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Socio-Cognitive Behavioral Therapy for Suicidal Behavior with a Puerto Rican Male Adolescent

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Abstract

In 2015, fifteen percent of Puerto Rican adolescents attempted suicide. In general, females have more suicidal thoughts while males are more likely to die by suicide. However, few evidence-based treatments have been developed for this population.

Objectives.—The aim of this study was to illustrate the therapeutic process of a male Puerto Rican adolescent treated with the Socio-Cognitive Behavioral Therapy for Suicidal Behavior (SCBT-SB), a culturally informed protocol, and to discuss how developmental, feminist, and family system perspectives were incorporated in the SCBT-SB treatment model.

Method.—A case study is presented: Julio received the SCBT-SB after a psychiatric hospitalization subsequent to threatening to commit suicide. Baseline and post-treatment assessments evaluated diagnosis, risk factors (e.g. hopelessness), treatment satisfaction, and suicidal behaviors.

Results.—Julio demonstrated clinically significant change in depressive symptoms, hopelessness, suicidal ideation, and aggressive/impulsive behaviors.

Conclusions.—The SCBT-SB was feasible to implement and proved acceptable to the client and his family.

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Keywords

suicidal behavior; adolescence; culturally sensitive treatment; evidence base psychotherapy; masculinity; cognitive behavioral therapy

Adolescent suicidal behavior not only affects adolescents but also their family members and peers. Although female adolescents in Puerto Rico are more likely to engage in suicide ideation than their male counterparts (Duarté-Vélez, Jones, & Spirito, in press; Lippe, Brener, Mcmanus, Kann, & Speicher, 2008), there is no gender difference in suicide attempts resulting in injury (CDC, 2005–2015). However, on average adolescent males in Puerto Rico die by suicide almost five times more often than females (Kölves & De Leo, 2015). Latino adolescent males living on the Island are more likely to attempt suicide (14%) than their stateside U.S. Black (7.2%), White (3.7%), and Latino male counterparts (7.6%) (CDC, 2015; Kann et al., 2016). Although completed suicides among adolescents are much higher in the United States (Kölves & De Leo, 2015) studies have found that suicide ideation and attempts are risk factors for future suicidal attempts (Lewinsohn, Rohde, & Seeley, 1994; Nock et al., 2008; Spirito, Valeri, Boergers, & Donaldson, 2003). Despite the high suicide risk for adolescents in Puerto Rico, evidence-based treatment options are limited for those with a history of suicide ideation and attempts (Duarté-Vélez & Bernal, 2008; Goldston et al., 2008).

Help seeking behavior among males

Males typically have more difficulties initiating and engaging in therapy than females (Grubbs et al., 2015; Rochlen et al., 2010). Although studies are limited, treatment research results have shown that males tend to show less commitment and cooperation with the therapeutic process resulting in lower levels of clinical improvement overtime compared to females (Grubbs et al., 2015; Rochlen et al., 2010). Rochlen et al.'s (2010) qualitative study examining barriers for seeking treatment among adult males showed that male norms of self-sufficiency might interfere with seeing the usefulness of psychotherapy. This may also be due to existing cultural stigma against mental health treatment. Within this stigma framework, seeking help and the expression of feelings among males shows vulnerability, which is seen as a deficit and/or weakness among some males (Rochlen et al., 2010).

Masculinity-based socialization may interact with other socio-cultural attitudes, beliefs, and values which inform cultural-specific manifestations of distress and help-seeking. Sen's (2004) findings among a group of racially and ethnically diverse adolescents including Latinx youth with past year depression and self-injury behaviors, showed that boys were less likely to seek help than girls. Sen suggests that particular cultural factors, such as language, acculturation, and gender beliefs/attitudes among immigrants in the U.S. in particular, might impact their willingness to seek help more generally. Accordingly, De Luca and colleagues (De Luca, Schmeelk-Cone, & Wyman, 2015) examined Latinx adolescents' help-seeking behaviors within the school context when compared to non-Latinx White adolescents. Findings showed that Latinx youth were less willing to seek help, and reported less favorable attitudes toward the belief that adults at school could help suicidal youth, than their White adolescent same-gender counterparts. The authors argue that this may be due to

cultural norms that favor looking for help within the family. However, De Luca and Wyman (2012) found a positive relationship between greater school engagement and help seeking behavior among Latino adolescents.

