Raising Children in Different Cultures: Working with Latinx Youth with Suicidal Behaviors and Their Families

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ABSTRACT

In the United States suicide is the third leading cause of death among Hispanic youth ages 10 to 14 and the second leading cause for those ages 15 to 24. Given that Rhode Island's Latinx/Hispanic (L/H) population is growing, and L/H youth are more likely to attempt suicide compared to their White peers, culturally relevant interventions are needed. The objective of this case presentation is to illustrate the application of a cultural approach when working with L/H families using the Socio-Cognitive Behavioral Therapy for Suicidal Behaviors (SCBT-SB).

KEYWORDS: Latinx/Hispanic families, suicidal behaviors, cultural approach, evidence-based intervention

INTRODUCTION

In Rhode Island (RI), the Latinx/Hispanic (L/H) population constitutes 16% of the total population, and has increased by approximately 39% in the last 10 years.[1,2] In the United States (US), suicide is the third leading cause of death among L/H youth between the ages of 10 and 14 and the second for L/H youth ages 15 to 24.[3] According to the 2017 and 2019 Youth Risk Behavioral Surveys in RI, L/H youth are more likely to attempt suicide in comparison with their White peers.[4,5]

The aim of this case report is to illustrate the application of a cultural approach when working with L/H families using the Socio-Cognitive Behavioral Therapy for Suicidal Behaviors (SCBT-SB), particularly regarding the strategies used with adolescent's caregivers. Integrating L/H caregivers into the treatment of adolescents with suicidal thoughts and/or behaviors (STB) is crucial for various reasons including assessing protective and risk factors at home, having caregivers as allies monitoring teen's symptoms, and putting in place a realistic safety plan with the family.[6] Additionally, families have their own struggles and having a child with STB increases their stress and can lead to feeling worried, anxious, or overwhelmed.[7]

L/H immigrant families face multiple challenges, including the acculturation process/stress, which includes adjusting to and adopting a new culture and language.[8,9] At the same time, families sometimes face the difficult task of keeping their own traditions and values (enculturation process). In this context, many immigrant caregivers stay close to their culture, while their children get more acculturated to the American culture. In many instances, adolescents become bicultural (identifying and valuing both cultures), which allows them to navigate both cultures fluently.[9]

TREATMENT APPROACH

The SCBT-SB is a treatment protocol that was developed in Puerto Rico with Puerto Rican youth.[10] Subsequently, it was expanded to L/H youth and their families living in the US through a pilot randomized clinical trial (RCT).[11,12] An RCT is currently in place testing the efficacy and effectiveness of the SCBT-SB (1R01MD013907, PI: Duarte-Velez). The SCBT-SB takes into consideration cultural, contextual, and social circumstances that influence STB in L/H adolescents. The SCBT-SB Core Module focuses on stabilization and providing basic skills to manage STB and includes individual, family, and caregiver sessions throughout nine visits. After finishing the Core Module, a participant can choose based on their needs which other modules they would like to complete next.[10] Each participant can select from nine different modules: Thoughts, Emotional regulation, Family communication, Activities, Social interaction, Trauma, Identity affirmation, and Substance use. Workbook manuals are supplied to teens and caregivers in their preferred language, English or Spanish, as part of the SCBT-SB. Treatment is provided through intense home-based services, which includes three to five hours of direct contact per week.

This article presents the case of one L/H youth with STB who participated in the RCT. The objective is to illustrate the process of addressing cultural considerations in SCBT-SB when working with L/H caregivers. Specifically, four of the core sessions conducted with the caregivers will be discussed: *Understanding the suicidal crisis*, *Raising children in different cultures*, *Parenting skills,* and *Family Communication*.

The first core session, *Understanding the suicidal crisis*, is a family intervention focused on getting to know the family, identifying possible barriers to treatment, learning the family story regarding the suicidal crisis, identifying social and contextual risk factors that need to be addressed, identifying family strengths and resources, and providing psychoeducation regarding the SCBT-SB conceptual approach to the

suicidal crisis and the teen's mental health. The clinician also reviews safety measures, prevention agreements, and develops a family emergency plan.

