Apoyar El Baile Multicultural (Supporting the Multicultural Dance): A Qualitative Study of Social Workers Treating Latina Adolescents with Suicidal Ideation and Behaviors

Samantha G. Schindelheim
University of Pennsylvania, sschind7@upenn.edu

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Abstract

Objective: This qualitative study explores the experiences of social workers who work with Latina adolescents with suicidal behaviors. Specifically, this work explores social workers’ knowledge and utilization of sociocultural risk and protective factors (e.g., level of acculturation) when engaging Latina adolescents in suicide risk assessments and safety planning. “Latinx/Latine” will be used throughout the dissertation to reference the entire Latinx/Latine community as well as for gender non-conforming adolescents, and where gender is not relevant, unknown, or nonspecific, whereas “Latina” will designate Latina cisgender females. Research over the past two decades has shown that Latina female adolescents have higher rates of suicidal ideation and attempts over time compared to non-Hispanic White, Black, and African American adolescent females (CDC, 2017, 2011; Price & Khubchandani, 2017; Romero et al., 2014; Silva & Van Orden, 2018) and are twice as likely to report suicidal ideation, prior suicidal plans, and suicide attempts compared to Latino male adolescents (Kann et al., 2018). Given the significance of suicidality among Latina adolescents, the study explores the understudied therapeutic relationship between Latina adolescents and their social workers to understand the facets that support therapeutic trust and risk assessments from the therapists’ perspectives when engaging in treatment to mitigate suicide risk.

Method: This study employed grounded theory methodology. The researcher used purposive, targeted, convenience, and snowball sampling to recruit 20 licensed social workers from outpatient mental health agencies in New York City. Participants each completed a single, in-depth, semi-structured interview about their therapeutic work engaging Latina adolescents and their parents in treatment for suicidality. The interview guide included questions and prompts addressing the following topics: social workers’ experiences treating Latina adolescents with suicidal behaviors; the understanding and use of Latinx/e sociocultural factors when assessing for suicide risk and safety planning including familismo, perceived as a factor that encourages keeping problems and concerns within the family (Steidel Lugo & Contreras, 2003); immigration and generational challenges; language barriers; perspectives on the significance of the therapeutic relationship; and training intervention needs. Interviews were transcribed verbatim for analysis. Using the constant comparative method, the researcher completed open coding to develop an iterative codebook, in addition to deductive coding using concepts from literature on suicidal behaviors for Latinx/e individuals and theoretical constructs surrounding Latinx/e beliefs and experiences regarding mental health and mental health care. The researcher worked with a qualitative methods expert and a content expert to analyze and synthesize data into findings.

Findings: Interview data supported the importance of social workers’ understanding of sociocultural factors in suicide treatment with Latina adolescents and their families. Specific factors identified by participants included the following: large acculturation gaps between the parent and adolescent; challenges acquiring independence and individual identity away from their family systems while balancing how autonomy looks for the family and the girls; pressure to embody the Latina female gender role; burden to create a better life than their immigrant parents; immigration status and discrimination; cultural and religious traditions values as protection; and family cohesion. Implicit biases were evident in all interviews and were not dependent on the participant’s self-identified race or ethnicity. These biases are highlighted by the researcher to increase contextual awareness viewpoints held in therapeutic care with Latina adolescents and their families. The primary importance of the social worker’s relationship with the adolescent, their parents or other family members, and the collective relationships with outside community members/providers involved in the adolescents’ lives contributed to effective treatment from the social worker’s point of view. The trusting, therapeutic role that bilingual and bicultural social workers...
hold due to their ability to grasp a deeper understanding of sociocultural factors was emphasized throughout the interviews as well. Engagement and effective care for Latina adolescent clients and their family members were aided by the following: utilizing relational growth strategies, including building trust and transparency around multiple identities in treatment; providing concrete therapeutic tools to both the adolescents and their family members such as teaching perspective-taking and increasing psychoeducation around suicide risk and safety planning; and social workers’ engagement in identity work outside of the therapeutic relationship.

Discussion: Sufficient trainings and a comprehensive understanding of Latinx/Latine sociocultural risk and protective impacts are necessary to effectively provide suicide treatment for Latina adolescents and to support their families. Findings speak to a significant gap in theoretical understandings of the clinical relationship in this context. Specifically, findings suggest elements that may flesh out the Ecodevelopmental Model including mental health treatment, the relationship with the social worker, and their knowledge of sociocultural factors to broaden a trajectory away from the Latina adolescent’s suicide attempt. Dominant cultural messaging about Latinx/e families and White-centered mental health practices that inform provider bias and approaches require ongoing analysis and discussions in order to increase engagement in growth-fostering therapeutic care for suicide risk.

Conclusion: This research finds several essential clinical needs for working with Latina adolescents exhibiting suicidal behaviors. These needs include the following: building a comprehensive sociocultural understanding of Latina adolescents that reduces biased assumptions of the girls and their families, the contexts they live in, and their immigration statuses; integrating family values and members into care; and building trust with cultural humility. It is essential to add to the knowledge base and minimize ongoing explicit and implicit bias of the mental health providers who serve this high-risk population in order to help Latina adolescents navigate and thrive in their complex multicultural worlds.

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Allison Werner-Lin, PhD, AM, EdM, LCSW

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Carolina Vélez-Grau, PhD, LCSW

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Apoyar El Baile Multicultural (Supporting the Multicultural Dance): A Qualitative Study of Social Workers Treating Latina Adolescents with Suicidal Ideation and Behaviors

Samantha Schindelheim, LCSW-R

A DISSERTATION

in

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Presented to the Faculties of the University of Pennsylvania

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Allison Werner-Lin, PhD, AM, EdM, LCSW
Supervisor of Dissertation

Sara S. Bachman, PhD
Dean, School of Social Policy and Practice

Dissertation Committee
Carolina Vélez-Grau, PhD, LCSW
ABSTRACT

Objective: This qualitative study explores the experiences of social workers who work with Latina adolescents with suicidal behaviors. Specifically, this work explores social workers’ knowledge and utilization of sociocultural risk and protective factors (e.g., level of acculturation) when engaging Latina adolescents in suicide risk assessments and safety planning.

“Latinx/Latine” will be used throughout the dissertation to reference the entire Latinx/Latine community as well as for gender non-conforming adolescents, and where gender is not relevant, unknown, or nonspecific, whereas “Latina” will designate Latina cisgender females. Research over the past two decades has shown that Latina female adolescents have higher rates of suicidal ideation and attempts over time compared to non-Hispanic White, Black, and African American adolescent females (CDC, 2017, 2011; Price & Khubchandani, 2017; Romero et al., 2014; Silva & Van Orden, 2018) and are twice as likely to report suicidal ideation, prior suicidal plans, and suicide attempts compared to Latino male adolescents (Kann et al., 2018). Given the significance of suicidality among Latina adolescents, the study explores the understudied therapeutic relationship between Latina adolescents and their social workers to understand the facets that support therapeutic trust and risk assessments from the therapists’ perspectives when engaging in treatment to mitigate suicide risk.

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treatment from the social worker’s point of view. The trusting, therapeutic role that bilingual and bicultural social workers hold due to their ability to grasp a deeper understanding of sociocultural factors was emphasized throughout the interviews as well. Engagement and effective care for Latina adolescent clients and their family members were aided by the following: utilizing relational growth strategies, including building trust and transparency around multiple identities in treatment; providing concrete therapeutic tools to both the adolescents and their family members such as teaching perspective-taking and increasing psychoeducation around suicide risk and safety planning; and social workers’ engagement in identity work outside of the therapeutic relationship.

Discussion: Sufficient trainings and a comprehensive understanding of Latinx/Latine sociocultural risk and protective impacts are necessary to effectively provide suicide treatment for Latina adolescents and to support their families. Findings speak to a significant gap in theoretical understandings of the clinical relationship in this context. Specifically, findings suggest elements that may flesh out the Ecodevelopmental Model including mental health treatment, the relationship with the social worker, and their knowledge of sociocultural factors to broaden a trajectory away from the Latina adolescent’s suicide attempt. Dominant cultural messaging about Latinx/e families and White-centered mental health practices that inform provider bias and approaches require ongoing analysis and discussions in order to increase engagement in growth-fostering therapeutic care for suicide risk.

Conclusion: This research finds several essential clinical needs for working with Latina adolescents exhibiting suicidal behaviors. These needs include the following: building a comprehensive sociocultural understanding of Latina adolescents that reduces biased assumptions of the girls and their families, the contexts they live in, and their immigration
statuses; integrating family values and members into care; and building trust with cultural humility. It is essential to add to the knowledge base and minimize ongoing explicit and implicit bias of the mental health providers who serve this high-risk population in order to help Latina adolescents navigate and thrive in their complex multicultural worlds.

*Keywords: Sociocultural factors, Latina/x adolescents, suicide, ecological theory, risk and protective factors, mental health providers, suicide interventions*
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DEDICATION

This dissertation is dedicated to all of the Latina adolescents and their families that I have worked with over the past 6 years. Thank you for opening your hearts and showing me the way you baile (dance) through some of the most painful experiences, leaping through your multiple cultures in both beautiful and dark ways. Your strengths to persevere are forever inspiring. It has been a privilege to help you dance. I also dedicate this work to all of the social workers who shared their stories of triumph and challenges treating Latina adolescents and their families and their quest to keep them safe. While this dissertation tried to bring deep meaning to your work, no words can really express the dedication, sacrifices, and brilliance you bring to the Latinx/Latine families you support.
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CHAPTER 1: INTRODUCTION

Problem Statement

Overview

Suicide, the act of intentionally ending one’s life, during adolescence is a significant public health concern (Centers for Disease Control (CDC), 2018; Lindsey et al., 2019; Nock et al., 2019). Suicide is currently the second most common cause of death among 10- to 24-year-olds in the United States (CDC, 2018; Lindsey et al., 2019) and adolescents have a higher risk of both recurrences of self-harm behaviors as well as suicide attempts following engagement in suicidal ideation and behaviors (Hawton & van Heeringen, 2009; Birtwistle et al., 2017). Suicide attempts and death dramatically increase during the transition to adolescence before decreasing during the transition from adolescence to adulthood (Nock et al., 2008; Nock et al., 2013). Mental health practitioners, primary care clinicians, and educators require intensive training in evidence-based practices to effectively manage suicidal behaviors including suicidal ideation, suicidal planning, and/or suicide attempts (Hawton et al., 2012; Witt et al., 2019).

Among the ethnic and racial populations of adolescents who have been researched over the past two decades up until 2017, research has shown that Latina female adolescents have higher rates of suicidal ideation and attempts over time compared to non-Hispanic White, Black, and African American adolescent females (CDC, 2017, 2011; Price & Khubchandani, 2017; Romero et al., 2014; Silva & Van Orden, 2018) and are twice as likely to report suicidal ideation, prior suicidal plans, and suicide attempts compared to Latino male adolescents (Kann et al., 2018). In 2017, 8.2% of Latina adolescents (N=2,796) reported a suicide attempt, which was higher than the national average of 7.4% (CDC, 2018) and in another study that surveyed adolescents from 2014 to 2015 found that one third of Latina adolescents required medical...
services following a suicide attempt (CDC, 2017). In a study of 76 Latina adolescents who had previously attempted suicide, findings revealed that two thirds of the adolescent participants had attempted suicide before and adolescents reportedly used a variety of methods often connected to items commonly found in their home to kill themselves (Hausmann-Stabile et al., 2012). Previous Youth Behavior Surveillance Surveys (YBS) revealed that Latinx/Latine students were the highest percentage group to attempt suicide compared to their Black and White non-Hispanic peers from 2009–2015, with a slight decrease from 2015–2017 before attempts increased again in the last few years (Ivy-Stephenson et al., 2020). Lindsey, Sheftall, Xiao, and Joe (2019) conducted logistic regression analyses of the Youth Risk Behavior Surveys from 1991 to 2017 and found that adolescent females from all racial and ethnic groups had a downward trend in suicide attempts aside from Black adolescent females.

In the last two YBS surveys in 2017 and 2019, Black female adolescents surpassed Latine/x adolescents as suicide attempts trended downward from 8.2% in 2017 to 8.9% while Black female adolescent suicide attempts rose from 9.8% in 2017 to 11.8% in 2019 (Ivy-Stephenson et al., 2020; Kann et al., 2018). It is unclear why we are seeing this trend and further research is needed to understand which specific factors have contributed to these changes. Further research needs to explore possible factors for this decrease as research has shown that seeking out mental health treatment is low and Latina adolescents receive less than adequate care (Stafford et al., 2019). It is also concerning that research on Latinx/Latine adolescents has decreased over the past decade. Furthermore, while the data is limited, suicidality among Latinx adolescents during the COVID-19 pandemic is of great concern and a recent study showed that emergency department encounters among female youth with suicidal thoughts or behaviors during the pandemic has greatly increased (Ridout et al., 2021; National Hispanic and Latino
MHTTC, 2021). In addition, the recent surgeon general report indicated that Latinx youth showed high rates of loneliness and mental health conditions during the COVID-19 pandemic from two recently published studies (Office of the Surgeon General, 2021; Flanagan et al., 2021; Rogers et al., 2021). This, along with the more recent change in trends for suicide attempts over the last couple of years among Latinx/Latine adolescents, indicates the ongoing need to understand what has been and can be helpful to decrease suicide risk for Latina adolescents.

The Importance of Focusing on Latina Adolescents with Suicidal Ideation and Behaviors

According to the 2021 US Census Bureau population estimate, there are 62.1 million Latine/x living in the United States making up 18.7% of the US total population and by 2060, it is projected that the Latinx/Latine population will reach 111 million and continue to grow (US Census Bureau, 2017). As the YRBS surveys indicate, Latina adolescents need increased support and the demand for trained clinicians working with Latina adolescents is growing. Theories such as Relational Cultural Theory as well as studies focused on the positive impact of the therapeutic relationship with adolescents (Ruiz, 2012; Jordan, 2013; Fernandez et al., 2016) and knowledge of mental health practitioners’ emphasis on building cultural humility and racial and ethnic awareness in their practice (Hook Davis et al., 2017) have focused attention on the positive impacts of a therapeutic relationship and in suicide treatment (Ibrahim et al., 2021). However, there is a major gap in knowledge around the tools and strategies that therapists utilize to engage and build relationships that serve to consider the impact of sociocultural risk and protective factors in suicide treatment, especially for Latina adolescents. Given Latinx/Latine youth’s unique needs and experiences, such as cultural dissonance, immigration, and differing levels of acculturation, we must better understand therapeutic approaches to support and strengthen these challenging factors that can lead to suicide risk.
The literature has also shown that despite the fact that risk assessments and safety plans mitigate suicide risk (Stanley & Brown, 2012; Stanley et al., 2018) and the use of culturally competent suicide risk assessments has an associated decrease in suicidal behaviors (Chu et al., 2017), there is minimal understanding about the ways in which mental health practitioners interpret and utilize knowledge of sociocultural factors when completing suicide risk assessments and safety plans with Latina adolescents with suicidal ideation and attempts, their multiple intersectional identities (e.g., gender, ethnicity, skin color, sexual orientation, and socioeconomic class) and how this impacts the therapeutic relationship. Thus, therapeutic interventions must also focus on working with the Latina adolescent and their caregivers on ensuring their safety through risk assessments and safety planning to prevent future suicidal behaviors in culturally attuned ways. In addition, it is important to understand the quality of the therapeutic relationship between Latina adolescents, their families, and their providers as this can serve as a significant mitigator in the trajectory toward a suicide attempt, especially when providers are socioculturally attuned to the Latina adolescents’ experiences navigating their multicultural worlds (Antshel, 2002; Falicov, 2013).

*Sociocultural Factors and Their Impact on the Therapeutic Relationship: Bringing Them to the Forefront of Mental Health Treatment*

Sociocultural factors play a major role in the association between increased risk and engagement in suicidal behaviors for Latina adolescents. Lower levels of mother-daughter mutuality and connectedness (Baumann et al., 2010; Zayas et al., 2010; Piña-Watson et al., 2014), conflicting levels of acculturation (Zayas et al., 2005), familism and family environment type (Peña et al., 2011), detainment or deportation of a family member (Roche et al., 2020), and ethnic discrimination (Duarté-Vélez & Bernal, 2008; Vargas et al., 2021) are associated with an
increase in suicidal behaviors among Latina adolescents. The Ecodevelopmental model, also known as the Sociocultural Model of Suicide (Zayas, 2005, 2011), and Relational Cultural Theory (Jordan, 2018) are important conceptual frameworks for understanding the ways in which multiple social, ecological, familial, and cultural factors of Latina adolescents’ environments interact and how system variants increase their vulnerability to engage in suicidal behaviors. It seems prudent that for conceptualizing and carrying out culturally attuned treatment interventions, clinicians will need to focus on multiple intersecting factors within the ecological system layers, the adolescent’s interpersonal traits, and the clinician and adolescent/family relationship, which these theories can help to substantiate.

Much of the research on Latina adolescents who engage in suicidal ideation and behaviors has focused on exploring multicultural factors through qualitative interviews with adolescents and their caregivers about the youth’s suicide attempts (Szlyk et al., 2019; Gulbas & Zayas, 2015; Gulbas et al., 2015; Gulbas, et al., 2011; Gulbas et al., 2019), quantitative studies analyzing data on their suicidal behaviors (Price & Khubchandani, 2017; Cervantes et al., 2014; Bauman et al., 2010), and through only one culturally attuned treatment intervention (Duarté-Vélez et al., 2016).

There is minimal research on suicide treatment, risk assessments or safety planning among Latina adolescents, their families, and their providers as the majority of studies in this context have focused on White adolescents (Hallfors et al., 2006; Horowitz et al., 2012, Brent et. al, 2009). While evidence-based practices for minority suicidal youth exist (Duarté-Vélez et al., 2016, Rotheram-Borus et al., 2000; Germán et al., 2015), many psychological treatments are still not informed by intersecting identity factors including gender, culture, immigration, racism, and language (APA, 2017). Additionally, Latina adolescents are less likely than White female
adolescents to receive mental health treatment (Garland et al., 2005) and barriers to treatment are often due to a number of sociocultural related factors including stigma of mental health treatment, providers’ failures to consider cultural factors, lack of culturally informed treatment practices, family members’ immigration statuses, and economic challenges (Comas-Díaz, 2019). Less is known about the providers’ perceived barriers and facilitators within the relationship with the suicidal Latina adolescents and their families. Therefore, it would be important to understand the extent to and ways in which providers engage Latina adolescents with suicidal ideation and behaviors through a sociocultural lens and how they incorporate sociocultural risk and protective factors when assessing for suicide risk and safety planning to prevent future suicidal behaviors.

In order to address these gaps in the literature and more effectively bridge research and practice, it is essential to understand how clinicians choose and consider sociocultural risk and protective factors in assessing suicide risk and safety planning for Latina adolescents. Furthermore, as there are more clinically trained social workers (over 200,000) than psychiatrists, psychologists, and psychiatric nurses combined (National Association of Social Workers [NASW], n.d.), it is imperative that we turn to this profession to best understand how they are serving Latina adolescents’ mental health needs. Comprehending social workers’ perceptions and use of culturally humble practices and an understanding of their own social location in the therapeutic relationship to mitigate suicide risk can provide meaningful insight around ways to best support Latina adolescents and their caregivers, navigate complex family dynamics, incorporate Latina adolescents’ multiple identities in treatment, and maintain the importance of the clinical relationship. Lastly, an understanding of the types of supports clinicians need to better equip them to attend to the sociocultural needs of the Latina adolescents with suicidality is essential to support these youth.
Research Questions

The current study seeks to examine the research gaps by asking the following questions of social workers working with Latina adolescents with a history of suicidal behaviors:

- In what ways do social workers consider the sociocultural experiences of Latina adolescents and their families in suicide risk assessment and safety planning?
  - How does the therapeutic relationship attend to sociocultural factors when engaging suicidal Latina adolescents and their families?

- What sociocultural risk (e.g., acculturation gap, immigration, cultural stigma of mental health) and protective factors (e.g., family cohesion, religion) are perceived by practitioners as strengths and barriers to interventions when assessing suicidal risk and safety planning with Latina adolescents?

- What are the sociocultural learning/training needs of social workers treating Latina adolescents and their families with suicidal ideation and/or behaviors?
CHAPTER 2: REVIEW OF LITERATURE

The Epidemiology of Latina Adolescent Suicidal Ideation and Behaviors

An Introduction to Suicidal Risk

The second leading cause of death among 15- to 29-year-olds in the United States is suicide (Centers for Disease Control and Prevention [CDC], 2018) and over the last two decades, Latina female adolescents have been shown to have higher rates of suicidal ideation and attempts compared to non-Hispanic White, Black, and African American adolescent females (CDC, 2017, 2012; Price & Khubchandani, 2017; Romero et al., 2014). “Latinx/Latine” will be used throughout the dissertation to reference the entire Latinx/Latine community as well as for gender non-conforming adolescents, and where gender is not relevant, unknown, or nonspecific. “Latina” will designate Latina cisgender females (del Río-González, 2021). Hispanics have Spanish heritage, often from countries such as Spain and “Hispanic” focuses more on the colonial Spanish nation as opposed to the people of Latin America. Thus, in order to represent individuals with ancestry in Latina America, it is essential to recognize that Latinx/Latine is not monolithic and researchers must consider the differences of origins both within and between groups through multiple cultural frameworks and intersectionalities (Torres et al., 2018).

The most recent Youth Risk Behavior Surveillance Survey (YRBS), which collects data on nationally representative samples of public and private school students in grades 9 through 12, found that Latina adolescents in the United States repeatedly had the highest number of students who attempted suicide from 2009–2015, with a slight decrease between 2015 and 2017 before increasing again in the last few years (Ivy-Stephenson et al., 2020). US-born Latinx/Latine adolescents are more likely to attempt suicide than foreign-born Latinx/Latine adolescents (Fortuna et al., 2007; Borges et al., 2012) and while the Latinx/Latine population
within the United States is heterogenous, individual ethnic group differences have not been well researched. The Latinx/Latine population is growing within the United States and projected to comprise 29% of the total US population by 2060 (US Census Bureau, 2017), thus there is an essential need to focus on supporting adolescent Latina girls who identify within this growing ethnic group.

Suicidal behaviors can be categorized into three groups: suicidal ideation (thoughts about the desire and method for death by suicide), suicide planning (the development of a specific method through which a person has some intent to end one’s life), and suicide attempt (engaged in potentially self-injurious behaviors with either explicit or implicit intent to die) (Oquendo et al., 2003, O’Carroll et al., 1996; Silverman et al., 2007). Research focused primarily on suicide attempts, sometimes with attention to adolescents who made multiple attempts, and the methods for death by suicide. For example, Price and Khubchandani (2017) analyzed data from the YRBS from 2001 to 2013, and found that Latina adolescents were most likely to engage in death by suicide by suffocation (66.6%), poisonings (13.8%), and guns (12.5%). A mixed-methods study conducted with 76 Latina girls between the ages of 11 and 19 from the New York City metropolitan area who had previously attempted suicide found that the most common method for attempting suicide among the participants was through means found in their home, including cutting with items such as knives, pieces of glass, and nail files (42.1%), and overdosing with over-the-counter or prescribed medications (36.8%; Haussmann-Stabile et al., 2012). Out of all the participants, 61.7% presented with previous suicide attempts, highlighting the importance of understanding how to work with families to increase safety after an attempt and furthering the need to understand how mental health providers manage the safety of Latina adolescents in their homes after disclosure of the attempt.
Research shows that Latina adolescents have risk factors for suicide similar to adolescent peers of other ethnic and racial backgrounds. Family history of suicide, history of child abuse, mental illness (e.g., depression), alcohol and drug abuse and family history of drug abuse, previous suicide attempt history, poor academic functioning, and bullying are all associated with increased risk of suicide for Latina adolescents (Romero et al., 2018; Romero et al., 2013; Cervantes et al., 2014, Canino & Roberts, 2001). In addition to these main risk factors, there is a growing body of research that points to sociocultural factors, which impact the risk and resiliency of the Latina adolescent population, particularly factors that pertain to the family system. Lower levels of mother-daughter mutuality and connectedness (Baumann et al., 2010; Zayas et al., 2009; Pina-Watson et al., 2014), conflicting levels of acculturation (Zayas et al., 2005) between more acculturated youth and their less acculturated parents, contrasting perceptions of familism and family environment type (Peña et al., 2011), detainment or deportation of a family member (Roche et al., 2020), and ethnic discrimination (Duarté-Vélez & Bernal, 2008) have all been shown to increase suicidal behaviors among Latina adolescents.

**Sociocultural Influences: Familism and Parent/Teen Relationships**

Familism is a well-researched cultural value among Latinx/Latine communities defined as the idea that the family’s needs take precedence over individual necessities and beliefs, family members should maintain strong emotional bonds and be involved in each other’s daily life, and they hold a duty to protect the family’s honor and name (Lugo Steidel & Contreras, 2003). There are known specific gender differences within Latinx/Latine households as Latinas are more commonly known to be more pressed to be family oriented, passive, responsible to family obligations, maternal, and self-sacrificial (Zayas, 2011). Outside their homes they often follow different cultural prescriptions to align more with their acculturated peers to fit in. This has
shown to create more familial discord when the Latina adolescent does not follow the typical
Latina gender role and strives for autonomy and sexual independence (Szlyk et al., 2019; Zayas,
2011). This suggests that there is a cumulative model of risk for Latina adolescents and unique
experiences of what it means to be a Latina in the United States.

From 2005–2009, researchers gave more attention to the phenomenon of Latina
adolescents, their families, and suicidality. Zayas, Gulbas, Fedoravicius, and Cabassa (2010)
explored the high rate of suicide attempts among Latina adolescents in New York City through a
mixed-methods study assessing and interviewing 232 Latina youth and their parents (n=122
Latina adolescents who had made at least one suicide attempt within six months before the study;
n=110 Latina adolescents who had no history of suicide attempts). Seventy-two percent of the
girls were second generation (See Table 1) and the majority of mothers (76%) and fathers (81%)
were born outside of the United States. The girls self-identified as Dominican (28%), Puerto
Rican (35%), Mexican (12%), Colombian (10%), Ecuadorean (4%), Guatemalan (1%), and
multiple Latinx/Latine groups or both American and part of a Hispanic/Latinx/Latine subgroup
(7%). Identifying the young women’s heritages was a major strength of this study given that the
research on Latina adolescents tends to focus more on categorizing the group as “Latina” while
ignoring the multiple identities, distinct cultural factors, and nuances across Latinx/Latine
groups, and the research also tends to concentrate on making global assumptions through
“othering,” or “that process which serves to mark and name those thought to be different from
oneself” (Weis, 1995, p. 18).

Zayas and colleagues used questionnaires and in-depth qualitative interviews to reveal a
variety of patterns among both groups (those who attempted vs. those who had not). The authors
found that Latinas who had attempted suicide rated their families as less cohesive than did non-
attempters while Latinas with no attempt histories had higher ratings for mutuality with their mothers (Zayas et al., 2010). The findings also revealed that the adolescents who attempted suicide were not receiving the level of affection or support they needed from their parents and that communication was weaker with their parents, compared with the girls without attempt histories. In contrast, the parent responses showed that mothers viewed mutuality with their daughters who had attempted much stronger than their daughters did (Zayas et al., 2010), hinting that the significant relational and generational gaps often led to conflict, and it has been theorized that types of relationships can also lead to the Latina adolescent’s decision to attempt suicide (Zayas et al., 2005). The comparison of differences in mean scores of mother/daughter perceived conflict revealed that adolescents who attempted suicide had a much wider difference score in comparison to the difference score between adolescents who did not attempt suicide and their mothers.

Other relevant findings from Zayas et al. (2010) identified that girls with suicide attempts had higher levels of internalized distress than girls who did not attempt, and the parents of the Latina adolescents who attempted suicide revealed perceptions of increased depression and somatization among their daughters. This study provided significant contributions related to the importance of communication with parents and the development of an increased sense of self among Latina adolescents, and suggests that improvement in relationships between Latina adolescents and their parents could buffer the possibility of a suicide attempt. Despite the ecological theoretical frame of Zayas’s theory, this study did not address the relational role of mental health providers for the girls who were receiving treatment during the study, which is another dimension in the ecology of the adolescent, which could also be a significant buffer for suicidal behaviors. Understanding the knowledge and strategies used by mental health providers
to support Latina adolescents and their parents by fostering mutuality, cohesion, and sense of self both individually and within the parent-adolescent relationship would be an important next step in the research. Thus, this study fills in this gap by potentially adding an unexplained domain to the theory-the role of the mental health clinician and how this relationship may or may not add to the Latina adolescents with suicide ideation or histories of suicide attempts’ collective support networks. The therapeutic relationship can also shed light on the clinician’s understanding of Latinx/Latine sociocultural risk and protective factors as a relational growth strategy, or one that drives us to “grow through and toward connection” as their knowledge has the potential to foster deeper meaning and strength for these young women (Jordan, 2018, p. 3).

*Familismo* or familism and the family environment type are other factors that serve as suicide risk mitigators among the Latina adolescent population (Zayas, 2011; Peña et al., 2011). Peña et al. (2011) used latent class analysis to study the relationship between familism and family environment type (the combination of family cohesion and conflict) and suicide attempts among Latina adolescents who had attempted suicide (*n*=109) compared to Latina adolescents with no history of past attempts (*n*=107) in New York City. The girls identified as Puerto Rican (35.7%), Dominican (29.6%), Mexican (10.2%), Colombian (10.2%), and Other (14.4%). Tight-knit families where high cohesion and low conflict were evident were significantly less likely to have an adolescent attempt compared to intermediate-knit families or loose-knit families. Familism increased the likelihood of being in a tight-knit family unit compared to the loose-knit family (e.g., low cohesion and high conflict) suggesting that familism may protect against suicide behaviors among Latinas. Given that family interventions are highly recommended when working with Latinx/Latine populations (Cervantes et al., 2014) and that the family is an essential part of the Latina adolescent’s life, it would be helpful to understand how treatment
providers foster and facilitate healthy relationships. It would also be helpful to understand how they may impede the relationship because they may be more acculturated to the American values of independence within the family system while working with distinct family environments.

Another study examined the association between Latina adolescents’ perceptions of mother connectedness, father connectedness, parental caring, autonomy granting from their parents, and parental interest in their child’s school life and suicidal ideation (Piña-Watson et al., 2014). They utilized a sample of 345 Latina adolescents from the National Longitudinal Study of Adult and Adolescent Health (AddHealth) (54.7% Mexican, 15.6% Puerto Rican, 11.5% Central/South American, 4.7% Cuban, 5.3% Chicano, 12.9% Other Latina American countries) and found that high perceived mother connectedness, father connectedness, parental caring, and academic interest were all associated with decreased risk of suicidal ideation. Location of birth (US vs. Latin America) was a strong predictor of suicidal behavior, which is in line with other studies. The acculturation gap, defined as first generation parents adapting to a new culture at different rates from their children, leads to intergenerational differences in cultural values (Phinney et al., 2000; see Figure 1), and intergenerational family conflicts (Zayas, 2011; Phinney et al., 2000). Piña-Watson et al. (2014) suggest that caregivers who are able to communicate effectively and connect with their Latina adolescent children even when symptoms of depression are present can mitigate the risk of suicide (Piña-Watson et al., 2014). Given that there were multiple countries of origin represented in this study, it would have been important to compare the data within each origin group in order to identify any specific distinctions. Immigration journeys and country of origin histories differ significantly, an aspect that this dissertation hoped to explore more by identifying the different Latinx/Latine ethnic groups being treated and the distinct and/or similar experiences of ethnically diverse Latinx/Latine adolescents.
Lastly, a recent study looked at data from the 2019 New Mexico Youth Risk and Resiliency Survey to identify whether relationships that New Mexican Latinx/Latine adolescents hold with adults influenced suicide attempts (Hall et al., 2021). The authors found that as positive relationships with adults at home or in the community increased for both Latinx/Latine boys and girls, the probability of attempting suicide decreased by 27–54%. In addition, positive relationships with same-age friends also showed reduced suicide attempts. One significant limitation of the study was that the survey did not specify the types of different adults in the community or at home, which can be an essential factor in determining which adults may be more protective against suicide. However, it is helpful knowing the impact that positive relationships hold for Latinx/Latine adolescents both at home and within their communities.

**Sociocultural Influences: Immigration and Discrimination**

<table>
<thead>
<tr>
<th>Immigration Generation Status</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Generation</td>
<td>Individuals who immigrate to a new country before or during their early teens.</td>
</tr>
<tr>
<td>Second Generation</td>
<td>Children born in the US to immigrants to at least one immigrant parent.</td>
</tr>
<tr>
<td>Third Generation</td>
<td>Those who have both US born parents, but one or more foreign-born grandparents.</td>
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</tbody>
</table>
Other family and cultural-related stressors that are associated with Latina adolescents’ mental health problems, particularly suicidality, is the current or recent detainment or deportation of a family member. Roche and colleagues (2020) studied the effects of immigration policy changes during the Trump administration by collecting survey data from 547 randomly selected Latinx/Latine adolescents. US-born adolescents comprised 88.1% of the study sample and their parents’ countries of origin were Mexico (45.2%), countries in Central America (12.1%), South America (12.2%), other Latin American countries (did not define specific countries; 6.8%), or non-Latina American countries (2.7%). Data was analyzed using multivariable, multivariate logistic models to examine how family member detention or deportation over the last 12 months was associated with changes in suicidal ideation, alcohol use, and clinical externalizing symptoms. Initial mental health and risk behaviors were statistically controlled. The authors found that among the 136 adolescents surveyed who had a family member detained or deported within the last year, there was a higher likelihood of suicidal ideation (Roche et al., 2020). In another recent study, Roche and colleagues (2021) found that psychological worry and behavioral withdrawal were common responses to immigration actions and news, and they are shown to be significantly greater among adolescents with parents who were foreign-born in comparison to US-born parents. This was also the case among adolescents with undocumented, Temporary Protected Status (TPS) or permanent resident parents in comparison to parents with documented citizen status. Their responses were associated with higher levels of adolescent internalizing and externalizing symptoms, and with higher likelihood of substance use, depressive symptoms, and suicidal ideation.

Madubata, Spivey, Alvarez, Beblett, and Prinstein (2021) studied the effects of racial and ethnic discrimination in both overt and subtle forms among African American (n=85) and
Latinx/Latine youth \((n=73)\). They found that subtle and ambiguous forms of discrimination were concurrently associated with suicidal ideation among both African American and Latinx/Latine youth. Another study authored by Vargas, Calderon, Beam, Cespedes-Knadle, and Huey (2021) surveyed 390 Latinx/Latine adolescents (50% female) attending a high school in Southern California to assess for suicidality, depressive symptoms, and perceived discrimination. They found that discrimination was significant beyond depressive symptoms, as these variables were associated with increased suicidality among Latinx/Latine adolescents and the discrimination-suicidality associated was stronger for Latinas than Latinos. The authors also hypothesized that Latinas may be more affected by discrimination due to experiencing marginalization from their multiple intersectionalities (e.g., gender and ethnicity). Given the ongoing complexities and changes within immigration policies in the United States, the consistent growth of this ethnic group in the United States—by 2060, the Latinx/Latine population will reach 111 million and continue to grow (US Census Bureau, 2017)—and the continuing risks of suicidality among Latina adolescents, it is important that research continues to focus on factors that are associated with increased risk of suicide along with providers’ awareness of the ways in which immigration and migration history, discrimination, and immigration policies impact Latinx/Latine families.