Social context.

In addition to understanding the cultural context in which adolescent suicidality occurs, it is equally important to understand how adverse stressors/events, affect these behaviors. Locke and Newcomb's study (2005) among a community sample of Latino adolescents (N = 349) in Los Angeles, California, found that 80% had some suicidal ideation, and a quarter had a suicide attempt history. These authors identified several psychosocial factors that increased the risk of suicidality (suicidal ideation and behavior). The strongest predictive factor was a history of emotional abuse, followed by hard drug use, sexual abuse, and finally, having a mother with alcohol-related problems (Locke & Newcomb, 2005). Greater self-efficacy, having a good relationship with parents, and being law abiding, were protective factors against suicidality. A harsh family environment and poor coping skills were associated with suicidal ideation in community and clinical samples of Latinx adolescents living in Puerto Rico (Duarté-Vélez, Lorenzo-Luaces, & Rosselló, 2012; Rosselló, Duarte-Vélez, Zuluaga, & Bernal, 2008).

Psychopathology.

Psychopathology is a robust risk factor for suicidal behavior among Latinx and Non-Latinx adolescents in the contiguous U.S., as well as in Puerto Rico (Husky et al., 2012; Jones, Ramirez, Davies, Canino, & Goodwin, 2008; Nock et al., 2013). A large national study conducted stateside showed that depression, anxiety, behavioral and substance use disorders were linked to suicidal behaviors (e.g., severity of attempts, planned and unplanned attempts, and having a suicide plan) among 13–18 year olds (Husky et al., 2012; Jones et al., 2008; Nock et al., 2013). A study in Puerto Rico with two representative youth samples (a community and clinical sample) showed that most psychiatric disorders were associated with increased suicidal behavior (Jones et al., 2008). Risk for suicidal behavior was higher among girls with a mood disorder in the clinical sample, while for boys in both clinical and community samples, the strongest predictor of suicidal behavior was having a disruptive behavior disorder.

Psychotherapy for suicidal Latinx adolescents

There is scant information on what treatments are efficacious or effective for suicidal ideation and behaviors among adolescents in general (Spirito, Esposito-Smythers, Wolff, & Uhl, 2011), but particularly among Latinx adolescents (Duarté-Vélez & Bernal, 2008; Goldston et al., 2008). This scarcity exists despite evidence suggesting that culturally tailored treatments are more effective than standard treatment among Latinx groups (Bernal & Domenech-Rodríguez, 2012; Smith, Domenech-Rodríguez, & Bernal, 2011).

Latinx individuals in the U.S. are a heterogeneous group differing in important cultural aspects (e.g. migration and immigration history, national background, documentation status, language use) (Duarté-Vélez & Bernal, 2007). However, Duarte-Vélez and colleagues

(Duarté-Vélez, Torres-Dávila, Spirito, Polanco, & Bernal, 2016) argue that shared core cultural values among this group make it possible to develop a culturally informed intervention for suicidal behavior that can be individually tailored to Latinx adolescents and their families from various Latinx ethnicities. This can be accomplished by developing a strong case conceptualization and making the treatment plan relevant to their particular socio-cultural contextual experiences and clinical presentation. Accordingly, Duarte-Velez et al (2016) developed a theoretically derived Socio-cognitive Behavioral Treatment protocol for suicidal behavior (SCBT-SB) for Latinx adolescents living in Puerto Rico, informed by empirical evidence.

The development of this treatment protocol was informed by studies focusing on Latinx populations, and two evidence based CBT protocols: one for teens with suicidal behavior and substance use problems with a predominantly White population in United States (Esposito-Smythers, Spirito, Hunt, Kahler, & Monti, 2011) and a CBT culturally adapted intervention for depressed Latinx teens living in PR (Rosselló & Bernal, 1999; Rosselló, Bernal, & Rivera-Medina, 2008). Outcomes of a small open pilot using the SCBT-SB showed that treatment completers had clinically significant positive changes and reductions in suicide risk as well as positive treatment satisfaction (Duarté-Vélez et al., 2016).