The session *Raising children in different cultures* was developed to foster empathy and rapport with L/H caregivers while trying to understand their personal stories. This session has the following objectives: assess the caregivers' values and expectations regarding child rearing during the adolescent phase; for immigrant caregivers, explore and discuss cultural differences between their country of origin and the US, including the caregiver's experiences growing up in a different country or with a different language; for non-immigrant families, explore and discuss the differences between the time in which they grew up and the present.

The *Parenting skills* session is aimed at exploring the caregiver's parenting styles and discussing effective parenting strategies. During the parenting skills session, the protocol's cultural and societal premises are discussed, as well as differences in parenting strategies by country (US vs. Country of Origin) or time period. The *Communication* session targets exploring communication patterns in the family and teaching basic communication skills with the purpose of increasing positive interactions between family members.

Table 1. Outcome variables teen report

Variables	Baseline	3 months	6 months
Suicide Attempts[13]	2	0	0
Suicide Ideation Questionnaire-JR[14, 15]	52	17	19
Children Depression Inventory CDI-2[16]	27	19	19

Note: SIQ-JR cut off point = severe suicidal ideation ≥ 31; CDI cut off point = severe depressive symptoms ≥ 19

Table 2. Family variables: teen and caregiver report

Variables	Teen		Mother	
	Baseline	6M	Baseline	6M
Open Communication Scale (OCS)[17]	21	32	41	46
General Family Functioning (GFF)[18]	79	71	57	34
Family Critic (FC)[19]	18	14	--	--

Note: OCS teen= ($\bar{x}$=29.80, SD= 10.08); OCS caregiver = ($\bar{x}$=36.38, SD=9.15); GFF = is a subscale of the Family Assessment Device and higher scores implies worst functioning; GFF teen= ($\bar{x}$=65.83, SD=10.50); GFF caregiver= ($\bar{x}$=59.76, SD=11.89); FC = ($\bar{x}$=20.21, SD=4.5)

CASE PRESENTATION

Ana (pseudonym) is a 16-year-old cis-gender woman, from a second-generation family (caregivers were born in a Latin American country and Ana in the US). Ana lived with both biological parents (Spanish-speaking only). Ana was fluent in both languages, but reported her preferred language as English. Her self-report questionnaires indicated a moderate to high identification with both cultures. For example, Ana highly identified with and valued the L/H culture and customs and felt proud of being Latina. She also reported that American values are part of her life and that she enjoys the language. Her mother reported higher connection with the L/H culture; however, she reported that she values the American culture as well and that it is very important for her to raise her children with both American and L/H culture and values. These reports highlight some differences in acculturation between Ana and her parents, particularly in their preferred languages. In addition, differences between Ana and her mother were found in the religious faith questionnaire. The mother had a high score while the teen had the lowest score on this scale. Self-report questionnaires (See **Table 2**) showed that Ana's mother at baseline had a more positive view of their communication compared to Ana. Similarly, in their self-report for the general family functioning, the mother reported a more positive view than Ana.

Ana had a history of one previous psychiatric hospitalization, STB, anxiety, depression, and post-traumatic stress disorder (PTSD) related to exposures to multiple traumatic events. Ana presented to the emergency department (ED) after a suicide attempt (SA) via overdose. The lethality of the SA required medical intervention, stabilization, and psychiatric inpatient hospitalization for two weeks. Ana presented with suicidal ideation and depressive symptoms in the severe range (See **Table 1**). Ana and her parents consented to participate in the study for their aftercare. Ana's clinical presentation was assessed at baseline, 3- and 6-month follow-up.

The parents demonstrated engagement in treatment, developed a positive rapport with the clinician, and showed willingness to learn how to support their teen throughout the therapy. Ana's parents participated in a total of 11 sessions after the intake, which included 7 caregiver sessions and 4 family sessions that included Ana and sometimes her siblings. Ana completed the Core and Thought Modules. Therapy was provided by a bilingual master's level mental health counselor trained in the SCBT-SB and supervised by the second author. Sessions with the parents were performed in Spanish. Joint sessions including the teen and siblings were conducted utilizing both languages; while the parents communicated in Spanish, the teen did so in English. Sometimes the teen was able to speak directly to her parents in Spanish, while other times she needed the clinician to translate for her.