**Unique Contributions of Qualitative Studies**

While quantitative data can assist in understanding risk factors based on surveys and other methodological measurements, qualitative studies have the unique ability to capture the sociocultural interactional elements that form the pathways of the Latina adolescent’s suicide attempt and answer questions around the relationship between the social worker and the Latina adolescent, which have not been explored before.
Understanding the Relational and Psychological Influences of the Suicide Attempt

As mentioned previously, Zayas, Gulbas, Fedoravicius, and Cabassa (2010) conducted a large mixed-method study with Latina adolescents and their parents to understand the phenomenology of suicide attempts. Gulbas and Zayas (2010) analyzed 10 qualitative interviews from the larger study with Latina adolescents who had previously attempted suicide and compared them to 10 Latina adolescents who had not attempted suicide. Each group’s parent interviews were also examined. The overall goal was to understand why the girls attempted suicide when experiencing similar cultural challenges of managing within a bicultural world and the familial factors that serve as protective or risk factors. One limitation of the study was that the intensity of maximum variation of sampling of interviews was selected by the authors in order to capture the most detailed information about the adolescents’ attempts.

The authors found that the adolescents who had previously attempted suicide had more subjective distress (e.g., distress from poor academic performance, conflict from familial academic ideals, physical or sexual abuse, witnessing domestic violence); they revealed conflicting perceptions about their roles, duties, and obligations among family members; and they experienced emotional isolation and loneliness that increased familial tensions (Zayas et al., 2010; Gulbas & Zayas, 2015). Adolescent Latinas with no history of suicide attempts appeared to be more capable of utilizing social and familial resources that equalize the interpersonal challenges. The authors theorized from their findings that the adolescent Latinas with a history of attempting suicide did not have the support from peers or other adults (e.g., school counselor) to balance out their lack of relational connections with family and/or friends and thus resorted to escaping their distress by making an attempt, further emphasizing the importance of building the therapeutic alliance for Latina youth. Falicov (1998) has shown that individuals within
Latinx/Latine families experience psychological processes relationally, supporting the idea that the process toward a suicide attempt is not just an individual process, but where multiple relational layers exist and must be worked on in order to mitigate the risk. Thus, there are multiple points of entry to intervene for mitigating the suicide risk.

Gulbas et al. (2011) also studied the qualitative interview data from the larger mixed-method project described previously (Zaya et al., 2010) to better understand the organization of family relationships among 24 Latina adolescents (12=with history of attempting suicide and 12=without history) through analysis of the family style categories: reciprocity, asymmetry, and detachment. The majority of adolescents with no history of suicide defined their family relationships as reciprocal in that “they engaged in practices in which each individual contributes to the overall functioning of the family” (Gulbas et al., 2011, p. 319). The largest number of families in this study fell within the asymmetrical relational category, which was described as the presence of one family member who provides the most support and attention to other family members without reciprocation from the other members. All the families that fell into the detached relationships included adolescents who had attempted suicide (Gulbas et al., 2011). Detached relationships were characterized by a lack of commitment and respect by all family members, and physical abuse by family members was revealed. The families in the study viewed the attempts as attention-seeking behaviors or a way to harm the family, resulting in disbelief and anger from the parents and continuing the patterns of disconnection (Gulbas et al., 2011).

Gulbas and colleagues’ study shows the clear divide between families who use reciprocal parenting structures to foster their adolescent’s contributions to the family system as opposed to ignoring their role within the household. An important factor that is worth exploring is the family’s perceived value levels of marianismo (a Latina female gender role that emphasizes
purity and strength) and machismo (a Latino male gender role that emphasizes masculinity and masculine pride), as both cultural characterizations may further shape the family’s relational styles and contribute to protective or risk factors. As consistent in past literature, the study by Gulbas et al. (2011) demonstrated that family tensions often exasperate suicidal behaviors among Latinas, and it makes important recommendations that therapy with Latina adolescents and their parents should focus on supporting interdependent decision making and use the family relational categories to make informed recommendations that also encompass commonly found Latinx/Latine cultural values such as respeto and personalismo.

Latina Adolescents’ Experiences with Mental Healthcare

Zayas and colleagues’ original mixed-method project also examined the treatment narratives of 68 Latina adolescents with a history of suicide attempts (Hausmann-Stabile et al., 2017). The participants were currently or previously engaged in outpatient mental health treatment (n=47), inpatient psychiatric services (n=17), inpatient medical treatment (n=2), or outpatient pediatric care (n=2). The findings revealed four factors that were central to the discussion about patient outcomes: the pathways to services and treatments after a suicide attempt, positive experiences of care, negative experiences of care, and communication in clinical services. Regarding pathways to treatment, adults, peers, or the adolescents themselves engaged in services after the suicide attempt. Adults, which included relatives along with school and medical staff who came in contact with the adolescents, initiated the majority of request for services (72.1%), which mostly happened following the discovery of evidence of an attempt (e.g., cut marks). Positive experiences with care among the Latina adolescents in inpatient psychiatric hospitals involved helping the adolescents reduce the mental illness stigma associated with suicidal thoughts and behaviors as well as relating the “everyday experiences” that led to
the suicidal behaviors (Haussman-Stabile et al., 2017, p. 4). In outpatient mental health services, providers normalized their experiences, fostered agency, and improved family interactions. More than half of the participants expressed negative experiences regarding their care, which was predominantly related to mismatches in expectations of the care perceptions and what was provided, stigma associated with receiving psychiatric care, and feelings of isolation and the inability to have a voice in their treatment (Haussman-Stabile et al., 2017). This is an essential finding that needs to be explored further through this dissertation as we need to understand why and what contributes to them having these negative experiences.

Haussman-Stabile et al. (2017) demonstrate the essential need to understand how sociocultural factors impact engagement in mental health care and the importance of conceptualizing cultural perspectives of mental health treatment of suicidal behaviors. This dissertation seeks to understand providers’ sociocultural conceptualizations of care for Latina adolescents when they are at high risk of suicide with a primary goal of providing insight and recommendations for the considerations of sociocultural factors in care with Latina adolescents and their family members. Clinical strategies that were beneficial to the Latina adolescents’ positive growth in treatment were identified as those that increased the adolescents’ feelings of connections with their providers, which nullified feelings of loneliness and isolation and improved communication with their family members. While this study provides important information about the barriers and facilitators to mental healthcare with Latina adolescents, the voice of the mental health providers working with Latina adolescents and their family members was absent. The mental health providers’ perspectives on their therapeutic relationships with Latina adolescents and their families are an important aspect of the well-being of Latinas and can be crucial in mitigating suicidal risk. It is particularly important for the Latina youth population
because of their high risk of suicide attempts, the lack of treatment interventions developed particularly for them, and the cultural, relational, and developmental aspects that lead Latinas toward an attempt. Thus, a key component can be how clinicians intervene. Clinicians must also consider how the sociocultural variables at play foster safety and socioemotional strengths to engage the teens and their family members in their treatment. This dissertation will incorporate the missing voices of social workers in order to learn how to improve interventions and care for this vulnerable group, adding a much-needed component to the ecological framework of suicide among Latina adolescents as it can add a deeper understanding of the components of therapeutic relational factors that can or cannot mitigate the attempt. This research has the unique potential to be able to apply mental health relationships and the understanding and utilization of Latinx/Latine sociocultural factors for future interventions and research.

**Suicide Intervention Research**

*Suicide Risk Assessments*

Suicide risk assessments that are commonly used in mental health treatment settings with adolescents include the Columbia-Suicide Severity Rating Scale (C-SSRS; Posner et al., 2008), the Ask Suicide Screening Questions (ASQ; Horowitz et al., 2012), and the Suicidal Ideation Questionnaire (SIQ-JR; Reynolds, 1987). While the assessments have been validated and proven reliable across many studies (Horwitz et al., 2015; Reynolds & Mazza, 1999; Horowitz et al., 2012), none of the questions in assessments pertain to cultural risk or protective factors. There is only one assessment, to the researcher’s knowledge, that integrates cultural risk factors (Chu et al., 2010). This is true despite research emphasizing the importance of incorporating culturally competent suicide risk management given that there are many cultural risk factors across race and ethnicities that can contribute to suicidal behaviors (e.g., family conflict, minority stress,
stigma around mental health treatment and suicide, and different expression of suicidal distress). The Cultural Theory and Model of Suicide (Chu et al., 2010) was one of the first comprehensive frameworks that provided an understanding about how culture can influence suicide risk across multiple cultural identities. The Cultural Assessment of Risk for Suicide (CARS), which grew out of the model, is a 39-item self-report measure that assesses culturally specific suicide risk factors (Chu et al., 2013). Based on the model, four core constructs were measured: cultural sanctions (cultural messages about the acceptability of triggers for suicide and suicidal behavior); idioms of distress (culturally influenced displays of psychological distress that influence the way in which the suicidal behaviors are addressed); minority stress (added stress that individuals in minority cultural groups experience, which makes coping more challenging); and social discord (interpersonal problems within one’s support system) (Chu et al., 2013).

The Cultural Theory and Model of Suicide provides a theoretical explanation about how culture influences a person’s decision to attempt suicide (Chu et al., 2010). CARS uses eight subscales to assess the four constructs including Family Conflict and Social Support, Sexual Minority Stress, Acculturative Stress, Nonspecific Minority Stress, Idioms of Distress-Emotional/Somatic, Idioms of Distress-Suicidal Actions, and Cultural Sanctions. Chu, Hoeflein, Goldblum, Bongar, Heyne, and Gadinsky (2017) published their culturally informed approach using the CARS with an Asian American veteran trans woman and detailed how discriminatory events were direct triggers of suicidal ideation and required problem solving and emotional processing of the discrimination with her provider to manage the suicide risk. The authors also emphasized the importance of considering multiple variations of the four constructs within specific cultures and the need to individualize risk assessments and safety planning for each dimension of an individual’s identity. The validity and reliability of the measure were tested in a
study with 950 adults (19.1% Hispanic/Latinx/Latine). The researchers found that the assessment demonstrated good internal consistency, convergent validity with scores on other suicide-related measures, and an ability to discriminate between participants with a history of suicide attempts vs. participants without (Chu et al., 2013).

While there is no documented validation or reliability of the CARS for adolescents or Latinx/Latine adolescents to this author’s knowledge, there are clear implications and concrete examples from the research that mental health providers can incorporate into care in order to support Latina adolescents demonstrating suicidal behaviors. Some practices to incorporate include thinking about cultural idioms of distress and the unique triggers based on knowledge of Latina risk factors, and recommending culturally appropriate coping strategies. The model would benefit from measures that focus on specific cultural and ethnic groups to identify explicit sociocultural constructs that may be missing from a more generalizable model.

In addition to the CARS measure, other researchers have provided guidelines on the utilization of culturally competent suicide risk assessments, which include incorporating ethnic minorities into the standardization of suicide assessments, increasing awareness of the differences in cultures to disclose suicidal thoughts and behaviors due to stigma and judgment, recognition of various cultural groups, considering cultural issues when assessing suicidal ideation and behaviors, and acute awareness to culturally-specific risk and protective factors along with attitudes related to the acceptability of completing suicide (Westefeld et al., 2008; Alonzo & Gearing, 2013). The below recommendations are important to consider when thinking about how mental health providers incorporate sociocultural factors into the risk assessment with Latina adolescents as well as which specific factors are more likely to be considered.
### Table 2. Recommendations for Incorporation of Sociocultural Risk and Protective Factors into Suicide Assessments

| Westefeld, Range, Greenfeld, & Kett (2008) | 1.) Cultural sensitivity should ensure that ethnic minority individuals are included in the development and standardization of suicide-assessment instruments.

2.) Cultural sensitivity should include awareness that ethnic minority individuals may be less likely to disclose suicidal information than majority individuals.

3.) There needs to be knowledge of different minority groups specific to mental health.

4.) Cultural sensitivity should involve careful attention to cultural issues when assessing for suicidal thoughts and actions. |
| Alonzo & Gearing (2013) | 1.) Immigration, acculturation, and mental health services utilization needs to be explored when assessing |
| Worchel & Gearing (2010) |  |
| Chu, Hoeflein, Goldblum, Bongar, Heyne, Gadinsky, & Skinta (2017) | 1.) Utilization of the Cultural Assessment of Risk for Suicide (CARS) Measure to improve awareness of cultural risk and protective factors to better inform suicide safety management/planning and identify culturally informed expressions of suicidal ideation and behaviors.  
2.) The CARS assessment can detect alternative cultural idioms of distress that standard risk assessment scales cannot identify. |
| --- | --- |
|  | for suicidal risk of individuals across cultures.  
2.) Practitioners should follow a model that allows room for a personalized assessment that balances culturally significant risk and protective factors and lending too much attention to cultural distinctions. |
Suicide Safety Planning

In order to prevent future suicidal thoughts and behaviors, mental health practitioners use risk mitigating plans or safety plans to help keep individuals safe. For example, Stanley and Brown (2012) developed the Safety Planning Intervention (SPI), a written, prioritized list of evidence-based coping strategies and resources for reducing suicide risk. The SPI is considered the “gold standard” of care for mitigating suicide risk and can be used as a brief, stand-alone intervention, or used throughout long-term outpatient or short-term inpatient treatment settings with adults and children (Stanley & Brown, 2012). Stanley et al. (2018) tested the effectiveness of the SPI (Safety Planning Intervention and telephone follow up) vs. usual care (initial assessment by nurse or social worker followed by a second evaluation by an ED physician along with a confirmed outpatient appointment or information on how to seek psychiatric care) on 1,640 adults who visited the emergency room for a suicide-related concern and found that the SPI condition was less likely to engage in suicidal behaviors than adults receiving usual care during a six-month follow-up period. Cognitive Behavior Therapy for Suicide Prevention (CBT-SP), which involved SPI in the treatment model for adolescents who recently attempted suicide, was an effective treatment model for decreasing reoccurrence of suicidal behavior and related risk factors (Stanley et al., 2009). However, only 13.8% of participants who were identified as Hispanic/Latinx/Latine were included in the study and the SPI is a generic tool that does not incorporate sociocultural risk and protective factors.

Chu et al. (2010) recommend using a culturally informed risk management or safety plan following the CARS assessment and providing recommendations such as incorporating warning signs and triggers (e.g., minority stress) and coping strategies (e.g., attending identify specific support group) into suicide safety plans. Literature is also lacking on how to involve
Latinx/Latine caregivers in safety interventions most effectively, especially safety plans that take sociocultural risk and protective factors into consideration. For example, the challenges with restricting knives when cooking can be a large part of the individual’s household role, making parents less likely to want to restrict access. Other examples of barriers within minority cultures for implementing a safety plan could include managing stigma associated with suicide and mental health treatment as well as enforcing behavioral limits such as not being allowed to date, which adds to the need for mental health providers to understand sociocultural risk and resiliency factors and how to work with the Latina adolescent and their family most effectively to keep the teen safe.

Furthermore, Zayas and Gulbas (2012) suggest that Latina suicide attempts are a cultural idiom of distress. A cultural idiom of distress is the way a culture expresses stress, which is often expressed somatically (Nogueira et al., 2015). The researchers argue that suicide attempts are similar to other cultural idioms of distress such as ataque de nervios. The suicide attempt is viewed as a response to intra and interpersonal problems and challenges within their social network or themselves (Zayas & Gulbas, 2012). Since the experience of distress is recurrent among Latina adolescents who hold a marginal position within the United States and their own cultural group (Zayas & Gulbas, 2012), a suicide attempt is commonly viewed as an idiom of distress that results from multicultural challenges. While this may help to explain the impact of culture on suicide attempts among Latina adolescents, defining the suicide attempt this way could also serve to further marginalize these young women by deflecting perceptions of emotional vulnerability and conveying hysteria as psychoanalytical perspectives have done historically. Furthermore, given that suicidal attempts among Latina adolescents can be recurrent, it is important to understand the ways in which providers can support Latina
adolescents and their families through thorough safety plans that focus on destigmatizing mental illness and incorporating Latinx/Latine sociocultural factors along with the adolescent families’ own unique ethnocultural values. This would be an important next step in developing evidence-based methods to treat and engage Latinx/Latine teens.

Suicide Interventions with Sociocultural Considerations

Few interventions have been shown to be effective to reduce suicidal behaviors among Latinx/Latine adolescents that incorporate cultural risk and protective factors. Villareal-Otálora, Jennings, and Mowbray (2019) conducted a scoping review of clinical interventions focused on reducing suicidal behaviors among Latinx/Latine adolescents and identified eight interventions that matched the criteria. These criteria were as follows: a focus on interventions targeting suicidal behaviors, at least 40% Hispanic/Latinx/Latine adolescent participants, and published online in a peer-reviewed journal between January 1, 2013 and December 31, 2017. The eight interventions that matched these criteria were: Dialectical Behavioral Therapy, general outpatient mental health treatment, general inpatient mental health treatment, emergency room/crisis stabilization, Life is Precious, Familias Unidas, Project Wings, and Depression literary outreach. The authors found little research on interventions that specifically target Latinx/Latine/Hispanic adolescents. Villareal-Otálora et al. (2019) found that the majority of interventions reviewed were not created specifically for Latina adolescents as most were developed for White adolescents and adapted for Latinx/Latine youth. In addition, they are not RCT interventions, as the only RCT with Latinx/Latine adolescents is the Socio-Cognitive Behavioral Treatment Protocol for Puerto Rican adolescents with Suicidal Behavior (SCBT-SB). This was a treatment protocol conducted with 11 Puerto Rican adolescents, and suicide risk showed to decrease for those who completed the intervention (8 out of 11; Duarté-Vélez, Torres-Dávila, Spirito,
Polanco, & Bernal, 2016). Therefore, the majority of empirically tested clinical interventions were not created for Latina adolescents and the samples are less than 40%, which is considered standard for being considered relevant for minoritized individuals (Glenn et al., 2019; Villarel-Otálora et al., 2019).

The eight interventions/programs provided some important findings. The scoping review study focused on the importance of incorporating familism, cultural gender norms, language, immigration issues, and nativity (Villarel-Otálora et al., 2019). The majority of the interventions emphasized the importance of increasing the coping skills of the adolescents and their parents through behavioral modification, and the need to incorporate interpersonal-psychological perspectives to understand suicidality among Latina adolescents, which has shown to be effective in the literature (Franklin et al., 2017; Zalsman et al., 2016; Germán et al., 2015). One promising study presented additional support for Dialectical Behavior Therapy for Adolescents (DBT-A), recommending that two dialectical corollaries (DBT-A) be added to the treatment when working with Latinx/Latine adolescents. “Old school versus new school” and “overprotecting versus underprotecting” balances the emphasis on Latinx/Latine cultural value of respeto and suggests that collateral sessions with family members should be included in the treatment, highlighting the importance of family involvement (Germán et al., 2015).

One program that was specifically developed to target suicidal behavior among Latina adolescents is Life is Precious (LIP), a community-based program in New York City. All participants who are eligible to participate are at risk of engaging in suicidal behaviors and the program is considered a supplement to mental health treatment, which provides supportive services such as tutoring, family counseling, and conflict management skills, as well as creative expression workshops. Humensky, Gil, Mazzula, Diaz, and Lewis-Fernández (2017) conducted
focus groups with Latina adolescents \((n=31)\) engaged in LIP services and their mothers \((n=8)\) using a grounded theory approach to evaluate the program. Humensky et al. (2017) found that LIP was helpful with improving peer and family relationships, facilitated academic performance improvements, and was a “safe haven” to escape from stressors (p. 428). They also concluded that LIP specifically helped the girls reduce suicidal risk factors of poor self-esteem, and family, school, and peer conflicts. Including the mothers in the LIP activities facilitated mother/daughter bonding and the mothers found increased support for their own needs to be very helpful. Given that research shows that the lack of mother daughter mutuality is a significant risk factor for the prediction of suicidal behaviors (Baumann et al., 2010), this study has promising recommendations to support the mother/daughter dyad and build protection from the suicidal risk among the Latina adolescent.

One limitation of the study was that the girls and mothers volunteered to participate in the focus groups, making it possible that LIP participants who were dissatisfied with the program were less likely to attend. Given that school nurses may be one of the first treatment providers whom adolescents reach out to when at risk for suicidal behavior (Pestaner et al., 2021), the authors recommend that school personnel (e.g., guidance counselors, school nurses, teachers, etc.) should be aware of Latina adolescent suicide risk factors as well as community-based treatment options such as LIP. In addition, this dissertation will provide further information about the ways in which school personnel and treatment providers can facilitate sociocultural protective factors to help build the adolescent’s resiliency and work with the families through preventive approaches.

Comas-Días (2019) provides recommendations to build upon mental health interventions through incorporating the Latina’s first-hand accounts and impressions of living within an
oppressed group as well as using a holistic approach to mental healthcare through art, social justice action, spirituality, holistic healing practices, and physical activity such as yoga. Comas-Días encourages the use of Latina feminist therapy, which is a type of multicultural feminist therapy focused directly on combating racism, gendered racism, sexism, poverty, race, colorism, and intersectional oppressions through global solidarity and collective liberation (Comas-Días, 2019; Bryant-Davis & Comas-Días, 2016). The importance of group and family psychotherapy models using testimonio (testimony) and autohistoria (Latina self-history using media) as narrative therapy approaches to empower resilience, social justice, and cultural strengths was another recommendation (Comas-Días, 2019). Lastly, Mujerista Psychotherapy is a “Latina feminist healing approach with a psychospiritual base” (Comas-Días, 2019, p. 175) that is grounded in theology of liberation, psychology of liberation, Latina feminism, and mainstream psychotherapy and has shown to be beneficial in treatment with Latina adolescents (Bryant-Davis & Comas-Días, 2016). Mujerista psychotherapists encourage decolonization of white structured values through empowerment and liberation, grounding this approach by helping Latina adolescents develop their ethnocultural identity and by utilizing “strategies of resistance” (Comas-Días, 2019, p. 175). Given that sociocultural factors significantly impact the Latina adolescent, it is essential that mental health practitioners ground treatment through the girls’ lived experiences, their own knowledge and of social, political, and cultural values along with self-reflective work, and through the incorporation of therapeutic elements that foster sociocultural strengths that not only allow the girls to survive, but also promote healing and personal attainments.

When working with Latina adolescents, providers must consider their minoritized place both within society as well as within the disciplines of psychotherapy, through both social work
and psychology lenses. The dominance of psychotherapy in the United States and some Euro-centric countries such as the United Kingdom and Australia has allowed conventional psychotherapy techniques, diagnoses, and treatment modalities to be developed with the needs and problems of the West, isolating individuals who do not belong to Western cultures, who become further marginalized due to the lack of culturally appropriate treatment (Marsella, 2009). Marsella (2009) argues that the Western worldview is in direct conflict with views of non-Western cultures as they have their own ontological, epistemological, and linguistic assumptions that shape their own cultural backgrounds. Thus, given that psychotherapy has been shaped by the needs of the Western world, other groups may not fit into Western diagnostic and treatment models (Koç & Kafa, 2019), which impacts their willingness and ability to seek and engage in treatment given the contrast and misalignment in cultural values and constructs. Therefore, research should continue to focus on the unique therapeutic needs of all ethnic and cultural subgroups and better understand how different countries, ethnicities, and cultures conceptualize mental health treatment overall.

**Barriers and Facilitators to Engagement in Mental Health Treatment for Latina Adolescents**

Latina adolescents’ use of mental health treatment has been shown to be very low for a variety of reasons, despite the fact that approximately a third of Latinas who attempt suicide require medical services following their suicide attempt (Kann et al., 2016) and Latinas overall are more likely to experience persistent feelings of sadness or hopelessness (40%) compared with their White (36%), Black (31.5%), and male peers (26.8%; females 46.6%) (Centers for Disease Control and Prevention; 2019; Stafford et al., 2019). Disadvantaged socioeconomic status, immigration and acculturative stress, discrimination, and lack of appropriately informed mental health treatment have been documented as primary reasons for the lack of engaging in
mental health treatment for this particular group (Comas-Días, 2012, 2019; Stafford & Draucker, 2019). The stigma toward depression, fear of being labeled as “loco/a” (crazy), a common belief that antidepressants are addictive (Cabassa Lagomasino et al., 2008), lack of knowledge of available treatments for depression, difficulty affording treatment (Barrio et al., 2008), and lack of linguistically and culturally competent care (Uebelacker et al., 2012) are some of the most common barriers to engagement in treatment interventions for Latinx/Latine adults. However, developing a warm and caring relationship with providers has been shown to facilitate engagement (Cabassa et al., 2008; Uebelacker et al., 2012; Hausmann-Stabile et al., 2017).

Stafford and Draucker (2019) interviewed 25 Latina adolescents (mean age=16.7) with a history of depressive symptoms in order to understand barriers and facilitators of engagement in treatment for depression. They found that over half of adolescents had negative views about treatment engagement including the stigma that treatment is a sign of weakness, that feeling this way is portrayed as immature, and that the symptoms were “not a ‘real’ problem” (p. 10). In addition, several participants believed that adolescents should not take medication, which seemed to be influenced by family views. Half of the participants also thought the treatment approach used with them was not helpful, they experienced distrust of their mental health provider (describing them as “strangers”), and they found psychiatric hospitalizations fearful (Stafford & Draucker, 2019, p. 7). In addition, some participants had difficulty finding a therapist for long-term treatment. Cost of treatment was also found to be challenging for several of the adolescents. But, getting a new perspective from their therapist on how to manage their depression, learning strategies to deal with their problems, forging a meaningful connection with their therapist, and having family encouragement to engage in treatment were all revealed as facilitators to engagement. Two limitations of the study were that the participants had been self-
selected and that the authors did not collect information about the specific treatment modalities or medications the adolescents were receiving. Randomization of participants and the identification of specific treatment modalities or medications has the potential to reveal an even clearer picture of engagement barriers and facilitators for Latina adolescents. Thus, the present research study will add to the knowledge on how providers’ realization and perspectives of sociocultural factors serve to address and support Latina adolescents’ engagement in safety planning and risk assessments in treatment.

Recommendations to improve treatment engagement with Latina adolescents in the literature include the need for mental health providers to implement treatment modalities that foster connections and address the interpersonal and intrapersonal tensions that adolescents experience with their families (Hassman-Stabile, Gulbas, & Zayas, 2018). Using language that normalizes adolescent stress and providing information about the commonality of mental health disorders among adolescents can serve to decrease the negative cultural beliefs associated with treatment (Stafford & Draucker, 2019). In addition, mental health providers should commit to cultural competence/humility as a lifelong learning process and “ground treatment in a Latina lived experience” (Comas-Díaz, 2019, p. 171). Olcón and Gulbas (2018) emphasize the importance of using cultural competence when delivering mental health services and the need to move away from stereotyping, forming biases, and making assumptions about cultural interpretations of the psychosocial circumstances that immigrant youth face. Furthermore, mental health education programs within Latinx/Latine communities, particularly in schools and communities, is suggested throughout the literature to normalize mental health challenges and to help adolescents access professional help (Haussman-Stabile et al., 2018; Stafford & Draucker, 2020; Humensky et al., 2017).
Research has clearly shown that Latina adolescents are at a heightened risk of attempting suicide in comparison to the majority of their peers. Both quantitative and qualitative studies have been conducted that demonstrate this increased risk through analysis of the multitude of Latinx/Latine sociocultural risk and protective factors such as cultural family and relational values (e.g., familismo, parenting styles) and the acculturation gap between the parent and child. Incorporating sociocultural factors into risk assessments and suicide safety planning is one way to better support Latina adolescents and their families; however, little is known about the mental health providers’ knowledge and utilization of these factors when working with Latina adolescents and their families. Given the risk of engagement in suicidal behaviors for Latina adolescents, knowledge around the suicide risk and protective factors and the ways in which culture greatly shapes an individual’s pathways through life, we must now turn our attention to the extent to which social workers utilize this knowledge base to protect, strengthen, and align with Latina adolescents and their families when the adolescents are at risk of attempting suicide.
CHAPTER 3: THEORETICAL FRAMEWORKS

Theoretical Frameworks for Understanding the Related Factors and Intervening with Adolescents with Suicidal Behaviors

This study is built on the theoretical lenses of the Ecodevelopmental Model of Latina Suicide and Relational Cultural Theory. In literature on Latinx/Latine socioemotional development, suicidality, and the cultural and societal risk factors, researchers consider the below theories to highlight the unique needs and experiences of Latinx/Latine populations in informing therapeutic care practices and future research (Zayas et al., 2005; Zayas, 2011; Gulbas et al., 2019; Gonzalez, 2014; Ruiz, 2012). This dissertation contends that the Ecodevelopmental Model and Relational Cultural Theory considered in combination have the potential to better inform working therapeutic practices for suicidal adolescent Latinas and their families and to contribute meaningful insight into the ways in which practitioner knowledge of Latinx/Latine sociocultural factors influence the practitioner/client dyad, family system functioning, and the Latina adolescent’s safety.

The Ecodevelopmental Model of Latina Suicide Attempts

The Ecodevelopmental Model grew specifically from conceptualizations of Latina adolescent suicide attempts and was influenced by Bronfenbrenner’s Ecological Systems Theory and Vygotsky’s Sociocultural Theory (Zayas et al., 2005). This model strongly supports this dissertation’s aims to conceptualize sociocultural risk and protective factors that influence the multiple pathways to Latina adolescent’s suicide attempts. Further, the Ecodevelopmental model can inform supportive, culturally attuned mental health providers treating Latina adolescents. The Ecodevelopmental model assumes that Latina adolescents who attempt suicide often experience multiple triggers “spread across in a series of incidents that weaken the girl’s coping
capacity or overwhelms her” (Zayas, 2011, p. 133), rather than an isolated trigger event. In other words, psychological and social factors, cultural traditions, acculturational differences, and family functioning characteristics within the community and family unit are intertwined with adolescent development, maturation, social experiences of racism and social pressure and influence the contexts that lead to a suicide attempt (Zayas, 2011). The Ecodevelopmental model also incorporates aspects of developmental and family systems theory, family stress and coping models, adolescent development, culture, and cultural traditions of Latinx/Latine families (Zayas, 2011).

The first theory that influenced the Ecodevelopmental model was Ecological Systems Theory, which was formulated in the 1970s and views child development through nested systems of relationships that are affected by complex interactions known as the microsystem, the mesosystem, the exosystem, the macrosystem, and the chronosystem (Bronfenbrenner, 1994). Ecological Systems Theory advances this dissertation’s aim to understand the influence of sociocultural risk and protective factors and the client/social worker relationship from the practitioner’s perspective; this includes the wide range of sociocultural factors woven throughout the multiple ecological layers that influence an individual to attempt suicide.

Figure 1. The original Ecodevelopmental Model of Latina Suicide (Zayas, Lester, Cabassa, Fortuna, 2005).
Sociocultural Theory also informed conceptualization of the Ecodevelopmental Model’s attention to the adolescent and her family, constituting Bronfenbrenner’s (1994) microsystem. Sociocultural Theory posits that the child’s cultural interpretations develop from interactions with the larger society as well as the connections with specific people such as family members (Vygotsky, 1980). Vygotsky believed social interaction plays an important role in learning and that language is an essential tool in the learning process (Vygotsky, 1978). Vygotsky hypothesized that children’s capacity for learning exists within a range, called the Zone of Proximal Development. This extends the range of abilities that can be performed by the individual with the guidance of an expert such as a parent as they cannot perform these skills yet on their own (Vygotsky, 1978). The Ecodevelopmental Model incorporates the assumptions of Social Learning Theory by including the process of learning cultural values and traditions from parents and other family members. Within the Zone of Proximal Development, Latina adolescents learn what is valued, how to behave, and what values to have, all of which are shaped and taught to them by the adults in their lives (Zayas, 2011). This heightens the potential for additional learning in the context of the therapeutic relationship. Consequently, Sociocultural Theory supports this dissertation as the clinician’s knowledge of Latinx/Latine sociocultural risk and protective factors and utilization of cultural humility practices have the potential to encourage learning and growth within the therapeutic dyad.

Thus, Ecological Systems Theory and Sociocultural Theory interwoven along with a much deeper understanding of Latinx/Latine sociocultural factors form the Ecodevelopmental Model. This dissertation argues that social workers can expand this framework to incorporate additional microsystem and relational factors by attending to the therapeutic alliance with the Latina adolescent and her family members.
The Ecodevelopmental Model suggests that there are multiple risk factors within different ecological layers that influence suicidal behaviors including but not limited to psychopathology (e.g., depression), social relationships, cognitive factors, negative life events, and cultural influences. In order to understand a child’s development, one must consider the individual’s microsystem along with interactions occurring in their larger developmental environments, one of which is especially pertinent to the Latina adolescent: biculturality or multiculturality. Latina adolescents are often forced to navigate the expanse between US culture, which emphasizes independence and achievement, with a Latinx/Latine culture that promotes obligation to the family, collective well-being, and more “traditional” gender roles (Humensky et al., 2017). Navigating between the family’s cultural belonging and identity, along with alliance to American culture in their school and social environments, is a particular challenge for Latina adolescents whose parents grew up in another country. It may not be carefully considered as something that impacts the adolescent by providers who have not had similar experiences. Language, cultural values, and familial expectations may be even more distinct than if the parents were born in the United States (Zayas et al., 2009; Borges et al., 2012). The adjustment between generational and acculturational gaps along with culturally sanctioned levels of emotional attunement from their parents to meet their emotional and developmental needs can lead to despair and increase the risk of suicide attempts among Latina adolescent girls (Zayas, 2011).

Zayas (2011) describes this bicultural experience as “straddling two cultures” and further illustrates the experience as “an intricate dance that she must learn to bring together in her heart and mind the many cultures and identities that she encounters while the ground on which she
dances is shifting between the traditional and the modern” (p. 134). In other words, from the model’s perspective, the way in which the Latina adolescent and her family “dance” can impact adaptation and flexibility, determining whether or not she is at a higher or lower risk of suicidal behavior. Falicov (2018) also describes this experience as “living in cultural borderlands” where there are overlaps and similarities between cultural borders and barriers that shape Latina adolescents’ lives. The clinician’s role can be seen as a supporter, helping the adolescent and her family “dance” together both individually and together. Latina girls who struggle with moving through their multiple cultures and are not in care lack the opportunity to process their challenges and learn strategies to navigate their worlds. Therefore, more attention and understanding are needed to support this “dance.”

When working with Latinx/Latine adolescents, it is important to recognize that Latinx/Latine culture isn’t monolithic; Latina adolescents living in the United States come from a variety of extremely diverse geographic, political, and sociocultural backgrounds impacting every aspect of life. Understanding the differences among specific Latinx/Latine cultural groups (e.g., Nicaraguan vs. Dominican) and contributing factors of Latina suicidal behaviors is a major limitation in the research (Szlyk et al., 2019; Goldston et al., 2008). However, what has been revealed in the research over the last few decades is that Latina adolescent girls struggle to adapt to their unique multicultural world, to the stigma around mental health care and suicide, and to the marginalization of this community in the United States. There are also commonly shared cultural values among Latinx/Latine families such as familismo, respeto, gender roles, and espiritualidad (Antshel, 2002), which impact the developmental trajectory for the Latina adolescent across multiple ecological systems at once. For example, Kuhlberg and colleagues found a negative relationship between familism and parent-adolescent conflict and a positive
relationship between internalizing behaviors and self-esteem (Kuhlberg et al., 2010). Thus,
higher familism may act as a protective factor against parent-adolescent conflict, which is
consistent with this literature review. However, if the teen girl is often silenced by family and/or
cultural norms, keeps her problems to herself, and is unable to vocalize her needs with her
parents, familism may not buffer less cohesive or emotionally attuned families (Zayas, 2011).
Thus, this model can be used as an essential tool to provide clinicians with an understanding of
cultural protective and risk influences on the Latina adolescent suicide attempt trajectory.