Theoretical Model

The socio-cognitive behavioral therapy for suicidal behavior (SCBT-SB) is informed by Cognitive Behavioral Therapy (CBT) (Dieserud, Roysamb, Ekeberg, & Kraft, 2001; Wenzel & Beck, 2008) and is embedded within an ecological framework (Ayyash, 2002). SCBT-SB emphasizes the contextual and social circumstances that influence adolescents' suicidal behavior (Duarté-Vélez et al., 2016). This approach is different from traditional CBT in that it moves away from an individual conceptualization focusing on psychopathology, to a multidimensional and multi-faceted understanding of suicidal behavior. Innovative and unique aspects included in this new treatment approach are the inclusion of developmental, feminist, and family systems perspectives (Duarté-Vélez et al., 2016). In many families the task of adolescent identity exploration and development (e.g., individuation) creates family tension (Hausmann-Stabile, Gulbas, & Zayas, 2013; Turner, Kaplan, Zayas, & Ross, 2002). Family conflict in combination with other stressors leads to negative adolescent outcomes (Smetana, Campione-Barr, & Metzger, 2006). The developmental perspective emphasizes adaptive adolescent identity formation (e.g. sexuality, gender identity and expression, future life and career goals, etc.) as a major task of normative development. Thus, in addition to symptom reduction, this understanding is an essential feature of SCBT-SB treatment conceptualization and collaborative treatment planning and goal-setting.

The feminist perspective emphasizes understanding the role of gender (and other aspects of identity diversity) socialization practices, recognizing and challenging social norms and expectations about what it means to “being a male” or “being a female”. This is particularly important in understanding and conceptualizing the manifestation of adolescent psychological distress and suicidality within Latinx families (Hausmann-Stabile, Gulbas, & Zayas, 2013). Finally, the family systems perspective emphasizes understanding systems-based interactions within families, which can consist of unhealthy alliances and rigid or

diffuse hierarchies among family members, affecting the well-being of the family unit and its individual members (Kuhlberg, Peña, & Zayas, 2010; Zayas, Bright, Álvarez-Sánchez, & Cabassa, 2009). Thus, this theoretical framework is used to inform each individual's unique case conceptualization in order to provide a client- and family-centered tailored intervention.

Socio-Cognitive Behavioral Therapy for Suicidal Behavior (SCBT-SB)

Protocol

SCBT-SB uses a modular approach to the treatment of adolescent suicidality. After the first mandatory module (Crisis module), and at the end of each subsequent module, the therapist works with the adolescent and caregivers to determine the next treatment module and/or treatment termination. The full treatment plan is determined by what skills would be the most helpful for the adolescent and the family (See Table 1 for more information on each module and number of sessions). The main objective in the Crisis Module is to understand and manage the suicidal crisis and the provision of core skills. Main topics discussed, and skills taught, in these module include: a chain analysis to understand the unfolding of events leading to the suicidal crisis, personal and family emergency planning, understanding the power of thoughts and cognitive restructuring, learning effective communication skills, engaging in adaptive decision making, learning acceptance of uncontrollable events and family interactions, learning about effective parenting styles, and learning effective family communication. The following optional modules include three to five sessions covering one major topic each: Thoughts, Emotional Regulation, Family Communication, Social Interactions, Activity, Trauma, Substance, and Identity. At least one caregiver or family session is included in each module, typically at the end of a module. However, the number of sessions used to cover the content of any module could vary depending on the specific needs of each patient. The Family Communication Module is composed of family sessions focused on improving communication among family members. The last phase of treatment consists of termination processing, relapse prevention, and follow up booster sessions.

The only CBT protocol currently considered probably efficacious for adolescents with suicidal behavior used two therapists (Esposito-Smythers et al., 2011): one for the caregivers and one for the teen, providing individual, parent training, and family sessions (Wolff et al., 2017). In the SCBT-SB, one therapist provides all the interventions, primarily individual with the teen, but also including family and caregivers' sessions.

