and

programs that resonate with the experiences and challenges specific to the Hispanic/Latinx community (Paniagua, 2024). This approach not only empowers community members but also guarantees interventions that are relevant, respectful, and impactful for their community (Thoumi et al., 2023).

The role of community mental health interventions is indispensable, especially when addressing the mental health needs of the Hispanic/Latinx community. Involving community leaders and resources helps create interventions that are inclusive and culturally aligned, ultimately improving outcomes in underserved communities (Goodkind et al., 2024). The integration of these community strategies is a crucial step in reducing disparities and promoting mental well-being.

Evaluation of the TSL Program

TSL is a suicide prevention community-based program that was developed by AFSP. The program is listed in the SPRC Best Practices Registry (BPR), a national resource supported by SAMHSA that identifies and promotes effective and evidence-based suicide prevention initiatives. Inclusion in the BPR indicates that a program has undergone a rigorous expert review process assessing its alignment with evidence-based practice standards, safety considerations, and available evidence (SPRC, 2025). In September 2025, AFSP announced that TSL had earned recognition from SPRC's BPR, making it a nationally endorsed suicide-prevention educational program (AFSP, 2025). This recognition confirms TSL's standing as a trusted, research-informed program.

The TSL program is designed to provide a comprehensive overview of suicide prevention, including the latest research on suicide, risk and protective factors, warning

signs, and strategies to assist individuals with suicidal ideation (AFSP, n.d.-a). The effectiveness of the program lies in the way complex information is made accessible and viable to equip community members with practical knowledge and skills to recognize and respond to suicide risk.

Program evaluation data from AFSP indicate that participants demonstrated a significant increase in suicide prevention knowledge, greater awareness of warning signs, and increased confidence in asking directly about suicide when someone may be at risk. These outcomes are consistent with the broader goals of community-based suicide prevention efforts, which focus on equipping non-professionals with the knowledge and skills needed to recognize and respond to suicide risk within their communities (AFSP, 2024c). Furthermore, adaptations of the TSL program for specific cultural contexts, including the Hispanic/Latinx community, highlight the program's relevance for diverse populations and its capacity to strengthen culturally responsive suicide prevention efforts (AFSP, n.d.-b).

In addition, this AFSP program has been recognized for its evidence-informed approach, through its inclusion in the SPRC BPR, which reflects expert review of the program's design, content, and alignment with established suicide prevention standards (SPRC, 2025). The program content emphasized the importance of understanding the sociocultural factors, such as stigma, cultural beliefs, and access to mental health resources, which contribute to suicide risk and influence help-seeking behaviors (AFSP, 2024c). By addressing these factors, the TSL program equips participants with practical

knowledge and skills to respond to suicide risk within their communities, fostering a supportive environment for those who struggle with suicidal ideation (AFSP, n.d.-b)

The Role of Culturally Adapted Programs in Bridging Gaps in Suicide Prevention

Research has shown that culturally adapted interventions that integrate community values achieve better results and are more effective among Hispanic/Latinx populations (Parra-Cardona et al., 2022). Programs that incorporate family values and community support resonate more with the Hispanic/Latinx community, thereby increasing participation and retention (Ayón et al., 2010). A meta-analysis by Griner and Smith (2006) concluded that culturally adapted programs systematically outperform standard approaches within minority populations. It aligns closely with participants' values, beliefs, and life experiences. This alignment fosters trust and increases the likelihood of achieving positive results, thereby contributing to the success of culturally adapted programs. Culturally adapted programs such as TSL fill critical gaps in suicide prevention by addressing cultural and linguistic barriers that limit engagement in standard mental health education (Benish et al., 2011)

This AFSP program content encouraged respectful mental health conversations that consider cultural values such as familism and respect. Through these conversations, participants created safe spaces to interact without fear of being judged or excluded (Ruiz & Primm, 2010). Additionally, TSL is available in Spanish, and the culturally adapted version ensures that the information is accessible and comprehensive for individuals receiving education and seeking support (Bernal & Domenech Rodríguez, 2012). This facilitates understanding and knowledge retention. Moreover, when participants see their

cultural experiences reflected in the program, they relate to it and can more easily internalize the lessons, thereby later extrapolating this knowledge to their real-life experiences (Benish et al., 2011). In summary, this program can lead to significant behavioral changes, such as willingness to openly talk about mental illness, identify signs and symptoms of someone who is suicidal, and take proactive steps to intervene (Chu et al., 2022).

Summary

This study examined the effectiveness of the program TSL in increasing suicide literacy among the Hispanic/Latinx community. The literature identified suicide as a global public health issue and highlighted gaps in culturally adapted programs that meet the unique needs of the Hispanic/Latinx community. Guided by these concerns, the purpose of this study was to determine whether the culturally adapted version was more effective in increasing suicide literacy than the translated version among Hispanic/Latinx participants.

This chapter also emphasized the ethical considerations within the social work profession. The study aligned with the core values of NASW, including social justice, human relationships, the dignity and worth of the person, and professional competence (NASW, 2024). In addition, this chapter reviewed community-based programs that are culturally diverse and reiterates the importance of culturally sensitive approaches as an essential strategy to reduce suicide rates and promote mental health equity among Hispanic/Latinx individuals. Building on these findings, Section 2 details the research design used to evaluate both TSL versions.

Section 2: Research Design and Data Collection

Introduction

In this study, I evaluated how the program TSL, translated version, and the culturally adapted version for the Hispanic/Latinx community enhanced suicide literacy. Each program was individually assessed to measure the increase in literacy that resulted from participation. Additionally, they were compared to determine whether they were equally effective or had differing impacts on literacy. Through quantitative research, I aimed to fill a gap in practice knowledge by examining a methodology to determine whether there was a difference in how Hispanic/Latinx individuals received information from two programs. Additionally, I explored whether culturally adapted materials were more effective in increasing understanding of suicide prevention. Ultimately, through systematic data collection and analysis, this research provided empirical evidence on the efficacy of TSL, thereby supporting the efficacy of suicide prevention strategies adapted to the Hispanic/Latinx community.

Research Design

The research design for this study was a quantitative pre- and posttest comparison of the literacy outcomes of both versions of the program (translated and culturally adapted). I also evaluated whether there was a difference in the efficacy between the two programs. The pretest established a baseline measurement of participants' knowledge, skills, or attitudes toward suicide literacy before the intervention, allowing for a clear comparison with posttest results. This comparison helped determine the programs' effectiveness, with knowledge increase indicating a positive impact. Moreover, pre- and

posttest analysis provided quantitative data that were statistically analyzed to draw objective, evidence-based conclusions. This approach allowed me to identify areas for potential program improvement based on participant progress. To increase access, the programs were provided in Spanish, both virtually and in person, to the Central Florida Hispanic/Latinx Community.

Methodology

I used an observational design to compare changes in suicide literacy resulting from participation in two existing versions of the TSL program: a translated version and a culturally adapted version. The objective was to understand how each version influenced suicide literacy among the Hispanic/Latinx community after completing the training. By comparing the outcomes of each program version, I examined the differences in the impact of suicide literacy between the two trainings. An established measure called the LOSS was used as a pre- and posttest to assess changes in suicide literacy for the purpose of this study.

In this section, I describe the steps taken to complete the study. Figure 1 summarizes and captures the key components of the methodology, which include acquiring legal permissions from creators to use materials; preparing trainers with the skills and knowledge needed to deliver the program effectively; building a network by partnering with relevant organizations, community leaders, and stakeholders; and creating marketing materials to effectively communicate the program's objectives and benefits to the community. Each component played a critical role in ensuring the program's success and in effectively engaging and benefiting the target community.

Figure 1

Methodology



To execute this study, the first step was to request permission to use both versions of the program from the AFSP. Several conversations took place with the Department of Education, their research department, and the Impact Evaluation Team, resulting in securing permission to access both programs. The notification was initially issued verbally by Moutier, the AFSP's chief medical officer, in early 2023. It was later formalized in a letter that allowed us to use both programs.

The next step taken was to request permission to use the LOSS to assess understanding and suicide literacy among Hispanic/Latinx participants. Permission was

granted via email by the form's creator, Batterham, from the Australian National University.

The next step was to obtain Walden University Institutional Review Board (IRB) approval before proceeding with the project. Upon their approval (# 06-27-25-0615023) on June 27, 2025, location(s) to provide the training were identified.

After receiving approval, Spanish-speaking trainers were recruited. In July 2024, the necessary training was facilitated to prepare these individuals to effectively administer both the translated and culturally adapted versions of the programs to the community. Several places were visited, and a collaborative relationship with various community organizations, including churches, supermarkets, and other venues, was established to help recruit a diverse pool of participants. Central Florida churches were key partners in building trust within the community. Ensuring their partnership facilitated marketing the training, as promotional materials were displayed during services, on bulletins, and at various events. Hispanic/Latinx supermarkets also have a high and diverse traffic of Hispanic/Latinx members. The plan was to distribute flyers and provide information at these venues. Similarly, engaging with community centers, nonprofit organizations, and businesses that work with the Hispanic/Latinx community aims to increase the reach of community members who might not frequent other venues. These efforts ensured a broader representation of the community. Ensuring diversity among participants was a priority for this study. By working with specific subgroups within the Hispanic/Latinx community and collaborating with various community organizations, I aimed to create an inclusive and representative sample. These organizations can serve not

only as recruitment avenues but also as resources to help us ensure that recruitment materials and training content are culturally relevant and resonate with the community. Moreover, they assisted in identifying suitable training locations.