The Expanded Ecodevelopmental Model

The Ecodevelopmental model is a clinically useful framework to understand the suicide
risk factors for Latina adolescents with suicidal ideation and behaviors from a multisystemic
approach. By understanding risk factors and the pathways to suicidal behavior through this
model, mental health practitioners can make informed practice recommendations and advocate
for policy and practice changes (e.g., clinic policies, social movements). Towards this end, this
dissertation aims to continue expansion of the Ecodevelopmental model to include sociocultural
humility practices and the therapist/adolescent/family relationships as additional, and ideal
mitigators in suicide prevention. Zayas and colleagues formulated the original Ecodevelopmental
Model based on a decade of research that revealed how familial influences, demographics, and
sociocultural factors such as cultural values, levels of acculturation, and immigration status
impacted the Latina adolescent’s suicide risk factors (Trautman, 1961; Zayas, 1987; Hovey &
King, 1996). In 2011, the model was reformulated to incorporate the indirect influences
impacting adolescent girls, such as the teen’s struggle to be independent and how this interacts
with the influences of the common collectivist perspective of their Latinx/Latine culture (Zayas,
2011). The current model presents a synthesized hypothesis in that “the forces that are distant
from the actual attempt play a supporting or background role, but are not the specific trigger or the proximate factors for the attempt” (Zayas, 2011, p. 151). The more nuanced model allows for stronger emphasis on the collision that commonly occurs between the competing cultural traditions, the cultural environments the Latina faces, and the ongoing changes among the outlying cultures (Zayas, 2011). The model also examines the family’s functioning at a deeper level, pulling from family stress and coping models (Boss et al., 2016) to capture additional pressures that may lead to a suicide attempt.

Consideration of Additional Macro and Exosystem Factors

The current Ecodevelopmental model assumes multiple circumstances contribute to suicidal behavior. The model navigates from left, including distal factors such as social, economic, political, community and neighborhood, schools and social image (exosystem or

Figure 2. The Expanded Ecodevelopmental Model (Zayas, 2011).
macrosystem components) to the proximal factors in the adolescent’s immediate network. The model assumes macro or exosystem factors influence Latinx/Latine families and their children but are further away from direct microsystem impacts (Zayas, 2011). Other macro and meso systems examples include Latina youth who are living in low socioeconomic areas and regularly exposed to geographical stress, poor quality education, and dangerous neighborhoods (APA, 2017), which increase the risk of suicide. The influence of celebrities and the media on body image is another example of a macrosystem factor.

Immigration history is a critical macrosystem factor that impacts family values, the parent and adolescent relationship, and the adolescent’s psychosocial development. US-born Latinx/Latine adolescents with immigrant parents are 2.87 times more likely to attempt suicide (Peña et al., 2008). Research shows that the family’s stress from immigrating to another country, whether from the parents who have immigrated or the adolescent included, influences levels of family adaptability/cohesiveness, familism, acculturation, and mutuality. This variation significantly impacts the Latina adolescent’s suicidal behavior (Gulbas & Zayas, 2015; Piña-Watson et al., 2014; Bauman et al., 2010; Zayas, 2011). For example, Gulbas and Zayas (2015) interviewed Latina adolescent who attempted suicide and their parents to explore relationships among culture, family, and factors associated with the attempted suicide. Findings highlighted that interpersonal discord, which develops among adolescents and their parents due to low social support, can arise from parental migration. The study illustrated one specific example where one parent regularly used documentation status to create power imbalances within the family system, overwhelming the girl’s lack of control of the world around her and subsequently leading to a suicide attempt (Gulbas & Zayas, 2015). Knowledge of the family’s immigration history and its impact on the adolescent Latina is just another example of the multiple sociocultural factors that
impact the numerous cross sections of the ecological system layers, which mental health providers must consider when working with Latina adolescents and their families.

*Additional Mesosystem Factors*

Family influences, known as mesosystem factors, are likely more influential on suicidal ideation and, thus, placed closer to the suicide event as these factors have shown to more directly influence the girl’s suicidal behaviors (Zayas, 2011). For example, Zayas’s main study comparing 122 adolescents who attempted suicide to 110 Latina adolescents who did not (with very similar demographic variables) found that Latinas with no attempt histories rated higher levels of mutuality and less conflict with their parents than Latinas who had attempted suicide (Zayas, 2011). Zayas and colleagues (2011) concluded that the mesosystem factors (e.g., factors that affect the family system, the family’s stress, and interactions) impacted the adolescent’s trajectory toward or away from the suicide attempt.

Extending from school and social images in the model are the pathways to peers and friendships, which are additional mesosystem factors. Zayas distinguishes *peers* in the girl’s school, community, or organizations from *friends* who the girl has an emotional closeness to. Friends therefore have a strong influence on the development of her self-esteem and can be a buffer against peer pressure (Zayas, 2011). Romero, Wiggs, Valencia and Bauman (2013) investigated incidences of bullying among 650 adolescent Latina girls using quantitative measures of suicide and depressive symptoms from the Arizona Youth Risk Behavior Survey (YRBS). Following the control for depressive symptoms, girls in their study who were bullied were 1.5 times more likely to attempt suicide, indicating the important buffer of peer and friend relationships. Zayas and Gulbas (2015) studied Latina adolescent relationships when they interviewed 10 Latinas who attempted suicide and their parents along with 10 Latinas with no
lifetime history of suicidal behaviors. Latina adolescents who had attempted suicide also had limited social outlets, increased interpersonal conflicts, and subjective distress, which enhanced their experiences of emotional isolation (Gulbas & Zayas, 2015). Latinas without a lifetime history of suicide attempts were able to obtain resources that seemed to alleviate challenges with managing family conflict through supportive relationships such as a teacher and classmates (Gulbas & Zayas, 2015), emphasizing the impact of positive, healthy relationships in mitigating the risk of suicide.

*Expanding on the Microsystem Influences*

The center of the model is composed of the family microsystem and has three dimensions: the family system (e.g., familism, parenting style, cultural traditions, the parent-adolescent interaction (e.g., affection, mutuality, perspective-taking), and the Latina adolescent (e.g., psychosocial development and functioning). There are multiple factors within each dimension to describe the microsystem influences on the suicide attempt trajectory. Zayas and colleagues determined that the Latina adolescent’s ability to cope and regulate distress comes from the family environment, thus the family component is an essential part of treatment (Kuhlberg et al., 2010; Zayas et al., 2009).

Critical points, which Zayas (2011) calls “nodes,” are placed within the model to indicate “significant relationships among the many forces and factors in the adolescent’s life” that can be changed, increased, or quieted (e.g., trauma, psychosocial functioning) (p.155). The nodes have a patterned texture to represent that some of the influences are understood while the weight of the influence depends on the mediators of each side of the node. Zayas (2011) provides an example by highlighting the influence of the friendships with adolescents who engage in deviant
behaviors and explains how the level of parental supervision and the parent-adolescent relationship can mediate the effects of peer pressure to engage in deviant behavior.

**Expanding the Model Even Further**

This dissertation aims to highlight social workers’ experiences treating Latina adolescents with suicidal behaviors, their consideration of the multiple sociocultural factors affecting the teens’ lives, and the impact of mental health treatment and the Latina adolescents’ relationships with their providers in potentially changing the trajectory of their attempts. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), professional social workers are the largest group of mental health services providers in the United States (National Association of Social Workers [NASW], n.d.). Thus, it is imperative that we turn to this profession to best understand how they are serving Latina adolescents’ mental health needs.

*Potential Protective Role for Social Workers*

The dissertation aims to expand the Ecodevelopmental model to include the adolescents’ relationships with social workers, which, depending on their ability to understand and incorporate sociocultural factors into treatment, may serve to mitigate the weight of risk factors. Additional nodes to explore for the purpose of this dissertation include how culture and suicidality are discussed in the therapeutic space with both the Latina clients and their families, the family’s perception of mental health treatment, and the ongoing feelings of isolation and misunderstandings of the Latina adolescent experience in the United States, which are further challenged within their bicultural world.

The relationships between the social workers, the Latina adolescents, and their families, along with culturally supported treatment interventions, can serve to mitigate future risk of suicidal behaviors and thus could be positioned in the model close to the nodes of mediation.
Providers have the capacity to support the adolescents’ interpersonal relationships with peers, friends, and family members, facilitate improved functioning in school and home environments, and support tolerance and resiliency of the larger external factors impacting their growth (e.g., socioeconomic disadvantages, immigration history). Without mental health treatment and the adolescent Latinas’ relationships with their providers, they are at further risk of following the pathways toward an attempt. Thus, this dissertation argues that a further expanded version of the Ecodevelopmental model needs to include mental health clinicians and the relationship between the Latina adolescents, their family members, and the clinicians as critical factors that may mitigate suicide risk. By including the therapeutic relationship and engagement in culturally supported treatment interventions within the Ecodevelopmental model along with the unique personal constructs that make up the relational context described below in Relational Cultural Theory, this dissertation can provide a thoughtful, theoretically grounded approach to better understand the impact of the mental health provider and Latina adolescent therapeutic relationships.

Sociocultural Factors as Protective or Harmful Tools

Despite this model’s decades-long existence, there is less understanding around utilizations of this model on effective clinical and culturally attuned interventions to reduce suicidal behaviors in Latina adolescents. Villarreal-Otálora, Jennings, and Mowbray (2019) completed a review of the literature and identified eight interventions that specifically focus on reducing suicidal behaviors among Latino adolescents. They concluded that the majority of the interventions incorporated sociocultural concepts of familism, cultural gender norms, language, immigration issues, and nativity, emphasizing the importance of family therapy work and the inclusion of the therapist’s cultural awareness. Future intervention design and testing are still
needed that incorporate individual, parenting, and family work along with an understanding of how to apply treatment interventions across diverse cultural variances to address the complex, interacting systems that affect Latina adolescents who attempt suicide. Life is Precious, for example, is a community-based program created to meet the needs of Latina adolescents with a history of suicidal behaviors. The program serves as a supplement to mental health treatment. Qualitative research on the program revealed that the LIP counselors and tutors were helpful in improving parent/child relationships through promotion of communication and conflict resolution strategies such as perspective-taking, improving self-esteem through creative art therapies and connecting them with peers, and coordinating support with school officials to combat bullying (Humensky et al., 2017). This suggests the essential role of clinicians in supporting and engaging families in collateral treatment and attending to their cultural backgrounds to mitigate suicide risk. However, none of the interventions reviewed assessed the significance of the client/provider relationships. Thus, this dissertation aims to study the therapeutic relationship between social workers and their Latina adolescent clients and their families. This work will foster understanding of how sociocultural factors shape the client/clinician relationship and provide opportunities for reducing suicidal behaviors.

**Relational Cultural Theory**

Relational-cultural theory (RCT) was developed to understand “the importance of growth-fostering relationships in people’s lives,” to decrease suffering from “chronic disconnection and isolation, …to increase the capacity for relational resilience, and to foster social justice” (Jordan, 2018, p.27). RCT’s core assumptions are that people grow through and toward relationships throughout the life span as relationships are central to our lives. “Growth-fostering relationships” are the main “source of meaning and empowerment” (Jordan, 2018, p.
RCT pushes the essence of meaningful relationships through “mutual empathy” or the ability for each person in a relationship to “see, know, and feel the responsiveness of the other person,” and to create change across relationships and systems (Jordan, 2018, p. 7).

RCT helps situate this dissertation by providing meaning to the importance of the therapeutic relationship between the Latina adolescent client and the mental health provider. RCT supports growth-fostering relationships within the Latina girl’s family as its central view is that “culture is more than the scenic backdrop for the unfolding development; rather, culture is viewed as an active agent in relational processes that shape human possibility” (Walker, 2005, p. 48). RCT posits that sociocultural identities are essential factors in relational development, with an initial focus on women’s experiences (Jordan, 2018). Extrapolated to other important relationships, RCT can provide insight into the Latina adolescent’s understanding about how their culture influences their worldview and their experiences embodying multiple sociocultural identities in marginalized spaces. According to the core assumptions of RCT, client perspectives and lived experiences are emphasized, clients are viewed as collaborators, therapists strive toward an egalitarian relationship, they value diversity and exploration of complex cultural identities, and they aim to push toward change as a goal within the therapeutic work (Enns, 2004). RCT also strongly encourages the therapist to engage in self-reflective practices focused on individual privileges and the power differential within the therapeutic relationship (Enns, 2004) as the therapist can be viewed as an outsider actively looking into their Latina adolescent clients’ lives. This could lead to the perception that the therapist is a colonizer, dictating how their clients should “ideally” cope with distress. Thus, RCT assumptions are very much in line with this dissertation’s sociocultural and relational perspective as this theory aims to better
understand the factors that help facilitate or inhibit supporting Latina adolescent girls at risk of engaging in suicidal behaviors.

**RCT with Latina Adolescents and Their Families**

Gonzalez (2014) supports using RCT with individuals that identify as Latinx/Latine/Hispanic since “relational social work is predicated on inclusiveness of the client’s social reality, which includes the way specific cultural values or characteristics directly affect effective treatment” (p. 96). Traditional Latinx/Latine cultural values such as simpatía, personalismo, familismo, respeto and confianza are inherently relational and serve to inform treatment strategies to decrease psychological distress (Gonzalez, 2014). He argues that RCT provides practitioners with culturally and contextually informed strategies to work with a client population that is less familiar or accepting of psychotherapy and vulnerable to economic and social (e.g., discrimination) factors (Gonzalez, 2014). This dissertation study suggests that utilizing RCT and the Ecodevelopmental theories in combination may improve engagement in treatment and alleviate suicidal risk as growth-fostering relationships and the therapist’s knowledge of sociocultural factors hold many suicide mitigating factors for the Latina adolescent.

Additional elements of RCT including mutual empathy and empowerment, connections, condemned isolation, the central relational paradox, and “power-over” dynamics can be helpful in understanding the challenges Latina immigrants face in everyday life and in traditional therapeutic contexts (Ruiz, 2012). Mutual empathy develops when two or more individuals see connection and change as possible and willingly make room for growth and presence within the relationship (Jordan, 2018). When individuals are not able to respond to each other, disconnections may lead to psychological dysfunction, shame, and powerlessness. This creates
what RCT terms “condemned isolation” (Miller, 2008). Miller and Stiver (1997) explain this concept further:

This is not the same as being alone. It is feeling that one is locked out of the possibility of human connection and of being powerless to change the situation. In the extreme, psychological isolation can lead to a sense of hopelessness and desperation. People will do almost anything to escape this combination of condemned isolation and powerlessness. (p. 72)

When this disconnection occurs, a “power-over” dynamic results, allowing the dominant group to exploit minoritized groups due to a lack of empathy (Ruiz, 2012), and playing out with therapists who are “strangers” (as noted in the literature review). This “power-over” dynamic may be the perception of Latinx/Latine teens and families of white therapists and institutions.

*Empirical Support for RCT*

Western industrialized societies encourage “power-over” dynamics through emphasis on competition and freedom (Jordan, 2018). As Latinx/Latine culture is rooted in collectivist principles (CDC, 2012), it would be helpful to assess where the Latina adolescent’s family aligns along the spectrum of individualist and collectivist values, and how to utilize RCT to build upon their connections to strengthen mutual empathy and empowerment. Ruiz (2012) argues that the RCT framework can be used with Latina immigrants and recommends assessing for sociopolitical and cultural factors to help providers understand the disconnections that are affecting the individual’s life. This dissertation argues that the tenets of RCT are relevant in therapeutic relationships with US-born Latina adolescents, especially Latina adolescents of immigrant parents, as they are also dealing with straddling multiple cultures depending on their family members’ levels of acculturation.
In line with the core RCT concept of mutual empathy, a study by Baumann, Kuhlberg, and Zayas (2010) on familism, mother-daughter mutuality, and suicide attempts of adolescent Latinas demonstrated the benefit of mutuality (reciprocal empathy and engagement) in familial relationships. They analyzed quantitative data from 169 mother-daughter dyads (86 with, and 83 without, history of suicide attempts) and found that gaps in familism, where mothers scored higher than their daughters on the familism scale, predicted lower mother-daughter mutuality and more externalizing behaviors (e.g., rule breaking and aggressive behaviors). Additionally, lower mother-daughter mutuality was negatively correlated to internalizing and externalizing behaviors, which predict suicide attempts. Thus, RCT’s core assumption that mutually growth-fostering relationships, where individuals contribute to the well-being of others while also feeling cared for and treated with respect, serves as a protective factor for Latina adolescents from attempting suicide. Mutuality is an important element to bring into the therapeutic relationship both for the individual provider and in fostering relational growth between the adolescent and their caregivers. Furthermore, RCT suggests adolescent girls develop resilience and “relational competence” when they engage in growth-fostering relationships, mitigating the greater likelihood that they may experience distress or develop suicidal ideation (Jordan, 2013, p. 5).

Lastly, Lenz (2016) conducted a systematic review to uncover empirical studies that support RCT and its ability for “explaining individual experiences, assessing theoretical constructs, and providing an effective treatment option” (p. 415). Zayas, Bright, Alvarez-Sanchez and Cabassa’s (2009) study on the degree of communication and mutuality between Latina adolescents and their mothers and its association with self-harm was analyzed in the review. Lenz (2016) highlighted that the significance of adding a relational therapeutic
component when working with Latina adolescents and their specific mental health needs given that such an addition “promotes perceptions of mutuality” and is a useful framework for helping therapists understand client experiences.

In conclusion, this dissertation highlights the importance of growth-fostering relationships as the study seeks to examine how social workers treating Latina adolescents with suicidal ideation and behaviors and their families utilize RCT and understand sociocultural contextual factors in an effort to decrease their clients’ pathways toward a suicide attempt.


CHAPTER 4: METHODOLOGY

Research Design

This dissertation assessed how licensed social workers utilized their knowledge of Latinx/e sociocultural risk and protective factors in building a relationship with Latina adolescents with suicidal ideation and behaviors. This study used a qualitative approach to find deep meaning through the complex realities of participants (Padgett, 2016). Grounded theory methodology was used to understand the essential components of the social workers’ and clients’ relationships, the therapeutic processes critical to building these relationships, and the social workers’ knowledge and utilization of Latinx/e sociocultural factors to assess suicide risk and safety plan with Latina adolescents who are suicidal and their families. Grounded theory methodology utilizes systematic strategies to collect and analyze data to build mid-range theories (Chamaz, 2007) such as the one investigated in this study. As this dissertation sought to expand a mid-range theory, the goal was to support an emerging theoretical expansion of the Ecodevelopmental model to include the impact of the therapeutic relationship and the practitioner’s knowledge of Latinx/e sociocultural factors as mitigating factors of the suicide attempt informed by Relational Cultural Theory. Grounded theory methods included analysis of participant interviews and data simultaneously as an iterative process. The study was approved by The University of Pennsylvania Institutional Review Board (IRB).

Sampling and Recruitment

In order to gather rich data on the participants’ experiences treating Latina adolescents, purposive, non-probability sampling was used. This sampling strategy allowed for participants to be included who are actively working with Latina adolescents and their families. Recruitment started with a flexible strategy that focused on community mental health agencies and primary
care clinics within the New York City area that specifically serve Latinx/e communities. Emails (Appendix A) and recruitment flyers (Appendix B) were sent to community mental health clinics in New York City as the primary sources for sampling methods. Convenience sampling was then used for facility/ease. The researcher contacted colleagues by email as well as messaged self-identified social workers in mental health agencies in New York City through LinkedIn to connect to additional providers (Creswell & Poth, 2016), in order to focus on one specific metropolitan area with a large Latinx/e population. The goal was to focus on a mid-Atlantic urban area with rich cultural and linguistic diversity as well as large immigrant communities with dedicated and targeted social service agencies. Snowball sampling was also used when participants were willing to notify their own network (Creswell & Poth, 2016). Given that social workers who work with Latinas with suicide risk are scarce, several sampling methods were used to collect data. Theoretical sampling ensured that rich data was collected through the emerging theory and filled in gaps in the development of theory (Butler et al., 2018). In addition, intensity sampling was used to select participants who have a depth of experience working with Latinx/e adolescent girls experiencing suicidal behaviors (Creswell & Poth, 2016). The researcher aimed to interview 10–15 participants or until data saturation was reached.

Inclusion Criteria

Licensed Social Workers (LMSW or LCSW) actively working with Latinx/e teens and their families who practice in a New York City mental health agency were included in the study. Additional criteria included: 1.) approximately 50% or more of the providers’ caseloads consisted of Latinx/e teens and families; 2.) social workers currently worked with at least one Latina adolescent with suicidal ideation and/or behaviors; 3.) they had experience working with teens of any background engaged in suicidal behaviors, including suicidal ideation (thoughts
about the desire and method for committing suicide), suicide planning (the development of a specific method through which a person has some intent to end one’s life), and suicide attempt (engaged in potentially self-injurious behaviors with either explicit or implicit intent to die) (Oquendo et al., 2003; O’Carroll et al., 1996; Silverman et al., 2007); and 4.) they had at least 2 years of practice experience post graduate degree and license (LMSW or LCSW). Originally, the study aimed to recruit participants with 3 years or more practice experience post license with a range of ethnic and racial identities, however, to include an additional male social worker in the study, the recruitment criteria was expanded by decreasing the required number of professional practice experience from 3 years or more to 2 years or more. This inclusion criteria ensured that participants could speak to the research’s aims and provide a wealth of information to support the emerging expanded theory.

*Exclusion Criteria*

Social workers in private practice or working primarily in inpatient psychiatry were excluded from this study. In addition, clinicians who have worked with fewer than 10–15 Latinx/e teens were also excluded.

**Human Subjects Research/Institutional Review Board (IRB)**

All interested individuals were voluntarily enrolled in the study by contacting the primary researcher through email or phone as provided to them in the recruitment email. Interested participants received an emailed copy of the informed consent form (Appendix C) and the researcher followed written informed consent procedures. Participants were required to complete an IRB approved informed consent form prior to the interview. The primary researcher was responsible for all consenting procedures. Prior to the interview and the consenting process, potential participants completed a telephone screening to ensure that they met inclusion criteria.
Those who did not meet inclusion criteria were not included in the study. This only occurred with one interested social worker.

Interested participants who met the study inclusion criteria were scheduled for interviews over Zoom, which lasted approximately 60 minutes. All participants involved in the study received a confirmation email with the date, time, and an individual Zoom link. At the beginning of the interview, informed consent forms were reviewed with all participants and the researcher elicited and answered any participant questions as well as reviewed the risks and benefits.

Potential risks to participation included a breach in confidentiality if the researcher’s computer was stolen; however, this was very unlikely. The researcher took all precautions to prevent this from happening and the computer was password protected. There was a chance that the topic of treating adolescents with suicidal ideation and behaviors triggered uncomfortable and distressing past professional experiences. Therefore, risk for emotional distress was considered with all study participants and clearly described as a risk in the informed consent process. No participant experienced distress, but the interviewer was willing to stop and provide emotional support as she has advanced training in clinical mental health interventions and trauma-informed treatment should this have occurred. The researcher/interviewer attempted to reduce this risk by providing clear informed consent. Furthermore, the risks were reasonable in relation to the benefits of the study as there is limited qualitative research in this area.

Participants received a $25 Amazon gift card in compensation for their time.

Data Collection Methods

Semi-Structured Interviews

Participant interviews were conducted through Zoom with an option for in-person interviews should it be safe and permissible to do so due to COVID-19 from August 2021 to
October 2021. However, due to increased concerns because of the COVID-19 Delta variant spreading, all participants chose to have their interviews conducted on Zoom. Participants were encouraged to find a private space in their setting. Interviews consisted of one meeting, approximately 60 minutes in duration, and used a semi-structured interview design. Interviews were scheduled at a time that was most convenient for the participants. The researcher developed an interview guide with topics that focused on social workers’ experiences treating Latina adolescents with suicidal behaviors, understanding and use of Latinx/e sociocultural factors when assessing for suicide risk and safety planning, perspectives on the significance of the therapeutic relationship, and training intervention needs. See Appendix E for Interview Guide.

Privacy and Confidentiality

The Penn Zoom platform for completing the interviews was passcode protected and each participant received their own unique link prior to accessing the interview. Informed consent paperwork was completed through email and documentation of completed consent forms were maintained in a secured file within the student researcher’s password protected computer. A copy of the informed consent form was provided to each participant. The primary researcher conducted all interviews. An Excel document was used to track participants including data collection of interviews and basic demographic information with a pseudo name assigned based on a pseudonym similar to ethnic identity.

Data collection, including all written notes, were digitally stored in the same password protected computer within the researcher’s home. Interviews were recorded through Zoom and saved in the cloud, which could only be accessed by the primary researcher through their username and password. Interviews were transcribed using a professional service and the transcribed data was checked for accuracy and analyzed through Microsoft Word. All electronic
files were transferred to the primary researcher’s password protected computer. All data that is shared by the primary researcher with the dissertation committee were de-identified (e.g., names changed, agency blinded) for confidentiality through encryption.

**Data Analysis Methods**

The researcher followed an informant-driven approach where participants teach the investigator and the investigator engages participants in a non-judgmental and empathic manner (Padgett, 2016). The researcher used the constant comparative method consistent with grounded theory procedures while collecting data and analyzing the transcripts of the interview audio. All recordings were transcribed verbatim by the transcription service. Themes emerged iteratively from the data. The researcher analyzed transcripts through inductive (open) coding and deductive coding from the interview guide and identified theory in order to attend to the sensitizing concepts from the theoretical frameworks (e.g., Ecodevelopmental Model and Relational Cultural Theory) until the point of saturation when themes emerged to the point of redundancy and no new information could be obtained.

**Reflexivity Statement**

I am a clinical social worker in a home-based crisis intervention program in New York City where I provide intensive psychotherapeutic services to youth (5–18 years old) and their families in their home or local community. Children and adolescents are referred to this program because they are at imminent risk of admission to higher levels of care (e.g., inpatient hospitalization) due to suicidal behaviors (ideation, planning, intent, past attempt[s]). I primarily work with first- and second-generation Latinx/e/Hispanic Americans (primarily of Dominican origin) and focus on adapting evidence-based treatments for a Latinx/e and immigrant-dominant community.
As a White, non-native, bilingual (Spanish and English-speaking) mental health provider, I hold a complex identity role balancing my privilege with my strong interests and care for the Latinx/e community that I serve. Because of my identity, I found it extremely challenging at times to look at this research through a critical eye. It was very hard to see how much bias clinicians are bringing into their work and to confront the fact that we all hold biases no matter our race or ethnicities. My instinct was to run away from these biases due to my immense gratitude for these clinicians’ support in my research as well my appreciation for the work they are doing with their Latina adolescent clients and family members. In addition, I hold a Jewish identity, which has its own “isms” and while I can connect to an “anti-mentality,” I had to continuously interrogate my own biases and positionality in this work throughout the process as well. I was reminded by my committee that confronting the biases in research is an invaluable effort as it brings awareness and understanding to the therapeutic relationship and how this can impact trust and the overall work that is being done. I attempted to present this research with as much awareness of my own identities and critical reflection as possible with the recognition that these are biases that I have personally been socialized into, which have been reinforced by majority culture, as with the biases of the participants.

Furthermore, I am an outsider and can be seen as a colonizer, benefiting from the good feels of “white saviorism” to ease my guilt of what my race does to Black and Brown people. I am often asked why I primarily work with the Latinx/e community given that I am not Latina. I have been drawn to Latinx/e culture all my life, largely due to the privilege of traveling through multiple Spanish, Latin American, and Central American countries where I have been greeted kindly as the foreign “gringa” and witnessing the vast beauty of a collectivist society. There are
many strengths of Latinx/e culture that I wish Americans could adopt such as personalismo and collectivism.

Supporting, advocating, and empowering the Latinx/e communities that I serve and at the same time, addressing mental health disparities and practicing with a social justice lens are some of the ways that I can give back to the communities that have shown me beauty and strength. Social workers hold the unique role of bringing social justice and community-oriented lenses to their work. Practicing with cultural humility, working alongside coworkers in solidarity to uphold antiracist practices, and engaging in self-reflective practices are essential, and I have seen the benefits of these ongoing practices firsthand. By engaging in such a practice, therapeutic spaces are created for individuals to be open and trusting of their care, which serves to create a paradigm shift as antiracist practices have the potential to foster an open, supportive, and effective therapeutic space for all races and ethnicities.

Over the years, I have worked with many Latina adolescent girls following a suicide attempt or at the stage where they had planned or thought about attempting, but were identified in advance by school social workers, parents, or the girls themselves asking for help. These adolescents have so much potential, but at the same time they are often lost between multiple cultures, holding immense pressure to create a better life than the ones their parents fled with limited supports. Zayas (2011), who also is a social worker, developed the Ecodevelopmental model, which provides understanding of the multiple reasons a Latina adolescent may attempt suicide and has greatly helped me throughout my practice in conceptualizing and understanding the challenges and incredible strengths my clients face. However, we don’t know much about the impact of my therapeutic role and the role of other social workers in mitigating future suicide risk, especially when incorporating the Latinx/e sociocultural risk and protective factors.
identified within the model. The relational capacity between myself, the Latina adolescent, and their family is often the key to remaining in the crisis intervention program and thriving, or disengaging and falling back into a cycle of attempting or ideating. This relationship needs to be studied further and a starting point can be with the provider. I recognize that I hold a very strong bias in this work as I believe the therapeutic relationship, along with a strong sociocultural understanding of Latinx/e values, can mitigate suicide risk. I was excited to have the unique opportunity to gather and learn from social workers’ experiences treating Latina adolescents with suicidal ideation and behaviors. I aimed to explore the therapeutic relational role and am determined that it can be an added mitigator to positively change the trajectory for so many of these young Latina women.

**Trustworthiness and Rigor**

The primary researcher was responsible for providing informed consent to all participants enrolling in the study and ensured that every participant understood the purpose of the study and what they would share prior to being interviewed. After each interview, the researcher took detailed notes on themes and core statements. The primary researcher’s qualifications and student role was written clearly and stated to participants as a doctoral student studying clinical social work at the University of Pennsylvania.

The primary researcher ensured rigor through support and close collaboration with the dissertation committee and the dissertation workgroup. Partnering with a research team helped address researcher bias and foster creativity, rigor, and new ideas (Noble & Smith, 2015). The primary researcher met regularly with the dissertation committee who are experts in the field of qualitative research and adolescent suicide risk in Latinx/e communities to provide guidance and debrief the research process. Debriefing is a tool use to identify themes that may be overlooked
during data analysis as a result of being deep in the research process (Padgett, 2016). Debriefing was also used to understand the researcher’s reactions to participants’ attitudes and responses. In addition, the dissertation workgroup, which consisted of four student colleagues and the student researcher’s dissertation chair, provided additional methodological and conceptual guidance and debriefing to support this inquiry. The data analysis process was tracked through an audit trail and reviewed regularly by the dissertation committee for rigor and transparency (Bowen, 2009).

Reflexivity allows for researchers to “better understand the role of the self in the creation of knowledge” in order to “avoid biases, beliefs, and personal experiences on their research” (Berger, 2015, p. 220). This is a critical component of quality control in qualitative inquiry. To ensure reflexive engagement with personal and professional biases, the primary researcher also kept a reflexivity journal to increase self-awareness and attunement to the qualitative methodology. The researcher monitored her clinical and personal biases in the journal to capture unique and highly personal experiences shared by the participants in the interviews. Acknowledging an awareness of this trust and the credibility toward the profession of social work (Cope, 2014), and acknowledging the power differential between the participant and researcher, are essential. Both were done through personal reflections and honest discussions with the dissertation committee and dissertation workgroup. The process of reflexivity ensured that findings are transferable and credible for creating meaningful change in the therapeutic relationships for the Latina adolescent with suicidality population and their families.
CHAPTER 5: FINDINGS

Organization of Findings

The purpose of this qualitative grounded theory study was to understand social workers’ conceptualization and use of Latinx/Latine sociocultural factors in suicide treatment with Latina adolescents, and the ways in which the therapeutic relationship impacted their suicide attempt trajectory. The findings are organized into four main themes: *The Therapeutic Relationship, Building Therapeutic Approaches for Treating Latina Adolescents and Their Families, Harnessing Strategies to Build More Culturally Responsive Safety Planning*, and *Seeing Social Worker Needs*. These sections will include subheadings and direct quotations to support these concepts. Verbatim communications from all 20 participants were essential to ensure that a breadth of perceptions, experiences, and knowledge of the concepts were found.

Interview data supported the importance of social workers’ unique understanding of sociocultural factors in suicide treatment with Latina adolescents and their families and examined how these clinicians build these relationships. Participants found that the majority of Latinx/Latine sociocultural factors considered in their risk assessments and safety plans were considered both protective and risk factors. Destigmatizing cultural views of mental health, incorporating sociocultural risk and protective factors in suicide treatment, and building the collective resources around the adolescent Latina were identified as significant reasons for building a Latinx/Latine sociocultural understanding into treatment for suicidality. The primary importance of the individual relationship with the adolescent, the social workers’ relationship with their parents or other family members, and community supports contributed to more effective treatment from the participants’ perspectives. The essential role that bilingual and bicultural social workers hold in grasping a deeper understanding of these factors to connect with
their clients was emphasized throughout the interviews. Utilizing different modalities of care (individual, collateral, and family), providing therapeutic tools, and engaging in trainings, identity work, and processing their own lived experiences aided the social workers’ abilities to successfully engage and provide effective care for their Latina adolescent clients and their family members in suicide treatment. Throughout the findings, the researcher attempted to demonstrate how participants’ biases reflected the need to increase awareness of these implicit and explicit positions and its impact on suicide treatment for Latina adolescents. Lastly, the findings focused on evidence for expanding the Ecodevelopmental model to include mental health treatment, the Latina adolescent’s relationship with the social worker, and the social worker’s knowledge of sociocultural factors to broaden the trajectory away from the Latina adolescent’s suicide attempt.

**Demographics**

Findings are derived from 20 social workers (See Table 3). Two of the participants were male and 18 were female, and collectively they ranged in professional social work practice experience from 2 years to 28 years. Racial identification was broken down as: Caucasian $n=6$ (30%), Black $n=1$ (5%), Latinx/Latine/Hispanic $n=10$ (50%), Asian $n=1$ (.05%), and Multiracial $n=2$ (.1%). Eleven social workers were recruited from outpatient community-based mental health clinics in Manhattan, Brooklyn, and Queens, one from a community-based extracurricular program for Latina adolescents with a history of suicidal behaviors, and the remainder were working in outpatient hospital-based mental health clinics in Manhattan and the Bronx. Out of the total number of participants, 12 social workers were bilingual English and Spanish-speaking therapists. Seven participants were monolingual English-speaking and one participant was Tagalog and English-speaking. Participants worked with Dominican, Puerto Rican, Guatemalan, Ecuadorian, Mexican, Costa Rican, and Honduran first and second-generation Latina adolescents.
with the majority of their caseload US-born Latinas. Participants’ ethnic and racial backgrounds and languages spoken are labeled after their quotes for the reader to gain a deeper understanding of the impact identity can have on the therapeutic relationship with their Latina adolescent clients and family members. Pseudonyms were given to each participant based on a list of common names associated with each ethnic identity group.

Table 3. Demographics of Participants.