Method

This case study is the third in a series of case studies resulting from an open trial conducted in Puerto Rico as part of the treatment development process of the SCBT-SB protocol (Duarté-Vélez, Torres-Dávila, & Laboy-Hernández, 2014; Duarté-Vélez, Torres-Dávila, & Laboy-Hernández, 2015; Duarté-Vélez et al., 2016). The open trial inclusion criteria were: being 13 to 17 years of age; admitted to an Emergency Department (ED) for suicidal ideation or a suicide attempt, hospitalized, stabilized and then referred for outpatient care; and having a legal guardian willing to participate. Exclusion criteria included a psychotic disorder or a pervasive developmental disability, an IQ below 70, already receiving psychotherapy (patients receiving psychiatric care with psychotropic medication only were

accepted), and involvement in a legal proceeding that required psychological care mandated by the judicial system. As part of this trial, eleven families were enrolled in the SCBT-SB. For a more detailed description of the treatment development process, including the rationale for cultural adaptations, the treatment protocol, and the open trial see Duarté-Vélez and colleagues (2016). This is the first male case study, consequently the principal aim herein is to illustrate the therapeutic process considering the experiences of a Puerto Rican heterosexual, cisgender, adolescent male, and to illustrate how developmental, feminist and systemic perspectives were incorporated in treatment conceptualization and implementation.

Procedures

Julio was referred by his treatment team after being hospitalized in an inpatient psychiatric unit due to homicidal and suicidal threats. Maternal consent and adolescent assent were obtained during their time on the unit and baseline assessments were completed immediately after discharge by a doctoral level student evaluator. A post-treatment assessment was done at six months after baseline assessment as part of the SCBT-SB open trial study (Duarté-Vélez et al., 2016).

To assess clinically significant outcomes a diagnostic interview, the reliable clinical index change (RCI) in self-report instruments, and Julio's and his mother's verbal report during therapy sessions informed treatment planning and termination. The RCI measures the degree to which one person has a substantial change according to his/her baseline scores. The RCI is calculated by subtracting pre- from post-treatment scores and dividing by the standard error of the difference. Indices above 1.28 are considered clinically significant improvement at the 90% confidence level (Wise, 2004). This study received IRB approval from the University of Puerto Rico.

Measures

Assessment instruments included the Diagnostic Interview Schedule for Children-Spanish version (DISC-IV) (Canino, 2000; Shaffer, Fisher, Lucas, Dulcan, & Schwab-Stone, 2000), the Columbia-Suicide Severity Rating Scale-Spanish version (CSSR-S) (Posner et al., 2007) for suicidal behavior and history, a Spanish translation of the self-report Suicidal Ideation Questionnaire (SIQ-JR) (Duarté-Vélez, 2007; Reynolds, 1988), the Children's Depression Inventory-Spanish version (CDI) (Kovacs, 1992), the Hopelessness Scale for Children (HSC) (Kazdin, Rodgers, & Colbus, 1986) Spanish version (Duarté-Vélez, 2007), the Piers-Harris Children's Self Concept Scale-Spanish version (PH) (Piers & Herzberg, 2002), and the Family Assessment Measure-Brief version-Spanish version (B-FAM) (Skinner, Steinhauer, & Santa Barbara, 1995).

Presenting Problem

Julio was a 17-year-old Puerto Rican male (second child) of mixed-race ancestry living with his mother, three siblings (the oldest one being a 19 year old female), grandmother, and uncle in a two-bedroom house. Julio's mother was his primary caregiver and the one who consistently participated in treatment. At treatment initiation, Julio met criteria for Recurrent Major Depressive Disorder with Psychotic Features, Disruptive Behavior Disorder NOS and Attention Deficit Hyperactivity Disorder (ADHD) Combined Type (by medical history).

He did not have any general medical conditions. He received psychiatric treatment and counseling for ADD for four years while he was a child, but was not taking any medication at the time of the suicidal crisis. According to his mother, Julio failed two years in high school because he was not paying attention and skipping classes. Julio also engaged in verbally aggressive, rude and challenging behavior, as well as occasional physical fights that affected his relationships with family members, schoolmates, and school staff. However, at the time of SCBT-SB treatment initiation he was able to function and perform general obligations at home, school, and extracurricular activities (sports team).