Social media was also used as a recruitment strategy to promote attendance and community participation. That includes advertisements on Facebook and Instagram targeting the Spanish-speaking Hispanic/Latinx community. Hispanic/Latinx community groups on social media platforms such as Facebook and WhatsApp were also used to disseminate the information. Collaboration with community leaders and influencers in the Hispanic/Latinx community served as an extension of efforts to recruit participants. Creating Facebook events and Eventbrite, using hashtags such as #HablarSalvaVidas, #SalvandoVIDAS, or #PrevenciondeSuicidio, increased visibility and encouraged participation.

The goal was to start training the community in Central Florida during the Winter of 2024, in person and/or via telehealth; however, the timeline was delayed due to the extended IRB approval period, challenges in recruiting sufficient participants, and the time needed to promote the program properly. Training was open to Hispanic/Latinx community members living in the United States and Puerto Rico who speak Spanish. However, participation in the research was limited to those aged 18 or older living in Central Florida.

Targeted Audience and Format

Data collection focused on individuals aged 18 years or older who are Spanish speakers living in Central Florida and self-identify as Hispanic/Latinx. I aimed to recruit

a diverse representation of Hispanic/Latinx, explicitly targeting at least 100 participants from different countries, ages, religions, genders, professions, and sexual orientations. Participants were asked to commit to both pre- and posttests.

To improve the study's rigor, participants with extensive knowledge or training in suicide prevention within the past 3 years were excluded from the research. By focusing on participants without specialized training, I could provide more accurate insights into the attitudes and behaviors of the broader population, leading to more generalizable and reliable results.

To ensure the sample is representative of the broader Hispanic/Latinx community in Central Florida, a community-based convenience sampling with targeted outreach to approximate balance across demographics approach was used. Recruitment efforts were structured in collaboration with community organizations, supermarkets, churches, and other frequent gathering places for diverse Hispanic/Latinx individuals, preventing excessive representation of a specific demographic group. This community-based sample was used to ensure diversity across relevant demographic factors, including place of origin, socioeconomic status, gender, and age. However, the dominant participants were from Puerto Rico, as the main population in Central Florida is from the island. By focusing on these strategies, the goal was to achieve a more comprehensive representation of the Hispanic/Latinx community and to avoid biases that may arise if the population is limited to a specific group.

The LOSS was administered pre- and posttraining to assess participants' literacy changes after exposure to each program format. The primary trainer explained and

disseminated the consent, while the primary researcher disseminated and collected the LOSS before and after each training.

There were two groups: one group received training with the translated version of TSL, while the other group used the culturally adapted version for the Hispanic/Latinx community. Multiple training sessions were provided until all data collection was completed. Participants were not randomly assigned to program conditions. Assignment to either the translated or culturally adapted version of the TSL program occurred through a community-based, non-randomized allocation process. Training sessions were scheduled in advance based on trainer availability, community partner requests, and logistical considerations (e.g., in-person vs. virtual format, venue availability). Program versions were alternated across training sessions to reduce systematic bias and to promote exposure to both versions across diverse community settings. As a result, participants attended the version offered at the training session they chose or were invited to attend. This approach reflects real-world community implementation and supports the ecological validity of the findings, while acknowledging limitations related to internal validity.

Data Collection and Analysis

I used an observational approach to gather data on two existing versions of the TSL program, a translated version, and a culturally adapted version. Data analysis focused on comparing pre- and posttest scores on the LOSS to evaluate the effectiveness of both versions of the program. The LOSS survey was administered to participants at the beginning of each training session (pretest) to establish a baseline on suicide literacy. After completing the training, participants retook the LOSS survey (posttest) to assess

changes in knowledge.

This process was designed to observe the impact of each existing program version without altering the training content or delivery. The LOSS survey served as an objective tool to evaluate each program's effectiveness by assessing whether participants gained knowledge as a result of the training. The following paragraphs expand on the process by which the data were collected and outline the steps taken to ensure accuracy and reliability. Given that there are two modes—in-person and online—the approach is explained for each audience.

In-Person Participants

For in-person training, participants were welcomed with a general description of the training schedule. Before the training starts, participants can scan a code in the presentation to navigate the survey. Copies of the survey were also available on paper for participants with limited technological access or those who prefer a more traditional method.

Participants were asked to complete the scale individually. They were encouraged to ask any clarifying questions they might have before submitting the survey. The primary trainer and I were available to answer questions and ensure participants understood each item on the scale, thereby promoting accurate and reliable data collection. The posttest was administered after the question-and-answer section at the end of the training. Once again, participants were asked to scan the code on the presentation or request a paper copy of the survey. Participants were encouraged to reflect on what they had learned during the training. The completed surveys were revised to ensure the

highest possible response rate and accuracy. After the surveys were collected, each trainee received a certificate.

Online Participants

An email with a link to an electronic LOSS survey was sent to each registered participant. The email provided detailed instructions for accessing and completing the survey. In addition, a QR code was shared before the training to take them to the survey. There was a short tutorial and demonstration at the beginning of each session to familiarize participants with the platform used to complete the survey and ensure accuracy. For the posttest, at the end of the training, after the question-and-answer section, participants were provided with the QR code on the presentation slide, which they could scan to access the survey. Participants were given 15 minutes at the end of the training to complete it. Afterward, a participation certificate was emailed to each participant. The online platform automatically saved responses in a secure, encrypted database.

To ensure consistency and avoid procedural bias, both in-person and online participants followed identical steps in completing the pre- and posttest. Both groups received detailed instructions for completing the LOSS before and after the training. In-person participants could complete the survey via QR code or on paper, while online participants were directed via a link or QR code during the training. All participants had the same amount of time to complete the test. Trainers and the researcher were available to clarify questions and ensure uniformity throughout the test administration.

In terms of data management, participants completed both the pre- and posttest. If

any test was missing, that participant's data were excluded from the analysis, as it is crucial to have both data sets to make comparisons and measure changes in suicide literacy. Excluding incomplete data helps maintain data analysis integrity, ensuring that only participants with valid, comparable results are included. Statistical methods to account for missing data were not used, as the focus was to analyze complete data sets.

Accuracy and Reliability

To ensure the accuracy and reliability of data collected through the LOSS survey, clear, detailed instructions were provided to both in-person and online participants. At the beginning of each session, the main trainer explained the purpose of LOSS and its role in evaluating the program's effectiveness. It also explained the importance of honest answers to measure better the impact of suicide prevention training on suicide literacy. Participants were encouraged to read each statement carefully and to answer based on their current knowledge or understanding. It was advised not to overthink the questions but instead to respond intuitively. It was also explained that an "I do not know" answer was available, and they could mark it as an option if it better suits their answer. In-person participants were encouraged to ask questions if any of the items seemed unclear. For online participants, a designated support person was available through the chat to assist with any issues or questions. After the training, participants were reminded of the importance of posttest completion to measure any changes in their knowledge about suicide. It was reminded once again of the importance of answering questions independently based on the knowledge they have.

Training Format

Both the TSL translated version and the one for the Hispanic/Latinx community lasted 120 minutes (2 hours), with the last 30 minutes reserved for a Q&A session and survey completion. Mental health providers who have been trained on AFSP 101 and both TSL programs provided both presentations.

The translated version covered the depth of the problem, research work, prevention tools, and what people can do to help those in need. The culturally adapted version begins with an introduction explaining the Hispanic/Latinx experience, understanding suicide, what is known about suicide, risk factors, prevention, signs, and what they can do to help.

The LOSS survey was conducted at the start of each training course. After the training and Q&A session, and before participants left the training premises, the LOSS was repeated. Secure digital data was used to store participants' information. Any paper-based data collected is stored in a locked cabinet with access restricted to the researcher.

Data Security

Participants were reassured that their responses would remain confidential. All data is securely stored. For in-person participants who completed the survey on paper, personal data is securely stored in a locked cabinet accessible only to the primary investigator. Digital data for the online survey was encrypted and stored in a secure database.

Data Analysis

Excel and IBM SPSS Statistics programs were used to analyze and compare the

data. The comparative analysis between both versions of the training was essential to determining the effectiveness of each intervention to increase suicide literacy among participants. The statistical methods used were fundamental to identifying significant results within both groups. For each group, both pre- and posttest descriptive statistics (such as mean, standard deviation, and frequency distribution) were calculated to provide a general description of the baseline suicide literacy levels and the changes observed after the training. This step helps in understanding general trends and the range of improvement within each group.

To evaluate the effectiveness of each program independently, a paired sample *t*-test was performed for each group. This compared the mean scores from pre- and posttests for the same participants, allowing us to determine whether there was a statistically significant increase in suicide literacy after the training. The paired-samples *t*-test is suitable for within-group comparisons, as it measures changes in suicide literacy following the training by accounting for the dependency between the two tests taken by the same individual.