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<th>% of Participants</th>
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The Therapeutic Relationship

1. Building the Individual Relationship

Participants conveyed that creating individual therapeutic relationships with the Latina adolescents was the most essential part of their treatment for suicidal ideation and behaviors. While it was difficult at times to decipher between participants’ skills in mental health treatment vs. suicide treatment specifically, the researcher attempted to label when participants intentionally mentioned relationship building strategies when treating suicidality. Many common strategies for forming the individual relationship with the Latina adolescent were discussed including building trust by creating a non-judgmental space to break down barriers of cultural stigma of mental illness; focusing on ethnic, racial, and gender identities within the dyad by being transparent about social workers’ individual cultural and racial identities; and sharing limits of confidentiality. Participants discussed the need to build trust as a product of Latinx/Latine cultural views of mental health treatment and more specifically, views on suicide treatment as a barrier to building trust such as the influence of familismo, which is commonly perceived as a value that encourages keeping problems and concerns within the family (Lugo Steidel & Contreras, 2003). Participants’ perspectives were that Latinx/Latine families prefer to resolve their problems within the family and the girls were less likely to disclose their distress because of this. Participants reported their Latina adolescent clients worry that disclosure of their interpersonal problems with family members or personal safety due to suicidal behaviors would be jeopardized by telling an “outsider.”

a. Creating a Non-Judgmental Space

Several participants shared their perception that the need to build trust in the therapeutic relationship comes from cultural stigma of mental illness and suicidality, concerns with telling
adults outside of their family, and family members' immigration statuses, hindering the ability to build trust for fear that their status will be disclosed. For example, Daniela, a Dominican American social worker who works mostly with Mexican American, Guatemalan, and Dominican clients in a community-based mental health agency, perceived that mistrust can be associated with immigration status based on her perception of the families she serves along with her own cultural experiences learning that Latinx/Latine families tend to keep their problems "within the family." She perceived that these factors perpetuate distrust in others, causing a greater need for social workers to focus on distinct ways for building trusting relationships with the Latina adolescents:

...you know there’s a lot of trust building that needs to happen, but again, you see, with Latinas specifically there’s even more distrust in other people and trusting others. Because again there’s a lot of those other factors of like immigration, or you know, like family. They want to keep things in the family. We [Latinx/Latine culture] don’t share things with other people. Let’s keep things in the family. And again, that kind of adds another layer of like really building trust and really building connection. (Daniela, Dominican American, English and Spanish-speaking)

Aside from identifying the need to spend more time building trust with Latinx/Latine families, participants described the importance of building trust with Latina adolescents with suicidal behaviors to be a primary goal in treatment due to cultural stigma of mental illness and more specifically, suicide. Kathy, a White social worker, described the relationship as a suicide treatment “tool,” emphasizing the importance of nurturing and caring for a trusting relationship, describing times when she doesn’t “click” with the teen, which could also be due to other reasons such as identity and language that she doesn’t name here:
I think [the trusting relationship] like makes it or breaks it, to be honest, like I think that like I – there has been situations where like for whatever reason like it was really hard for me to click – not – like I was trying to click, but like there was a barrier for like the teen. And like I’ve seen the treatment just not work [without the relationship]. And I think that like – so like just being like really, really mindful of the relationship and how the relationship is utilized as a tool and taken care of and making sure that you’re being consistent and following up and that you’re demonstrating that you’re trustworthy and not judgmental, I mean it’s like huge. (Kathy, White, English-speaking)

Maria, a Dominican American social worker, shared her perception about the importance of trust with her Latina adolescent clients and their families and that without its presence in the therapeutic relationship, suicide treatment cannot happen:

I think that that’s the main component. I think in other ways if there is no trust, it’s very difficult to more understand where the client is coming from and sort of for them to also feel comfortable sharing their feelings and I think being honest about the urges and the intrusive thoughts that they are having and the intensity of those thoughts. So, I think it’s very important to build that relationship and that trust because otherwise it’s not possible to do the work. (Maria, Dominican American, English and Spanish-speaking)

Another element of building a trusting relationship with the Latina adolescents with suicidal ideation and attempts was the social worker’s ability to listen and emotionally tolerate what is shared in sessions. Several participants explained the significance of handling the Latina adolescents’ stories of engaging in suicidal behaviors within a safe, trusting space. They named the challenge of disclosure as a necessary skill for relational growth. Isabella explained how she
conveys safety of their painful stories to increase openness around topics that the adolescents have learned due to a negative stigma associated with admitting to suicide risk, which she was aware of from her own Latina background:

And so, I do think once I sort of also approach it [the disclosure of suicidal thoughts or behaviors] with this doesn’t scare me as a clinician, like in hearing what’s going on, I think is also very helpful in establishing them to really open up and really get to what it really is. Like these are the certain topics that we shouldn’t be talking about. Maybe just setting the tone initially really is important there to get to a place where, okay, this is what’s going on and this is the intention and this is why this is happening. (Isabella, Colombian American, English and Spanish-speaking)

Lastly, Emily also used the approach of conveying a trusting relationship by explicitly stating that she can hold their painful experiences within the therapeutic space without “falling apart” or having a judgmental reaction:

I feel like a big thing that I see is can I share this with you [the therapist] without you falling apart and being very concerned about my feelings and everything about me and the piece of just owning that and naming it, right? (Emily, White, English-speaking)

b. Being Transparent About Identity

Many participants who identified as Latinx/Latine spoke about using their own identities as a crucial piece in breaking down barriers to building the relationship. Sofia’s Colombian American identity and knowledge of mental illness stigma from her own experiences growing up as a Latina and from working with Latinx/Latine communities inform her strategy of starting slowly and letting the adolescent lead the beginning sessions of treatment builds trust. Her bias that Latinx/Latine families are not trusting informs her desire to avoid barriers to engagement
through disclosure of her own identity and not pushing when gathering information at the start of treatment:

I just think being Latina and kind of meeting them where they’re at, and kind of starting slow and letting them guide the conversations in the beginning, not pushing too much, is helpful for them. They come from families who are not trusting, so oftentimes they are also not trusting and hold back a lot. But if you move too fast and just throw everything at them – because sometimes we are starting these sessions with a lot of information.

(Sofia, Colombian American, English and Spanish-speaking)

Further, participants found that disclosing their racial and ethnic identities helped bridge connections and trust in the relationship. Latina social workers used their identities as tools to build trust in the relationship. Carla spoke about the importance of labeling her identity as a Latina in order to build trust and comfort, hoping to ease discomfort of revealing their personal challenges through a connected identity:

[Sometimes it’s] feeling a little bit like almost like there’s an elephant in the room or they don’t want to discuss it [ethnic identity] so I’m always like very open and honest about you know who I am. Yeah, but I feel like that plays a huge role, because just based off looking at someone and just wondering like okay there’s already a huge stigma within the culture, I don’t know this lady I don’t know if she will understand where I’m coming from. (Carla, Paraguayan and Cuban American, English and Spanish-speaking)

For non-Latina identifying social workers, disclosure of their distinct identities was also helpful to break through barriers of trust and comfort and created a more transparent and open therapeutic relationship. Jessica, a White social worker who acquired Spanish language skills in school and uses Spanish in her practice, shared how she talks about her identity:
But I think having an honest conversation about how patients feel about my background or maybe what barriers they think could come up in treatment and we just talk about how they feel and I validate for them – and yeah. I think just putting it out there. (Jessica, White, English and Spanish-speaking)

Jenna, another White participant, explained the importance of identity authenticity in building therapeutic trust, but that this is not unique to working with Latina adolescents as she holds the perspective that all adolescents require this in the therapeutic relationship building process:

Well, I’m not Latina…And that treating your authentic self to the work because teenagers can kinda see right through anything you pretend. So, really being authentic no matter who you are is I think key to building that relationship. And being consistent and reliable. (Jenna, White, English-speaking)

Speaking to the significance of a shared identity that does not involve race or ethnicity, Sylvia, a participant who immigrated from Southeast Asia when she was 10 years old, spoke about her shared immigrant identity as a valuable relational growth tool with Latina adolescents who immigrated to the United States or with their parents:

If they disclose something about being from an immigrant family or background that is something that I share with them as well. That’s my background as well. If there’s something I can relate with them as far as those factors then I do disclose that. (Sylvia, Southeast Asian, English and Tagalog-speaking)

The two Latino male social worker participants explained how engagement and disclosure of identity to the Latina adolescents can be difficult given their comfort working with someone of the opposite gender, particularly for those with a history of abuse by a male caretaker. However, disclosing their identity as a part of the same culture along with an
easygoing and openminded approach helped Latina adolescents break down their barriers to engagement. Diego explained his strategies of taking a non-judgmental stance and providing the Latina adolescents with a different perspective of a Latino male helping professional and his intersectional identities. Diego saw that by withholding judgment in the therapeutic space, he can communicate to the Latina adolescent that he is trustworthy, allowing the teen to create or recreate a positive interpretation of a Latino male provider:

Well, I think that as a male therapist, it’s the idea of giving them a different perspective on who they are working with and to look at concept of communication respect and the ability to share without being judged. I think that the idea that having a male working with them that can be supportive, that is not judgmental, that is not abusive brings a different spark to the process. So, working with females becomes a little bit of difficult at times is the idea of creating what I call a universal nest and I bring it up. I’m a male, I was raised in the Caribbean so I can understand but I want to hear from you, the fact that I can provide support and be nonjudgmental, it’s very important. And it takes time.

(Diego, Puerto Rican, English and Spanish-speaking)

\[c. \text{Sharing and Managing Limits of Confidentiality}\]

Being honest and transparent from start of treatment, by offering psychoeducation of limits of confidentiality as well as revisiting the topic regularly, also served to increase openness and trust in the Latina adolescents’ social workers. While limits of confidentiality are expected to be discussed with all clients of any race or ethnicity in treatment, Sofia’s perspective was that taking more time to go over these limits is especially important for Latina adolescents because of her perception that Latine/x families lack familiarity with mental health care due to a negative stigma associated with seeking out services. She explained how Latina adolescents may withhold
information if they think their social worker will disclose information without their permission and the importance of specifically going over confidentiality limits when their safety is at risk:

It affects how open they are with us initially, because they don’t want to share too much, or they feel that we’re gonna talk to their parents. Part of the information that we do is provide a lot of psychoeducation at the beginning about confidentiality and the process…Some kids will say, they tell my mom everything. And then we want to clarify what that means, because if they told them about the suicidal ideation, they need to understand confidentiality and the limits that we have, and what we do have to disclose. Maybe no one’s really went over that with them. So, that’s helpful. And then knowing that I’m not breaking the confidentiality is also very important. (Sofia, Colombian American, English and Spanish-speaking)

In addition, all of the participants mentioned how they aim to include parents or other family members in the Latina adolescents’ treatment because they have seen familial therapeutic engagement benefit the treatment in creating more open dialogue around the adolescent’s distress and help parents process their experience raising an adolescent with suicidal ideation and behaviors. However, several social workers mentioned that they encounter challenges maintaining confidentiality when there is a safety risk and have to disclose their concerns to family members as the adolescent does not want their parents to know due to the shame of admitting they are struggling. They shared that balancing the core therapeutic relationship with the adolescents when trying to maintain safety is challenging. Henrietta, who predominantly works with Dominican American and Mexican adolescents, thought about this barrier to engagement when managing suicide risk in her interview:
And I wonder - and as I’m thinking about it, I’m like I wonder if [including families] also affects how much they tell me sometimes. But I think that once I think suicide is brought up, I have to get support around them because I can’t be there for them and I’m not in their home, so I’m definitely quick to juggle that. And then after it’s over, again, I maintain their confidentiality so it’s not like I’m calling the parent like listen, I just want to tell you that she told me that. I maintain it and try to have that contact with the family as needed, right, or how severe or high risk what they told me was. (Henrietta, Puerto Rican and African American, English and Spanish-speaking)

2. Forming the Parent Relationship

Social workers discussed their experiences entering a separate therapeutic relationship with the parents of the Latina adolescents where they aim to empower, culturally understand the parents’ perspectives about mental health treatment, and increase the parents’ understanding of the severity of their suicide risk. When asked what was the biggest challenge they encountered when treating Latina adolescents for suicidal behaviors and working with their families, the majority of participants expressed difficulty getting buy-in from their parents to engage in treatment and utilize recommendations from the social worker to increase safety and support for their children.

The participants perceived that this was due to cultural stigma around mental illness leading to challenges trusting mental health providers as well as prioritizing other psychosocial stressors (e.g., financial and economic burdens) over engagement in mental health care. Several participants spoke about the “fear of stigma,” or concerns with engagement because of cultural and societal negative messaging around seeking mental health treatment and/or being labeled as mentally unwell. Participants’ perspectives that fear of mental illness stigma keeps families away
from treatment is concerning. We need to consider the much wider reasons why this stigma exists. Stigma of mental illness needs to be recognized as the fear of being involved in an American system and the consequences of mental illness labeling. The tension between mental illness stigma versus the importance of prioritizing the health and well-being of the parents’ daughters needs to be addressed on a societal level. With this in mind, it was clear that social workers hold a unique responsibility in building a trusting relationship, establishing mutual empathy through understanding both the parents’ and the clinician’s goals, and addressing barriers to engagement within all ecological layers that surround the adolescent (e.g., family/home, school, political environment). And while stigma of mental illness, mental health treatment, and suicide is strongly rooted in Latinx/Latine culture and within individual families’ perspectives, participants revealed how Latina adolescents and their families will engage in the therapeutic process once consent, confidentiality, and treatment structure are established, pointing again to the importance of the clinician’s role in reframing the families’ perspectives of mental health care.

Examples of parental barriers to engagement due to stigma of mental illness and the involvement of systems can be seen through one participant’s description that parental concern for disclosure of their child’s behaviors would cause other systems to get involved such as Child Protective Services or immigration officials. Sofia described this fear from her perspective of working with predominantly Latinx/Latine immigrant parents, “…the parents that are not documented are very – they lack a lot of trust in agencies. They spend a lot of time staying away from anything that can bring attention to them or result in affecting their immigration status” (Sofía, Colombian American, English and Spanish-speaking).
In addition, denial was another component that participants noticed had hindered relationship building with their adolescent’s therapist. Carlos, a Dominican American social worker, perceived that gender-specific expectations within Latinx/Latine culture impacts parents’ abilities to accept their child’s suffering. These core assumptions prescribed toward each gender serve to blame poor treatment engagement among Latinx/Latine parents and perhaps dismiss other explanations on multiple ecological layers surrounding the adolescent (e.g., therapist, parents, other family members, school, societal and cultural messaging):

Mom is in her feelings because Mom doesn’t wanna come around to saying my daughter hurts herself. Or Dad is machismo culture, I don’t talk about my feelings, everything’s fine, arms crossed and I don’t see why my daughter’s even here. (Carlos, Dominican American, English and Spanish-speaking)

As previously mentioned, cultural stigma with seeking mental health care can lead to less awareness of and comfort with mental health treatment and impact familiarity of symptomatology. Henrietta, who works primarily with Dominican American parents, explained how some parents may attribute suicidal behaviors to attention-seeking or laziness of the adolescent. She described how it is common for parents to say to her, “I think it’s she’s just being lazy. No, she’s just acting” (Henrietta, Puerto Rican and African American, English and Spanish-speaking) and perceived this as a defense mechanism to distance themselves from acknowledging their child’s mental illness, one likely rooted in the stigma associated with not wanting her daughter to be experiencing more serious concerns. Given that all participants reflected on the importance of parent engagement in suicide treatment with Latina adolescents as a core benefit from their perspectives, a deeper look is needed into the ways in which relational growth building between the therapist and the parent can occur. Participants spoke about using
empathic understanding, validation, and sociocultural conceptualization of the root of their emotional experiences and behaviors when working with the teen’s parents.

Carlos discussed the ways in which he integrated the parent’s migration history and the impact of trying to focus on building their “American Dream” to empathize and validate the parents’ experiences as well as to help the parents validate their adolescent’s current challenges:

...okay, we’re gonna talk a little bit about what it was like when you first came into the country, and what kinda work did you do? So, let’s talk about how you had five jobs and you were unable to always be around your kid. Right? And maybe that’s why your kid’s having a bit of a hard time, right? And it’s not a judgement. …But throughout the course of the early work and establishing that therapeutic alliance, really getting an understanding of where the family’s at within the socioeconomic, political. …So, exploring that experience and understanding how that experience impacted them, and how that stands in relation to the other family members and community members is so – is such a vital component. (Carlos, Dominican American, English and Spanish-speaking)

Henrietta describes a similar experience taking time to understand the generational period when parents were raised to better conceptualize the adolescent’s current challenges with suicide risk and how to work with their parents with these experiences in mind. It is important to highlight that her own generational bias and perspective of each generation shapes the way she may interpret these questions:

I also think about the time that they’re living in, too. Right? So, if a mom was born in the 70s or 80s versus whether they were born in the 50s and 60s, right? Because I think that kind of different frame of what all this means, right, and they’re like what? I’ve never heard of this and why’s my daughter doing this, and this is new to me. So, I feel like I -
based on what frame and what was - how women were seen in their time…Or if I’m talking to the father, well, his culture, he’s a different generation or like, these things that he is believing that is leading him to teach - to treat the, his stepdaughter this way, right? Those kinds of things. And I feel like that really helps me with thinking about okay, how can I explain this? (Henrietta, Puerto Rican and African American, English and Spanish-speaking)

Another way social workers shared how they work with parents separately in suicide treatment for Latina adolescents is through the use of empowerment. Diego, a Puerto Rican social worker, serves to empower his clients’ parents by reminding them of their essential role in the Latina adolescent’s life and how they can support the work that he is doing to improve their overall functioning. He explained their fundamental contribution to their child’s treatment:

One thing that I say to parents when I am treating adolescents or children is that they become my eyes and ears, so I want to hear from them what’s going on, what’s working and what’s not working, that this is not a process of one person. And that’s very important, that you, within the boundaries of the main client, would be the Latina adolescent, that you work conjointly with the family, trying to maintain that relationship.

(Diego, Puerto Rican, English and Spanish-speaking)

Sonia, a Dominican American social worker, utilized a similar strategy in which she named the parent as the parenting “expert” to empower their role:

I will say things to involve the family, to make them know that their participation and treatment is very valuable. I remind them, I’m only with your daughter for 45 minutes, max, an hour. You’re with her 24/7. You’re the expert of your child, so your insight is very valuable. And this seems to make them feel like, yeah. I do know about my child,
and what I say is important. (Sonia, Puerto Rican and Dominican American, English and Spanish-speaking-speaking)

Isabella, a Colombian American social worker who works primarily with Mexican, Dominican, and Puerto Rican families, empowered parents to work toward using strengths-based parenting practices and held a view that caring for an adolescent who attempted suicide is traumatic. Her perception that immigrant Latinx/Latine parents are “rigid” in order to survive in this country is shaped by her own upbringing as an immigrant:

And also, in terms of coming to this country and assimilating and following the rules and all this stuff. So, I take that rigidity from the parents and I tap into that to offer a different perspective. And that perspective is that you are also capable of changing. What is happening now can be something of great strength that maybe wouldn't have been possible had this traumatic event happened. (Isabella, Colombian American, English and Spanish-speaking)

All of the participants described working separately with the adolescents’ parents as a core need in suicide treatment with Latina adolescents, noticing that safety and the parent/child relationship were improved through their engagement with their child’s therapist. Participants perceived that their adolescent clients suffered when parents were absent from their child’s treatment. Valentina perceived that parents’ absences are often due to their inability to accept their contribution to their child’s suicide risk because of their own past trauma, which may be shaped by her own upbringing as a Latina adolescent:

The other half it’s like, here, take care of my child. They’re having issues, and sort of they have nothing to do with it. I think a lot of people think that way, and it’s very, very hard for people to come to terms with any role that they might be playing because they
have their own generational trauma that maybe fit in the same place. (Valentina, Puerto Rican and Dominican American, English and Spanish-speaking)

Further along in Sonia’s interview, she shared how the absence of the parent is the most difficult challenge she faces when working with Latina adolescents and their parents around suicide. She perceived that parental absence negatively impacts the adolescent’s treatment trajectory and incorporating skills training, or reaching out to check in on how the parent is managing, can be helpful with more hesitant parents:

It is the family that just is not interested in engaging, will not either answer the phone or will come to one session, and are very resistant to therapy. They’re elsewhere. Or it’s a mentality of well, she’s seeing you. And she’s still likes this. It’s on you, without you understanding how important family support is, whether it’s reminding of let’s practice your skills. Or just being an ear for them or checking in on them. That’s really the most difficult part, especially with suicidal behaviors. (Sonia, Puerto Rican and Dominican American, English and Spanish-speaking)

Participants who are parents themselves shared that they use disclosure of their parenting identity as a tool in the parent relationship and described how their own challenges raising their children served to connect and validate the Latinas’ parents’ caretaking struggles. Emily, a White social worker, described this connection:

As a parent, and that being part of my identity, I feel like I could also kind of be in sort of like a caretaking like really - you know the kids who drive you crazy and all the provocative stuff. I feel like I have so much more empathy as a parent because I’ve seen my kids suffer. And in a way, I definitely use that whenever I think it would be helpful
for parents to know, right? Whenever I think it would be helpful. (Emily, White, English-speaking)

Overall, all participants described that the Latina adolescents benefitted from parent involvement in Latina adolescent suicide treatment and that parent engagement served to impact the trajectory of treatment as Daniela explained:

It takes the work of me, helping the parent trust me and that helps the parent sort of help the adolescent and then that helps my relationship with them. …But it takes a family effort, and I think if you disregard the parents it's going to be that much harder to work with the adolescent. I found that working with parents has led to so much better progress in terms of my therapeutic work and therapeutic relationship with the adolescent.

(Daniela, Dominican American, English and Spanish-speaking)

Lastly, Daniela also highlighted that greater safety and protection can be achieved with the parent’s active engagement in their daughter’s treatment. She stated, “Involving them in treatment and not just informing them of treatment. I think that’s also really important to assist in providing a protective environment for the patient” (Sonia, Puerto Rican and Dominican American, English-speaking and Spanish-speaking).

a. Missing the Father

Participants noted that participation in therapy sessions was mostly comprised of Latina adolescents and their mothers. They spoke about the need and desire to include fathers in treatment both from their own perspective and from the Latina adolescents’ perspectives. Several participants attributed the fathers’ absences to working long hours to provide for their families while others spoke about single-mother households where the father was either not in the adolescent’s life or came and went without providing a consistent support role. Isabella
mentioned that she has never worked collaterally with a father and conveyed the significance of recognizing his absence in her interview:

Like the room has always been me, the adolescent, and the mom. I don't think there's been more than that. Maybe like a younger sibling and just sort of seeing that dynamic. But that really stands out to me. Which I think brings us to another conversation in terms of like *machismo* in the culture and the way men sort of view mental health. And so, I have to tell you, I can't remember a time where, yeah, where a dad was involved.

(Isabella, Colombian American, English and Spanish-speaking)

A different interviewee, Sofia, who mostly works with single-parent household families, shared how the absence of the father in the adolescent’s life impacted knowledge of the paternal family history. She spoke about how this hindered her ability to better conceptualize the child’s emotional challenges from a biological perspective. The significance of the underlying biological vulnerabilities of the adolescent is likely shaped by the biopsychosocial conceptualization of mental health that social work students learn early on in their clinical training:

Oftentimes- if let’s say for example, they don’t have the dad in their lives …or maybe the mom had just a very brief relationship with the father of the child, they don’t have much information. So, they don’t know if anything’s ran in the father’s side. They don’t know if anything could have been inherited from the father’s side. They don’t know anything about the father’s side’s mental health. So, they give me only theirs. So oftentimes some things run in families, and they question why did this happen? Why is my child like this? …or left a partner in their country, or just came, sometimes we see some of that. And that affects the parent’s ability to understand their child, understand why this might be happening. (Sofia, Colombian American, English and Spanish-speaking)
Participants further spoke about the challenges they have faced when working with fathers due to a greater stigma toward mental health treatment for Latinx/Latine men. Several participants contributed this to *machismo* culture, encouraging men to be strong and emotionless, and the unwritten rule of keeping everything within the family or within themselves. Henrietta described these challenges working with a Latina adolescent and her stepfather:

> I have a girl who wanted to tell the stepfather that she had a boyfriend. And so, afterwards, I processed that visit with her and she said he didn’t like it because he felt like we were telling our business to you and he doesn’t like that when other people, outsiders, are in our business. …After that session, her father hasn’t really been involved like that. He’s like what’s the need for this and I don’t feel like this has helped anything. We could’ve just talked about this in the house, why did you bring me over here? (Henrietta, Puerto Rican and African American, English and Spanish-speaking)

Participants perceived that cultural stigma of suicide may prevent families from revealing information about their family history of mental illness. Maria spoke about a Dominican American adolescent who recently attempted suicide and how her mother disclosed confusion for this behavior despite the fact that her husband had thought about attempting suicide in the past. Seeing her child go through a similar experience proved to be much more challenging, but wasn’t surprising to Maria as she mentioned that she worked with other Latinx/Latine parents who have disclosed a similar history as their Latina adolescent daughters:

> But I think it’s not unusual to uncover the mother had suicidal ideation or had a suicidal attempt that has never been disclosed to the family. Just yesterday, I was having an important conversation with a mother and she has a really hard time understanding why the child is so guarded, won’t talk to them, is very difficult to read, but the father presents
in the same way and mom disclosed that there might have been, at some point, as an adult, a point where dad was so overwhelmed that he thought of suicide, but the family has never really talked about it that way. (Maria, Dominican American, English and Spanish-speaking)

Diego, a Puerto Rican male participant, shared his perspective that therapy holds a greater pull toward female participation based on his own practice of working primarily with Latinas, further perpetuating the absence of male caregivers and stigma that males do not engage in mental healthcare:

I wish more fathers can get involved. I think that we still see therapy as something that is more female related. …It’s a quote unquote female world…I have worked with some fathers but also, I need to say that many of our clients come from single mother’s family. (Diego, Puerto Rican, English and Spanish-speaking)

Daniela, a Dominican American participant, also mentioned how Latina mothers are more involved in their adolescent’s treatment because of the perceived traditional role placed on mothers as primary caretakers for their children within Latinx/Latine culture. For some participants, it was hard to tease apart from the interview data whether having the fathers in the room was a result of the teen’s interest or the therapeutic modality that may or may not subscribe to the cultural roles commonly found within Latinx/Latine families. Daniela expressed that she wants the father to be involved in order to understand his perspective of his daughter’s functioning to get a thorough interpretation.

It's not often that I work in therapy with the dad. I always encourage it. They're not as present during it. You know again like in terms of the more traditional views dads will be like well mom is the one that takes care of the kids. I'll try to encourage like hey, you
know you're the dad, you’re part of the family, we’re a team. (Daniela, Dominican American, English and Spanish-speaking)

Lastly, participants spoke about the desire to learn more about the Latina adolescent and father relationship, how to improve treatment engagement with Latino fathers, and strategies to improve relationship building between the Latina adolescent and their fathers. Sonia shared her experience working with several Latina adolescents of single-mother households who wanted help building relationships with their fathers:

…I personally haven’t read anything on the relationship between a young lady and her father, especially in the Latina community. I can think of six off the top of my head that have really sought treatment because of the fallout from the relationship with their dad, whether it was divorce, abandonment, you’re 18, I no long have to support you. Or, they felt there was a lack of emotional support, or financial. Or, I can’t communicate. Their manner is so non-emotional, is what they’ll say. Maybe my dad wasn’t taught to have emotions, and doesn’t know how to express it. And he thinks giving me money is showing me love, but I need more, and how do I communicate that. (Sonia, Puerto Rican and Dominican American, English and Spanish-speaking)

In response to this desire to learn more, she offered a program recommendation that could serve to increase the father’s presence:

But there could be a six-week session where you have one therapist working with the teen girls. Whether it’s a male therapist, maybe, working with the fathers, seeing a male be vulnerable and discuss emotions, and talk about that, and so we want that history. And then integrate both. I think that would be so great to address that. Because it’s almost leaving it up to the teen to learn the skills and the communication, and how to express
that to someone who’s not receiving any feedback, any support. (Sonia, Puerto Rican and Dominican American, English and Spanish-speaking)

3. Scaffolding Adolescents and Their Families Toward Their Strengths

a. Finding Resources

Another element that enhanced treatment for Latina adolescents with suicidal ideation and behaviors was the strengthening aspects of Latinx/Latine collectivism and overall community belonging. Participants shared experiences helping Latina adolescents and their families build community around them to increase protection from suicide risk and the strategies they used to work collaboratively with other providers to create a community to improve the adolescent’s overall well-being.

Maria, a Dominican American social worker, described an example of building collective support by helping a Mexican American adolescent with self-harm behaviors and a history of a highly lethal suicide attempt find educational supports outside the normal NYC public school academic trajectory. Maria, who works in a hospital-based mental health agency with predominantly low-income Dominican American families, considered the adolescent’s psychosocial needs as the family looked for this adolescent to help provide for the family:

In this particular case, building that community in a different way. Connecting to a different type of school setting, it was more of a vocational GED program and I think connecting back to that socioeconomic status, it was a school program, and this was a person who was presenting with chronic truancy, the connecting to a program that had a vocational component that also offered paid work. And this really was a game changer for them, being able to go to school and also have an income while thinking that there were still so little of support that they had and being able to connect to other adults and
other youth and that way and also make some money I think was really helpful for this young person. (Maria, Dominican American, English and Spanish-speaking)

Social workers increased resources around the Latina adolescent by making referrals to other agencies as a supplemental support with ongoing outpatient mental health treatment. Sofia explained how her community-based agency, which serves predominantly low-income and recent immigrants from Ecuador and Colombia, has access to many community programs and allowed her to build the Latina adolescent’s supports.

We’re a huge agency that we have a lot of access to different programs. We have home-based crisis intervention services. We have health home services. We have preventive services that we’ve been able to support the family with, even in the event that ACS does not accept the call. Then it lets us be able to make a psychiatric referral and kind of move forward with putting in all the services that are needed to ensure safety. (Sofia, Colombian American, English and Spanish-speaking)

When asked about the ways in which her agency serves to best support Latina adolescents, another participant, Jenna, who identifies as White and works at a community-based program, described how case management services, a program that assigns a case manager to each individual adolescent and checks in on them regularly as well as collaborates with their clinicians, are essential for building their support network:

I really think the building of the supportive community. So, and then, the girls often say it’s been so important that my case manager just checks in with me so that they know that there’s someone on their side and that they’re not alone. So, I mean, I think the comprehensive case management and then youth development group work is always critical for them. The case managers do a lot of collaboration also with therapists so that
they – so we’re on the same treatment plan. And then, often just navigating tensions
within the family. Sometimes we’ll get calls when they are fighting with their mom or –
to kinda help build stronger communication between them. (Jenna, White, English-
speaking)

Jenna expanded on the supports her program provides Latina adolescents. She perceived that
building the adolescent’s collective can also be tangential by creating a culturally attuned space,
making the agency a community for the Latina adolescent and their families all on its own:

It’s decorated and painted in a way that’s very youth friendly but also has a lot of
representation from Latina culture and art. …And it’s also really important for us to help
them connect with, and identify other, maybe distinguished Latinas to see people who are
doing really good things. (Jenna, White, English-speaking)

She also spoke about additional supports that her agency has found to build the collective instead
of seeking resources from outside:

…During the pandemic we saw that our families were in great need, so we started a
weekly parent support group in Spanish. That was an opportunity for them build
relationships with other parents who are going through similar things. They talked about
their own histories and how it might be hard for them to be fully present for their kids if
they have their own unresolved trauma or own mental health needs. Another thing the
parents talked about was how the lack of English-speaking skills has interfered with them
being out the job market and connecting with schools. So, we started, last summer, an
ESL class for our parents. So, we’re adapting to what they tell us they need and then kind
of see if we can do it. (Jenna, White, English-speaking)

Carlos, a Dominican American social worker, summarized the positive impact of these additional
supports on the Latina adolescents’ well-being:

This changes to where, all of a sudden, the kid now has all these superheroes around them that they see as superheroes, that they welcome as superheroes and they wanna work with. And everyone’s just working together like this beautiful quilt. And that’s the amazing point. (Carlos, Dominican American, English and Spanish-speaking)

b. Building Their Community

In addition to identifying specific resources to build community around the Latina adolescents and their families, social workers also discussed the importance of collaboration with other services and providers involved in their treatment in influencing a positive treatment trajectory. Sonia, a hospital-based outpatient mental health agency social worker, explained how her collaboration with the adolescent’s psychiatrist demonstrated for the adolescent and the family that they have a treatment team who are working together to help improve the Latina adolescent’s acute suicidal risk to increase the adolescent’s comfort and engagement in treatment. “But we communicate. And I’ll let them know what we’ve discussed, and to help also bridge that relationship, and adding additional interventions to them” (Sonia, Dominican American, English and Spanish-speaking). Lisa, who works at a different hospital-based outpatient mental health agency, also shared how she utilizes a team approach to collaborate around ways in which each therapeutic team member can support the family differently. She explained how her support staff (e.g., teaching assistant, teacher) are helpful in building a community around the adolescent to increase a sense of cultural familiarity and belonging. By contrast, this approach also served to colonize, increasing the likelihood of having the families listen to the team as opposed to finding out why they may not be following the team’s recommendations and fostering the family’s own decision-making process.
I think our support staff, I think that goes a very long way with our kids who are from Latinx backgrounds. Our teaching assistant, she’s a paraprofessional, is from the Dominican Republic and is bilingual and she is often the one who contacts the parents to kind of say look, you gotta listen to the clinical team because they’re really trying to help you and she knows what some of those road blocks are, the kids feel very comfortable with her, sometimes they’re telling her things that they’re not sharing with their – with our therapists and so that environment I think is very inviting. (Lisa, White, English-speaking)

In some cases, participants described giving the adolescents tools that may not be considered within their therapist role. For example, Kathy, a White social worker, described how she balanced treating a Latina adolescent with suicidal behaviors and depression, while also targeting her academic goals and providing support as a college advisor to help them continue on the path toward thriving rather than just surviving. Thus, social workers approach suicide prevention in multifaceted ways, stepping into different roles depending on their needs. She recognized that sociocultural factors such as having monolingual Spanish speaking parents and the family’s values of marianismo, encouraging Latinas to remain at home, can impact life goals due to the potential parental pressure. She also highlighted that the lack of knowledge about the college application process that first-generation college students may hold within their family in addition to not having sufficient resources available to them at their high school. Kathy described how this additional role has the potential to positively improve their needs:

So, there’s this pressure to perform and do well and have good grades, but then maybe most of the teens I’ve worked with were first generation for college, and so then not having like a parent who maybe fully understood the process but then maybe going to
like a lower-resourced school so they’re not getting a ton of support with applying and figuring out college. And so then I’m ending up being their like college advisor. And like I – luckily, I’ve done this like in the – I did like college advising stuff in the past, so it’s helpful. But it’s just – it’s tough because like we’re trying to figure out their emotions and their suicidality and keep them safe. But then part of keeping them safe is creating that life worth living and like helping them reach their goals and like that’s a big part of their goal. (Kathy, White, English-speaking)

Summary

This section reinforces the idea that relationship building is an essential part of the therapeutic process when treating Latina adolescents and working with their family members. From their perspectives, to do this work, significant efforts are required from clinicians to engage in culturally attuned practices that convey mutual empathy and understanding of shared connectedness and trust, as well as to shape the adolescent’s trajectory away from the attempt by focusing on cultural strengths to build familial and community support around them.

II. Building Therapeutic Approaches for Treating Latina Adolescents and Their Families

As mentioned before, participants identified in their interviews that the therapeutic relationships were the most essential component of treatment of Latina adolescents and their family members. Some of the workers’ approaches are mentioned throughout the findings, however, this section serves to place them into distinct categories. To approach these unique therapeutic relationships, four common themes were explored by the participants: Providing Psychoeducation, Benefiting from Biculturality and Bilingualism, Teaching Perspective-Taking, and Balancing Individualism and Collectivism. Participants conveyed in their interviews that these therapeutic approaches help move the Latina adolescent from surviving to thriving. This
researcher added findings related to *Holding Clinician Biases* to recognize the impact that clinicians’ implicit and explicit biases hold within these relationships, impacting relationship building, potentially causing harm, and perhaps increasing hesitation from clients to engage in care.

1. **Providing Psychoeducation**

   Social workers described how they provide psychoeducational tools about suicide, mental health, and treatment strategies, and act as an emotional language broker between mental health care systems and families to foster understanding for the Latina adolescent and their parents. Several participants spoke about the explicit, concrete strategies they used with families, such as teaching parents ways to validate their children’s experiences and introducing coping strategies to tolerate emotional distress. Others discussed the tools abstractly, including teaching adolescents and families through psychoeducation about sociocultural factors that relate to suicide risk for Latina adolescents. Another strategy was reminding and building on the tools families already have, as Isabella recognized, “And so, the way that I approach it from a cultural perspective is that it’s sort of reminding the parent that the child is also very resilient and that the family is also capable of being very resilient” (Isabella, Colombian American, English and Spanish-speaking), validating the strength and resilience that the immigrant families she works with hold from both her own personal experience immigrating to the United States and through an awareness of a marginalized Latinx/Latine status in the United States.