Julio was hospitalized in a psychiatric unit due to threatening to kill everyone at school and then himself by jumping from a second floor. His baseline evaluation revealed a significant life history of undisclosed suicidal ideation including thinking about different ways of killing himself (e.g. overdose, jumping from a building), and both non-lethal and potentially lethal suicide attempts (e.g. taking a few pills, walking onto a highway). Julio did not have any prior psychiatric hospitalizations. There was no history of suicidal behavior in the family according to his mother's report. However, there were two family members with learning disorders, one with depression, and two close relatives with substance use disorders.

Case Conceptualization

Family and Community Context.—Julio reported numerous psychosocial stressors including witnessing domestic violence since he was little perpetrated against his mother at the hands of his stepfather. An escalation of physical aggression toward his mother in the year prior to treatment initiation, forced their family of 5 (Julio, mother, and three siblings) to change their living arrangements and move into a single bedroom at his maternal grandmother's house which was located in an under resourced and violent neighborhood (e.g. a lot of gangs and drugs-related crimes) in Puerto Rico. Julio reported not having a relationship with his biological father since childhood. This was a significant source of stress for Julio as he reported feeling pressured by his family to develop a relationship with his dying biological father (Latinx value of *Respeto*).

The nuclear and extended family experienced severe economic difficulties (e.g., insufficient finances to meet basic needs for a family of 5), which in combination with the stress resulting from crowded living conditions, lack of financial and social resources, and exposure to substance use (uncle and grandmother), often led to family arguments. Namely, there was a constant cycle of misunderstandings and aggressive communication between family members. Additionally, the two primary caregivers, mother and grandmother, often disagreed about discipline. Julio's interactions with his grandmother were particularly negative. He reported in therapy that she would on occasion come home drunk and initiate (verbal) fights with him. Moreover, there were significant conflicts between the siblings, however, Julio (the second of four children) was often identified as the scapegoat.

Academic Context.—Julio was on academic probation and also experienced difficulties with his peers and teachers. Nonetheless, he expressed that school was a relief from family conflict, and on occasion, a place where he was able to enjoy himself. Julio was involved in athletic extracurricular activities, which was a source of stress relief. His involvement in

sports formed a central part of his identity as he wished to become a professional athlete and wanted to go to college in order to become a physical education teacher.

Cultural Context.—Cultural messages about “hypermasculinity” related to general societal norms, and *Machismo* specific to the Latinx context, affected Julio’s developing identity and was relevant to understanding his externalizing behaviors and suicidality. *Machismo* is understood in the literature and colloquially as beliefs, values, manifestation, performance and embodiment of traditional male-gender role socialization (i.e., man of the house, bread-winner, invulnerable to emotional/psychological distress). Machismo-based socialization and beliefs can have toxic effects on psychological, social, and interpersonal functioning (e.g., externalizing behaviors, impulsivity, proneness to violence, and substance abuse). Further, this form of masculinity can stigmatize help-seeking (Creighton & Oliffe, 2010). Witnessing extreme behavioral manifestations of these beliefs (i.e., domestic violence, community violence, and substance abuse) were a central part of Julio’s lived experience and informed his own gender identity and expression. Namely, the expectation that as a male he had to “act tough” informed his personal beliefs that showing or expressing his emotions, particularly sadness or sorrow, would make him seem “weak” or “*Un bobo*” —a “chump”. He was verbally, and sometimes physically, aggressive at school with peers, authority figures, and at home with family members. According to his narrative, he found himself in a position where he had to constantly defend himself in order to survive in a “tough environment”.

A nuanced understanding of the construct of masculinity provided opportunities to develop a culturally-congruent and personally-relevant treatment plan. Namely, an often-ignored aspect of traditionally gendered masculinity-based socialization known as *Caballerismo*, loosely translated as chivalry, is associated with interpersonal connection (e.g., looking after and taking care of family and significant others) and adaptive coping (Arciniega, Anderson, Tovar-Blank, & Tracey, 2008). The cultural messages Julio received about “what it means to be a man” also informed a sense of self-determination and social responsibility (toward neighbors, peers, and family). He envisioned a future in which he would become “independent”, achieve his career goals, get married and start a family. He expressed a wish to be the father he felt he never had.