To compare the effectiveness of the two-program version, an independent *t*-test was used. This test compared the mean changes in suicide literacy between the group that received the translated version and the group that participated in the culturally adapted version. The independent-samples *t*-test indicated a statistically significant difference in the effectiveness of the two interventions. By analyzing the differences, the study identifies that there are benefits in utilizing the culturally adapted program over the translated version in enhancing suicide literacy within the Hispanic/Latinx community. In

addition to significance testing, effect size was calculated to quantify the magnitude of the difference and provide a comprehensive understanding of the practical significance of the findings. T-tests were selected due to their suitability for measuring mean differences within and between two related groups. Effect size (Cohen's d) was calculated to determine the magnitude of observed differences.

Ethical Procedures

Informed consent was obtained from each participant before they engaged in the study. The process involved a detailed explanation of the study, procedures, potential risks and benefits, and participants' rights. For in-person sessions, participants received a consent form that was read and signed before participation. For online training, participants were required to electronically acknowledge the release consent prior to participating in the program. To ensure that participants fully understand their rights, including the right to withdraw at any time without penalty, the consent was written clearly and straightforwardly. The leading trainer, as well as the principal investigator, was available for both in-person and online training to answer any questions participants had about the study or the consent form. Additionally, an overview of the consent process was provided at the beginning of each program to ensure participants were fully aware of the study's nature.

Confidentiality was strictly maintained throughout the study. For the in-person training, data collected on paper did not require names and were securely locked in a cabinet with a key, which the principal investigator is the only person with access to. Digital data, including electronic survey responses, is stored on a secure, encrypted server

to prevent unauthorized access. Identifiable data were securely stored in a password-protected, encrypted file accessible only to the researcher. No directly identifying information was collected; instead, each participant was assigned a unique pseudo code consisting of their initial and part of their phone number, used only to match pre- and posttest. This process ensured that individual identities remain confidential. Regular audits have been performed to ensure the integrity and security of the data. Participants' rights were discussed and reiterated throughout the study, including their right to withdraw without consequences or fear of retaliation. If a participant decided not to participate, their data was promptly removed and securely destroyed to maintain confidentiality.

Before data collection began, the study obtained Institutional Review Board (IRB) approval, ensuring that all procedures were conducted ethically in research involving human subjects. This process entails a detailed review of the study methodology, consent process, and data protection measures to safeguard the rights and well-being of each participant. No vulnerable population participated in this research, and all adults were fully capable of providing informed consent. All ethical procedures have been and will continue to be applied to ensure that each participant is treated with dignity and respect and that their data is handled with the utmost care.

Limitations of the Study

This study faced some practical limitations due to the researcher's dependence on other facilitators and partner organizations to conduct the TSL training; therefore, multiple sessions were repeated in order to reach the desired number of participants. The

survey's length also contributed to participant fatigue, leading to withdrawal and uneven sample sizes. These factors extended the overall timeline and introduced variations in how and when the sessions were delivered. Despite efforts to balance the two groups, final participation remained uneven because some individuals did not complete both the pre- and posttests. Additionally, reliance on others' schedules and self-reported data limited consistency and accuracy in data collection. Availability also limits consistency in data collection.

Despite these challenges, the study provides valuable insights into the implementation of community-based suicide prevention programs and underscores the importance of collaboration when serving diverse populations. Future research should explore the retention of literacy gains over time and the program's impact across other Hispanic subgroups.

Summary

Through the methodology, data analysis plan, and ethical considerations implemented in this study, meaningful insights were obtained regarding the effectiveness of the TSL suicide prevention programs for the Hispanic/Latinx community. The quantitative research approach included descriptive statistics, paired *t*-tests, and independent *t*-tests to examine changes in suicide literacy and to assess the magnitude of those changes.

This approach allowed the analysis to capture not only whether improvement occurred, but also the strength of the observed effects. The findings support the value of suicide prevention programs that address the silence surrounding suicide within the

Hispanic/Latinx community and provide guidance for the continued development of culturally responsive approaches that reflect the lived realities and needs of diverse communities.

Section 3: Presentation of the Findings

Introduction

In this section, I present the quantitative results of the study examining how cultural adaptation enhances learning outcomes in suicide prevention education. Specifically, I analyzed the impact of the TSL program, both the translated and the culturally adapted version, on suicide literacy among Hispanic/Latinx adults. In this study, suicide literacy was measured using the LOSS, a validated instrument in which higher scores indicate greater suicide literacy, including knowledge of warning signs, risk factors, protective factors, and help seeking resources. Descriptive statistics, a paired *t* test, and an independent *t* test were used to assess the differences in pre- and posttraining knowledge and compare the effectiveness of the two program versions.

Findings revealed that both versions of the TSL program increased participants' knowledge about suicide. However, the culturally adapted version produced greater improvement in suicide literacy compared to the translated version. These findings are consistent with the principles of SCT, which emphasize that learning is strengthened when new information is presented in a culturally relevant context. The inclusion of cultural elements in the adapted version may have contributed to higher levels of participant engagement, comprehension, and retention of suicide prevention concepts through modeling, imitation, and reinforcement processes described in SCT.

A total of 115 participants completed both the pre- and post-LOSS survey: 41 in the translated version of TSL and 74 in the culturally adapted version. Participants represented 13 different Hispanic/Latinx countries, with a large portion from Puerto Rico

at 63.5%, followed by Colombia at 12.2%, the Dominican Republic at 6.1%, and Venezuela at 5.2%. Participants' ages ranged from 18 to 91, with a median age of 60. Most participants (79.1%) were first-generation immigrants (born in a different country and the first in their family to move to the United States). Approximately 10.4% were second-generation, 8% were third generation, and fewer than 1% were fourth-generation or beyond. This reflects the community-based suicide prevention initiative in Central Florida.

A total of 41 individuals participated in eight translated sessions held between July 17 and September 25, 2025. For the culturally adapted version, 74 participants attended seven sessions between July 18 and September 23, 2025. Both programs were delivered through a combination of virtual and in-person formats. There were two trainers: one facilitated the translated version, and the other facilitated the culturally adapted version. Both hold a bachelor's and a master's in social work from the University of Central Florida, are licensed clinical social workers (LCSWs) in Florida, and currently serve as clinical supervisors at Hispanic Family Counseling, Inc. As second-generation Puerto Ricans in their early 30s, their shared educational and cultural backgrounds ensured consistency in program delivery and minimized facilitator bias.

Data Analysis Techniques

Data was analyzed using Microsoft Excel and SPSS. Descriptive statistics (means and percentages) summarized participant responses before and after each training version. The percentage improvement (posttest minus pretest) was calculated to measure change in knowledge both by question and overall.

To ensure reliability, only participants who completed both the pre- and posttest were included in the final analysis. Data integrity was maintained by using an identical survey instrument and standardized facilitation procedures across both program versions. Paired *t* tests evaluated whether participants' knowledge changed within the same individuals, while descriptive comparisons of mean gain scores between versions assessed which program achieved greater increases in suicide literacy. Further, an independent *t* test was used to compare both groups against each other in terms of the mean difference of total scores from pre to post for each. The independent samples are those in the translated version and those in the culturally adapted version.

Each correct response received a score of 1; incorrect, "I don't know," or blank responses received 0. The total points per question were summed and divided by the number of participants to obtain the mean number of correct responses. This procedure was applied to both the translated and culturally adapted versions. Visual representations such as bar charts and tables were created in Excel to illustrate changes and highlight the relative effectiveness of each program version.

Findings

Overall, the analysis revealed that both groups demonstrated posttraining improvement. The translated version's mean score increased from 54.69% to 73.26%, representing an 18.57 percentage-point increase, equivalent to a 33.96% relative increase. In comparison, the culturally adapted program showed a substantial increase in knowledge, rising from 53.12% to 80.72%, representing a 27.60 percentage-point increase, equivalent to a 51.96% relative increase. Paired *t* test results confirmed that both

increases were statistically significant ($p < .001$). This significance indicates that the observed increases were unlikely due to chance and represent meaningful learning gains. The 9.03-point difference between versions corresponds to a 48.6% relative improvement in knowledge, demonstrating not only statistical but also practical significance. This reinforces that cultural adaptation plays a measurable and meaningful role in improving suicide literacy among Hispanic/Latinx participants.

When the two versions are compared directly with each other, the independent samples t test shows a statistically significant difference $t = -2.60$ ($df = 113$) $p < .01$, showing that participants in the culturally adapted program achieved higher gains than those in the translated version. This effect reflects a *medium effect size*, indicating that the advantage of the culturally adapted version is not only statistically detectable but also practically meaningful.

At the question-level, both groups showed significant gains in Question 6, “There is a strong relationship between alcoholism and suicide”, Question 15, “People who are anxious or agitated have a higher risk of suicide”, and Question 17, “Men are more likely to commit suicide than women”. In both programs, these topics address the correlation between mental health conditions and suicide, as well as the impact of lethal means and gender differences in suicide mortality. Such improvements support the program’s objective to normalize the conversations about suicide and reduce the stigma, encouraging help-seeking behavior.