   Several participants explained how they utilize psychoeducation consistently in treatment sessions on numerous mental health topics, and they specifically spoke about the content they teach the teens’ parents. Henrietta used psychoeducation to make the connection between suicide risk and acculturative distress: “I think psycho-educating the families, too, about acculturation
and what does that mean” (Henrietta, Puerto Rican and African American, English and Spanish-speaking), while Valentina teaches about the family’s influence on the adolescent: “I try to make connections sometimes about the family experience if there’s – what the family dynamic can be, be aware about that, if there’s another language being spoken” (Valentina, Puerto Rican and Dominican American, English and Spanish-speaking).

Participants held a variety of assumptions based on the ethnic Latinx/Latine groups that they worked with, leading to biased views about Latinx/Latine cultural experiences and immigration pathways of leaving and entering the United States. These were partially grounded in how some clients described these experiences, and partially grounded in unexplored socialization to sociocultural stereotypes. Laura perceived that Latinx/Latine parents who had experienced immigration trauma were less naturally attuned to their child’s emotional needs based on real or imagined methods of entering the United States. She grounded her work in these assumptions and used psychoeducation to teach parents validation strategies. Laura believed that the immigrant parents that she works with benefitted from learning how to validate their children’s emotions:

They’re like well, you have a roof over your head, you have food, you’re going to school. I don’t see what the issue is. Why are you so upset, right? That’s something that I hear. They don’t understand that there’s also emotional needs that the children need. So, I think maybe having a little bit more psychoeducation around that. (Laura, Afro Cuban and German American, English-speaking)

Maria, a Dominican American social worker, shared that she provides psychoeducation on the adolescent’s diagnosis and symptoms, and that understanding the parent’s awareness of the impact of mental health on their well-being is really important when teaching about these topics.
Her description connects back to the role of the social worker as cultural broker between Western, industrialized methods of conceptualizing and delivering therapeutic care and immigrant/migrant experiences:

I think when it comes to providing a lot of psychoeducation in terms of what’s presenting and I think diagnosing as well, but I think more describing it in a way that families can hear it and understand it in terms of the stressors that are coming up. (Maria, Dominican American, English and Spanish-speaking)

In terms of concrete psychoeducational tools, several participants mentioned teaching the adolescents a variety of coping strategies. Camila explained that she teaches adolescents using metaphors to reinforce these strategies. She also spoke of teaching the same coping strategies to the parents with the goal of prioritizing parent well-being and to model emotional self-regulation for their child, which several participants identified was a common challenge for parents as well. Camila explained this in her interview:

I think [parents] have noticed which strategies work, whether it’s problem-solving skills, mindfulness, whatever works, and they implement that. I always tell both of my clients you can’t, whether it’s the parents or it’s the child, we’re gonna pretend we’re on an airplane and they always say you have to make sure your mask is on first before you help someone else, so I always tell them you need to help yourself first before you can help other people. If mom is feeling stressed out, you’re not gonna help your daughter because you are stressed out. So, I always tend to kind of do a little coping skills with mom as well. (Camila, Ecuadorian American, English and Spanish-speaking)

a. Mentalizing vs. Physicalizing
Participants perceived that Latinx/Latine cultural stigma around mental illness and level of education led families to focus more on concrete medical needs over abstract mental health concerns, requiring providers to better understand cultural and familial perspectives of mental health to enhance engagement. This, again, points to the importance of understanding why this stigma exists. It is important to understand the multiple layers, built from fear of becoming involved in an American system and the consequences of mental illness labeling, rather than focusing on the idea that parents are prioritizing avoiding the stigma over their child’s mental health concerns. The need to enhance engagement comes from the providers’ views directing treatment goals and objectives, and perhaps is grounded from their own desire to see client improvements and beliefs around how parents should perceive their children’s mental health concerns. Building awareness of the benefits of engagement in mental health treatment, validating the challenges of addressing emotional needs, and using metaphors and self-disclosure to increase treatment buy-in were some of the specific strategies social worker participants spoke about during their interviews. All but two participants mentioned stigma of mental illness within Latinx/Latine community as a barrier to engagement or in response to the Latina adolescent’s overall mental health functioning at least once during the interview. Several participants summarized that this was due to negative cultural views of mental health, the family’s religious beliefs, or a family member’s negative experience seeking mental health services. It was clear from the interview data that an important next step can be increasing knowledge of the reasons why cultural stigma of mental illness exists from a larger systems perspective.

Many participants mentioned how Latinx/Latine parents take a concrete view of the adolescent’s overall functioning through the dichotomy of mentalizing (Allen, 2003) versus physicalizing mental health disorders. Emily described how many parents she works with speak
about their Latina adolescent’s symptoms concretely, which she viewed as a barrier in that it prevented the parent from reaching out for help because they could not “see” the suicidal thoughts, an important aspect of depressive symptomatology. This highlights the importance of providing psychoeducation around the less observable symptoms of depression and suicidality:

I feel like when I hear parents’ perception, sometimes it’s more like she’s tired, so more of a noticing of physical state or noticing eating and sleeping and that the other stuff is very internal. Because medical – we all know, we all bring kids to the pediatrician and how important that is, and mental health is something so much more abstract than that.

(Emily, White, English-speaking)

Carlos also described the challenge of guiding parents, when discussing the severity of suicidal behavior, to see their child’s pain without labeling them as mentally ill, due to its abstract nature of the child’s pain. Carlos grounded this aim in his own experience growing up as a Latino and from working with a predominantly Dominican community. He spoke about using a strengths-based perspective with Latinx/Latine parents while also prescribing his own beliefs and ideals around what he believes is needed to change the adolescent’s treatment trajectory:

Getting the parents or guardians to recognize the severity of what’s happening without stigmatizing their child. Which is – it’s such a – I feel like it’s like surgery on the heart. Right? Because we’re, on the one hand, trying to validate these parents that feel exhausted and feel like they’ve failed as parents. And trying to highlight that their strengths were them bringing their kid in… And I would say if your daughter walked in here with a broken arm and I wasn’t holding the door for her when she was coming into my office, you would have an issue with that. And you need to start treating your kid that way. (Carlos, Dominican American, English and Spanish-speaking)
Participants also spoke about an unwritten understanding within the Latinx/Latine community that mental illness is not to be discussed within Latinx/Latine families. Jessica shared in her interview, “There is some secrecy, I feel like, involved in mental health and just the desire to want to keep it more private” (Jessica, White, English and Spanish-speaking). Carlos expressed concern that Latina adolescents may hold back disclosure of suicidal thoughts or behaviors in sessions because of a lack of open dialogue regarding suicide and mental illness among family or community. He shared, “Sometimes it’s just the inability to have a discussion about a very uncomfortable topic, especially coming from a background that’s either ethnically or in the family, we just – we [Dominican Americans] don’t talk about mental health” (Carlos, Dominican American, English and Spanish-speaking), a bias shaped by his own upbringing as a Latino.

Carla, who identifies as Latina and works primarily with Dominican and Puerto Rican families, discussed the secrecy of mental illness as a barrier to seeking services in Latinx/Latine communities that developed from fear of being called “crazy” by others:

A lot of that stigma is that it’s just therapy is for crazy people and really just letting them know that this is not the case. If someone is expressing thoughts of self-harm or suicide it does not mean something is like wrong or they’re crazy. They just need some help and support. (Carla, Paraguayan and Cuban American, English and Spanish-speaking)

Daniela also mentioned how it can be challenging to engage Latina adolescents due to cultural and familial values such as familismo and the importance of “family protectiveness,” factors she is aware of when building the therapeutic relationship, and which have been shown in the literature as both a protective factor and a risk factor in the Latina adolescent attempt trajectory (Zayas, 2011; Peña et al., 2011):
So, there is sort of like yeah like that family protectiveness of we are keeping everything within the family. Don’t share everything like even if it’s your therapist. Be mindful of what you share. So, you know it adds that other layer of like building this relationship and building this trust. (Daniela, Dominican American, English and Spanish-speaking)

In addition to the stigma of mental illness and therapeutic care being passed down across familial generations for suicidality and in general, several participants mentioned how religion within Latinx/Latine communities, which is predominantly Catholic, can be both a protective factor and a barrier in treatment as this religion holds the belief that suicide is immoral and the connection between immorality and suicide is often put onto the Latina adolescents despite them being often less religious than their parents, as Valentina explained:

Religion. Not as much these days, I want to say, but a lot of times they’re Catholic based or Christian. Even if they don’t – they’re not super religious and going to church a lot, parents pray over them, or they pray together, or they believe in God or some higher power, and know or believe that they shouldn’t harm themselves. They have a lot to live for, and that’s a sin. (Valentina, Puerto Rican and Dominican American, English and Spanish-speaking)

One Latina participant, Valentina, spoke about her own journey with starting therapy in her 20s and the fears associated with branching away from her family in order to engage. She highlighted how she can relate to how challenging it is for adolescents to balance Latinx/Latine collectivism and familismo with American therapy due to its pull toward individualism. She shared how difficult it was for her to disclose personal information about herself at first due to not wanting to go against her family’s Latinx/Latine cultural values of keeping family stories and experiences within:
I was not a social worker yet but working in this field, I was 24, and I think I had always had a curiosity about therapy, but it took me a really long time to consider or be like, it’s okay to do that. So, my own experience, I think, contributes a lot because I remember my first time I ever saw a therapist, I said – and she was asking me about my fear of being there, and I was so uncomfortable, and I said something about my family, like what they would think about me being here. And she was like, who cares? Why do you have to tell them? Or something like that. I was like, what do you mean? I have to tell them. I don’t know, to me that was so horrid that I wouldn’t talk about something so important to my family. Where I was like, oh, people do this? They keep those things to themselves? I don’t know. (Valentina, Puerto Rican and Dominican American, English and Spanish-speaking)

When highlighting the concern of mental illness stigma as a barrier to care within their Latina adolescent client’s family, participants explained how they address this concern through naming the stigma, using a strengths-based perspective, and providing more psychoeducation about mental health treatment and suicide in unique ways compared to other ethnic and racially diverse clients. Some participants mentioned that they address stigma of mental illness within Latinx/Latine culture from the very beginning when they meet the teens. For example, Sonia mentioned from having years of experience working with Latinx/Latine clients in a pediatric healthcare setting that she takes a detailed history of the adolescent’s family’s previous and/or current engagement in mental health services, their views of treatment, and whether their family is supportive of the adolescent seeking services at this time.

So, part of our first appointment is really asking regarding their family history, regarding any barriers to treatment. Is there anyone else in your family who has had mental health
therapy, just to get an insight on what their experience has been. The patient may say, oh, yes. I have a cousin who was maybe hospitalized and is taking medication. But then people talk about her in certain ways, so I don’t want people to know. Another example could be, I have cousins who attend, and it’s fine. I told them why I want to go and I thought that was a good idea. So, getting to know, not just the family history, but also how do you think the family supported that person? (Sonia, Puerto Rican and Dominican American, English and Spanish-speaking)

Diego, a Puerto Rican social worker, considered known biases around the family’s country of origin and socioeconomic status to better assess variation in how clients view mental health:

In the Puerto Rican culture, the idea of going to therapy is much more open than in South American culture, except within, there is other layers on this that is socioeconomical status. If you come from a very poor area, a rural area, so there’s still stigma in mental health but if you come from the metropolitan area or a middle class, middle-upper class family, it’s much more open. (Diego, Puerto Rican, English and Spanish-speaking)

Jessica, a White social worker, also explained the need to “unpack” the family’s beliefs of suicide treatment to get a better sense of how this may impact treatment and safety from the beginning of engagement.

Just feeling like oh, they won’t understand or they’re gonna think I’m crazy, I hear that a lot from kids. Like oh, my mom thinks that people who are in mental health treatment are crazy. And then unpacking that and understanding more about that. (Jessica, White, English and Spanish-speaking)
Another participant, Camila, an Ecuadorian American social worker, shared that she incorporates Latinx/Latine culture views of mental health treatment into her care and the origin of these views when considering strategies to implement treatment goals:

But a lot of it is just understanding what mental health is and how it kind of goes against their culture, their religion but it’s kind of just using those two major factors and kind of implementing it within therapy, within the treatment. I think that once they start opening up and seeing like oh, okay, it’s a safe space, I can talk based on engaging which is great because ultimately it helps. (Camila, Ecuadorian American, English and Spanish-speaking)

Lastly, Carla explained that she prefers to outwardly name stigma of mental illness within Latinx/Latine communities and is able to do that openly because of her Latina identity. She expresses to families her goal of doing this work based on her own perceptions of Latinx/Latine stigma of mental illness and the desire to show how engagement can be beneficial:

Being very like transparent with the parents and the kids. Yeah, I'm aware that this is the stigma. And just you know, this is not how it really is, let me show you what therapy is and what it's for. And I can really help. (Carla, Paraguayan and Cuban American, English and Spanish-speaking)

2. Benefiting from Biculturality and Bilingualism

The importance of a shared language and biculturality combined were primary relational growth factors that the social workers of all ethnic and language abilities identified that support building a relationship with both the Latina adolescents and their family members. Participants shared their perspectives that biculturality and bilingualism increased connection across shared cultural backgrounds leading to deeper therapeutic work. Camila found that her bicultural
identity as well as her bilingual Spanish and English language abilities allowed her to understand colloquial sayings that would likely be misunderstood by a provider without these abilities:

I think that’s what kind of makes them feel a little bit more comfortable as well that this is someone who has most likely a similar upbringing or similar culture beliefs and maybe similar religious beliefs that we do. I could understand when they would say stuff like oh, there was a dead person sleeping on top of me because I felt like I couldn't move. Normal people [non-Latinx/Latine clinicians] would be like that’s sleep paralysis, but culturally for us, that’s like oh, there’s a dead person in the room, maybe they came to say hi. So, I can definitely relate to that and I think that makes them feel like okay, I’m not weird or I’m not crazy and we can engage in those discussions as opposed to maybe someone else will say well, it looks like they’re having some hallucinations. (Camila, Ecuadorian American, English and Spanish-speaking)

In addition, her identity as a US-born Latina helps her to relate and bring this perspective to the Latina adolescents around the similar challenges that she faced growing up with parents who were born in South America. While there wasn’t sufficient data to understand whether identity as a US-born Latina hindered rapport with immigrant clients, participant immigration status is an important factor to consider.

I can kind of relate with them the struggle that it is to kind of incorporate both cultures because maybe mom and dad can’t really relate to the American side and you’re trying to teach them how to kind of balance it both out and it’s a struggle. So, I can kind of relate to them in that sense where they might feel stressed out or annoyed or embarrassed or something and I can kind of help them navigate through that. I think that that part, I think
it helps them connect on another level because language is the, similar, and traditions and customs are similar. (Camila, Ecuadorian American, English and Spanish-speaking)

Maria, a Dominican-born social worker, also described a shared connectedness through cultural and linguistical identities, deepening the relationship with both the Latina adolescents and their families. Maria explained how mutual empathy, a Relational Cultural Theory (Jordan, 2018) strategy, brings easiness and trust into the relationship:

    Identifying as a Latina person myself and as a second-generation immigrant and as a parent, I think that making use of the self with experience and the things that I have in common with both the caregivers and with the adolescents I think has been helpful. I think use of language, I think being bilingual and being able to go back and forth easily between family members is also very helpful in building the trust. (Maria, Dominican American, English and Spanish-speaking)

Sonia, another Dominican American participant who was born in the United States, explained her perspective that the individual relationship with the Latina adolescents is stronger when they recognize that their provider understands their cultural identity and speaks Spanish so that they can communicate with the teen’s parents:

    With the Latina patients, I think it’s been so constructive in building that relationship because they feel understood, based on what they inform. Or, because of the language as well, I can involve their parent, and also find ways to explain mental health, to also inform the parent I’m aware of the cultural stigma. I say, I understand Latino families. So those little moments is where you see progress. (Sonia, Puerto Rican and Dominican American, English and Spanish-speaking)
Daniela, a bilingual Spanish and English social worker, shared that she sees this similar openness with the Latina adolescents’ parents once they hear that she speaks Spanish:

…Oh, you speak Spanish. I can just talk to you directly. I don’t need to go through like an interpreter or you know translation services to build this rapport with the therapist. So you know, it adds like sort of that that layer of comfort I’ve noticed parents are like oh my gosh you speak Spanish. Great! And I think that helps bring down their level of guardedness and that’s helped in my relationship with the families that I work with.

(Daniela, Dominican American, English and Spanish-speaking)

Along with the bilingual and bicultural participants’ accounts that these abilities build greater trust and openness in the relationships with the Latina adolescents and their parents, they also spoke about their knowledge of common cultural values that led them toward knowing how to build a deeper relationship. Maria spoke about the value of *personalismo* or the emphasis of relationship building before going into more serious topics around safety and risk:

I think definitely with Latina populations, a lot of that chit chat matters or just sort of getting to know them and not going straight to business, that can be sort of a moment to just kind of check in and talk about what’s going on in the community and opening that little bit of space, a new business opened up or something closed down. If something was in the news that happened in their home country that we can talk about that and ask about how their family members are doing. I think all of that helps build the trust, so oftentimes it doesn’t have to be necessarily personal, but a personal touch. (Maria, Dominican American, English and Spanish-speaking)

Bilingual and bicultural social work participants also discussed consistently using self-disclosure about their shared cultural identities, an important strategy that was discussed earlier in the
findings. They described how normalizing through the process of self-disclosure can be a core strategy to build empathy and relatedness. Maria elaborated further along in her interview that she discloses her identity as a parent, her own upbringing, and her knowledge of other Latinx/Latine families’ struggles to increase connectedness with their adolescent children:

Sometimes if the parents feel very stressed in the parenting and I would share about my stressors that I encounter as a parent as well and same with the adolescents, also, some of the challenges that I had at their age or typical things that we see in other Latino families, not necessarily myself, but that normalizing that we see this in other families in our community as well. (Maria, Dominican American, English and Spanish-speaking)

Carlos also described how he uses self-disclosure around his Latinx/Latine and bilingual identities along with his knowledge of the community he works in as a therapeutic tool to build the therapeutic relationship:

My – for – particularly for my Latin, Latina youth students that I work with – me being honest about my own experiences as a Latino male, and talking about the challenges I’ve had. Working through my own self-disclosure with them is more as a tool, and talking with them about what I’ve seen in my community, right, without being specific but like, yeah, I’ve seen the women be yelled at, I’ve seen women be abused in the community and no one do anything. (Carlos, Dominican American, English and Spanish-speaking)

Sonia, a second-generation Latina, explained how she can connect more with her Latina adolescent clients and their families because she is likely to understand their previous lifestyle living in their country of origin from visiting and hearing about her own family’s country of origin and their specific Latinx ethnic cultures:

And people don’t greet you as warmly. We’re New Yorkers, we get it. But they come
from a culture that’s so warm and inviting, and they know. So, when they experience that, I may share a story of a family member more specific. So, I’ll say, I can imagine exactly. What I just say, you wake up and you’re outdoors, and you’re in the fresh air and here it feels trapped… So, sharing those stories or relating to the country, depending on which it is, I think it’s been helpful in those relationships. (Sonia, Puerto Rican and Dominican American, English and Spanish-speaking)

Sonia also shared the power she holds in changing the stigma of mental illness based on her own cultural perceptions of the Latinx/Latine community in New York City by holding more representation of Latinx/Latine bicultural and bilingual clinicians working in mental health care. She emphasized the community’s preference to value provider and mental health resource recommendations from each other over reading reviews online and that this pathway can help to promote increased family engagement in care:

We are the reviews. The culture in the community is the review. I think in terms of building that relationship and being able to be almost familiar with the language, that makes a patient feel comfortable. There’s some familiarity. You speak the language, or you’re from this place, or oh, we both just happen to be Latinos. There’s some familiarity, and that just brings some comfort to many Latinos. (Sonia, Puerto Rican and Dominican American, English and Spanish-speaking)

Participants who were not bilingual or bicultural concluded that the lack of these shared identities hindered relational growth with their Latinx/Latine families. Emily, a White, monolingual, English speaking participant, explained how both bilingualism and biculturality are instrumental in shaping the work with Latina adolescents and their families:
We have families who work with English-speaking clinicians with translators and it’s not the same. It’s also not the same working with a White clinician who speaks Spanish as a Latina clinician. So, in thinking about running a program, as much as we can do a cultural and language match, it’s just huge. (Emily, White, English-speaking)

In addition to this, Kathy expressed the challenges she faces as a White, monolingual, English speaking clinician due to the difficulty communicating and connecting with Latinx/Latine families:

The language barrier is definitely a challenge sometimes, and I do think that the language barrier does mean there’s more of a time commitment needed. If the parent is processing things in Spanish that maybe are new and more like American like English language, then like how they translate or make sense to them could be different, and so just like I generally can be like kind of quick and fast, and so like making sure that I’m like not going so fast and making sure there’s time for processing and checking in- something I have to be really mindful of. I also think that a big, big part is that I’m not parentifying the teen, so I’m not having the teen translate anything for me, I’m like using the interpreter for all of that. (Kathy, White, English-speaking)

Shanice also pointed out how parent engagement in the Latina adolescent’s treatment can be impacted due to the language barrier of being a non-bilingual speaker:

Because I’m not bilingual in Spanish so, it’s hard to just be able to communicate that effectively with an interpreter. So, I like to as much as possible refer them to a therapist who does speak Spanish but sometimes, they’re like oh no, no, no. My child speaks English, you can speak to her. (Shanice, African American, English-speaking)
Lastly, bilingual and bicultural Latinx/Latine participants shared concrete tools that help bridge the parent/child relationship, especially when the child’s level of Spanish fluency is less advanced than their parents. Henrietta explained that she gives the adolescents words that describe their emotions in Spanish in order to communicate more effectively with their parents, “And sometimes I have to be like okay the word in Spanish is this so that they can tell their parents and their parents can communicate back, right?” (Henrietta, Puerto Rican and African American, English and Spanish-speaking). Maria described in her interview the reasoning for giving this tool:

> We have so many families where parents feel more comfortable in Spanish and the youth feels more comfortable in English and just the language barrier that that causes in particularly in communicating thoughts and feelings, that emotional language that it’s very difficult to express when there isn’t a shared language. (Maria, Dominican American, English and Spanish-speaking)

To also address the language barrier, Sonia shared how she assigns the adolescent and their parents specific tasks to do together at home:

> So, I’ll give them either an assignment, certain days, this hour, it’s your time to build. And I have them continue that, because many teens just want communication or understanding, at least to make them feel that when they choose to go to their parent, they can. They might not be ready to discuss what they actually want to discuss, but building that relationship is helpful. (Sonia, Puerto Rican and Dominican American, English and Spanish-speaking)

3. **Balancing Individualism and Collectivism**
The participants perceived that focusing solely on the client did not align with what they identified as Latinx/Latine collective values and oftentimes impeded relational growth between the social worker and the Latina adolescent and their family members. The social workers spoke about how they help build community around the adolescent through parenting and family sessions rather than isolating the adolescent in treatment through individual therapy. Many participants emphasized that psychotherapy treatment for Latina adolescents with suicidal behaviors is not just an individual journey, but a collective one; they elaborated on the challenges providers face balancing the oftentimes well-acculturated and independent American Latina adolescents with their parents’ community-oriented, collectivist Latinx/Latine culture. Camila shared her own bias of wanting to encourage the Latina adolescent client to make her own decisions while also trying to respect the family’s collectivist values. She explained the need to balance multiple opinions of care based on encountering this challenge with many families in the past while also striving to empower parents and adolescents individually to make their mental health treatment decisions:

One thing I always have to work on is the fact that for parents, family is a big thing, and they take their opinions from their sisters, their brothers, their aunts, their uncles, anyone, and it’s kind of a collective decision, it’s not just an individual decision. The whole family has to be on board before making or reaching a decision and I try respect that and make sure that it’s okay and that I’m understanding, but at the same time I try to share that it could also just be your decision, what’s best for you or what’s best for your daughter and just kind of knowing that they can make that decision on their own and they don’t have to include my uncle from Mexico who spoke to one therapist before and the therapist said something completely different or they don’t need medication, they’re fine,
they just need to eat better or something. (Camila, Ecuadorian American, English and Spanish-speaking)

At the same time, Camila spoke about ways to encourage collectivist values by supporting clients to gather outside supports from religious leaders, “Or they ask their pastor or their priest for a lot of advice and they seek a lot of their help, and I would say it’s a good thing, it’s a good support system.” (Camila, Ecuadorian American, English and Spanish-speaking)

Participants discussed other strengths of building the collective relationships around the adolescent while also helping them to assimilate should they choose to have an independent American lifestyle. Henrietta shared the valuable benefits of bringing Latinx/Latine collectivist values into treatment to increase suicide safety by including parents in treatment:

There’s also a community – they’re more aware so that they are paying more attention. And sometimes it can be suffocating to the adolescent, but at other times it’s like they’re thinking about you. So, I had one girl who, she’s in college now, and her mom was already thinking how do I keep her from not feeling depressed and sad and having these thoughts of suicide while she’s in college? And so, we set up a system of check-ins with her sister and her mom and her mom cooking her meals or visiting. I have another mom who notices now, like hey, ‘just wanted to let you know so and so is not sleeping, and I see that she doesn’t want to go outside. What do I do?’ I definitely feel that our therapeutic relationship is strong, but then afterwards, I think. ‘okay I need to make sure that they’re ongoingly protected’, and part of that is being connected in an ongoing way with the parents. (Henrietta, Puerto Rican and African American, English and Spanish-speaking)
One barrier to balancing individualism and collectivism in suicide treatment mentioned by some participants was the difficulty maintaining a strong therapeutic relationship with the Latina adolescent without jeopardizing the teen’s close relationship with their parents or the parent’s relationship with the social worker. Sylvia shared the concerns parents have expressed to her that she associated with allowing an “outsider” to know about their child’s struggles:

I get a lot where they’re suspicious of the relationship. Like, ‘why is my child telling you things that I’m not being told or why would they need to talk to you when I’m there? They can tell me things and talk to me about things.’ So, sometimes I have to navigate that and ensure that I’m not trying to be a parent to your child, but I can help in this way.

(Sylvia, Southeast Asian, English and Tagalog-speaking)

Daniela also noticed this challenge as she highlighted a pattern of protectiveness and caution in treatment with Latinx/Latine families particularly due to stigma of mental illness treatment and lack of familiarity around traditional individual psychotherapy, which is a view that is shaped by her own identity and experience working with Dominican and Puerto Rican families for many years. She spoke about how solidarity to one’s family can create barriers to forming the individual relationship with the therapist. The importance of balancing both individual therapy sessions and collateral or family therapy sessions together was identified by Daniela and several other participants to be the most effective structural model for treatment with Latina adolescents and their families, especially when suicide risk and safety are the primary concerns.

There is family protectiveness of, ‘we are keeping everything within the family. Don't share everything even if it's your therapist.’ But I've noticed how much more guarded my Latino families are, and it does take that much more effort to really help the family as a unit build trust and my relationship with the adolescent. The adolescent feels like they’re
not going to break this trust. They’re going to be loyal. They’re not bringing it up in therapy. So, in my relationship with these adolescents, it’s a lot of family building and getting to know the family as a unit. Giving the adolescent the space to share things with me that are within the family. That it's okay and it's safe to share with ease to help them progress on their own. (Daniela, Dominican American, English and Spanish-speaking)

Lastly, participants shared strategies that they use to form the “we” with the Latina adolescents and their families through their understanding of the values of Latinx/Latine collectivism and *familismo* along with joining the family through self-disclosure. Diego recognized how the use of self and disclosing his identity and cultural experiences are essential skills that are not encouraged or used skillfully in Western psychotherapy, but which work successfully with engaging Latinx/Latine families, from his perspective:

But it’s the idea that you become a piece in the family, and, as clinicians, we are told that you need to keep your distance and detach, and in the Latino culture, that’s not possible because then you don’t engage. You need to be able to connect and to be part of that family keeping some boundaries, but again, and we go back to why these models of treatment, it doesn’t work. (Diego, Puerto Rican, English and Spanish-speaking)

4. *Teaching Perspective-Taking*

Participants identified perspective-taking as a primary strategy to improve the Latina adolescent and parent relationship in suicide treatment. Based on the participants’ narratives, perspective-taking is the “assumptions an actor makes about the knowledge, beliefs, and motives of others” (Krauss & Fussell, 1991, p. 2). Kathy described the need to teach this strategy due to the perceived lack of awareness and understanding of the Latina adolescent’s and their parents’ individual stories, which can increase the risk for suicidal thoughts and behaviors:
I’ve seen that come up a lot of how that has influenced a teen feeling very invalidated or not understood by their parent which then results in emotion dysregulation and then not having skills for that emotion dysregulation—results in this like statement of, ‘I want to die, life is too hard, I want to die.’ (Kathy, White, English-speaking)

Isabella, a Latina immigrant, explained how she incorporates knowledge of parents’ levels of acculturation, specifically their language abilities, generation status, cultural stigma around mental illness, and overall adjustment to American culture to help Latina adolescents communicate with their families about their suicidal thoughts and/or behaviors:

…also, the communication between the parent and the child because often as, let’s say, an immigrant child coming to this country with their parent, you know, as the child gets older, they learn more English. And the parents stay behind and sort of how that can really can get in the way of communication. And so that is also something I consider in all the sociocultural process. (Isabella, Colombian American, English and Spanish-speaking)

Later on in her interview, Isabella provided an example of how, from her perspective, a father’s limited English language abilities, combined with the general Latinx/Latine cultural stigma of mental illness, made disclosure challenging for a more acculturated Latina adolescent to communicate her distress, highlighting the importance of teaching perspective-taking in treatment:

…because he had very limited English. And so, she was very isolated for a long period of time. And I think suicide is already a very tough thing to talk about still. And now, add on to that…how do I translate that to something that my dad would understand? I definitely feel that that isolation in that way is a tremendous risk factor because this is
already hard to talk about culturally. (Isabella, Colombian American, English and Spanish-speaking)

Processing cultural influences that shape one’s parenting style and increase Latina adolescents’ awareness of parental sociocultural experiences were perceived as helpful strategies that the participants used to grow these relationships. Participants also perceived that these strategies decreased the adolescent’s engagement in suicidal thoughts and/or behaviors. Social workers observed that the need to teach perspective-taking to adolescents and their families in this context stems from a wide acculturation gap between Latina adolescents who were either born in the United States or came at a young age and parents who immigrated to the United States after growing up in their country of origin. Maria explained this perceived dissonance and her ability to help bridge these disconnections in treatment:

I think particularly with the immigrant experience, a big part of that dissonance is that because the parents did not grow up here, it’s very difficult for them to imagine what it’s like to be a teenager and what are the challenges. And because the youth did not grow up in their country of origin, it’s also very difficult for them to figure or to understand what it must have been like for the adults growing up. I enjoy exploring stuff with family treatment tasks and I think oftentimes when you ask the adults, everything that they have, they faced is not that different, they did face similar challenges. (Maria, Dominican American, English and Spanish-speaking)

Many participants shared that guiding parents and Latina adolescents through learning each other’s narratives, past experiences, and current challenges allowed the dyad to gain meaning around the function of their behaviors and emotions, increasing mutual empathy and support. They explained that they teach perspective-taking in individual, parenting, and family
therapy sessions. Later in Kathy’s interview, she described how she approaches this challenge through deepening the Latina adolescent’s perspective of her mother’s sociocultural experiences through a dialectical perspective, which she is also learning more about as a White clinician who does not have these life experiences:

It was a lot of helping her understand what was playing out in her household and the differences in the ways that her mom viewed things versus how she viewed things. So, we definitely considered that cultural factor… realize the beauty in the way that her mom viewed things and also the challenge in it, so really helping her understand like the dialectic of it. Like her mom really wants the best for her and that’s why she’s pushing all these things, and it’s really uncomfortable and challenging for the patient to have to endure it. (Kathy, White, English-speaking)

Valentina, a Latina social worker, explained how she helps the adolescent understand the roots of their parents’ behaviors and what those behaviors are tied to (e.g., oppression, colonialism). She holds this understanding because of her own ethnic background:

I’m aware of generational experiences that have occurred or what their life was like, and I think that, while I’m validating or empathizing with my client, I encourage them to think about, too, maybe their parents’ experience at their age and over time and how that influences their own parenting style or their own ability to understand or explore some of those parts. (Valentina, Puerto Rican and Dominican American, English and Spanish-speaking)

Several participants shared how they perceive parents have a difficult time understanding why their child would engage in suicidal behaviors. Participants considered this even more difficult for immigrant parents who came to the United States with the primary goal of giving their child a
better life, and attributed this to a lack of understanding their children’s mental health issues due to the barrier of the stigma of mental illness and suicide in the community and feelings of failure as a parent. Valentina summarized this perspective:

A lot of the feedback is, ‘I had to deal with ten times as much of the things that they deal with when I was their age. It should be easier for them, and why are they feeling like this, you know?’ That’s a lot. That’s very common across the board. I think it’s denial – if I accept that my child is depressed and is considering suicide then I failed as a parent.

(Valentina, Puerto Rican and Dominican American, English and Spanish-speaking)

Further into her interview, Valentina shared how she taught perspective-taking through rephrasing ideas to foster mutual empathy and shared respect with a Latina adolescent’s mother who held the views stated in the quote above:

I rephrased some of the things that she said, and she came around, was like, ‘you’re right. That makes a lot of sense, what you’re saying.’ It was just about rephrasing it. She was just like, ‘oh, this is unfortunately what we have to go through.’ (Valentina, Puerto Rican and Dominican American, English and Spanish-speaking)

Laura discussed how she teaches perspective-taking, particularly around possible reasons the adolescent may be thinking about suicide, for immigrant parents whom themselves had a challenging upbringing. She uses this skill as a safety tool to increase buy-in to the therapeutic process from the parents to prevent further suicide risk:

They just feel if you’re an American, things are so much better. Parents have said I was working when I was 10 years old, and I didn’t have a childhood, so I don’t know what she’s complaining about or what she’s upset about. So, I think that maybe that might be a good part of kind of helping a parent understand and safety planning. That they’re not
just doing this for attention. (Laura, Afro Cuban and German American, English-speaking)

Finally, Henrietta explained that she uses perspective-taking in treatment through helping the adolescent and parent dyad find shared goals, giving them the skills to dance between their multicultural worlds:

The message that I try to help them both understand, that it’s like you both want to be successful and your child is growing, right?...Taking these social cultural pieces as well as the safety planning, addressing… these misunderstandings around culture, valuing that mom has her own way of seeing things as well as this teen is really trying their best to live in both worlds. (Henrietta, Puerto Rican and African American, English and Spanish-speaking)

5. Holding Clinician Biases

Implicit and explicit biases around clients’ ethnic origins, parenting styles, socioeconomic factors, clinical styles and strategies, and educational experiences were evident throughout the interview data whether or not the participants were from a Latine/x background. These biases are shaped by lived experiences and the specific ethnic client population the social worker engaged with, as well as by dominant stereotypes and cultural tropes regarding Latine/x immigrant populations regarding socioeconomic status, immigration journeys, and community resources. These biases are an important finding for ongoing improvement when engaging in this intensive, help-providing work with Latinx/e families. The researcher attempted to point out these biases, whenever possible, throughout the findings with the goal of identifying distinct perspectives. Exploring clinician’s biases puts forward an effort to understanding how assumptions can hinder therapeutic engagement and more specifically, disclosure of suicide risk.
Biases around the parental role, distinctions between parents’ countries of origin and expectations of American lifestyles, and parental contributions in their adolescent’s treatment were evident throughout the interview data for all participants. Laura, who predominantly works with low-income US-born adolescents and their immigrant parents, shared how she tries to build compassion for the Latina adolescents’ parents when doing parenting work by thinking about the parent’s access to resources growing up in their country of origin. However, Laura perceived her clients to be minimally resourced in their countries of origin and in the moment, and, thus, unable to prioritize their child’s mental health treatment due to placing a greater need on addressing significant pragmatic stressors (e.g., financial burdens). She described a Mexican American adolescent with suicidal and disordered eating behaviors and conceptualized that sociocultural factors (stigma, country of origin norms, and cultural values) impacted the mother’s ability to comprehend her daughter’s suffering:

They just are trying to navigate being an immigrant. A lot of times [they] come here undocumented, right? So, you wanna kinda not be accusatory. You wanna have a little bit of compassion and understand. … If you’re in a poor country, you don’t have the luxury of sometimes worrying about your feelings and emotions. You’re just focused on survival. So, where those things are kind of taken care, she couldn’t envision why her daughter felt so depressed and suicidal, right? There was a lot of psychoeducation around helping her understand that. And not eating, she’s like, ‘I didn’t have enough food when I was younger. Why would she stop eating.’ right? (Laura)

Clinicians also held biases toward other providers. Carlos shared his personal concerns about clinicians who are not engaged in self-reflective and cultural learning work outside of the therapeutic relationship. From his perspective as a Latino social worker, he warned what could
happen if the therapist does not engage in outside self-reflective and self-care work, especially when the therapist does not identify as Latinx/Latine and works with Latina adolescents:

Counselors that are not as aware of those challenges [e.g., oppression], either because they come from a different culture or different ethnicity. So, all of the transference that comes up, all the unprocessed work that needs be put on the table, that hasn’t been put on the table. All that trickles down to the client, sadly. And so, again, big social justice issue, right, because we don’t exist in a vacuum, as counselors, so how are we being impacted by everything that’s going on and really being honest about the challenges of the work, and all that heavy stuff? (Carlos, Dominican American, English and Spanish-speaking)

Social workers also recognized that their biases came from learning and living in a Western and predominantly White-centered society. For example, Emily, discussed how she uses her training in family therapy and an understanding of Western views to shift her own biases and build the Latina adolescent’s strengths of including the family or the “we” in treatment. Her assumptions emphasized the need to recognize non-Western views that foster community and familial strengths, which may be challenging to understand for clinicians who are born in the United States and not socialized around a collectivist perspective:

So, with White, Western psychotherapy individuation, and I’m also a family systems person of like, let’s understand you in this. And the collective, right, which is seen in White Western as so pathological with no identity and you’re enmeshed with your family all that stuff. Well, no, right? There are different ways to look at this. And for this kid and having those peers and sister in a very traumatic household as a “we” was very protective. So, I think the collectiveness can also be an incredibly protective factor.