CONTEXTUAL FACTORS

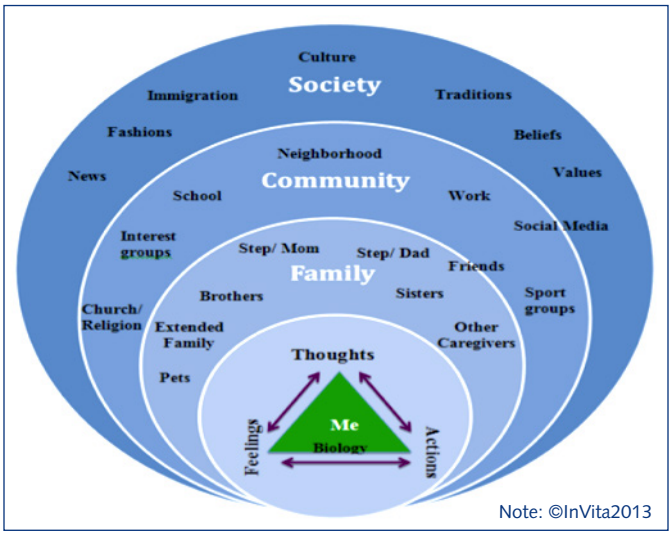
The patient experienced different stressful situations that included multiples exposures to community violence. Trauma symptoms contributed to maintaining the patient's avoidance of certain places, including school, and further complicated her depression. Consequently, Ana was struggling with academic performance and school attendance.

Directly working with the school was an additional part of the clinician's work. Another stressor that impacted Ana was that her religious beliefs were different from those of her parents. For example, Ana's parents used Biblical verses seemingly with the intention of encouraging her to do better and provide emotional support. However, this was seen by Ana as her parents trying to force their beliefs on her, which at times made her feel worse.

Family Session: Understanding the suicidal crisis

All family members (Ana, both parents, and siblings) participated in the first therapy session. This session provided an opportunity to explore how each family member experienced the patient's crisis, to promote a safe space for communication, and to generate a family safety plan. Therapy was discussed as a collaborative process in which everyone has a role and works together to support the teen. The psychoeducation around the SA as a crisis helped Ana's parents be more understanding. The SCBT-SB conceptual model (see **Figure 1**) was introduced by explaining the positive and negative factors in each level (individual, contextual, societal/cultural level) that may have had an impact on the teen, as well as on the family as a whole. For example, the stress around immigration, societal expectations and norms, violent events at school, and relationship issues, among others, were discussed.

Figure 1. Understanding the suicidal crisis: Socio-cognitive behavioral model



Caregiver Session: Raising children in different cultures

Motivations and barriers to engaging in treatment were initially explored with each caregiver with the purpose of addressing any resistances. Both parents were motivated, no significant barriers were identified, and they both actively participated in the session. They provided examples about themselves growing up in another country and commented on the differences in comparison to the US. The clinician built trust and rapport with Ana's caregivers by paying attention to their life experiences and showing appreciation for their culture. The exercise "walking in my teen's shoes" allowed Ana's parents to empathize with their teen's reality of being an adolescent in two different cultures and have a conversation with the clinician about realistic expectations for her. One of the differences they mentioned was the freedom and access to connect with neighbors and others, for example, "*in our country, kids go outside and play and here that does not happen that often*". Additionally, they recognized aspects of their culture they wanted to continue promoting in their family and started to contemplate areas that needed to change. Ana's parents decided that they wanted to ask more questions to allow her emotional expression, have more open conversations, and listen more.

Caregiver session: Parenting skills

During this session both parents participated and multiple topics were discussed, including parenting styles, examples of parenting skills, and popular ideas regarding gender roles. Both parents were very receptive and showed a willingness to learn more. They were able to identify that they work as a team and recognize how the way they grew up influences some aspects of their parenting. Both parents acknowledged that they could increase the way they provide warmth and support. This included identifying positive things about their teen to help their child's wellbeing. The SCBT-SB protocol includes a worksheet in which examples about parenting strategies are discussed. Ana's mother found this discussion very helpful, and both parents wanted to continue implementing these strategies at home.