Of the 26 survey questions, participants in the culturally adapted version demonstrated higher gains in 19 items compared with the translated version. On the other

hand, the translated version showed higher gains in five questions; two of those questions, Question #3 “Seeing a psychiatrist or psychologist can help prevent someone from suicide” and Question #13 “People who have thoughts about suicide should not tell others about it”, had a scores above 97 % correct for the culturally adapted version, leaving little room for improvement. The other three questions where the translated version achieved a higher score were Question # 8 “People who want to attempt suicide can change their mind quickly”, Question #10 “A person who has made a past suicide attempt is more likely to attempt suicide again than someone who has never attempted”, and Question #16 “Most people who suicide are younger than 30”.

One question reflected equal improvement across both programs. Question #5, “Only experts can help someone who has suicidal ideation”, was the item with the same gains. These findings align with the purpose of TSL, which emphasizes the idea that open communication and community involvement play a critical role in suicide prevention, not limited to professional intervention.

Knowledge gains were evident across all items in the culturally adapted version, whereas no changes were observed in two items of the translated version. Question #1, “Nothing can be done to stop people from attempting once they have made up their mind to kill themselves,” showed the least overall improvement, with no improvement in the translated version and a modest 10.81% increase in the culturally adapted version. Nevertheless, this small increase represented a perfect 100% score posttraining, making it the only question to achieve complete accuracy. The translated version also reflected a high percentage of correct answers (87.80%), which is understandable given that the

program's title, TSL, implies the correct answer. Similarly, Question #23 (“A time of high suicide risk in depression is the time when the person begins to improve”) showed no change in the translated program.

The following tables and figures summarize the findings for both versions of the training program. Table 1 presents the demographic characteristics of the 115 Hispanic/Latinx participants from Central Florida who completed the pre- and post-LOSS survey, including program version, country of origin, average age, and generation status. Table 2 displays the mean pre- and posttest scores for participants in both versions. This comparison provides an overview of the knowledge gains associated with each version and serves as the basis for the other analysis; Table 3 offers a question-by-question comparison of pre- and posttest percentages, highlighting where learning gains occur most prominently. Table 4 compiles the paired t-test sample, confirming statistically significant improvements within each group ($p < .001$). Table 5 compares the two versions using an independent t-test, demonstrating that the culturally adapted version of the TSL program produced a significantly higher gain in suicide literacy compared to the translated version, $t(113) = -2.60$, $p = .011$, $d = .49$, 95% CI [0.12, 0.86], indicating a medium effect size. Specifically, participants in the culturally adapted version demonstrated a 48.6% higher improvement in posttest scores, confirming the substantial impact of cultural adaptation on learning outcomes. Table 6 displays the independent samples effect size analysis (Cohen's $d = -0.51$), which further supports a medium effect, indicating that the culturally adapted version produced substantially greater gains in

suicide literacy compared with the translated version. The 95% CI ($-0.89, -0.12$) confirms that this difference is both statistically reliable and practically meaningful.

Figures 2 through 6 visually illustrate these outcomes, highlighting the distribution of gains across individual questions and emphasizing areas where knowledge improvement was strongest. Across most questions, the culturally adapted version achieved higher accuracy than the translated version, suggesting that culturally adapted programs enhance learning effectiveness and message retention among Hispanic/Latinx participants. Figure 2 visually depicts this comparison, showing the relative knowledge gains for each question across both versions.

Table 1

Demographic Characteristics of the Participants

Variable	Category	<i>n</i>	%
Program version	Translated	41	35.7
	Culturally adapted	74	64.3
Country of origin	Puerto Rico	73	63.5
	Colombia	14	12.2
	Dominican Republic	7	6.1
	Venezuela	6	5.2
	Other (9 countries)	15	13
Age range	18-91 (median = 60)	--	--
Generation status	First generation	91	79.1
	Second generation	12	10.4
	Third generation	9	7.9
	Fourth generation or beyond	1	0.9
	Did not respond	2	1.7
Region served	Central Florida community-based initiatives	--	--

Table 2*Pre- and Posttest Mean Scores for Both Version*

Group			Mean	<i>N</i>	Std. Deviation	Std. Error Mean
Translated	Pair 1	Pretest	14.22	41	5.087	.79443
		Posttest	19.05	41	3.75	.58638
Culturally adapted	Pair 1	Pretest	13.81	74	4.64	.53934
		Posttest	20.99	74	2.31	.26903

Table 3*Question Level Summary of Pre- and Posttest Percentages*

Question	Translated Pre	Translated Post	Culturally Adapted Pre	Culturally Adapted Post	Translated Gain	Culturally Adapted Gain
Q1	87.80%	87.80%	89.19%	100.00%	0.00%	10.81%
Q2	58.54%	80.49%	54.05%	85.14%	21.95%	31.08%
Q3	85.37%	97.56%	91.89%	97.30%	12.20%	5.41%
Q4	73.17%	78.05%	74.32%	95.95%	4.88%	21.62%
Q5	68.29%	82.93%	82.43%	97.30%	14.63%	14.86%
Q6	39.02%	78.05%	37.84%	86.49%	39.02%	48.65%
Q7	46.34%	73.17%	58.11%	90.54%	26.83%	32.43%
Q8	29.27%	65.85%	35.14%	63.51%	36.59%	28.38%
Q9	68.29%	87.80%	59.46%	82.43%	19.51%	22.97%
Q10	56.10%	90.24%	68.92%	83.78%	34.15%	14.86%
Q11	48.78%	58.54%	40.54%	59.46%	9.76%	18.92%
Q12	46.34%	51.22%	55.41%	71.62%	4.88%	16.22%
Q13	75.61%	92.68%	85.14%	98.65%	17.07%	13.51%
Q14	63.41%	82.93%	70.27%	94.59%	19.51%	24.32%
Q15	29.27%	70.73%	35.14%	90.54%	41.46%	55.41%
Q16	56.10%	73.17%	45.95%	59.46%	17.07%	13.51%
Q17	31.71%	63.41%	27.03%	83.78%	31.71%	56.76%
Q18	60.98%	80.49%	56.76%	90.54%	19.51%	33.78%
Q19	36.59%	53.66%	37.84%	64.86%	17.07%	27.03%
Q20	65.85%	80.49%	54.05%	90.54%	14.63%	36.49%
Q21	60.98%	70.73%	51.35%	75.68%	9.76%	24.32%
Q22	60.98%	73.17%	45.95%	77.03%	12.20%	31.08%
Q23	24.39%	24.39%	9.46%	36.49%	0.00%	27.03%
Q24	53.66%	75.61%	43.24%	79.73%	21.95%	36.49%
Q25	19.51%	43.90%	14.86%	51.35%	24.39%	36.49%
Q26	75.61%	87.80%	56.76%	91.89%	12.20%	35.14%
	54.69%	73.26%	53.12%	80.72%	18.57%	27.60%

Table 4*Paired Samples t-Test Results by Program Version*

		Paired Differences					Significance			
		Mean	Std. Deviation	Std. Error	95% Confidence Interval of the Difference		<i>t</i>	<i>df</i>	One-sided <i>p</i>	Two-sided <i>p</i>
Group translated	Posttest - pretest	4.83	4.84	0.76	3.30	6.36	6.39	40	<.001	<.001
Culturally adapted	Posttest - pretest	7.18	4.51	0.52	6.13	8.22	13.68	73	<.001	<.001

Independent Sample t-Test Results (Between Versions)**Table 5***Independent Sample t-Test Results (Between Versions)*

		Levene's test for equality of variances		<i>t</i> test for equality of means							
		<i>F</i>	Si g.	<i>t</i>	<i>df</i>	Significance		Mean difference	Std. error difference	95% confidence interval of the difference	
						One-sided p	Two-sided p			Lower	Upper
Mean gain	Equal variances assumed	0.06	0.8	-2.60	113	0.005	0.010	-2.35	0.90	-4.13	-0.56

Table 6*Independent Sample t Test and Effect Size (Cohen's d)*

		Standardizer ^a	Point estimate	95% confidence interval	
				Lower	Upper
Gain 2	Cohen's <i>d</i>	4.63	-0.51	-0.89	-0.12
	Hedge's correction	4.66	-0.50	-0.89	-0.12
	Glass's delta	4.51	-0.52	-0.91	-0.13

^aThe denominator use in estimating the effect sizes

Note. Cohen's *d* uses the pooled standard deviation. Hedge's correction uses the pooled standard deviation, plus a correction factor. Glass's delta uses the sample standard deviation of the control (i.e., the second).