(Emily)
Participants also held views around religion as creating barriers to treatment by limiting the Latina adolescent from admitting their suicidal thoughts and behaviors. Participants viewed religious doctrine condemning suicide as creating an added burden for teens to hold their pain inside or aid as a protective factor in suicide treatment due to the belief that suicide is immoral. Carlos shared a case example to illustrate his perspective on a balancing strategy he used with a Latina adolescent to highlight the challenge he experienced validating her family’s history and religious beliefs while needing to convey the need for mental health treatment. He alludes to his own implicit biases around spirituality and a pull toward conceptualizing “religious experiences” as a mental illness:

And then, weeks and weeks of unpacking, and it’s like, so you have a great grandmother – or going four or five generations of all the women having schizophrenic features, and that being conceptualized as a religious experience. Right? And so, now how do we walk along this really weird line of I’m gonna respect your spiritual values and your identity, but also that we’re over spiritualizing actual mental health issues. (Carlos)

In an effort to demonstrate the value of recognizing biases, Henrietta shared how she reflected on her positionality as an Afro-Latina woman born and raised in the United States by a Puerto Rican mother who was well-assimilated to the United States and the work she did to better understand different acculturation processes. She identified closely with a client she described below because of her position as a daughter of an immigrant. She pointed out that the teen’s and parents’ cultural values may differ due to the way they have each adapted to American life. From her perception, the therapist’s goal in this situation is to aid the parent in understanding the child’s perspectives while bringing awareness to herself about her own biases to best support the family:
I had to check myself and really read on how do I help both of them understand that they’re changing-how do I help this teen function within her culture and where she is, right, in the US, and other teens are trying to do what she’s trying to do [acculturate] and help mom understand? (Henrietta add nationality and language)

Acknowledging that biases can hinder the therapeutic relationship in a variety of ways (e.g., trust, disclosure), we must further understand how clinician’s and client’s differing and/or similar identities including gender, race, country of origin, language, and sexual orientation impact treatment, especially with populations of more marginalized statuses.

Summary

This section highlights that to be able to grow these relationships to increase trust and safety, the mental health system needs to ensure that there are sufficient bilingual and bicultural providers to work with teens and their families and significant resources to support the providers. Social workers equip the adolescents and their families with valuable tools and strive to support a healthy narrative around mental illness and suicide given their knowledge of Latinx/Latine stigma of mental illness. Thus, participants saw an essential need to incorporate a greater focus on Latina sociocultural factors in suicide treatment such as cultural stigma of suicide, acculturation differences, and language abilities along with providing concrete tools, such as teaching perspective-taking, to improve adolescent/parent/family relationships that can be hindered by differing levels of acculturation. In addition, regardless of ethnic identity, participants communicated implicit and explicit biases and the need to bring further awareness and understanding of unique human perspectives to this work in a stronger effort to avoid harming therapeutic relationships.
III. Harnessing the Strategies to Build More Culturally Responsive Safety Planning

Participants were asked about the specific suicide risk assessment and suicide safety planning tools that they utilized in their practice, whether these tools are sufficient to understand Latina adolescents’ level of risk, and whether they facilitate adequate planning to keep adolescents safe outside of treatment. The majority of participants identified the Columbia-Suicide Severity Rating Scale (C-SSRS, 2008) as their agency’s primary suicide risk assessment instrument. While participants utilized a variety of safety planning tools, the most popular was Stanley and Gregory’s (2009) Suicide Safety Planning Tool. Responses regarding planning tools are divided thematically into three sections: Adding Strategies to Conduct Safety Planning with Latinas, Incorporating Aspects of Sociocultural Protection and Risk in Safety Planning and Risk Assessments, and Strategies for Increasing Awareness of Latinx/Latine Sociocultural Factors in Suicide Treatment.

1. Adding Strategies to Conduct Safety Planning with Latinas

a. Language in Safety Planning

Participants identified a variety of needs to improve the risk assessment and safety plan tools such as using simpler language, increasing relational awareness for support, and providing more psychoeducation to increase understanding of the tools. Sylvia described the importance of simplifying the risk assessment questions for the adolescent to understand, particularly if English is not their first language, and for their parents.

I think just certain language around how they word things or the questions that are asked. And being more flexible around how adolescents think and if English is not their first language, how you can adjust to that. Also, so that their parents can also understand when you’re doing psychoeducation around [suicide risk]. (Sylvia, Southeast Asian, English
Kathy, an English-speaking social worker, also noticed the need to simplify many of the questions she posed to her Latina adolescents:

I’ve worked with some Latina and Latino teens who are like very much fluent in English, and still sometimes the language around some mental health stuff can be confusing. And so, while they are fluent in English and can have a therapy session in English, complex problem solving needed to be more in Spanish for them. And so like there is this complexity to thinking about your thoughts and understanding yourself and I think there are times where maybe I asked a question in English and realized I needed to just like simplify the question. (Kathy, White, English-speaking)

Henrietta, a bilingual English and Spanish-speaking social worker, shared that she adds to the tools by changing her word choice to match the adolescent’s vocabulary:

I try to use whatever the youth’s language is because I think that some of those questions are very specific and maybe they’re not targeting everything. They might be like ‘yeah, well, not that I wish that I was dead. I wish I was gone.’ Okay. Well, what does that mean, right? I’ll give you an example. So, this girl was like, ‘oh, I didn’t want to wake up.’ And so, I think the question in the C-SSRS is ‘Do you have thoughts where you wish you were dead or something like that.’ And then eventually we assess further, she’s like oh no, I just want to be in my bed. I just, I love my bed. So, it’s tweaking it. (Henrietta, Puerto Rican and African American, English and Spanish-speaking)

Participants also discussed needing to include “culturally sensitive” language and questions.

Carla explained her idea of adding a subsection to the risk assessment to pose questions that are more culturally directed around risks and strengths for the Latina adolescents:
The questions can be worded a little bit differently and a little bit more culturally sensitive. I feel like some of the questions might be a little too broad. Maybe just having like a sub section or something to really narrow down for the Latinas. (Carla, Latina, English and Spanish-speaking)

Nancy also noticed that questions in the risk assessment are not always clear and need to be developmentally adapted:

Figuring out what language the kids use, often times I feel like I do, but I think it’s important to figure out what they mean. Because if I ask a specific question, they’re having suicidal thoughts, but if I’m not asking it in the way it works for them they say, ‘no, you didn’t ask me that specific question.’ So having culture sensitive questions around that, too, would be really helpful. (Nancy, White, English-speaking)

b. Valuing the Therapeutic Relationship in the Safety Planning Process

Besides concretely adding components to the risk assessment and safety planning tools, participants also discussed the process of assessing risk and safety planning, and ways in which they have added to the process due to recognizing the impact that cultural stigma of mental illness has on engagement. Maria mentioned that growing the therapeutic relationship is even more essential for assessing and planning for suicide safety “than the tool itself”:

…it’s the relationship that’s developed-it’s the therapeutic alliance. Something that I’ve learned in this setting is normalizing these thoughts and feelings and validating what is able to be validated in terms of their experience and how hard things can get. (Maria, Dominican American, English and Spanish-speaking)

Sofia, a Colombian American social worker, also shared her perception that therapists need to build a trusting relationship before safety planning can begin, “How are we to complete a safety
plan if they’re not giving us anything? So, through conversation, little by little, we start developing it, and it works out well.” (Sofia, Colombian American, English and Spanish-speaking)

Henrietta shared that she uses problem solving strategies during the safety planning process with both the adolescent and their parents to better identify ways for the teen to tolerate distress and decrease their risk of attempting suicide, encouraging a collaborative approach to risk management. She explained that several Latinx/Latine families that she works with have a hard time accepting the need to engage in coping strategies or to develop a safety plan in their home due to not wanting other family members to know that the adolescent is struggling because of the stigma associated with suicidality in Latinx/Latine culture and the value of cooking and having the tools to provide for their families as mentioned here:

What are your coping skills, what are you using these days, what is not working. And sometimes that conversation leads to like well, I know we agreed on this but it’s not really helping me…Or even…talking to the parents and them telling me something like ‘oh, well I can’t put the knives that high or oh, but that’s ridiculous because I need the knives to cut,’ things like that. So I try to problem solve with them, like ‘okay maybe you use a knife, you clean it, you put it back.’ (Henrietta, Puerto Rican and African American, English and Spanish-speaking)

Participants also explained that they try to put a greater effort on providing psychoeducation when engaging the adolescent or their parents in the risk assessment or safety planning tool, particularly due to cultural stigma of mental illness and how that often leads to misinformation or not knowing. Carlos stated how using strategies such as normalizing the need for a safety planning tool with both the Latina adolescents and their parents is essential for engagement in
the planning process, “So, just a lot of normalizing. So, any tool that allows me to focus more on the educational component, I always think is more important.” (Carlos, Dominican American, English and Spanish-speaking)

Several participants also spoke of the struggle Latina adolescents encounter when tasked with identifying supportive family members or peers to include in their safety planning tools and attributed this to mental illness stigma within Latinx/Latine culture as stigma can create feelings of shame resulting in secrecy. Camila highlighted the need to target relational awareness in treatment by spending adequate time brainstorming teen and family supports. She suggested adding a few questions that target family dynamics when assessing risk:

I think that it would be good to include maybe family related stuff because for the Hispanic culture, it’s very black and white. Either families are not supportive, and I think you have no issues, or they are, but it’s very difficult to understand because the stigma associated with seeking help and just no one really talks about certain things. So, a question or two should be added regarding whether they have some type of family support or family involvement. (Camila, Ecuadorian American, English and Spanish-speaking)

A few participants did not find the safety planning tools to be effective overall with Latina adolescents. Sylvia felt that tools should be changed completely:

I think it needs to be adjusted just in general. I don’t know if writing out where would you go or who would you talk to is any more effective. Especially because I feel like when you hand them things, they don’t always hold on to them. So, I think there does need to be something else. (Sylvia, Southeast Asian, English and Tagalog-speaking)
Isabella shared the negative dynamic that results from agency policy requiring a safety plan when there is disclosure of suicide risk and the power dynamic that this brings up. From her perspective, she highlights the power imbalance that can result when the needs of the agency to document the client’s safety plan take priority over the needs of the client:

Of course, the role of like clinician and patient and the disproportionality of that power is definitely just uncomfortable when it comes to the safety plan. I wish that the approach of the safety plan – maybe it’s the wording. It just seems so sort of like we’re just trying to get this done and let’s name three. Come up and give me three. It just feels uncomfortable. (Isabella, Colombian American, English and Spanish-speaking)

**c. Needing More Safety Plan and Risk Assessment Training**

In line with the challenging power dynamic of pressing adolescents to engage in safety planning, many participants mentioned discomfort of having to disclose suicide risk to parents in the safety planning process, highlighting that this process needs to be part of their education and reinforced through practice. Participants explained that the gravity of suicidality, especially among a culture whose predominant religious values associate suicide with immorality, along with general negative stigma of mental illness care, makes this topic even more challenging to talk to parents about without burdening the adolescent. Diego disclosed experiencing this challenge early on in his career, which may have been shaped by his identity as an early career social worker wanting to be successful in engaging clients and his own background as a Latino male:

I think one of the things that I have found challenging at the beginning of my career was the family involvement in safety planning, disclosing the suicidal behavior, and the risk concerns to the family. I would say the most challenging part was having the patient
understand the reason to involve them while still maintaining therapeutic relationship with the patient and the trust. (Diego, Puerto Rican, English and Spanish-speaking)

Carla, along with other participants, mentioned the lack of training around suicide risk assessment and safety planning in their social work education: “We didn’t really touch upon these specific assessments as much as we probably should have” (Carla, Paraguayan and Cuban American, English and Spanish-speaking). And Kathy stated that she did learn about safety planning in her social work education program, but did not have experience practicing suicide assessment:

When I was in grad school, we had some training, but I don’t think it was put in full action until you like go and do the work and try it out. And then the safety plan – I think the same. Like I’ve definitely – you know, you get experience from just like doing it because half of the challenge of doing it is being like, ah, I need to like pull up this plan and, okay, we’re working on this plan. But there’s so much going on, and you’re trying to like just manage the room. (Kathy, White, English-speaking)

2. Incorporating Aspects of Sociocultural Protection and Risk in Safety Planning and Risk Assessments

a. The Sociocultural Risk and Protective Factors

When asked about the adequateness of the risk assessments for Latina adolescents, most participants expressed the need for questions to gather a better understanding of the effects of cultural stigma on the adolescent’s functioning, sociocultural barriers to treatment, and difficulty sharing the safety plan with their parents. Diego described:

Definitely a recommendation would be to explore any cultural stigma, any barriers to treatment, any barriers to discussing a safety plan with the family. What would prevent
it? To add barriers to discussing this with family, or to seeking support, and implementing this with your family. (Diego, Puerto Rican, English and Spanish-speaking)

Most participants mentioned that sociocultural protective factors, such as immigration history and citizenship status, language, and family dynamics, should be considered when asking risk assessment questions and developing a safety plan with Latina adolescents and their families. For example, Daniela explained that she incorporates additional questions in risk assessment to gather a broader understanding of sociocultural risk and protection. Daniela assesses for cultural protection and risk by asking about immigration status and assimilation to American culture:

There’s a lot of family factors and cultural factors that aren’t asked on risk assessments. …Again, with like Latina adolescents specifically I think there’s more layers that can’t be added on to generalized suicidal risk assessments….Like especially if they’re newer into the country, adapting to a new setting, a new language and those things really aren’t on risk assessments. (Daniela, Dominican American, English and Spanish-speaking)

Shanice, who predominantly works with Mexican and Puerto Rican adolescents, mentioned that she asks families about their cultural traditions, such as family gatherings, to build protective factors into their safety plan:

We really want to know what are those practices that have been helpful in your culture. So, whether the practice is we just have these family engagements every week, that’s a part of our family culture, whatever the case may be, how is that helpful for you. So, when you’re having a stressful week or when you’re feeling stressed are you looking forward to that family engagement, that’s going to help you? Does it cause you even more stress? We’re going into the depths of those practices and if it’s helpful, then we’re
definitely adding that to the safety plan, right. (Shanice, African American, English-speaking)

Several other participants shared that they include sociocultural protective and risk factors when safety planning with the Latina adolescents. Camila gave an example of using religious traditions, such as attending weekly mass, as coping strategies in their plan with a Latina adolescent who recently arrived to the United States:

So, one thing that we tend to do and that’s in their safety plan is that they feel like they do go to church every Sunday, they tend to pray before they go to sleep, so we tend to use that as protective factors when they’re feeling very down, or whenever they’re feeling low. Maybe if the family prays together, if that would help them or if they would just go to church, light a candle, that would help them. (Camila, Ecuadorian American, English and Spanish-speaking)

She also incorporated the adolescent’s favorite Mexican television shows:

…Or there are some programs they like to watch, I think it’s called Arosa and Guadalupe, it’s a Mexican show that they like to watch that because it’s very dramatic, but they like to see that there is a light at the end of the tunnel. So, we tend to incorporate those types of things into their safety planning where they can kind of feel like okay, it’s like home, it’s something that I’m used to, and we can kind of incorporate that. (Camila, Ecuadorian American, English and Spanish-speaking)

Leaning into the Latina adolescent’s extended support system was another way social workers build protection around suicide risk. More family members around the Latina adolescent built a natural safety network as mentioned in earlier findings, keeping more eyes on the adolescent and
offering social support as needed. Diego shared the significance of bringing the Latina adolescent’s extended family into treatment:

Latino families have an extended support system that you don’t see many times in the American culture…And you have layers there, it’s not only the parents or grandparents, but you have uncles, you have cousins, and many times you have cousins that are a little bit older so the way of looking at family is different. And what I mean with that is that sometimes your older cousins are, you consider them aunts and uncles, so they have a very important role in the hierarchy. They are respected. (Diego, Puerto Rican, English and Spanish-speaking)

An additional risk factor discussed in suicide treatment, though not added in agency risk assessments or considered when safety planning, was ethnic discrimination. Very few participants mentioned discrimination or oppression as factors they consider in suicide treatment. One Latina participant, Daniela, described her awareness of ethnic discrimination toward the Latinx/Latine community in the United States based on her own upbringing as a Dominican American female and working with this population. She explained how she addresses this in treatment, particularly as a risk factor for suicidal thoughts and behaviors for Latina adolescents:

So I do think there's a layer of just not feeling like you're accepted as your ethnicity. Not just as a person, but overall, like, I'm not accepted. My family is not accepted. That adds onto the layer of ‘I shouldn’t be here.’ You know, ‘do I want to wake up tomorrow?’ Because it validates that suicidal ideation in another context more than just the individual and others… she's been told this specific line like, ‘what country are you from’ and ‘geez I am from the US’ so again it continues to add that extra layer and validation in her mind of not wanting to be here. (Daniela, Dominican American, English and Spanish-speaking)
Daniela also identified the impact of ethnic identity confusion on Latina adolescents’ self-esteem, leading to another risk factor for suicidal behaviors:

And there's a lot of identity confusion within my Latina adolescents of like why I'm in this country, but I still look different, and my peers look different and I would say identity comes up as a factor as well, in terms of the negative thoughts about themselves and the suicidal ideation that tends to escalate. (Daniela, Dominican American, English and Spanish-speaking)

Carlos, a Dominican American social worker, considers fear of the current political climate as an essential sociocultural suicide risk factor among the Latina adolescents, “…where people like me seem like we’re not liked, people are trying to get rid of us.” He also mentioned “the lack of equity and access to resources” such as “equitable educational opportunities” and “job opportunities” impacting the Dominican American and Mexican American Latina adolescents that he works with. Carlos openly expressed the emotional burnout that working with Latina teens with suicidal ideation and behaviors creates for him due to historical oppression and marginalization toward the Latinx/Latine population in the United States while also describing the process of balancing opportunities to help these young girls and their families find their strengths:

I could say it very fluidly, but it’s very exhausting work [laughter]. It’s very taxing. And it’s one thing to understand it intellectually. But there’s another component of being there and sitting with the clients emotionally, and seeing the – just the systemic issues in the community and family. Kinda the same thing, right? And finding the uniqueness of their situation and really helping them to traverse out of that mess in their own fascinating and creative way. (Carlos, Dominican American, English and Spanish-speaking)
Additional sociocultural factors that participants mentioned as risk factors they assess for, but which are not included in traditional risk assessment documents or inquired about through a culturally attuned lens within their safety plans for Latinx/Latine clients, are listed in the table below.

**Table 4. Sociocultural Risk Factors Added to Risk and Safety Tools by Participants**

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Trauma</td>
<td>Is there community violence? (Isabella, Puerto Rican and Dominican American, English and Spanish-speaking)</td>
</tr>
<tr>
<td>Alcoholism among Indigenous Groups</td>
<td>Talking about the issue of alcohol use in the community, and maybe Dad’s watching the playoffs, having a drink. When this thing is just so normalized. (Carlos, Dominican American, English and Spanish-speaking)</td>
</tr>
<tr>
<td>Documentation Status</td>
<td>…issues with any documented status because that does bring a lot of pressure on these families. (Isabella, Colombian American, English and Spanish-speaking)</td>
</tr>
<tr>
<td></td>
<td>And also, just again the layer of sort of immigration also is a risk and it’s also a fear and it’s kind of can amp up the sort of suicidal ideation that isn’t assessed in the risk assessment. (Daniela, Dominican American, English and Spanish-speaking)</td>
</tr>
<tr>
<td></td>
<td>Well, I think that the idea what the – in generational, what generation you are in, it’s important. I also think the immigration status needs to be</td>
</tr>
</tbody>
</table>
Sociocultural protective factors that were asked about and included in their safety plans were predominantly focused on the Latina adolescent’s family, and are included in table 4 below.

**Table 5. Sociocultural Protective Factors Added to Risk and Safety Tools by Participants**

<table>
<thead>
<tr>
<th>Protective Factor</th>
<th>Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Engagement</td>
<td>Even like get togethers, where I feel in the Latino population, family is really close. (Henrietta, Puerto Rican and African American, English and Spanish-speaking)</td>
</tr>
<tr>
<td>Family Cohesiveness</td>
<td>I think there’s something in the family, that family structure, that provides some kind of protection that you might not see in, I mean, yeah, in other cultures. (Lisa, White, English-speaking)</td>
</tr>
<tr>
<td>---------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Extended Family Support</td>
<td>We definitely try to focus on the protective factors and if they do have an extended family, right, that can be a resource and we definitely want to focus more on that, right? (Laura, Afro-Cuban and German American, English-speaking)</td>
</tr>
<tr>
<td>Family Traditions</td>
<td>I kind of encourage my clients and their family to kind of just make it bigger than it should be and to just create the traditions that they would do over there to kind of just bring it here and if it needs to be a little bit modernized and how my client would want it or to include certain new things for them to be receptive of that. (Camila, Ecuadorian American, English and Spanish-speaking)</td>
</tr>
<tr>
<td>Family Goals</td>
<td>Their own desire to strive for more yes, their own desire to like really do better than like what their parents have done or really take advantage of everything that they all these opportunities that they have as a result of their parents’ sacrifice. (Carla, Paraguayan and Cuban American, English and Spanish-speaking)</td>
</tr>
</tbody>
</table>

Participants found that the majority of Latinx/Latine sociocultural factors considered in their risk assessments and safety plans were considered both protective and risk factors. Camila explained
in her interview, “They have a very strong sense of community within family. And so utilizing that as well, even though it might be a stressor it’s also a huge protective factor, siblings you know or close familial relationships” (Camila, Ecuadorian American, English and Spanish-speaking). Holding this perspective around the sociocultural factors described in this section would be beneficial in an effort to decrease biases. Overall, non-White social workers reported asking more about Latinx/Latine sociocultural factors than their White counterparts, and they provided a deeper understanding of these factors and how they incorporate these factors into suicide treatment than the White identifying participants. This assumption is likely due to an increased awareness from shared cultural connections and/or minoritized statuses rather than through education and training as the majority of participants have not had formal training on Latinx/Latine sociocultural risk and protective factors in suicide treatment. This is an important finding that will also be discussed later on.

b. Critiquing the Risk Assessments and Safety Plans from a Sociocultural Perspective

Participants shared challenges using the current risk assessments or safety planning interventions. Not being trained either in graduate school or in their current professional position on how to assess suicide from a sociocultural perspective was a significant theme discussed. Sofia shared her need to train on comprehensive suicide risk assessments that allow for comprehensive understanding of the ways sociocultural factors harm or protect adolescents. She provided a core recommendation that social workers should be trained on how to effectively gather this information comprehensively:

Sometimes, when you answer the question of religion, that’s not always sufficient. The clinicians need to be educated on how to ask these questions and gather more information from a question – or actually the comprehensiveness. Some questions will say religion,
and in parentheses give an example of what in relation to religion that you’re asking for, to make sure that no one is just putting Catholic or Muslim, or whatever it is, because how is that religion a protective or a risk factor. (Sofia, Colombian American, English and Spanish-speaking)

Henrietta recommended a separate assessment, “I think that there needs to be an assessment around what the family thinks of mental health in general” (Henrietta, Puerto Rican and African American, English and Spanish-speaking). Carlos shared that he asks additional questions around cultural stigma of mental illness to distinguish how the teen’s parents and family members view mental health treatment for suicidality, which helps him to better assess the Latina adolescents’ risk. He mentioned that these questions are not included in his agency’s standard assessment:

> When I get a client that’s suicidal from this community, I need to know everyone that’s home and I need to know where they’re at. I need to know how comfortable they are talking about what’s going on and I need to know if they are trying to get my client to suppress their feelings or if they’re encouraging my client to be verbal. (Carlos, Dominican American, English and Spanish-speaking)

Several participants provided criticism that the risk assessments and safety plans they use are not comprehensive enough to include the multitude of factors placing these girls at risk of suicide. Emily expressed concern that without a comprehensive risk assessment, which covers historical factors, social workers may not be able to fully capture the accuracy of the suicide risk.

In our assessment, we ask about cultural factors and cultural beliefs around suicide – around mental health issues, and in our full risk assessment like religious beliefs against suicide, that kind of stuff. I just feel like the long-standing chronic depression and anxiety
that like someone – they tell you no, I’m not thinking about suicide right now, no, right? And they might not be thinking about that right now, but it’s the accumulation of factors and I feel like many of these are accumulations. (Emily, White, English-speaking)

Carlos, who identifies as Latino, explained later into his interview that risk assessment questions need to be culturally attuned, and providers should give rationale for the risk assessment questions by providing information about the therapist’s evaluation process so that Latina adolescents and their parents are more comfortable providing the full extent of their distress:

How do we capture the importance of culture in asking a question like, are you feeling down or depressed, right? Where in my community, if you say someone’s depressed, the impulsive reaction that people are going to have is, you want to kill yourself now, why are you being like one of those crazy people, not my daughter. (Carlos, Dominican American, English and Spanish-speaking)

Finally, a few participants denied that their risk assessment or safety planning intervention needed to be changed for this population. One White identified participant shared that she did not assess for specific sociocultural factors risk and protective factors or consider these factors when engaging their Latina adolescent clients in safety planning. These participants stated that engaging in the research interview allowed them to consider how important these factors are, and several shared the desire to make a concerted effort to ask about these factors in the future. In response to a question about whether Nancy, a White social worker, incorporated sociocultural risk and protective factors into the risk assessment or safety plans with the Latina adolescents she treated, she stated, “No, but I should be. I mean, I would hope so, but overtly I don’t think I am. I think I’m –now that you’re saying this, I’m like, oh, there’s a lot of things that I need to do” (Nancy, White, English-speaking).
Summary

This section synthesized how participants conceptualized the impact of sociocultural factors in suicide treatment with Latina adolescents. They identified strategies that they utilize to help the adolescent and their families understand their culture’s risk and protective factors and the Latina adolescents’ adjustments to their multicultural worlds. Educating families about the influence of a wide acculturation gap between the adolescent and other family members, establishing a synthesis between two distinct sociocultural ideals, and using family supports to build protection around the teen are some of the strategies that they have found useful when assessing risk and safety planning to prevent suicidal behaviors. This section’s findings demonstrate the need to develop and test risk and safety tools that are socioculturally attuned, with specific questions around immigration, family dynamics, cultural practices, religious beliefs, and ethnic discrimination. In addition, participants pointed out their perspectives that cultural strengths such as the impact of familismo and family cohesion need to be a focal point of providers as thorough risk assessments and safety plans that incorporate sociocultural protective factors, such as family cohesiveness, can build a trajectory away from any suicide attempt (Zayas, 2011; Peña et al., 2011). Given the range in social workers’ interpretation and utilization of sociocultural factors, with the majority of non-White social workers identifying more comprehensive sociocultural factors, safety plans and risk assessments need to be tailored to each individual client to ensure that a wide range of sociocultural factors are included to better assess and safety plan against suicide risk for Latina adolescents.

IV. Seeing Social Worker Needs

Participants identified a wide range of needs to improve and/or maintain the work that they are doing with Latina adolescents and their families in suicide treatment. This section is
divided thematically into three sections: *Needing Supervision, Needing Latinx/Latine Sociocultural Training for Suicide Treatment, Needing a Social Worker Collective,* and *Doing Work Outside the Relationship.*

1. *Needing Supervision*

Social workers expressed that engagement in supportive supervision, receiving help from their supervisors in navigating the therapeutic relationship, and guidance with building awareness of the relationship from a professional outside of the social worker/Latina adolescent and family relationships were necessary components to doing their job well. About half of the participants mentioned the benefits of engaging in one-on-one or group supervision. A couple of participants who identified as non-White stated the importance of having a Latina supervisor because of their shared cultural experiences with the Latina teens and their Latina supervisor’s ability to understand the clients discussed in supervision. When mentioning that her ethnic identity did not match the Latina adolescents that she works with, Jenna, a White social worker, stated, “I think it’s really important for me to have a Latina supervisor” (Jenna, White, English-speaking). Kathy, another White social worker, summarized how her growth and confidence in treating Latina adolescents with suicidal behaviors developed by learning from a Latina supervisor:

My training about learning to navigate the family dynamics and the culture of Latina teens and their family has really come from [supervisor]. Working with her, talking with her, learning from her, understanding her framework, opened my mind and helped me see things differently when I was feeling really stuck and not understanding the family issue that was causing so much dysregulation. (Kathy, White, English-speaking)
One participant, Carla, who identifies as Latina, explained the easiness of supervision because she and her supervisor share their identity with the population she serves, “There are certain things that I don't even need to explain further. We delve into it because they identify the same as I do” (Carla, Paraguayan and Cuban American, English and Spanish-speaking). In addition to the shared understanding that Latinx/Latine supervisors hold in these learning spaces, some participants also mentioned that their supervisors help them increase their recognition of self-identity processing and power-over approaches to treatment (Jordan, 2018), which build a greater culturally humble understanding around countertransference within the therapeutic relationship. Valentina discussed her shared identity with the Latina adolescents and families that she works with and how her supervisor helps her use her identity as a treatment tool:

I have a great supervisor that I meet with once a week, and she’ll often make those connections for me because when you’re really in it, it’s hard to feel it. She’ll go, ‘I can see you really want to support the patient,’ or if I describe a situation that’s going on, and she might say, ‘this child is looking for a mom figure or an older sister or something,’ so, I’ll be more aware of it. And then I can lean in by recognizing some of the difficult things that they’re going through, validating their feelings, empathizing with them, letting them know that I’m there for them. (Valentina, Puerto Rican and Dominican American, English and Spanish-speaking)

Carla explained that while supervision benefits her practice, group supervision models would provide additional and important supports and perspectives:

I find that it [supervision] has its positives and negatives, because I get to have that direct one on one with my supervisor who knows my work and knows my clients. And then the way it can be a little bit limiting is because it's one person's perspective. It's that one-on-
one instead of maybe discussing with colleagues or within that group setting. (Carla, Paraguayan and Cuban American, English and Spanish-speaking)

Out of the participants who openly spoke about supervision as a training need, only one participant, Jessica, mentioned that she no longer receives individual supervision, “I don’t now. I did for a very long time until I got my LCSW” (Jessica, White, English and Spanish-speaking).

Carlos noticed a lack of supervisorial support within his clinic at times:

The gap is in seeking resource and community help from within the field. It’s impossible to be trained for everything that’s going to come through the door. But you should feel supported. (Carlos, Dominican American, English and Spanish-speaking)

Lastly, Kathy, a White social worker, who predominantly works with Dominican and Puerto Rican Latina adolescents with low resources, spoke about the lack of supervision when the COVID-19 pandemic began, particularly around how to treat suicidal adolescents and assess risk through telehealth, “COVID hit and now we’re virtual and now we just have to figure this out. I do think there should have been trainings and support around that” (Kathy, White, English-speaking).

Overall, participants saw supervision as an essential tool for doing this work effectively, and they saw it particularly essential to have a supervisor or professional process group that matches the treating population’s identity. Diego attributed to supervision his overall growth as a social worker and his ability managing this high-risk population:

I have grown a great deal. Training has been a major part of it but also having a good supervisor to help and guide you. (Diego, Puerto Rican, English and Spanish-speaking)

2. Needing Latinx/Latine Sociocultural Training for Suicide Treatment
In addition to needing individual supervision time, participants expressed that they could benefit from training about Latinx/Latine cultural values and cultural factors that influence treatment and how to hold conversations around these factors in treatment. Daniela explained:

I do always want to learn more. I feel like there isn’t a lot of trainings about the Latino community and at least through my agency or that I’ve seen really throughout the city.

(Daniela, Dominican American, English and Spanish-speaking)

All participants were asked if they had taken sociocultural trainings on Latinx/Latine risk and protective factors in their interviews and several participants shared that they have taken trainings on “culture” but none that specifically discussed sociocultural factors unique to a specific ethnic or racial group, or focused on sociocultural factors in suicide treatment. Participants also shared that their social work education programs did not prepare them enough for working with Latinx/Latine communities given that social work schools focus mostly on clinical training for general populations (e.g., children, adults, aging) and not specific races, ethnicities, or cultures. Henrietta mentioned such training could have been beneficial when starting her career in social work, “I don’t remember doing specific work on suicide validity and assessments specific to culture or anything like that. I wish I had more of that training in school” (Henrietta, Puerto Rican and African American, English and Spanish-speaking). Only one participant, Carlos, shared that he learned about the high rates of suicide attempts among Latina girls in school because he had professors doing research on this population, but he had not learned about the sociocultural factors impacting risk and protection since entering the field:

I had teachers that were able to talk about the research that they were doing, and like, hey, this is a big issue in the city, it’s actually one of the highest leading causes of death
for teenagers. And ironically, outside of that, never heard it. (Carlos, Dominican American, English and Spanish-speaking)

Participants also mentioned specific training topics that would be helpful to improve their care and understanding of Latinx/Latine populations in suicide treatment, including learning how to integrate topics of mental illness stigma into treatment sessions, decolonizing parenting practices by reclaiming positive parenting approaches that are “trauma-informed, healing-centered, nonviolent, and culturally focused” (Arreola-Hillenbrand, 2021), and finding more culturally attuned family therapy techniques. Sonia explained how a training on understanding and discussing cultural stigma of mental illness openly across generations in therapy sessions with the Latina adolescents and their families would be helpful:

Especially working with the Latinx community, a risk factor is the stigma between the family and the teen. Being able to understand that bit more, to integrate that understanding to the session. I think it would be very beneficial for not just myself, but absolutely the families I’m working with. So, I’m very interested in learning more about that, taking courses, continuing education credits regarding the Latinx community.