Family Session: Communication

All family members (Ana, both parents, and siblings) participated. A perspective-taking exercise was done which helped in two different ways, the first being as an icebreaker activity which allowed everyone to participate in a creative way and alleviated some of the tension inherent in starting treatment. They all laughed and collaborated while completing the activity. Secondly, the exercise provided the opportunity to talk about having different perspectives and the importance of understanding the other person's point of view. During this session, family members identified their communication styles and practiced some assertive statements to share with each other while maintaining consideration for family values such as *respect* (the L/H value of showing special regard to adults).

Closing session: Exploring gains received from therapy

At the end of treatment, gains/progress made with therapy were assessed with both Ana and her parents. Caregivers reported feeling satisfied with the progress they made. They highlighted some improvements in Ana and as a family.

They mentioned that Ana was more involved in family activities and that she had begun to look happier and more hopeful. Parents reported that she was expressing more of her thoughts and points of view at home. Additionally, they reported how the family sessions had also helped Ana's siblings become more patient and understanding with the family. The mother expressed, *"you educated us and helped the whole family and we all learned"*, expressing that, for example, they learned how to identify the appropriate moment to talk and communicate with each other. Another aspect of the treatment that the mother reported as helpful was having a therapy manual for them, *"Having things written down helped me to review it on my own time and if I forgot something, I could go back and read what was in there"*. During the closing session, therapists encouraged the parents to continue validating Ana, understanding her perspective even though they may have different opinions. The therapist reviewed the safety plan and provided resources to the family, including an outpatient referral to continue working with Ana's depressive symptoms and trauma.

Follow-up assessment

At the follow-up assessment, Ana did not report any SA and showed significant improvement in her suicidal ideation in comparison to her baseline (See **Table 1**). In terms of depressive symptoms, there was some decrease, but at 6 months still fell under the severe range. Regarding family variables at the 6-month follow-up, a noticeable improvement in general family functioning (two standard deviation difference) was observed, according to the mother's report, and a slight improvement was reported from the teen's perspective. Likewise, mother-daughter open communication increased significantly, according to Ana's report, and according to the mother, it remained around the same, which was seen as positive. In the Family Critic Scale, Ana reported a decrease of nearly one standard deviation, which translates to less perceived family criticism at the 6-month follow-up.

DISCUSSION

Ana represented a complicated case due to her comorbidity, multiple traumatic experiences, history of STB, the severity of her depressive symptoms, and her academic difficulties. One of the strengths of this family was their parental involvement and willingness to provide support, which eventually translated into more participation in therapy and increased communication at home. Both the teen and the mother reported improvements in family variables, which may have been related to Ana's substantial reduction in suicidal ideation, and no further suicidal crisis. However, her multiple diagnoses, including her trauma impacting her academic performance, were still affecting her mood (depressive symptoms), requiring further treatment.

Psychoeducation with this family regarding trauma and depression was fundamental. This permitted the parents to be more understanding of Ana's situation and more engaged in providing support. This case illustrated how family willingness to learn more about how to support their child is important. The use of motivational interviewing at the beginning of the treatment with parents can help the therapist better understand their positionality regarding therapy. Paying attention to psychoeducation and motivation for treatment may help parents become more invested in their teen's treatment. Additionally, the family interventions with a cultural approach helped this family increase mutual understanding and communication at home.

CONCLUSION

Cultural considerations when working with immigrant families are essential for treatment success. This case provides an example of exploring the level of acculturation of both patient and caregivers. One way to explore acculturation in therapy is having a conversation about the differences and similarities they observe between the American and L/H culture and their values. Clinicians can directly explore with caregivers how connected they feel, or not, to the American culture and how this may be different between them and the way they see their teen. Exploring these cultural factors with L/H families can make some caregivers feel seen and heard and be a crucial part of establishing rapport. In addition, this case depicts the use of a specific treatment to address a suicide attempt. The treatment, developed in Puerto Rico and expanded to be used with L/H families in the US, employs a modular approach that allows the clinician to address core components initially and then can be tailored to the needs of the family and the patient. Use of this culturally relevant treatment holds promise for addressing the specific needs of L/H adolescents, a population at high risk for suicidal behavior.

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