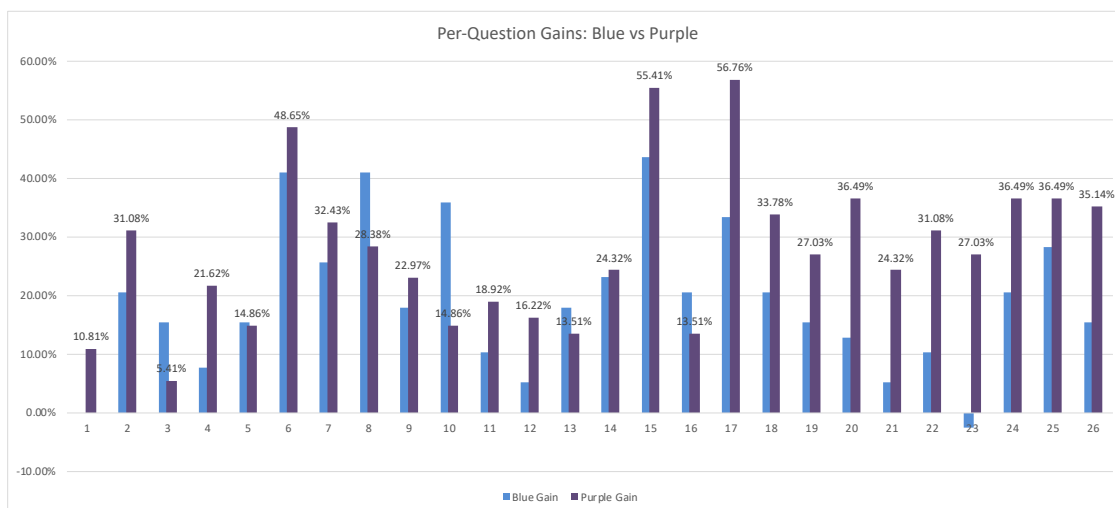
Figure 2*Comparison Question by Question Gain in Percentage*

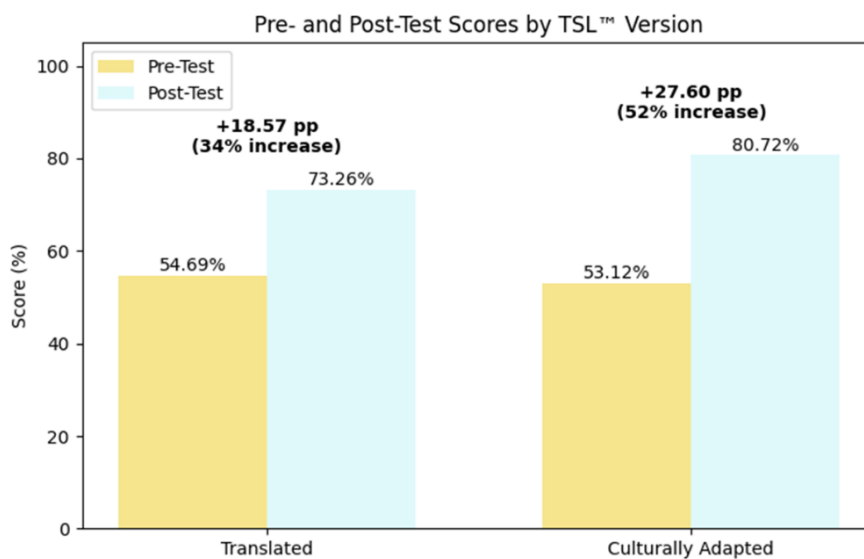
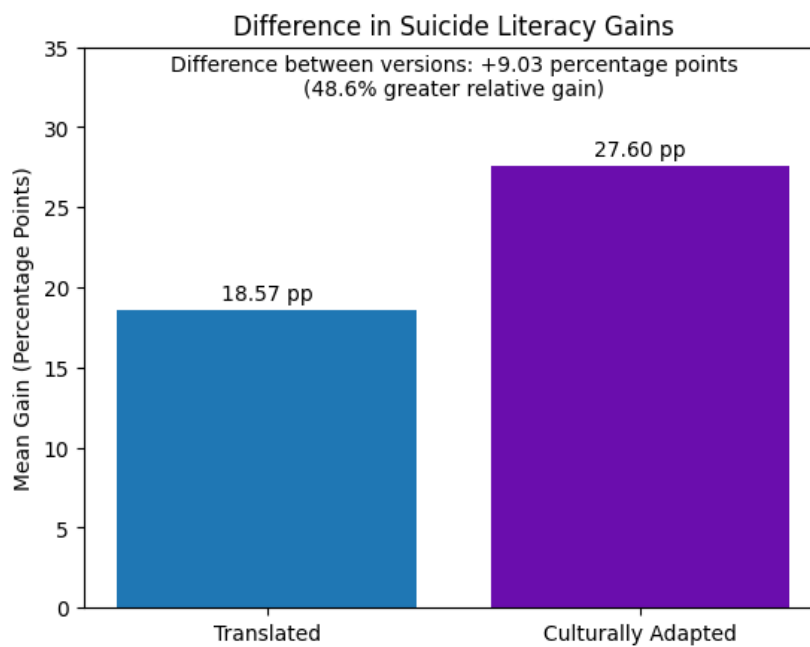
Figure 3*Pre- and Posttest Scores by Version***Figure 4***Mean Score Gains Comparison*

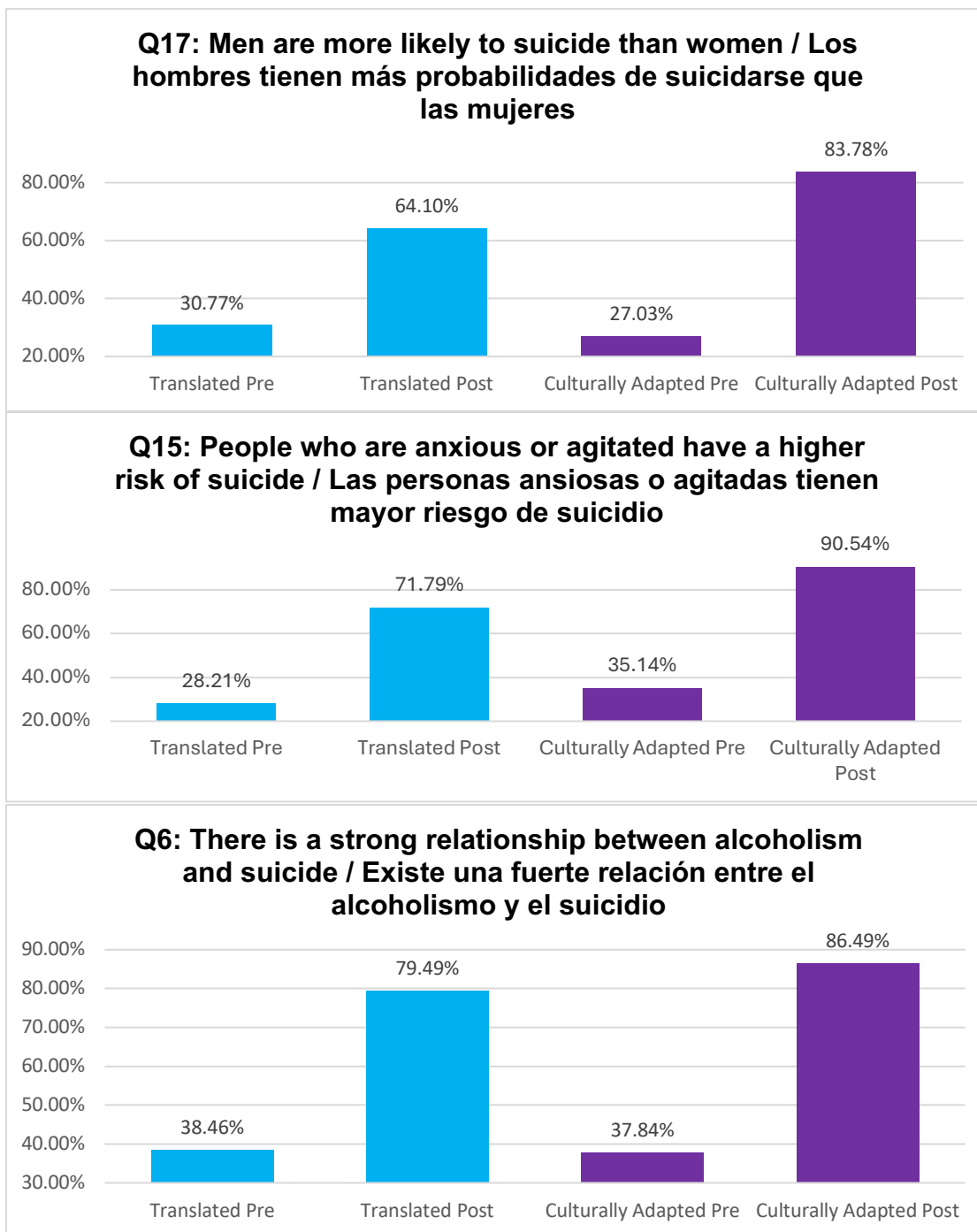
Figure 5*Questions with Higher Knowledge Gain*