(Sonia, Puerto Rican and Dominican American, English and Spanish-speaking)

Laura provided an example of how it would be helpful to learn how to work with Latinx/Latine parents around changing certain parenting practices that are considered corporal punishment in the United States, particularly when these practices may trigger suicidal behavior. Laura’s perspective highlights the “power-over” dynamic (Jordan, 2018) that therapists may hold in bringing systems of oppression into treatment and telling parents how they can and cannot parent their child. She highlighted how providers must call Child Protective Services, which hinders the relationship as it disempowers parents and she must introduce a novel system that Latinx/Latine
parents are not accustomed to in their countries of origins. Her bias of associating Latinx/Latine parenting practices with corporal punishment is likely shaped by her own exposure to communities who have used these practices before. Learning techniques to both validate and understand Latinx/Latine cultural parenting practices, teaching about the benefits of finding effective strategies, and introducing parenting strategies through a cultural lens based on the country of origin’s colonized history would be beneficial to her when supporting parents who engage in such practices:

And when it ends up like an ACS report, I think sometimes they don’t understand why the government is getting in their business because back in Ecuador, Mexico nobody does. So, they don’t understand making somebody kneel on rice for an hour or do certain things or throwing you in a shower and hitting you with a switch is not acceptable here. And that this is more detrimental. It’s not going to make the kids better and I think they come from a culture sometimes that they think that this is okay. So, that’s also I think another bridge sometimes in helping them understand we can’t do those things. (Laura, Afro-Cuban and German American, English-speaking)

Lastly, Emily shared that it would be helpful to learn about family therapy techniques through role play demonstrations as she has not seen adequate representation of Latinx/Latine clients throughout her training:

I would be very curious to see a Latina therapist working with a Latinx family and - or someone who’s not and who’s well versed and done the work and kind of what those look like from who you would consider experts or cultural experts or whatever you might, in the way you might see that. That would be great. (Emily, White, English-speaking)
3. Needing a Social Worker Collective

Social workers found that creating community among clinicians and having support from other coworkers were helpful when doing this work. A team approach for the Latina adolescent’s treatment minimized burnout and helped to maintain a strong level of support for the Latina adolescents, for their families, and for the therapists involved in their care. Kathy, who works in a hospital-based mental health agency, mentioned that her agency creates this:

A big part of supporting the work is the team, being mindful about training and giving support and what their team looks like and how their team can deliver service. To support an individual person in doing this work you need that community of support – because there’s always going to be moments where you’re like, did I do that right or did I miss something. I don’t think therapy can be done in this isolated, solo way. To provide good, quality therapy you need to have your own system around you and clinics naturally create that. (Kathy, White, English-speaking)

Carlos, who works in a community-based mental health agency, used the metaphor of basic training in the army to explain how essential seeking out a supportive professional community and developing a reciprocal learning space are, especially for newer clinicians entering the social work field:

I always tell new colleagues that just started in the field. We’re teams in the field and we can be your allies, this will be less stressful and you can find the answers you’re looking for. But if you get stuck in that little office, you’re going to get stuck with your client. It needs to be more community oriented and that’s how I work. And so, when I got to the office, I went to everyone. I was like, what do you do, what do you know because I don’t know that and if I get a client that’s struggling with that, I’m going come to you, and, this
is what I like to do, I do trauma work, so come to me, please ask me your questions, right? So, I think creating that environment where everybody can collaborate and work together. (Carlos, Dominican American, English and Spanish-speaking)

Maria, who works in a hospital-based mental health agency, also shared the importance of establishing a supportive clinic setting that integrates time for self-reflection and engagement with the community and how this environment benefits both the clinicians and the Latina adolescents. She spoke about an agency that she used to work for that incorporated these two components:

I did work for a community agency that no longer exists but the big focus was the Dominican community and I think that culture, identity, and privilege were embedded in the daily work. We had opportunities to just sit and talk about things that were going on in the community and sort of the community needs, listen to the community and have space for program participants from the variety of programs to share their experience. (Maria, Dominican American, English and Spanish-speaking)

Lastly, one participant spoke about her current needs to improve her collective. Isabella, also a hospital-based mental health agency social worker, explained that she is involved in affinity groups at the social work department at the hospital she works for, but could benefit from finding a space for Latinx/Latine identifying clinicians to talk openly about their shared experiences treating Latina adolescents and about challenges with battling imposter syndrome within their hospital system, and to seek inspiration and empowerment:

I'm looking for a space with other Latina clinicians– a safe space. I need a little bit more of that because I do feel often like I'm in my own island doing my own thing. And I think having a space where I can talk with other clinicians that have a shared experience,
there's always that sort of imposter syndrome when it comes to being in a hospital, doctors, psychiatrists, nurses, social workers. So, to have a place where I could feel empowered and empower others and they'll inspire me, I need to work on making sure that happens. (Isabella, Colombian American, English and Spanish-speaking)

These findings demonstrate the need for a greater support system for clinicians who are treating this high-risk population. Interview data highlighted a wide range of needs to help social workers improve and/or maintain the work that they are doing with the Latina adolescents and their families in suicide treatment. By having a secure and collaborative support network and ongoing learning opportunities, social workers can better serve Latina adolescents and their families and help them move from surviving to thriving.

4. Doing Work Outside the Relationship

a. Learning

Participants discussed time spent outside of the therapeutic relationships to learn, train, engage in identity work, and process lived experiences. They engaged in work outside of the treatment sessions with the Latina adolescents and their families to increase their knowledge and understanding to better inform and treat their clients. Some of this work on suicide treatment is provided to the social workers through their agencies, as Camila, a community-based outpatient mental health agency social worker, described:

This agency [has] numerous trainings and they do provide a lot of books and activities and stuff that we can learn and plan our sessions, and I think that that’s helped me.

(Camila, Ecuadorian American, English and Spanish-speaking)

While Jenna, a social worker at a community-based program that works only with Latina adolescents with a history of suicidal ideation and behaviors, spoke about providing surveys
“with parents and with the young people to see about what more things they need, what they want” (Jenna, White, English-speaking) to consider further program development.

Only one participant shared that she had received training on suicide treatment for Latina adolescents that she sought out on her own after she completed her social work degree. This highlights the essential need for social work schools and professional agencies to focus on this area in social work education. All participants mentioned that it would be helpful to get training specifically on Latinx/Latine sociocultural factors for consideration in suicide treatment with Latina adolescents and their families.

b. Self-Reflection

In addition to trainings and surveys to improve their practices, participants discussed self-reflective identity work that they have done to process personal biases and understand how their identities impact treatment of the adolescents and their families. As mentioned previously, Henrietta, a Puerto Rican and African American social worker, does a lot of work on processing her own biases and provided a case example of a first-generation Dominican American adolescent and her mother who was born in the Dominican Republic to demonstrate the personal work that she does outside of the therapeutic space. Henrietta explained how she recognized her own bias when she told this teen to “just” confront her mother:

I was born here in America, I’m like oh yeah - you can do whatever want. What are you talking about? Tell your - just tell your parents you don’t want to do it. And I have to check those notions. So, I think it’s definitely self-reflection for myself in the social political cultures affecting this family, checking my own biases of telling your parents. I remember one time telling one of my girls like oh, just have a conversation with her about it or communicate that that’s not what you want to do. And she was just like ‘no, I
can’t do that, Henrietta.’ (Henrietta, Puerto Rican and African American, English and Spanish-speaking)

Lisa spoke about locating herself in the therapeutic space among many diverse Latinx/Latine clients and the work she does to reflect on her own White identity when recognizing that Latinx/Latine ethnic groups hold different and varied histories of oppression and may not engage in the same Latinx/Latine cultural practices, “I think different, just appreciating yes, there are cultural sort of markers and each family is different, each family’s culture is different and just being careful not to stereotype, that takes time I think and experience and self-awareness work” (Lisa, White, English-speaking).

Emily, a White-identifying participant, explained how she does work outside of the relationship in her own therapy to learn how to openly discuss and hold different cultural views of parenting, especially given her privileges and learned biases as a White person born in the United States:

Do you consider your own therapy for a very long time a part of that? Because you can check me off for that in terms of my own self-understanding. As a White person who’s never had to deal with this, that’s my outside perception of this. And so, my perception of burden and caretaking, right, whereas caretaking can be very protective. I could say it’s important to try to hold onto that and to recognize if you’re from a different cultural background, how your perception could get in the way. (Emily, White, English-speaking)

Contrarily, Shanice, an African American participant, discussed engaging in her own self-reflective identity work outside of the therapeutic relationship but not necessarily bringing it into the treatment with her Latina adolescent clients due to prioritizing the focus onto them as the center of the relationship. Her decisions to limit discussions on her identity in the session and to
hold space for identity work outside of the therapeutic space instead could also be tied to her own experience with systemic racial oppression in the United States:

I identify as an African-American….my clients don’t know that and sometimes they don’t need to know that unless they ask. Normally I would want to ponder, what does that mean to them? But normally I’m making my clients the center of it. So there’s not a focus on me, that’s happening internally with me where I’m mindful of checking my own biases and making sure that I’m either validating them or things that would probably go unnoticed. As a clinician I’m bringing that to the forefront. (Shanice, African American, English-speaking)

Several participants shared the lack of focus on self-reflective identity processing in their social work education program, “It wasn’t a lot of work around cultural identity and the impact that has when working with people” (Jenna, White, English-speaking). Daniela, a Dominican American participant, explained how her own lived experiences helped her engage in this work on the side due to missing substantial resources to learn how to do this in her social work program:

It’s my lived experience and in grad school we did talk about identity and things like that, it was more textbook material. I feel like my lived experience as a therapist and working with a range of cultures beyond myself. It’s been a lived experience of mine to be able incorporate my identity but also understanding others’ identities in my work and validate that experience. (Daniela, Dominican American, English and Spanish-speaking)

Kathy, a White social worker who predominantly works with Dominican and Puerto Rican clients, identified that managing her anxiety around the Latina adolescent’s safety required work outside of the therapeutic space when she first started working with this population. She
acknowledged the need for social workers with high-risk clients to get more training and support around managing the uneasiness of treating teens with suicidal behaviors, especially when the suicidality is chronic.

Sunday had to be like a nourishing day, I had to really take care of myself, make sure I was hydrated, fed, exercise, clear minded to go into work on Monday so my brain was ready to work. I just like had to make those adjustments because I put the commitment in, and it gave me a lot of space to learn how to navigate cases and to manage my own emotions around it. And learning how to sit with that feeling is one of the most challenging parts about doing the work. (Kathy, White, English-speaking)

Lastly, Carlos, a Dominican social worker, discussed his own ability to reflect on social justice and cultural factors in care with the Latina adolescents and their families along with focusing on the suicide “trends” among Latinx/Latine youth. This curiosity flourishes from his education and from his shared cultural and community identities with his client population.

…all of these cultural components played such a big factor where having that education, mixed with personal experience, or exposure in my community as a kid, but also because of the work that I do, just being very aware of the trends, right? (Carlos, Dominican American, English and Spanish-speaking)

Summary

In conclusion, to meet the needs of Latina adolescents who engage in suicidal risk behaviors, social workers voiced various needs for ongoing supervision, training opportunities that focus specifically on Latinx/Latine sociocultural factors in suicide treatment, a supportive professional community, and time to process and learn outside of their clinical work. These
findings support recommendations to mental health systems and can serve to improve safety and sustainability of care across the Latina adolescent’s various ecological levels.
CHAPTER 6: DISCUSSION AND IMPLICATIONS

This dissertation explores the therapist and client/family relationship and the social worker’s knowledge of Latinx/Latine sociocultural considerations as key mitigating factors in the pathway to a suicide attempt for Latina adolescents. Through comparing and analyzing the data, the researcher generated thick descriptions that emphasized the role of the mental health practitioner, their relationship with the Latina adolescents and their family members, the social worker’s knowledge of Latinx/Latine sociocultural factors when engaging Latina adolescents in suicide risk assessments and safety planning, and their ongoing training needs to support this high risk and minoritized group.

The researcher documented a nuanced understanding of the relational role of social workers and clients and families in mental health care. Suicide in minoritized populations is still a new field of study in social work and this dissertation provides new insight and recommendations for how to implement suicide treatment more effectively with Latina adolescents. The participants’ knowledge of sociocultural factors in suicide treatment has the potential to provide Latina adolescents, their families, and providers with effective tools, awareness of specific risk and protective factors, and culturally responsive clinical interventions to mitigate the suicidal crisis and to help Latina adolescents thrive in their multicultural worlds.

By working at the provider level, the findings of this study can influence “best practices” to reduce suicidal behavior in Latina girls. Sociocultural factors are already indicated as influential in suicidal behavior for Latina adolescents (Zayas, 2011). With this theory in mind, the researcher sought to extend it to include the influential role of the social worker. This research can support social workers who treat these adolescents and harness the protective elements in the
various ecological system layers, particularly at the family level, that can serve to mitigate against the attempt and strengthen Latina adolescents’ well-being.

Implications for Clinical Practice

This study’s findings support the importance of placing a greater focus on the development of the therapeutic relationship with Latina adolescent girls and their families. The social worker’s knowledge and ongoing learning of sociocultural influences in suicide treatment are essential requirements for creating a strong working therapeutic relationship. These findings provide concrete recommendations to improve therapeutic and community interventions that are specifically developed for Latina adolescents’ and their families’ needs and build upon their numerous cultural strengths. In addition, the implications have the potential to inform future clinical research and support theoretical understandings of suicidality among marginalized and oppressed groups, which can serve to increase mental health providers’ knowledge of the unique challenges and strengths that Latina adolescent girls hold in the United States with a better plan for preventing future suicidal risk.

The Essential Role of Developing Therapeutic Relationships with Latina Adolescents and Their Families

Research consistently supports the importance of a secure therapeutic alliance/relationship for the client’s ability to increase engagement and motivation to work on therapeutic goals (Horvath & Luborsky, 1993) and more recently, it has recognized the power of the therapeutic alliance in mitigating suicidal risk with adolescents (Ibrahim et al., 2021). Thus, it was not surprising that this study’s findings reinforced the importance of the therapeutic relationship when working with Latina adolescents with suicidal behaviors, and even took it a step further to highlight that it is the most important part of treatment. When working with Latina
adolescents and their families in suicide treatment, findings showed that social workers hold many different roles within the therapeutic relationship. They are individual providers, parenting therapists, family therapists, collaborators, teachers, and learners. It is essential to also recognize that the implicit biases identified in the interview data were not dependent on a specific gender, race, or ethnicity, and these biases were evidently shaped by participants’ lived experiences and the populations and community settings that they work in. Acknowledging these biases in the interview data has the potential to create a platform to openly discuss and bring awareness to the ways that our biases as both human beings and clinicians shape therapeutic work.

*The Individual Relationship*

This study explored the common tools and strategies that social workers use to build the therapeutic relationship with the adolescent and their family members. The power of the therapist to *disclose their identity* (e.g., race, ethnicity, parenting role) and *cultural experiences to create shared connectedness and open dialogue about suicidality* was a major finding that participants described, a strategy that several participants spoke about as not being encouraged openly and taught as a core skill in their social work education programs. Self-disclosure of the social worker’s intersectional identities and cultural experiences was a core relational growth strategy that demonstrates respect and openly challenges the power differential within the relationship and among the Latina adolescent’s multiple oppressive systems in this study and others (PettyJohn et al., 2020). Furthermore, being upfront about their similar or differing identities served to increase trust in the relationship and build the commitment to engage in therapeutic work based on the participants’ reflections of treating Latina adolescents with suicidal behaviors. In addition, *taking a non-judgmental stance through expressing openness and transparency of limits of confidentiality led to trust, allowing for safety management to occur.* This was observed
in the interviews to develop from the social worker’s understanding of sociocultural factors such as immigration experiences, impact of religion and cultural stigma on accessing mental health care, and acculturation and assimilation gaps between the adolescent and their parents as well as shared cultural connections due to being part of the same culture and/or ethnicity or having significant knowledge of Latinx/Latine cultural beliefs and practices.

The participants’ clear intentions around limits of confidentiality and the therapist’s ability to hold the adolescent when safety was compromised or difficult past experiences were shared were additional essential strategies that allowed relational growth to occur between the Latina adolescent and their therapist. Lastly, discussing the cultural stigma of mental illness and treatment for suicidal ideation and behaviors within the Latinx/Latine community openly with both the Latina adolescent and their family members helped reframe the need to seek outside help, which served to decrease shame and empower confidence in the adolescent and parents’ decision to pursue care. This in turn helped to deconstruct an oppressive system, which is often a reason why Latinx/Latine do not seek professional mental health care outside of their own family system (Vargas et al., 2015).

Lastly, the majority of participants also reflected on the work that they do outside of the relationship to reduce biases, process their shared or differing identities with the Latina adolescents, connect with lived experiences, and engage in training to learn new therapeutic strategies. Thus, it is imperative that mental health care agencies provide significant resources to Latina adolescent treating therapists in order to support their learning of the impact of sociocultural factors on suicide treatment as well as decrease “power-over” approaches (Jordan, 2018) and provide identity processing opportunities, which is strongly in line with the social work profession’s core social justice values. This is true for clinicians of all races and ethnicities.
as individuals who identify and relate similarly to Latina adolescents may have a harder time recognizing their differences and could benefit from processing assumptions that are embedded so deeply in their practice.

The Collaborative Relationship

With knowledge of the significant value and impact of family on Latina adolescents, this study also aimed to provide a window of understanding on how social workers work one-on-one to support caregivers with managing their Latina adolescent’s safety and comprehend their child’s mental health needs, give parenting tools, and build relational growth between the adolescent and their family members. The therapeutic relationships with parents were one area in the interviews where biases were most evident as participants shared perceptions around their challenges engaging parents, which were often shaped by perspectives of the communities they worked in and/or lived experiences that the clinicians had from being socialized and professionalized inside the United States. These biases highlighted a need for further work to be done on processing these biases in clinical practice as this can impact trust and hesitation to disclose in treatment. For example, perspectives on the parenting role were impacted by participants’ lived and working experiences, and shaped the way they considered parent engagement in treatment and thought about the adolescent’s needs for increased resources and help. Participants highlighted that a lack of parent engagement with the social worker impacted the adolescent’s treatment trajectory negatively from their perspectives, reinforcing the need for family involvement in treatment with Latina adolescents, which is a consistent recommendation in the minimal literature on therapeutic interventions for this group (Villarreal-Otálorá et al., 2019; Duarté-Vélez et al., 2016).
Furthermore, participants spoke adamantly about the need to include parents and other family members in the Latina adolescent’s treatment for suicidality such as older siblings in treatment given the powerful role that families hold in being able to protect their child. The participants highlighted that their Latina clients’ parents were more open to working with them when the therapist was knowledgeable about Latinx/Latine cultural stigma on mental illness and suicide, and spoke openly and respectfully about it in the therapeutic space.

Many participants spoke about the “fear of stigma” that Latinx/Latine families hold as a barrier to seeking out and engaging in mental health care for their daughters with suicidal ideation and behaviors. The assumption of this fear emphasizes the need for social workers to hold a systemic perspective of stigma of mental illness as the fear is rooted in mistrust of an American system and the consequences of labeling individuals with diagnoses instead of the bigger picture that sees societal messaging around mental health treatment, mental illness, and suicide as harmful. It is clear from the data that therapeutic engagement is established once an understanding of the treatment structure and confidentiality limits are addressed, illustrating that the tension between mental illness stigma and the health and well-being of Latina adolescents may be about fear of an American oversight system rather than about parents not wanting their Latina adolescents to engage in care.

Empowering parents to build healthy relationships with their children through perspective-taking, introducing decolonized (healing-centered, trauma-informed) parenting practices, and educating parents about sociocultural influences on the adolescent’s suicidal behaviors (e.g., acculturation gap) were some of the core strategies that social workers used to indirectly support their Latina adolescent client. While at times, sociocultural barriers such as the impact and pressures of immigrating, acculturating, and assimilating on parenting Latina
adolescents effectively were identified in the interviews, many participants helped parents see that these barriers are maintained by systemic oppression and discrimination and utilized approaches including validation and mutual empathy when considering sociocultural factors as barriers to engagement.

Perspective-taking strategies were consistent with Zayas’s Ecodevelopmental Model (2011) as it is included as an essential factor within the parent/adolescent relationship within his model of Latina adolescent suicide attempts. The majority of participants used perspective-taking techniques to help the parent and adolescent understand each other’s narratives to increase mutual empathy and connectedness, fundamental principles of the Relational Cultural Theory (Jordan, 2018). Lastly, social workers hold a unique opportunity as their training is rooted in social justice values and practice and can help Latinx/Latine parents become more aware of the systems of oppression that impact their identities of marginalization, which leads to mistrust. Findings reinforce the idea that social workers, by supporting parents in this capacity, can help reframe the mental health experience for Latinx/Latine individuals.

**Engaging Latino Fathers**

One important finding that has not been commonly explored in previous literature was the social worker’s challenge engaging Latino fathers in the Latina adolescent’s treatment for suicidal ideations and behaviors. Participants shared that their Latina adolescent clients voiced interest in having their fathers engage in their treatment and the social workers also expressed this desire in order to gain a deeper perspective on the adolescent’s functioning and increase a safety network around them. Participants shared that the father’s absence was due to a variety of different factors such as placing the care-taking role on the mother, abandoning the daughter early on in life, not having a close relationship with their daughter, and the influence of
Latinx/Latine cultural perceptions on the paternal role (e.g., men are less emotional and hold negative stigma toward mental health treatment). Many social workers in this study recognized the absence of this important parental role in treatment and its impact on their Latina adolescent client’s trajectory toward a suicide attempt, which is concerning as research has shown that the father/daughter relationship has a mitigating effect on suicidal ideation and behaviors. De Luca, Whyman, and Warren (2012) conducted a large sample study of Latina adolescents (n=1,618) and found that perceived support from their fathers was associated with fewer suicidal ideations and/or attempts, but it was not consistent for perceived support from their mothers.

Participants shared narratives of their Latina adolescent clients’ desire to improve their relationships with their fathers and the negative impact the father’s absence (emotional or physical) had on their sense of identity and belonging. While one participant provided a suggestion on how to engage Latinx/Latine fathers in their daughter’s suicide treatment interventions by working with a Latinx/Latine male therapist and focusing specifically on breaking down and reframing sociocultural barriers limiting engagement in mental health treatment such as stigma and emotional restriction, further work is needed to explore core strategies in the therapeutic space to improve engagement along with increased community-based efforts to reduce the stigma. It is evident from previous literature and this study that Latinx/Latine fathers would greatly benefit from engagement in their daughter’s mental health care to receive support and develop parenting strategies to improve their daughter’s well-being. Falicov (2010) suggests that Latino males could receive support from clinicians in developing “alternative constructions” by using “cultural narratives” that are more empowering than the typical negative stereotypes formulated by views of machismo and cultural masculine traits (p. 309). O’Gara et al. (2021) published an exploratory dyadic analysis on 10 father-daughter
relationships among Latina adolescents who attempted suicide from Zayas’s large study data. The study’s implications suggested culturally sensitive practices that consider perspective-taking would be helpful along with identifying informal supports, which are similar findings in this study. Thus, providing more therapeutic space for the father, learning about and processing the father’s impact on their daughter’s well-being, reconstructing the masculine paternal role and having a core understanding of Latinx/Latine sociocultural factors impacting fathers specifically would be helpful recommendations for providers.

**Scaffolding the Adolescents and Their Families Toward Their Strengths**

Collaborating with additional mental health providers such as psychiatrists and case managers and identifying and acquiring additional resources to build the adolescent and their family’s community were other roles that the adolescent’s social worker held within the therapeutic relationship to build the Latina adolescent’s strengths and suicide safety. Participants identified the need to build the adolescent’s collective relationships if they did not have the support already from family and extended family members, school personnel, peers, or community programs. Given the high importance of collectivism within Latinx/Latine culture (CDC, 2012), it is not surprising that this is an important finding to support the Latina adolescent. In addition to this finding, participants also spoke about the social worker’s unique ability and need to balance the multicultural Latina adolescent’s dance between building their individuality and intersectional identities in Western culture while also honoring the elements of Latinx/Latine collective values. Participants highlighted that in order to support their multicultural worlds, creativity and understanding of this dialectic is a required skill to help the adolescents thrive in their cultures. Thus, the social worker is challenged to help build community around the Latina adolescent with support from their family members and
community resources to ensure safety and protection while honoring the individual as an independent being growing up in Western society.

Balancing the Latina adolescent’s desire for independence with the Latinx/Latine family’s collectivist values that are rooted in the desire to keep the family together (*familismo*) was revealed as an important strategy in both building relationships and helping the Latina adolescent and their family members find safety and relief away from suicide. The perspective from participants that family cohesion and prioritizing family needs could be both a strength and a barrier was an important finding given that most of the research on *familismo* has found that familism contributes to individual and community strengths. These perspectives highlight the need for providers to be able to tease apart the many elements of *familismo* that hinder and protect the Latina adolescent’s development in the United States. Working with families to identify their strengths of family engagements and cultural events and traditions while recognizing behaviors that may hinder the Latina adolescent’s future goals due to wanting to protect and prioritize familial cohesiveness can be an essential step. A primary goal for the clinician is to help the Latina adolescent find a level of autonomy that considers perspectives from both the Latina adolescent and her family.

In addition, *clinical team support and positive supervisory relationships*, particularly with *Latina identifying supervisors*, strengthened the social workers’ perceived confidence and decreased isolation in their multiple roles. Many participants shared the importance of their support network comprised of other clinicians working with Latina adolescents, resources from their peers and supervisors, as well as trainings to continue to improve their practice with this high-risk population specifically. Thus, *building collective relationships* and *finding resources*
are strategies that serve to strengthen multiple relationships within the micro and mezzo ecological layers for the adolescent, their family members, and the social worker.

Understanding Latinx/Latine Sociocultural Risk and Protective Factors in Suicide Treatment

Creating Supplemental Suicide Risk Assessment and Safety Management Tools

Findings showed that the current suicide risk assessment and safety planning tools that providers utilize in their practice do not adequately target sociocultural influences when treating the Latina adolescent’s suicide risk and functioning. While the majority of participants use the Columbia-Suicide Severity Rating Scale (C-SSRS; Posner et al., 2008) in their practice with youth and found it helpful for assessing acute suicide risk and common proximal and distal factors influencing the adolescent’s risk of engaging in present or future suicidal ideation or behaviors, additional clinical needs were stated for targeting sociocultural factors within the assessment for this population. Participants shared that the C-SSRS requires the provider to think about and ask independently about sociocultural risk and protective factors such as religious influence, perception of cultural stigma, immigration and discrimination factors, and familial influences and values. The same was shared by participants when critiquing the safety planning tools that they use, which the majority mentioned was The Safety Planning Tool (Stanley & Brown, 2012).

It was clear from the findings there is a varied range of sociocultural considerations in suicide treatment with Latina adolescents and providers vary in their conceptualization of Latina adolescent suicide from thinking about few factors to a thorough sociocultural assessment of risk and protective factors. Non-White social workers seemed to have a more comprehensive list of sociocultural factors that they considered in suicide treatment with Latina adolescents compared
to their White counterparts, which is likely due to their own lived experiences and/or shared cultural connections to their Latinx/Latine clients. In addition, social workers shared that the sociocultural risk and protective factors such as questions about their family’s immigration journey and family’s perspectives on mental health treatment that they ask about in the risk assessment or inquire about adding to the adolescent’s safety plan was not included in their social work education or field practical training and instead were learned either through their clinical jobs following their formal education or through lived experiences. Thus, given the significance of sociocultural risk and protective factors on the Latina suicide attempt, it is essential that the sociocultural risk and protective factors be comprehensive and standardized within risk assessment questions and incorporated in suicide safety planning tools. They also need to then be tailored to the Latina adolescent’s needs so that the safety plan best fits their unique experiences.

In addition, this dissertation argues that social work schools and professional practices need to provide formal training on sociocultural risk and protective factors of suicide targeted to the population that the social worker is working with, another finding that participants spoke about. The social workers who participated in this study shared specific factors to support questioning about sociocultural influences in suicide risk assessments and safety planning tools as identified in the table below. The below factors are combined with the Ecodevelopmental Model’s micro and mesosystem sociocultural influences (Zayas, 2011):

**Table 6. Sociocultural discussion topics and questions to be added to risk assessment and safety planning tools.**

<table>
<thead>
<tr>
<th>Sociocultural Factor (Zayas and)</th>
<th>Discussion Topics to Add to Risk Assessment and Safety Planning Tools</th>
<th>Suggested Language/Questions for Adolescents and Families</th>
<th>Lenguaje Sugerido/Preguntas para Adolescentes</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Participants</th>
<th>Latinx/Latine y Familias</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural Stigma of Mental Health and Suicide</td>
<td>• Does anyone know that you’re in this appointment with me today and that you’re interested in seeking mental health care? If not, then why?</td>
</tr>
<tr>
<td>• Perceptions of mental health care</td>
<td></td>
</tr>
<tr>
<td>• Nuclear and extended family members previously engaged in mental health treatment</td>
<td></td>
</tr>
<tr>
<td>• Family’s perceptions on the adolescent’s engagement in care</td>
<td></td>
</tr>
<tr>
<td>• Family members’ level of willingness to engage in adolescent’s treatment</td>
<td></td>
</tr>
<tr>
<td>• Family members’/broader culture’s views of suicide</td>
<td>• ¿Alguien sabe que está en esta cita conmigo hoy y que está interesado en buscar atención de salud mental? Si no, ¿por qué?</td>
</tr>
<tr>
<td>• Si le dijera a sus familiares/amigos, ¿qué crees que dirían?</td>
<td></td>
</tr>
<tr>
<td>• Si le dijera a sus familiares/amigos que estaba pensando en suicidarse, ¿qué cree que dirían?</td>
<td></td>
</tr>
<tr>
<td>• ¿Hay alguien más en su familia que haya tenido terapia de salud mental? Si es así, ¿Cómo ha sido su experiencia según su conocimiento?</td>
<td></td>
</tr>
<tr>
<td>• ¿La cultural a la que usted se adscribe tiene alguna percepción particular del suicidio d la que tenga conocimiento?</td>
<td></td>
</tr>
</tbody>
</table>
| Family | • Family members supportive of adolescent's engagement in suicide treatment  
• Family perceptions of suicide  
• Extended family supports  
• Protective qualities that family holds | • How has your family supported you in the past? What about now?  
• Who’s one person in your family who you speak to about deep issues?  
• Have you shared with your family that you have been thinking about suicide? If not, how do you think they would react?  
• What aspects of your family do you think protect you the most from thinking about killing yourself? | • ¿Cómo se ha apoyado su familia en el pasado? ¿Qué se parece ahora?  
• ¿Quién es una persona en su familia con la que habla sobre temas profundos?  
• ¿Ha compartido con su familia que ha estado pensando en suicidarse? Si no, ¿cómo cree que reaccionarían?  
• ¿Qué aspectos de su familia crees que se protegen más de pensar en suicidarse? |
| --- | --- | --- |
| Immigration | • Age when parents came to the United States  
• Age of adolescent when they arrived in the United States  
• Migration experience  
• Thoughts and feelings about their adaptation/assimilation journey  
• Parent’s experience adapting to American culture | • How old were your parents/family members/yourself when they/you came to the United States?  
• Can you tell me about your experience immigrating to the United States? How did you come here? | • ¿Qué edad tenían sus padres/miembros de la familia/usted mismo cuando ellos/usted vino a los Estados Unidos?  
• ¿Puede contarme sobre su experiencia al emigrar a los Estados Unidos? |
| Ethnic Discrimination | • Self-identity perspectives  
• Experiences of discrimination and oppression | • How would you describe your ethnic identity?  
• Please share some strengths about your ethnic and cultural identities from your perspective?  
• Have you ever experienced systemic oppression? Can you recall a time that you experienced ethnic or racial discrimination? What about a family member or friend and how did that impact you? | • ¿Cómo describiría su identidad étnica?  
• Por favor, comparta algunas fortalezas sobre sus identidades étnicas y culturales desde su perspectiva.  
• ¿Alguna vez ha experimentado opresión sistémica?  
¿Puede recordar un momento en que experimentó discriminación étnica o racial? ¿Qué pasa con un miembro de la familia o un amigo y cómo te impactó? |
| --- | --- | --- | --- |
| Religion | • Involvement in religious or spiritual practices  
• Personal and familial religious views on suicide and mental health disorders | • Do you practice a specific religion and if so, why do you practice this specific religion? (Probe whether | • ¿Practica una religión específica y si es así, por qué practicas esta religión específica? (Investigue si es porque la |
### Level of Acculturatio

| • Language used with peers and family members vs. at school/work  
| • Cultural identity/belonging  
| • Media preferences | • How often do you speak Spanish with your family, adult family members, at school, with your friends?  
| | • How often do you watch television in Spanish or channels from Latinx/Latine countries? |

#### Increasing Access to Bilingual and Bicultural Latinx/Latine Clinicians

One of the most important findings of this study was the impact on the therapeutic relationship among the social workers who identified as a Bilingual Spanish speaker and Bicultural Latinx/Latine. The data analyzed from the participants’ interviews showed much richer knowledge and experiences of Latinx/Latine identified social workers treating Latina
adolescents with suicidal ideations and behaviors than the participants who were not bilingual and bicultural. In addition, the participants who were neither bilingual in Spanish nor held Latinx/Latine ethnic identity demonstrated the added work that was needed on self-identity processing, particularly around privilege, and learning of Latinx/Latine cultural values than did their counterparts who were culturally and linguistically matched with the Latina adolescents. While many of the non-Latinx/Latine clinicians spoke about doing this work, there were several participants who were unable to speak to their self-identity or cultural learning work. One of the participants who immigrated from a Southeast Asian country at a young age spoke about a shared connection with her Latina adolescent clients who immigrated to the United States or their parents, showing the importance of identity disclosure to establish shared connectedness and mutual empathy (Ruiz, 2012).

In addition, Latinx/Latine social workers who matched the Latinx/Latine ethnic origin of their Latina client and more closely aligned with the adolescent’s level of acculturation described a stronger connection with their client and valued their unique ability to recognize shared cultural experiences and familial values. Thus, this researcher recommends that a cultural and linguistical therapist/client match would be ideal in supporting this population. When this match cannot occur, it is clear from the findings that non-Spanish speakers and/or those who are not Latinx/Latine bicultural social workers need to engage in consistent and ongoing work outside of the relationship to build their Latinx/Latine cultural humility and self-reflective processing practices to better meet the needs of their Latina clients. This is a suggestion very much in line with Relational Cultural Theory’s practical strategies (Jordan, 2018).

Overall, the impact that bilingual and bicultural Latinx/Latine social workers held in being able to personally relate to the Latina adolescent and their families greatly resulted in
shared connectedness, empowerment to maintain their safety and work with their parents and other family members to improve their suffering, and mutual empathy for each other’s lived experiences (Jordan, 2018). The bicultural and bilingual Latinx/Latine social workers were able to establish trust in the relationship with the Latina adolescent through their Latinx/Latine identity and shared cultural experiences along with the ability to communicate effectively with their family members, codeswitching between English and Spanish-speaking as needed. It appeared that the shared cultural and linguistical connections sped up the relational growth process as less cultural learning and increased relatedness led to a quicker connection. However, there was no data to support whether US-born Latina therapists had difficulty connecting with foreign born clients. This is an essential consideration, especially when working with Latina adolescents who were not born in the United States. In addition, there wasn’t enough data to focus on ethnic origin match, which is another factor consider given that there were many cultural biases discussed among the Latinx/Latine participants.

It is also important to note that a linguistical and cultural match can result in the social worker over-identifying and experiencing significant countertransference with their Latina client. Therefore, is also important that this study’s recommendations around peer support and supervision as well as ongoing sociocultural learning opportunities on suicide treatment for minoritized populations are accessible and readily utilized. Furthermore, given that participants of all ethnic and racial identities held implicit biases throughout the data, clinicians who identify similarly to their Latina clients also need opportunities to self-reflect so that these relationships are less impacted by assumptions that are embedded throughout their Westernized, White-centered socialization. While this shared identity was revealed as a strength from the perspectives of the Latinx/Latine participants, over and under identification can both harm the
relationships with the girls and their families, pointing to the importance of ongoing self-processing work for all social workers.

Non-Spanish speaking social workers shared how their inability to speak Spanish negatively impacted the relationship with the Latina adolescent’s family members as they had to use a phone interpreter, which resulted in the family’s diminished engagement in the adolescent’s care and/or made it more challenging to establish shared connectedness. They also spoke about being consciously focused on not parentifying the teen by relying on them to communicate and on creating a fair balance with the work that is done with the adolescent and their family members separately and possibly exacerbating their risk/burden. The topic of suicidality and the adolescent’s risk level made it even more challenging for English-speaking non-Latinx/Latine clinicians as having an interpreter took away the emotional expressiveness and required a greater focus on word choice in their psychoeducational explanations.

In addition, participants spoke about translating emotions and perspectives to the adolescent’s parents on mental health, which Latinx/Latine participants spoke about more frequently in the interviews and related to their own lived experiences of Latinx/Latine culture’s stigma of mental health. This finding is consistent with prior research, particularly the fact that a shared language is not enough (Gregg & Saha, 2007). Lanesskog, Piedra, and Maldonado (2015) conducted a qualitative study on 25 human service professionals in rapidly growing Latinx/Latine immigrant communities in the United States and found that the importance of language ability, cultural competence, empathy, and a desire to support the client’s behalf when delivering service are essential provider characteristics to improve delivery of good care. Therefore, a major finding from this study is that *Latinx/Latine Bicultural and Bilingual Spanish and English clinicians* serve in creating a positive developmental trajectory in suicide treatment
for Latina adolescents and their family members’ engagement in mental health care. *Increasing access to Latinx/Latine bicultural and bilingual clinicians* is a necessary implication from this study in order to provide the most effective treatment for suicidality and support the Latina adolescents’ healthy navigation through their multicultural worlds. This recommendation places great emphasis on our mental health system to train, support, and appropriately recognize these unique needs through compensation of the essential skills that bilingual and bicultural clinicians hold.

*The Social Worker’s Sociocultural Training Needs*

The majority of participants expressed a need for greater support on the provider level to ensure that significant training on Latinx/Latine sociocultural risk and protective factors on suicidality are provided through ongoing professional development opportunities as the majority of participants had never received a training before on this topic. *Opportunities to collaborate on care with clinical teams and within supervisory relationships* were also described as high needs to do this work. Many participants of all racial and ethnic identities also shared how the care they provided Latina adolescents with suicidal ideation and behaviors benefited from their supervisory relationship with a Latina identifying clinician as they were able to learn from the supervisor’s shared cultural and gender intersectional identities with their Latina client. Research supports using sociocultural and ecological theories to effectively implement strong mentorship and collegial learning (Spouse, 2008) and providers could benefit from Falicov’s Multidimensional Ecological Comparative Approach Framework (2014); Falicov argues that the supervisory relationship is a “an encounter between the supervisor’s, the therapist’s and the client’s theoretical and personal cultural maps” (p. 32). Culturally humble therapeutic practices were also essential in treatment with Latina adolescents and occurred from social workers’
engagement in racial, ethnic, and cultural introspective practices through processing their own lived experiences and/or engaging in these practices in their own therapy, with colleagues, or through trainings. Lastly, more clinicians who are qualified to work with this population must receive opportunities to be linguistically and culturally trained. MSW programs also need to introduce a language certification for social work students that teaches skills on how to provide psychotherapy both in another language and bilingually given that family sessions often require these skills and the topics of risk and safety cannot afford to be lost in translation. By having more qualified clinicians within the workforce, social workers will be better equipped to meet their Latina clients’ needs.

Table 7. Summary of Participants’ Recommendations.

| With the Individual Latina Adolescent                                                                 | • Create a non-judgment space to build trust and safety |
|                                                                                                         | • Be transparent about clinician’s location of self and intersectional identities |
|                                                                                                         | • Take time to share limits of confidentiality clearly |
|                                                                                                         | • Be open about sociocultural understandings related to stigma of mental health and cultural strengths |
| Safety Planning and Risk Assessments                                                                  | • Provide simpler and more developmentally appropriate language |
|                                                                                                         | • Incorporate more culturally sensitive language and questions |
|                                                                                                         | • Spend more time on relationship building prior to safety planning |
|                                                                                                         | • Normalize the safety risk assessment and planning process |
|                                                                                                         | • Increase training on culturally attuned safety planning and risk assessments |
|                                                                                                         | • Include sociocultural risk and protective factors |
| Increasing Awareness of Latinx/Latine Sociocultural Factors Throughout Treatment                        | • Build knowledge of parents’ and adolescent’s different levels of acculturation including: |
|                                                                                                         |   ○ Language abilities |
| With the Latinx/Latine Adolescents’ Parents/Family Members | • Spend time understanding generational period they grew up in  
• Gather immigration history and impact of focusing on their “American dream” in context of helping families understand and validate acceptance of adolescents’ suicidality  
• Utilize empowerment by focusing on the parent as the expert of their child  
• Focus on a decolonizing framework when discussing parenting practices by using a “trauma-informed, healing-centered, nonviolent, and culturally focused” (Arreola-Hillenbrand, 2021)  
• Can be helpful for clinician to disclose their own parenting identity |
|----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| With Latinx/Latine Fathers | • Provide option to work with Latinx/Latine male therapist  
• Focus specifically on breaking down and reframing sociocultural barriers that can engagement in mental health treatment  
• Learn about and process the father’s impact on their daughter’s well-being  
• Reconstruct the masculine paternal role  
• Carry a core understanding of Latinx/Latine sociocultural factors impacting fathers specifically |
<p>| With Latinx/Latine Families | • Build resources from community (e.g., after school programs, case management support) |</p>
<table>
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<tr>
<th>For the Clinician on Their Own</th>
<th>For Mental Health Agencies</th>
<th>For Social Work Schools</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Understand beliefs about therapy/mental health care, suicide</td>
<td>• Increase hiring of bilingual and bicultural Latinx/Latine clinicians</td>
<td>• Therapeutic language certification program</td>
</tr>
<tr>
<td>• Give psychoeducation</td>
<td>• More bilingual therapeutic materials and bilingual trainings for clinicians</td>
<td></td>
</tr>
<tr>
<td>o Validation of emotions</td>
<td>• Need more clinicians who match the ethnicity and race of the population being served</td>
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<tr>
<td>o Coping strategies</td>
<td>• Increase collective support for clinicians (e.g., peer supervision spaces, affinity groups for Latinx/Latine clinicians, mandatory individual supervision)</td>
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<td>o Mental health topics</td>
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<td>o Diagnosis and symptoms</td>
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<td>• Give bilingual language for emotions</td>
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<td>• Encourage parent/adolescent activities</td>
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<td>• Teach perspective-taking</td>
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<td>• Build awareness of the acculturation dialectic of individualism and collectivism and many elements of <em>familismo</em> that serve to protect and hinder the Latina adolescent’s development</td>
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<td>For Social Work Schools</td>
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<td>• Therapeutic language certification program</td>
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• Provide sociocultural training on suicide among marginalized populations
• Provide education on suicide treatment through a socioculturally attuned lens

Adding Mental Health Care Providers to the Ecodevelopmental Model

This study included a theoretical analysis of the sociocultural risk and protective factors that make up Zayas’s Ecodevelopmental Model of the Latina Adolescent Suicide Attempt. Zayas proposed that the suicide attempt for Latina adolescents is comprised of multiple ecological factors that culminate to form the adolescent’s attempt (Zayas, 2011). Based on the 20 interviews conducted for this study, all participants were able to identify specific Latinx/Latine cultural and social risk and protective factors as influences on the conceptualization of their clients’ suicidal ideations or behaviors, or how these factors such as immigration, acculturation levels, and cultural stigma of mental health are considered when treating the suicidality. It was also clear from the data analysis that social workers who identified as bilingual and bicultural Latinx/Latine had a more comprehensive understanding of multiple cultural and social factors that influence their Latina adolescent’s multicultural world, resulting in improved relational connectedness with the adolescent, their family members, and their overall community (the neighborhood they lived in or other providers and important figures involved in their lives). On the other hand, it is also important to note that as human beings, biased views about sociocultural factors were evidently mentioned, such as perceptions about how Latinx/Latine community immigrate to the United States and the type of lifestyle clients had back in their country of origin, which was often based on the client population the participant served and/or their own lived experiences. With this in mind, having a multifaceted socioculturally attuned approach to
treatment defined as a “practice that is aware and responsive to the intersections of social context, culture, and power in client experience and positioned to promote equity” (Kundson-Martin et al., 2019, p. 47) is essential. Social workers in this study revealed how their knowledge of sociocultural factors helped them build stronger connections with the Latina adolescents and their families, but it was not clear how their implicit biases may also impact these relationships (good or bad). Thus, an in-depth study on the impact of cultural biases within the therapeutic relationship would be helpful. With the data that was collected, an essential implication is that trust established from cultural connections and understandings as well as therapeutic approaches created a better therapeutic relationship, allowing for effective safety management and suicide treatment to occur.

Thus, the researcher argues for the importance of adding the mental health provider relationship to the Ecodevelopmental Model and the clinician’s knowledge of Latinx/Latine sociocultural risk and protective factors as an intervention in the Latina adolescent’s suicide attempt trajectory. By adding this to the theory, greater emphasis is placed on the essential need for more Latinx/Latine bilingual and bicultural mental health providers, trainings, and ongoing education around the influence of sociocultural factors on suicide treatment for Latina adolescents, and on the need for a greater push forward in creating more culturally attuned interventions that are specifically for Latina adolescents and not just adapted. This demonstrates that sociocultural attunement is a mitigating factor in the therapeutic relationship for suicide treatment and should be included as an essential influence within the Ecodevelopmental model.
for Latina adolescents. Lastly, by adding this important mediator to the theory, greater empirical evidence can add pressure to increase access and support for this minoritized group.

**Figure 3.** Mental Health Care as a Mediator Node for the Trajectory of a Suicide Attempt for Latina Adolescents.

**Figure 4.** The Ecological Model expanded to include the clinician’s relational and sociocultural involvement. Adapted from Zayas (2011).

*Mental Health Care as an Additional Mediator Node*

Mental health care in the expanded model is placed within a critical point, which Zayas (2011) calls the “nodes,” which represent “significant relationships” that shape the adolescent’s
life (p. 155). Each side of the node has additional mediators (e.g., immigration, parent/child relationship), which can influence the node. The mental health care node includes the clinician’s relationship with the adolescent, their parents/family members, and their community along with sociocultural knowledge and utilization within treatment.

The Therapeutic Relationship with the Latina Adolescent, Her Family, and Her Community

The findings showed that the most critical piece in mitigating suicide attempt risk with Latina adolescents was the social worker’s relationship with the Latina adolescent, her family, and her community. As mentioned previously, an essential finding that all participants shared in their interviews was the need for parental involvement in the Latina’s treatment for suicidality, and that without it, the trajectory of suicide risk moves further toward an attempt as depicted in Zayas’s model (2011). Strong therapeutic relationships with parents and other family members served to increase safety support and allowed family members to break down barriers of cultural stigmatization of suicidality and mental health care. In addition, participants alluded to the importance of their knowledge and relationship with the communities that they work in. By having valuable knowledge about the Latina adolescent’s community’s resources, exposure to the community’s history, and awareness of the community’s strengths and barriers to help Latinx/Latine families thrive, social workers can improve the Latina adolescent’s collective support system. These three relationships- the provider’s relationship with the Latina adolescent, the provider’s relationship with their parents and other family members, and the provider’s relationship with the Latina’s community- can move the adolescent from surviving to thriving within their multicultural worlds.

Clinician’s Comprehension and Utilization of Latinx/Latine Sociocultural Factors in Treatment
As mentioned previously, all of the social workers interviewed in this study were able to identify specific Latinx/Latine sociocultural factors that influenced suicide risk for their Latina adolescent clients and served as strengths to mitigate the risk away from the suicide attempt. Large acculturation gaps between the parent and adolescent, challenges acquiring independence and individual identity away from their family systems, pressure to embody the Latina female gender role, burden to create a better life than their immigrant parents, immigration status and discrimination, cultural and religious traditions values as protection, and family cohesion were the most commonly identified sociocultural factors that participants related to suicide risk and protection. It is essential to also raise awareness to the biases that clinicians of all races and ethnicities hold. Their perspectives around these factors are influenced from their learning and experiences, thus providers must be attuned to their implicit and explicit biases when conceptualizing and understanding the Latina adolescent’s Ecodevelopmental conceptualization as it can greatly hinder trust and ongoing therapeutic work. By using these factors to assess risk and build their safety management plans, participants could increase safety and establish connectedness, empathy, and relational growth with the Latina adolescents, their family members, and their community at a much deeper level. Most importantly, by being socioculturally attuned to the Latina adolescent in suicide treatment, social workers have the powerful opportunity to mitigate the suicide risk.

**Implications for Future Research**

Continued research within the field of suicide for minoritized identities, particularly to meet cultural, social, ethnic, and political needs, is necessary. This study indicates a need for continued research and further investigation into culturally and socially attuned preventive and therapeutic interventions for Latina adolescents with suicidality. Research should now look at
how culturally attuned suicide treatment that focuses on relational growth, cultural risk and protective factors, clinician biases, and family involvement aide in the development of mitigating suicidal risk for Latina adolescents. Furthermore, additional data collection with a similarly diverse or increasingly diverse population needs to be studied to understand the intersection of identities between gender, race, country of origin, sexual orientation, language, and immigration status.

As mentioned previously, The Cultural Theory and Model of Suicide (Chu et al., 2010) and The Cultural Assessment of Risk for Suicide (CARS), which grew out of the model, is a 39-item self-report measure that assesses culturally specific suicide risk factors. This is one of the first comprehensive frameworks that provided an understanding about how culture can influence suicide risk across multiple cultural identities (Chu et al., 2013). We need to reinvent and test the CARS with Latina adolescents with suicidality and determine whether a measure that is specifically developed for them would support a better conceptualization of the sociocultural factors that influence their suicide risk and help to formulate a more culturally attuned safety plan. Thus, research is needed to evaluate already established culturally appropriate tools and to create new tools that depart from the norm or White model as these lack consideration of indigenous and marginalized oppressive roots. Thus, this study recommends that cognitive testing followed by research to establish norms with Latinx/Latine families is used when testing these tools. Furthermore, additional qualitative studies with mental health providers other than social workers may help in broadening an understanding of the ways in which different therapeutic practitioners can support the Latina adolescent and her family members. For example, there is significant stigma around taking medication for psychiatric conditions within the Latinx/Latine community (Vargas et al., 2015) so adding culturally sensitive psychiatric
interventions specifically for the Latinx/Latine community could aid in providing additional ideas to combat this stigma and increase access to care. In terms of the suicide risk assessments and safety plans, it is clear from the findings and direct practice implications that incorporating questions around sociocultural risk and protective factors and developing a socioculturally attuned safety plan would be beneficial for Latina adolescents with suicidal ideation and behaviors. Therefore, implementation research is needed to expand the risk assessments and safety tools that providers utilize in their suicide prevention practice to include questions around sociocultural risk and protective factors. In addition, given that sociocultural factors may be more common or unique to different Latinx/Latine ethnic groups, it would also be helpful to develop research on the effects of sociocultural factors on suicide for each Latinx/Latine ethnic group. **Limitations**

A limitation of this study was that the majority of participants were female, which can impact perspective and narratives around the therapist’s experience treating Latina adolescents. All practice experiences were centered in New York City, limiting the study’s findings to those in one ethnically diverse metropolitan area. Future research should include a larger sample size in conjunction with social workers and Latinx/Latine populations from throughout the United States. The Latina adolescent perspective was missing from this important work and needs to be added in future research. Including perspectives from other mental health providers and community members (school personnel, after school programs) who interact with the Latina adolescent population at risk of engaging in suicidality would also be beneficial. Convenience sampling was used, which possibly allowed a sample with similar thinking. In addition, the study was not feasible for assessing within ethnic group differences. It would be
very beneficial for future studies to look into this as between group differences may be smaller than within group differences. The sample size was too small to compare differences between Latinx/Latine immigrants and other immigrant social workers, but future work could explore similarities and differences whether or not they share Latin roots. The sample was also too small to compare differences between Latinx/Latine immigrants and Latinx/Latine American-born clinicians, which would be helpful in understanding the therapeutic relationships with Latina adolescents born in the US vs. Latina adolescent born in their country of origin. Participants also had a range of practice experience with adolescents ranging from all of their caseload consisting of Latinx/Latine youth to participants with a smaller part of their caseload focusing on this subgroup. Lastly, none of the participants were working in inpatient, but that would be another important group to target next.

**Conclusion**

This study emphasized the power of therapeutic relationships and the significance of sociocultural knowledge when working with Latina adolescents with suicidal behaviors and their families. Therapeutic relationships with the Latina adolescents that are focused on their individual needs and strengths along with intentional relationships with the adolescent’s family members and communities foster sociocultural strengths, building a trajectory away from the Latina adolescent’s suicide attempt. Incorporating sociocultural risk and protective factors into suicide treatment is necessary for clinicians when working with this population and requires ongoing education and significant support. Through a greater focus on a socioculturally humble and attuned therapeutic practice in suicide treatment, Latina adolescents, their families, and their multicultural communities can thrive.
APPENDICES

Appendix A: Email for Participant Recruitment

Appendix B: Recruitment Flier

Appendix C: Informed Consent Form

Appendix D: Telephone Questionnaire

Appendix E: Interview Guide
Appendix A: Recruitment Email

Date: 
Dear Mental Health Agency Leader/Prof Org:

I am writing to introduce you to a research study I am conducting about social work practice with Latina adolescents who express suicidal intent. I am completing this research as part of the requirements for my dissertation at the University of Pennsylvania’s School of Social Policy & Practice (SP2). The study was approved by the University of Pennsylvania’s Institutional Review Board (add protocol number). I am writing to tell you about the study and to request approval from your agency to distribute recruitment information through your organizational listserv and/or provider member email list.

What is the purpose of this study?
Latina adolescents attempt suicide at a much higher rate than other racial and ethnic groups. Research suggests this may be due to sociocultural factors specific to Latina adolescents living in the US. The purpose of this study (Apoyar El Baile Multicultural (Supporting the Multicultural Dance): A Qualitative Study of Mental Health Providers Treating Latina Adolescents with Suicidal Ideation and Behaviors) is to understand how clinicians understand, evaluate, and address these factors in their practice. Findings may uncover or lead to the development of strategies to improve culturally competent treatment of suicidal ideation or intent. Findings will also be used to expand a theoretical framework for understanding suicide in Latinx/Latine populations to include the role of the therapeutic relationship.

Who am I recruiting?
I am recruiting licensed social workers who work with Latina adolescents with suicidal behavior and their families. I will adhere to the human subjects and research requirements for each organization or facility from which I recruit. Researchers will maintain the strictest standards to ensure privacy and confidentiality in all phases of the study.

What does the study entail?
Participants will complete one hour-long interview at a time and place of their convenience. There are no direct benefits and minimal risks associated with participation in this study. Participation is completely voluntary. Participants may withdraw from study participation at any time. Eligible participants will receive a $25 Amazon gift card for their participation.

Please contact me if you have questions about this study at (914) 275-8335 or sschind7@upenn.edu. A recruitment flyer is attached.

Thank you for your consideration,
Samantha Schindelheim, LCSW
University of Pennsylvania DSW Candidate
Appendix B: Recruitment Flyer

Apoyar el baile multicultural: A qualitative study of mental health providers treating Latina adolescents with suicidal ideation and behaviors

Are you a social worker in a NYC mental health community agency? Do you work with Latinx/Latine adolescents? You may be eligible to participate in a study investigating the role of risk and protective factors to reduce suicide amongst Latinx/Latine adolescents.

You may qualify if:
- You are a licensed social worker (LMSW or LCSW) with at least 2 years of post-graduate practice experience
- You work in a community mental health agency setting
- Approximately 50% or more of your caseload consists of Latinx/Latine teens
- You are currently working with at least one Latina suicidal adolescent
- You have experience working with teens of any background engaged in suicidal behaviors (suicidal ideation, suicide plan, and/or suicide attempt)

Participation involves:
- Completing a one-hour Zoom/Skype interview at a time of your convenience
- Participants will receive a $25 Amazon gift card upon completion of interview
- This study will have no direct benefit to you. Findings from this study may improve care of Latina adolescents and their families.
- This study has minimal risk for you.

To sign up: To learn more and to schedule an interview, please contact Samantha Schindelheim at sschind7@upenn.edu or call (914) 275-8335. Thank you!

NOTE: This research study is a part of a DSW doctoral dissertation. Participants will not be identified in any reports of findings.
Appendix C: Informed Consent Form

UNIVERSITY OF PENNSYLVANIA
RESEARCH SUBJECT
INFORMED CONSENT FORM

Protocol Title: Apoyar El Baile Multicultural (Supporting the Multicultural Dance): A Qualitative Study of Mental Health Providers Treating Latina Adolescents with Suicidal Ideation and Behaviors

Principal Investigator: Allison Werner-Lin, PhD, LCSW
3701 Locust Walk, Caster C16
Philadelphia, PA, 19104
awer@sp2.upenn.edu
(914) 924-9637

Co-Investigator: Samantha Schindelheim, LCSW, DSW Student
267 West 89th Street, apt 8D
New York, NY 10024
Sschind7@upenn.edu
(914) 275-8335

Emergency Contact: Kevin Fagan
(908) 875-8861

Research Study Summary for Potential Subjects
You are being invited to participate in a research study. Your participation is voluntary, and you should only participate if you understand the study requirements and risks of participation. You should ask the study team any questions you have related to participating before agreeing to join the study. If you have any questions about your rights as a research participant at any time before, during, or after participation, please contact the Institutional Review Board of the University of Pennsylvania (IRB) at (215) 898-2614 for assistance.

This research aims to learn about the experiences of licensed mental health practitioners who work with Latina adolescents with suicidal behaviors. This study will explore how practitioners consider sociocultural factors when engaging these adolescents and their families in suicide risk assessments and safety management plans. We are seeking to understand your experiences to improve education and practice of mental health practitioners working with this population.

If you agree to join the study, you will be asked to complete a single one-hour interview using zoom, skype, or another telecommunications technology.
This study will have no direct benefit to you. Your participation in this study could be of potential benefit to other mental health practitioners and inform clinical practice recommendations. The most common risks of participation are potential emotional discomfort
during the interviews when discussing client suicidal behaviors. You may request to end the
interview at any time.

**What is the purpose of the study?**
The purpose of the study is to learn about the experiences of licensed mental health practitioners
who work with Latina adolescents who are suicidal, with specific focus on practitioners
consideration and understanding of sociocultural factors when engaging these adolescents and
their families in suicide risk assessments and safety management plans.

**Why was I asked to participate in the study?**
You are invited to join this study because you are a licensed social worker employed at a mental
health agency, a substantial portion of your caseload includes working with Latinx/Latine
adolescents, you have prior experience working with adolescents of any background with
suicidal behaviors, and you are currently working with at least one Latina female adolescent with
a history of suicidal ideation, planning, and/or attempts.

**How long will I be in the study?**
By signing this form, you are consenting to participate in one interview using a zoom platform
and to possible follow-up by the researcher to clarify responses or ask additional questions. The
study will take place over a period of twelve (12) months, June 2021 to May 2022. Your
participation in this study includes time spent in individual interviews and any follow-up contact
from the researcher, each of which you are consenting to by signing this form. The researcher
may contact you after you complete the interview to ask a follow-up question or to clarify
something you said. If follow-up is not necessary, your study participation ends when you
complete your interview.

**Where will the study take place?**
Participants will be asked to download Zoom and choose a physical location that would provide
privacy and a quiet space for the interview. You may ask to work with the researcher to select a
suitable location.

**How many other people will be in this study?**
We aim to recruit 20 licensed mental health practitioners.

**What will I be asked to do?**
You will be asked about your experience as a mental health practitioner providing services to
Latina adolescents with suicidal behaviors and their families.

**What are the risks?**
The risks associated with participation in this study are minimal. One potential risk is that you
may experience emotional discomfort when you discuss providing mental health services to
suicidal teens and their families. If these feelings become unmanageable or unpleasant for you,
the researcher will offer to stop the interview. The interviewer is a licensed clinical social worker
with experience in assessment and crisis intervention. You may also request the interviewer
pause or terminate the interview at any time.
How will I benefit from the study?
This study will have no direct benefit to you. Your participation in this study could be of potential benefit to other mental health practitioners and inform socioculturally-attuned care for Latinx/Latine adolescents with suicidal behaviors, which may benefit you indirectly. In the future, findings from this study may help other practitioners offer culturally competent suicidal treatment as well as provide ways to foster therapeutic relational growth with a high-risk population.

What other choices do I have?
Your alternative to being in the study is to not be in the study.

What happens if I do not choose to join the research study?
You may choose to join the study or you may choose not to join the study. Your participation is voluntary. There is no penalty if you choose not to join the research study. There are no negative consequences to choosing not to participate.

When is the study over? Can I leave the study before it ends?
The study will end in June 2022 after all participants have completed one interview and any follow up contacts are completed. The study may be stopped without your consent for the following reasons:

- The researcher feels it is best for your safety and/or health-you will be informed of the reasons why.
- You have not followed the study instructions or are ineligible.
- The primary researcher, the sponsor or the Institutional Review Board (IRB) at the University of Pennsylvania can stop the study anytime.

You have the right to drop out of the research study at any time during your participation. There is no penalty or loss of benefits to which you are otherwise entitled if you decide to do so. Withdrawal will not interfere with your future work as a licensed mental health practitioner.

If you no longer wish to be in the research study, please contact co-investigator, Samantha Schindelheim, at (914) 275-8335 or sschind7@upenn.edu and take the following steps:

- Speak with Samantha Schindelheim or leave a voicemail at the phone number listed above explaining that you would like to withdraw from the study.
- You do not need to provide a reason; however, if you are willing to share the reason, the researchers would welcome it.
- There will be no negative consequences for choosing to withdraw from the study.

How will my personal information be protected during the study?
We will do our best to make sure that the personal information obtained during the course of this research study will be kept private. However, we cannot guarantee total privacy. Your personal information may be given out if required by law. If information from this study is published or presented at scientific meetings, your name, the agency name or identifying information about your agency or clients, and other personal information will not be used. You will be asked to
select a pseudonym prior to the start of the interviews. The Institutional Review Board (IRB) at the University of Pennsylvania will have access to the study records. An exception to confidentiality is if you report child or elder abuse or neglect, or if you report suicidal or homicidal ideation or intent to the research team. Any information about child or elder abuse or intent to harm yourself or others will be reported to the authorities, as required by law. Additional steps include:

- Every attempt will be made to avoid including identifying information in the digital recordings of the interviews. You will be asked to select a pseudonym at the beginning of interview. Demographic information will be scanned and uploaded to a password-protected computer by co-researcher, Samantha Schindelheim.
- All digital recordings and other study related electronic documents, such as transcribed interviews and consent forms, will be stored on a password protected computer. Only the researchers Samantha Schindelheim, LCSW and Allison Werner-Lin, PhD, LCSW will have access. Both of these researchers will maintain and adhere to only the highest standards of confidentiality related to your participation in this study.
- Any hard copy study related materials will be scanned and uploaded to the same password protected computer.
- An alphanumeric identifier will be used to identify each participant’s interview recordings and transcriptions, further protecting confidentiality.
- All study recordings will be destroyed at the conclusion of this study.

**What may happen to my information collected on this study?**
If information from this study is published or presented at conferences, your name, the mental health agency or identifying information, and other personal information which could identify you, will not be used. Your information will be de-identified. De-identified means that all information that could reveal the identity of a participant and the mental health agency in which they worked will be removed. Data could be stored and shared for future research in this de-identified fashion. This data will not be used for any other research, however, de-identified data can be shared without seeking additional consent in the future, as permitted by law. The future use of your information only applies to the information collected for this study.

**Electronic Medical Records and Research Results**
Medical records are not part of this study.

**What is an Electronic Medical Record and/or a Clinical Trial Management System?**
An Electronic Medical Record (EMR) is an electronic version of the record of your care within a health system. An EMR is a computerized version of a paper medical record.

**What happens if I am injured from being in the study?**
Sustaining an injury as a result of participation in this study is highly unlikely; however, if you are injured as a result of participation, please notify Samantha Schindelheim, as soon as possible. Ms. Schindelheim will make every effort to assist you in accessing medical care to treat injuries directly resulting from participating in this study, such as calling 911 emergency services, notifying a family member or friend, or making other appropriate efforts. The health care provider accessed may bill your insurance company or other third parties, if appropriate, for the
costs of the care you get to treat the injury, but you may also be responsible for some of the costs.

There are no plans for the University of Pennsylvania to pay you or give you other compensation for the injury. You do not give up your legal rights by signing this form.

If you think you have been injured as a result of taking part in this research study, tell the person in charge of the research study as soon as possible. The researcher’s name and phone number are listed in the consent form.

**Will I have to pay for anything?**
There are no costs to you for participation in this study.

**Will I be paid for being in this study?**
As a study participant you will receive a single $25 gift card to Amazon.com for your participation. Gift cards will be offered when the interview has been completed.

**Who can I call with questions, complaints, or if I’m concerned about my rights as a research subject?**
If you have questions, concerns, or complaints regarding your participation in this research study or if you have any questions about your rights as a research subject, you should speak with the Principal Investigator listed on the first page of this form. If a member of the research team cannot be reached or you want to talk to someone other than those working on the study, you may contact the IRB at (215) 898 2614.

When you sign this form, you are agreeing to take part in this research study. If you have any questions or there is something you do not understand, please ask. You will receive a copy of this consent document.

______________________       ___  _____________________________  Date
Printed Name of Subject       Signature of Subject


Appendix D: Telephone Questionnaire

Greeting: Hi. My name is Samantha Schindelheim. Thank you for calling!

I’d like to tell you about this study. I’d also like to ask you a few questions to make sure you are eligible to participate in the study. At the end of our conversation, if you decide to participate, we can schedule an interview time.

I am conducting interviews with licensed mental health practitioners with a partial caseload of Latina/Latine adolescents to better understand their use of sociocultural factors when treating Latina adolescents who are suicidal. I am interested in learning about your experience working with this particular population, how you consider sociocultural factors in treatment with Latina adolescents and their families, dynamics of the therapeutic relationship with Latinx/Latine adolescents and their families, and your ongoing training needs to best support them.

Some of the questions I ask may seem very private. You may decline to answer any question or simply stop participation and exit the study if you feel uncomfortable at any time.

Are you willing to answer a few questions at this time?

Questions

Demographics
Do you have a Master’s degree in social work from an accredited school of social work? Yes / No

Do you have at least 3 years of practice experience post graduate degree? Yes/No

Are you currently working in a community mental health agency in New York City? Yes / No

Does your caseload consist of approximately 50% or more of Latinx/Latine teens and families? Yes/No

Do you have experience working with adolescents of any background engaged in suicidal behaviors, including suicidal ideation (thoughts of engaging in behavior with the intention to end one’s life), suicide planning (the development of a specific method through which a person intends to die), and suicide attempting (engagement in potentially self-injurious behaviors with at least some intent to die)? Yes / No

Are you currently working with a Latina adolescent with suicidal behaviors? Yes / No

Follow up
If you agree to participate, I will ask you questions about your experiences working with Latina adolescents and their families, sociocultural factors that you consider when engaging them in suicide risk assessment and safety plans, and your ongoing training needs to best support this challenging population. The interview will take no more than one hour. Do you have any questions about any of this? Yes / No
Do you have any other questions for me at this time?  
Yes / No

Are you interested in participating?  
Yes / No

Would you be willing to schedule an interview with me?  
Yes / No

What is the best way to contact you for confirmation prior to the date of our interview? (email, phone) ________________________________

If participants meet inclusion criteria...

**Demographic Information**

Before we conclude our call today, may if I ask you a few demographic questions?

What mental health agency do you work at? ________________________________

What gender do you identify as? ________________________________

Please specify your ethnicity (select all that apply):
   A. Caucasian
   B. African-American
   C. Latinx/Latine or Hispanic
   D. Asian
   E. Native American
   F. Native Hawaiian or Pacific Islander
   H. Other/Unknown
   I. Prefer not to say

What is your license?
   A. LMSW
   B. LCSW
   C. LCW-R

Do you speak any languages other than English? Yes/No

If so, what language(s) are you fluent in? ________________________________
Appendix E: Interview Guide

Interview Guide

Introduction: Thank you for agreeing to be interviewed. The purpose of this study is to understand the experiences of mental health practitioners/social workers working with Latina adolescents who are suicidal and their families. In addition, this study will explore the ways in which practitioners utilize their knowledge and understanding of how social and cultural factors unique to Latinx populations are used to engage Latina adolescents in suicide risk assessments and safety planning interventions. In addition to environmental or ecological conditions, social and cultural factors may play a part in healthy and adaptive behavior and well-being or in maladaptive behavior and the etiology of mental disorder. I will conduct the interview in a semi-structured format in order to explore this topic with you openly. Please feel free to add in any information that you think will be helpful about this topic. Today we are going to complete one interview, that will last about 60 minutes. At your request, we can end earlier.

As indicated in the consent form, your participation is voluntary and you can terminate your involvement in this study at any time. Your personal identification information will remain confidential. However, I must inform you that I am a mandated report and must disclose any report of harm to yourself, others, or to a child to the Administration for Children’s Services. The consent form you signed reviewed how the information you provide is to be collected and maintained; specifically, where it will be housed and who will have access to it. Do you have any questions so far? Please feel free to stop me if you have any questions and I will be available after the interview.
1.) Tell me about your experience as a clinical social worker treating adolescents with suicidal behaviors:
   a. Can you describe how you learned the skills/interventions to manage adolescent suicidal behaviors?
   b. Do you refer to your clients as Latinx? Do your clients talk about that and do you refer to them as Latinx?
   c. Which Latinx populations do you work with most? Are there ways that suicidal behaviors are similar between Latinx adolescents and other adolescent populations?
   d. This dissertation is specifically interested in Latinx adolescent girls. Are there ways that Latinx adolescents present with suicidal behaviors in uniquely distinct ways? Do you see differences between Latinx girls or boys?
   e. What risk assessments and/or safety tools do you use with Latina girls? (prompt if needed- Columbia Suicide Severity Scale) Where did you learn these assessments/tools?
   f. Do you find that any of these tools need to be adjusted when working with Latina adolescent girls? What does that look like?

2. Are there ways in which you consider social and cultural factors when working with Latina adolescents? How so?
   a. What factors do you consider in your work with Latina adolescents (bring in 1c)?
   b. Are there specific Latinx social and cultural factors you consider protective against suicidal behaviors for girls?
c. Are there specific factors you consider that increase the likelihood of suicidal behaviors in your experience with Latina adolescents?

d. Are there ways in which you incorporate these factors into risk assessments and suicide safety tools with Latina adolescents? Can you provide a case example in which you have or where it would have been helpful to do so?

g. Are there certain social and cultural factors that you’ve observed to be more relevant in suicide treatment for specific Latinx ethnic origins?

3. What role does the therapeutic relationship play in treatment with Latina adolescents?

   a. To what extent do you include other family members in the treatment with Latina adolescents? What role does the therapeutic relationship with the family play in treatment? How do you navigate these roles?

   b. What social and cultural factors do you consider when building a relationship with Latina adolescents? What about with their family members?

   c. Are there particular strategies that you use to foster relational growth with Latina adolescents that you may not do with other ethnic or racially diverse clients?

   d. What has been one of the biggest challenges that you have encountered when working with Latina adolescents with suicidal behaviors and their families?

   e. How do you consider your identities in relation to your clients and how does this impact the relationship with your Latina clients?

4.) Now I’d like to talk about your training and your training needs:

   a. Are there ways in which you felt more or less prepared when you first started working with Latina adolescents with suicidal behaviors? How has this changed over time?
b. Have you taken any courses or trainings about Latinx social and cultural risk and protective factors or cultural humility practices or work around identity and privilege?

c. Looking back, can you identify gaps in your training and what are they?

d. What do you imagine would be helpful to support your ongoing work?

5.) Is there anything important about your experience treating Latina adolescents with suicidal behaviors and working with their families that I haven’t asked you about?
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