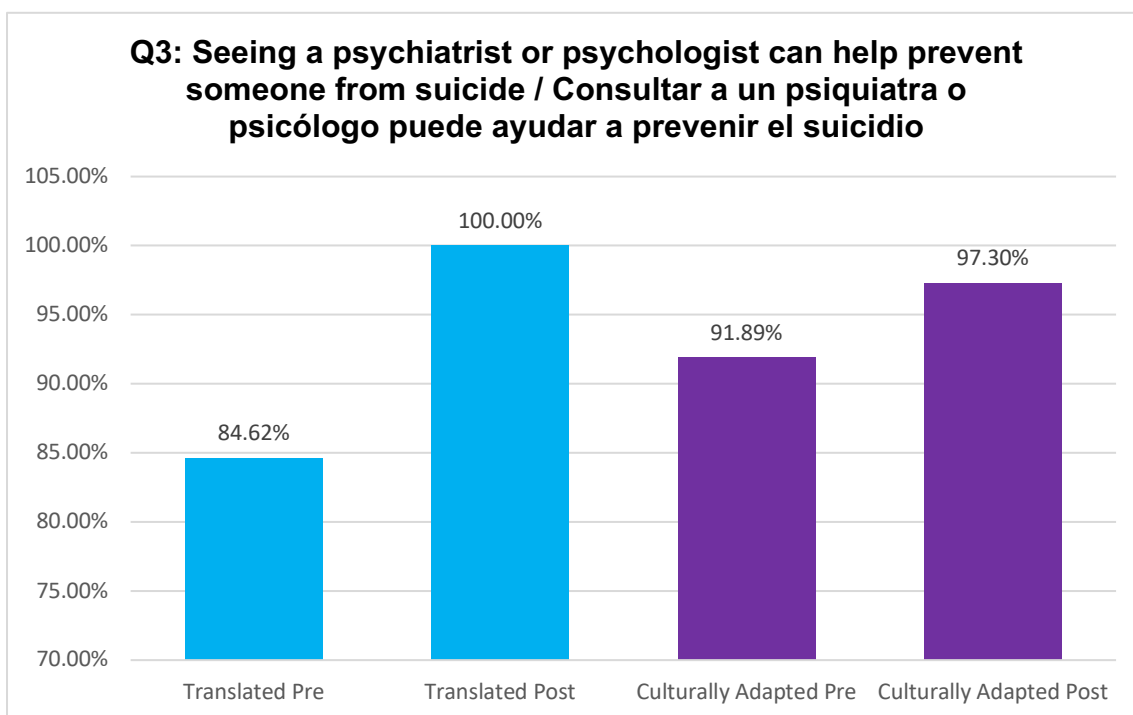
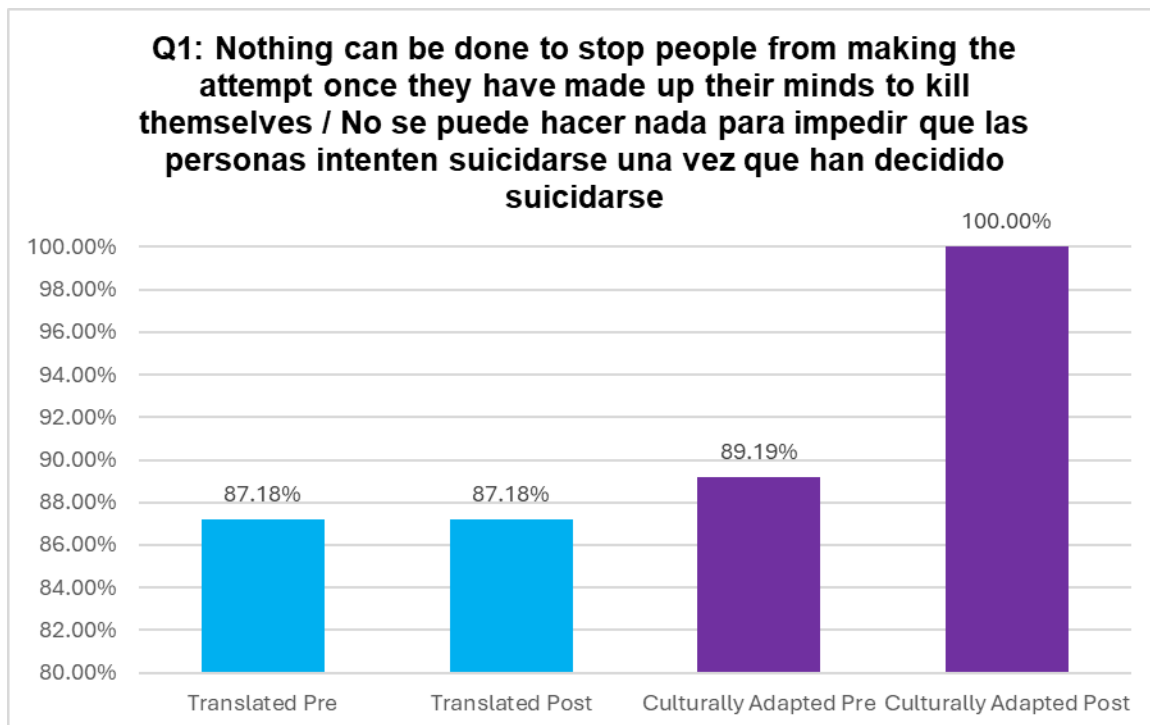
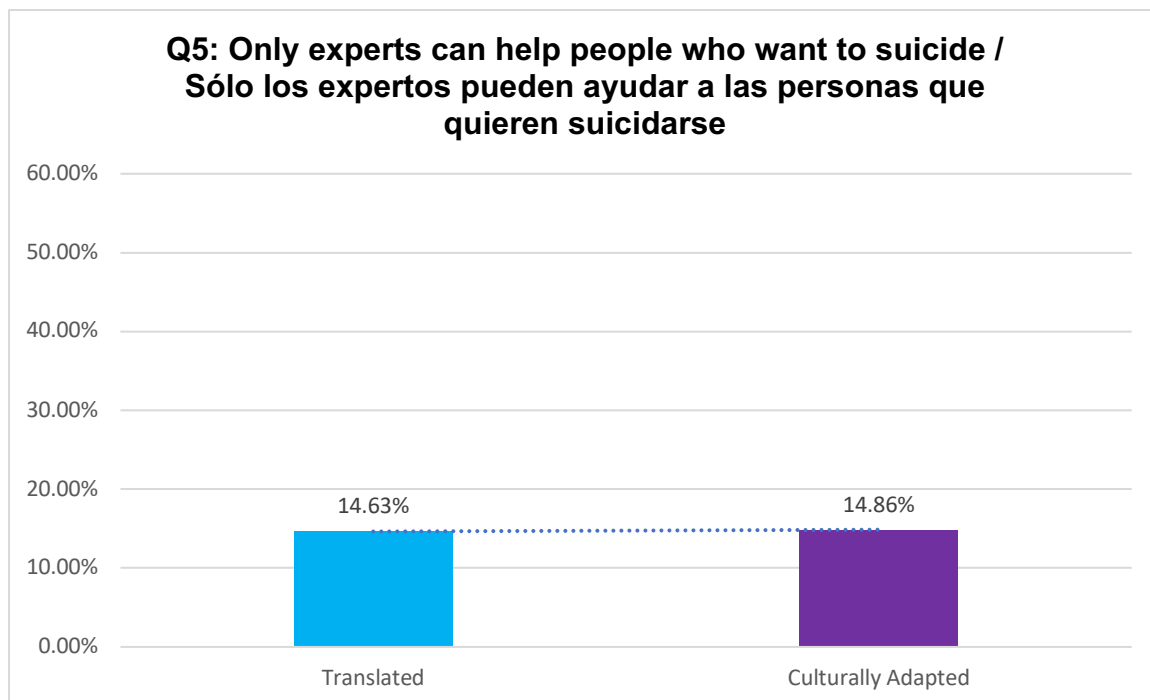
Figure 6*Questions with Lowest Knowledge Gain*

Figure 7

Same Knowledge Gain in Both Programs



Comparative Interpretation Results

When comparing the two versions of the TSL program, participants in the culturally adapted version demonstrated a mean score increase of 27.60, compared with 18.57 in the translated version. This represents a 9.03-point greater improvement, equivalent to a 48.6% higher gain in suicide literacy for the culturally adapted program. This difference represents a substantial effect size, indicating that cultural adaptation enhances both comprehension and internalization of suicide prevention principles. Figures 1 and 2 illustrate this pattern, where participants in the adapted version consistently scored higher. These findings confirm that culturally responsive educational

materials significantly improve learning effectiveness and message retention among Hispanic/Latinx populations.

By framing suicide prevention within familiar cultural values, language, and contexts, participants were able to connect the material to personal and community experiences, reinforcing the relevance of help-seeking and reducing stigma.

Summary

In summary, both versions of the training program effectively increased suicide literacy among Hispanic/Latinx adults. The translated version improved knowledge by 18.57%, while the culturally adapted version achieved a 27.60% increase. Paired t-tests confirmed significant within-group gains ($p < .001$), and the independent t-test indicated a significant difference favoring the culturally adapted version. Across the 26 survey items, participants in the culturally adapted program outperformed those in the translated version on 19 questions, demonstrating stronger knowledge retention and comprehension.

These findings align with the Social Cognitive Theory, suggesting that culturally relevant modeling and reinforcement can enhance learning outcomes among Hispanic/Latinx participants. It also underscores the purpose of the study, which was to evaluate whether one version of the program was better than the other in increasing suicide literacy. The results suggest that the culturally adapted version enhances relevance and learning outcomes, allowing participants to further connect with the content through culturally resonant examples, language, and needs. Even though both versions increase knowledge gain, the culturally adapted one appeared more effective in addressing misconceptions, normalizing help-seeking behaviors, and emphasizing the

importance of the community role in decreasing the stigma and normalizing suicide prevention.

In conclusion, the data showed that culturally sensitive education is not only beneficial but essential when working within the Hispanic/Latinx communities on sensitive topics, such as suicide. These results provide empirical support for the importance of cultural context in prevention efforts and support the study's hypothesis that the culturally adapted version yielded greater knowledge gain, confirming the importance of cultural relevance in suicide prevention education. Ultimately, these findings underscore that meaningful progress in suicide prevention necessitates not just translation but genuine cultural adaptation that respects the values, language, and lived experiences of the community being served.

Section 4: Application to Professional Practice and Implications for Social Change

Introduction

The purpose of this study was to evaluate the impact of the program on suicide literacy among Hispanic/Latinx communities, comparing the translated version to the culturally adapted version. In this observational evaluation, I examined two existing program formats to determine whether cultural adaptation more effectively enhances participants' knowledge and understanding of suicide prevention concepts. The broader goal of this research was to demonstrate the value of culturally responsive approaches that go beyond simple translation by integrating values, beliefs, and lived experiences—in our case, those of the Hispanic/Latinx community.

These findings are consistent with the principles of SCT, which emphasize that learning occurs through observation, modeling, and social interaction within a context relevant to participants. Participants exposed to the culturally adapted version demonstrated a deeper connection with the material, reflecting cultural values, language expressions, and lived experiences that, according to SCT, supported identification with the content and improved retention (Bernal et al., 2009). In contrast, while the translated version provided accurate information, it did not incorporate culturally meaningful elements that facilitate engagement and meaning making, which may have limited the depth of learning predicted by the theory. This interpretation is consistent with Bandura's assertion that individuals are more likely to model behaviors and adopt attitudes that are familiar and relevant to their social environment. As a result, the culturally adapted

version was associated with stronger observational learning processes and more effective educational outcomes.

The literature highlighted both a gap and an opportunity for culturally adapted suicide prevention programs within Hispanic/Latinx communities, which are disproportionately affected by stigma, cultural barriers, language differences, and limited access to mental health resources. The community-based suicide prevention program developed by AFSP has been recognized as a Best Practice Registry program by the SPRC. However, it has not been systematically evaluated for its effectiveness within Hispanic/Latinx communities or compared in terms of the impact of its translated versus culturally adapted versions. This research provides an opportunity to assess the relevance and effectiveness of this established curriculum when delivered in both formats.

The findings are encouraging as all participants, irrespective of the program, demonstrated improvement in suicide literacy. However, statistical analysis revealed that participants in the culturally adapted program achieved significantly higher posttest scores and greater overall knowledge gains than those in the translated version. The results suggest that while translation can make information accessible, a culturally adapted version enhances relatability, allowing the content to resonate more deeply with participants. Participants in the culturally adapted sessions were also noticeably more active and responsive to the examples and context that reflected their cultural experiences. This cultural resonance likely enhanced comprehension and retention of key suicide prevention concepts.

For social work practice, these findings underscore the importance of cultural responsiveness in educational intervention, emphasizing that translation alone is insufficient for meaningful engagement with diverse populations and that a “one size fits all” approach is unlikely to be effective. By providing empirical evidence of measurable differences between the translated and culturally adapted versions of the program, this study advances social work practice by demonstrating that culturally tailored interventions can more effectively enhance suicide prevention knowledge and engagement among diverse populations. The following section presents recommendations and proposes strategies for integrating culturally adapted programs into social work practice.

Application to Professional Ethics in Social Work Practice

According to the NASW (2024), the profession's primary mission is to help meet the basic human needs of all people, especially those who are vulnerable, oppressed, and living in poverty. Social workers must be attentive to cultural and ethnic diversity and strive to end discrimination, oppression, poverty, and other forms of social injustice (NASW, 2021). In this context, policies affecting the Hispanic/Latinx community in the United States that remained in effect in 2025 have intensified structural inequities and increased vulnerability among Hispanic/Latinx populations (NAMI, 2024). By evaluating the two versions, this study aligns with the ethical mandate for culturally competent and equitable practice. Addressing suicide literacy within the Hispanic/Latinx community fulfills the moral responsibility to serve those who historically have had less access to mental health education and suicide prevention resources.

The study's emphasis on cultural and linguistic responsiveness reflects the ethical principle of competence, which requires social workers to understand culture and its role in human behavior and society, while recognizing the strengths inherent in all cultures (NASW, 2021). The results showing higher levels of understanding in the adapted version highlight the ethical responsibility of going beyond translation – ensuring that educational materials align with the cultural values, beliefs, and lived experiences of the participants. As Sue et al. (2019) emphasized, such alignment reflects genuine cultural humility, which goes beyond competence -- by integrating openness and thoughtful reflection on people's lived experiences into the materials.

This ethical commitment also extends to the principles of service and social justice. Curtin et al. (2023) noted that suicide disproportionately affects Hispanic/Latinx and other minority communities' subpopulation, particularly youth and young adults; however, culturally relevant prevention materials remain limited. By evaluating and highlighting the benefits of a culturally adapted suicide prevention program, this research supports the call for more equitable access to mental health education. In line with Reamer's (2018) view of ethical practice, it reinforces the profession's responsibility to promote well-being and prevent harm by educating individuals to recognize warning signs and reach out to those in need.

In addition, this research reflects the ethical principle of integrity, as defined by the NASW (2021), which is a commitment to honesty, transparency, and respect for clients and participants. Consistent with Walden University's (2024) standards for ethical research, all materials emphasized transparency, voluntary participation, informed

consent, and confidentiality, reinforcing participants' dignity and autonomy. The observational design minimized risk and protected participants' rights to make their own choices, demonstrating integrity in practice.

Finally, this research promotes ethical responsibility in professional education and advocacy. Demonstrating that a culturally adapted educational program enhances suicide literacy provides valuable guidance for educators, policymakers, and practitioners. As Fong (2004) emphasizes, promoting inclusiveness and culturally responsive programming reflects both ethical practice and professional growth in cultural humility and suicide prevention.

In summary, this project integrates ethics, social justice, and cultural awareness to advance the mission of social work. It reinforces the responsibility of the profession to ensure equity in mental health education and suicide prevention by listening to communities, adapting programs with cultural humility, and removing language and cultural barriers to access.

Recommendations for Social Work Practice

This project helps advance ethical social work practice in several areas, particularly the profession's core values: service, social justice, dignity and worth of a person, importance of human relationships, integrity, and competence. The findings show that while translation improves access to suicide prevention education, cultural adaptation has a deeper and more meaningful impact on the Hispanic/Latinx community. By aligning with participants' lived experiences, language, and values, culturally adapted

programs increase understanding of suicide, promote conversations, encourage seeking help, decrease the stigma, and can ultimately save lives.

Social workers should go beyond simply translating materials and focus on cultural responsiveness. The greater knowledge gains in the culturally adapted version of the program suggest that translation alone is insufficient; programs should also reflect participants' cultural values, communication styles, and community experiences. Collaboration with cultural consultants, faith leaders, and local community members can help ensure that materials and delivery methods are relevant and respectful.

Ongoing training in cultural competence and suicide prevention is key. Professionals who are trained in both areas can address sensitive topics with confidence and empathy. Agencies and universities should continue to support the type of education that helps social workers understand cultural barriers and teaches them to engage with underserved communities more effectively.

Building strong community partnerships is also essential. Working with churches, schools, and community centers can increase access to suicide prevention education, promote conversations about mental health, and identify gaps in services. These partnerships can also provide valuable feedback for continuous program improvements, ensuring they are better received by the communities they serve.

Hispanic/Latinx-serving agencies and community organizations can use the findings of this study to intentionally develop, reinforce, or expand culturally adapted suicide prevention programs, rather than relying solely on translated materials. Similar to how programs such as *Soul Shop*TM have been adapted to meet the cultural and faith-

based needs of Hispanic communities, agencies can collaborate with cultural leaders, faith institutions, and community members to integrate values, language, and lived experiences into suicide prevention education. This approach enhances learning, increases engagement, and strengthens suicide prevention efforts in underserved communities by ensuring that programs resonate authentically with those they are intended to serve.

Culturally adapted programs send an important message to marginalized communities: *“You are seen, you are valued, and your life matters”*. When organizations invest time, resources, and commitment in programs that reflect people’s culture, values, and lived experiences, they communicate dignity and respect through actions, not mere words. For Hispanic/Latinx families who may feel targeted or devalued, social workers play a critical role by advocating, educating, and standing with those who are living in fear. This work reinforces the profession’s commitment to recognizing every person’s worth.

Finally, this research aims to motivate social workers to continue advocating for fair access to mental health education and resources. Beyond increasing knowledge, culturally adapted suicide prevention programs honor lives.

Implications for Social Change

According to NASW (2024), the primary mission of the social work profession is to enhance human well-being for *all* people, with particular attention to those who are vulnerable, oppressed, or living in poverty. In today’s social climate, some communities face pressing challenges. Among them, the Hispanic/Latinx community often lives under

constant stress due to discrimination, immigration concerns, and limited access to education – factors that, tragically, can contribute to a higher risk of suicide.

This research is a first step towards a positive social change by making suicide prevention education more accessible and relevant for the Hispanic/Latinx community. Findings demonstrate that when a program goes beyond language translation and adapts to the culture, participants develop a deeper connection to the message, gain valuable knowledge, and build a skill set that can save lives. Inclusion, therefore, requires understanding the community's values, beliefs, and even communication styles.

Culturally adapted programs reflect the social work values of professional competence and service. The NASW Code of Ethics calls on social workers to apply knowledge and skills that are responsive to clients' cultural backgrounds. This research demonstrated that culturally adapted programs not only increase program effectiveness but also show respect for the communities they serve.

Ethical social work practice also demands advocacy for equitable access to resources, a key driver of social change. Administrators and social work professionals should use these findings to advocate for funding and policies that prioritize suicide culturally adapted suicide prevention programs. By promoting fair resource allocation, social workers help reduce structural and systemic inequalities and advance social justice.

Staying current with research and grounding practice in empirical evidence is also essential for social change. Disseminating results encourages other professionals and organizations to invest in culturally adapted interventions and programs, fostering accountability and advancing the system's impact.

At the community level, this research can guide churches, schools, and local communities in the development of a suicide prevention program that encourages open conversations and reduces mental health stigma. Strengthening community relationships and collaboration promotes empathy and collective care, helping communities understand that seeking help is a sign of strength, not weakness. These initiatives build cultural awareness, strengthen communities, and promote social unity—essential for lasting social change.

Finally, social workers are ethically obligated to guarantee equitable access to essential services. This research underscores the importance of policymakers and advocacy groups investing in culturally adapted prevention programs. Supporting the programs could reduce disparities, promote systemic change, and create long-term social impact, advancing the core mission of social work: social justice, protection of vulnerable populations, and affirmation of the dignity of all people.

Summary

This research evaluated a translated version and a culturally adapted version of TSL on suicide literacy within the Hispanic/Latinx community in Central Florida. Both versions increase suicide prevention literacy, but the translated version improved understanding by 18.57%, while the culturally adapted version improved understanding by 27.60%, a 48.6% relative improvement over the translated version. These results suggest that interventions that incorporate cultural values, beliefs, and communication styles resonate more with participants and are therefore more effective. By aligning educational content with the lived experiences of the Hispanic/Latinx population,

culturally sensitive programs can support social work practice grounded in core values of service, social justice, and human dignity. Overall, this project contributes to the profession's commitment to equitable access, inclusion, and culturally competent care, saving lives through knowledge, compassion, and community collaboration.

In conclusion, culturally sensitive education is not only beneficial but essential when working with the Hispanic/Latinx community on sensitive topics such as suicide. The results provide empirical support for the importance of cultural context in prevention efforts and confirm that culturally adapted versions obtained greater knowledge gain, reinforcing the role of cultural relevance in suicide prevention.

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Appendix A: Literacy of Suicide Scale Pre- and Posttest

LITERACY OF SUICIDE SCALE – PRE TEST

Participant's ID: _____ (First Name Initial, Last Name, Last 4 digits of Phone Number)

Please answer the following questions. Your responses will be kept confidential and used only for research purposes:

Date: _____

Time: _____

Location: _____

Trainer Name: _____

Age: _____

Sex:

Male

Female

Other (please specify): _____

Prefer not to answer

Where do you currently live? (City and state): _____

What generation are you in the United States?

First-generation (born outside the U.S.)

Second-generation (born in the U.S. to immigrant parents)

Third-generation

Fourth-generation or more

What is your Hispanic/Latino country of origin? (e.g., Puerto Rico, Mexico, Dominican Republic, etc.): _____

Please read the following statements and indicate whether you think they are true or false:

	True	False	Don't know
1. Nothing can be done to stop people from making the attempt once they have made up their minds to kill themselves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. If assessed by a psychiatrist, everyone who suicides would be diagnosed as depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Seeing a psychiatrist or psychologist can help prevent someone from suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Most people who suicide are psychotic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Only experts can help people who want to suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. There is a strong relationship between alcoholism and suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. People who talk about suicide rarely kill themselves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. People who want to attempt suicide can change their mind quickly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Talking about suicide always increases the risk of suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. A person who has made a past suicide attempt is more likely to attempt suicide again than someone who has never attempted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Media coverage of suicide will inevitably encourage other people to attempt suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Not all people who attempt suicide plan their attempt in advance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. People who have thoughts about suicide should not tell others about it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Very few people have thoughts about suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. People who are anxious or agitated have a higher risk of suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Most people who suicide are younger than 30	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Men are more likely to suicide than women	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. People with relationship problems or financial problems have a higher risk of suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	True	False	Don't know
19. Most people who suicide don't make future plans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. If you asked someone directly "Do you feel like killing yourself?" it will likely lead that person to make a suicide attempt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. A suicidal person will always be suicidal and entertain thoughts of suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. A person who suicides is mentally ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. A time of high suicide risk in depression is at the time when the person begins to improve	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Motives and causes of suicide are readily established	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Most people who attempt suicide fail to kill themselves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Those who attempt suicide do so only to manipulate others and attract attention to themselves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

LITERACY OF SUICIDE SCALE – POST TEST

Participant's ID: _____ (First Name Initial, Last Name, Last 4 digits of Phone Number)

Please read the following statements and indicate whether you think they are true or false:

	True	False	Don't know
1. Nothing can be done to stop people from making the attempt once they have made up their minds to kill themselves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. If assessed by a psychiatrist, everyone who suicides would be diagnosed as depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Seeing a psychiatrist or psychologist can help prevent someone from suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Most people who suicide are psychotic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Only experts can help people who want to suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. There is a strong relationship between alcoholism and suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. People who talk about suicide rarely kill themselves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. People who want to attempt suicide can change their mind quickly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Talking about suicide always increases the risk of suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. A person who has made a past suicide attempt is more likely to attempt suicide again than someone who has never attempted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Media coverage of suicide will inevitably encourage other people to attempt suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Not all people who attempt suicide plan their attempt in advance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. People who have thoughts about suicide should not tell others about it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Very few people have thoughts about suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. People who are anxious or agitated have a higher risk of suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Most people who suicide are younger than 30	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Men are more likely to suicide than women	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	True	False	Don't know
18. People with relationship problems or financial problems have a higher risk of suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Most people who suicide don't make future plans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. If you asked someone directly "Do you feel like killing yourself?" it will likely lead that person to make a suicide attempt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. A suicidal person will always be suicidal and entertain thoughts of suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. A person who suicides is mentally ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. A time of high suicide risk in depression is at the time when the person begins to improve	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Motives and causes of suicide are readily established	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Most people who attempt suicide fail to kill themselves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Those who attempt suicide do so only to manipulate others and attract attention to themselves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. What did you learn about <i>Talk Saves Lives™</i> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Appendix B: Permission to Use Talk Saves Lives



Denisse Centeno Lamas, LCSW
Founder & CEO, Hispanic Family Counseling Inc.
1707 Orlando Central Parkway, Suite 480, Orlando, FL 32809

April 22nd, 2024

Dear Denisse,

I am writing to grant permission for you to use the AFSP Resource *Talk Saves Lives for Latinx & Hispanic Communities* in your evaluation of the program within the Latinx community. Please feel free to use this program without restriction as part of your project.

By signing below, I warrant that I have the right to grant the permission in this letter, and that I provide you with that permission.

Sincerely,



Christine Yu Moutier, M.D.
Chief Medical Officer
American Foundation for Suicide Prevention

Appendix C: Consent to Use LOSS



Denisse Lamas <lamasdc@gmail.com>

Stigma of Suicide Scale

Phil Batterham <Philip.Batterham@anu.edu.au>
To: Denisse Lamas <lamasdc@gmail.com>

Wed, Apr 5, 2023 at 7:53 PM

Dear Denisse,

Thanks for your email. You are welcome to use the SOSS in your evaluation. I have attached a copy of the scale, along with a related scale on suicide literacy (LOSS).

The SOSS (long or short form) is scored by calculating three separate scores, one for each subscale (stigma, isolation/depression, normalisation/glorification), based on the mean of all items within the subscale. Most people use the short form of the SOSS. A response of strongly disagree is scored 1, up to strongly agree is 5. The mean scores for each subscale will consequently range from 1-5, with higher scores indicating higher stigma, greater attribution to isolation/depression or greater normalisation/glorification. The LOSS is scored as the number of correctly answered items (most studies also use the short form, range 0-12; 'don't know' is scored as incorrect).

Please let me know if you need any papers related to either scale, and please let me know if I can be of further assistance. Best wishes with your project.

Kind regards,

Phil

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TEQSA Provider ID: PRV12002 (Australian University) | CRICOS Provider Code: 00120C

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