Intrapersonal Context.—The stressors, experiences, and cultural messages described above, in combination with his temperament, affected his core cognitions, “I am always the bad one in my family”, “things will never change in my family”, and “If I don’t act aggressively I will be seen as weak and a chump”. These cognitions, in turn, triggered sadness, hopelessness, disappointment and anger. Cognitions about himself and his family were inflexible. He thought it was impossible for his family to change because they were “bad” and “hypocrites”, and believed he could not change lest he be perceived as weak. His cognitive style often led to feelings of anger, which often resulted in impulsive and aggressive behaviors. These cognitions, emotions and behaviors formed a constant reinforcement loop, culminating in the suicidal crisis.

At the same time, Julio exhibited many strengths. He was highly motivated to reach his treatment and life goals. In the face of family conflicts, he valued the ideal of *Familismo*

(Latinx value regarding centrality of the family). He sought out and received emotional support from a close friend's family who he perceived as supportive, and wished to one day have a close family of his own. Julio said he believed in God when spiritual beliefs were explored during the Identity session, but religion did not play a central in his life. In therapy, Julio was able to build rapport with his therapist, was cooperative, receptive to feedback, and practiced the skills taught in each treatment module. In summary, based on Julio's report and assessment, his threat to kill others and himself at school was precipitated by an accumulation of family, peer, community and academic stressors.

Course of Treatment

Julio began treatment immediately after being discharged from the psychiatric unit and started concurrent pharmacotherapy with an anti-depressant and two antipsychotic medications. The active treatment phase was composed of 33 sessions (25 individual and 8 family interventions, four with the mother and siblings and four caregiver-only sessions). Therapy was conducted in Spanish, the native language of all the family members and the therapist. In total, treatment lasted six months; on average, Julio attended one session per week. The modules added to his treatment plan after completion of the Crisis module were: Emotional Regulation, Thoughts, Social Interactions, and Family Communication. He then received a booster session two weeks after completing treatment. After three months of treatment his medications were reduced to one anti-depressant.

Crisis Module (9 sessions; 1 teen & caregiver, 7 individual, 1 caregiver).—The objective of this module is to reduce the immediate suicidal crisis via safety planning and teaching skills to manage future crises. The initial session in the Crisis module is designed for the entire family, however, only Julio and his mother attended this session. Here each member is asked to describe the suicidal event from his/her perspective. Treatment objectives are explained and a case conceptualization per the socio-cognitive treatment model, informed by the family's narrative, is presented. Both Julio and his mother concurred that an argument with his grandmother precipitated the initial suicidal crisis. His mother mentioned this to the school counselor who in turn attempted to talk with Julio about it. However, perceiving the counselor's action as threatening, Julio reacted with anger and verbal aggression, subsequently threatening to kill himself and "kill them all", referring to the people in the school. This interaction was the antecedent that triggered the suicidal crisis, leading to an evaluation in the psychiatric emergency department and hospitalization for a week thereafter.

Julio's identified treatment goals were to: better manage his emotions, improve his communication skills with his family, improve interpersonal relationships, and achieve independence (a life goal). During the course of the Crisis module, Julio made a suicide attempt, precipitated by another argument with his grandmother, in which he ingests several pills from his own prescribed medication. He went to sleep expecting to die, but awoke with an upset stomach but did not tell anyone about the attempt. When the therapist assessed for suicide risk during the next session Julio reported the incident. The suicide attempt was addressed during the therapy session but there was no need to refer the patient to the ED because there was no imminent risk. At the end of the session, the therapist

followed the suicide risk protocol, informed his mother about the attempt, and reviewed and reinforced safety measures at home. Automatic thoughts such as, “They only see the negative”, and “I am always seen as the bad one” often triggered impulsive aggressive behaviors in response to arguing with family members. Though proving challenging at first, through a careful step by step analysis of the events leading to the suicidal crisis (i.e., Chain Analysis) (Miller, Rathus, Linehan, 2007), along with a discussion of what it means to “be a man in this society”, helped Julio understand how gendered messages of “maleness” and “hypermasculinity” were related to his aggressive and suicidal behaviors. After identifying thoughts associated with each event during the chain analysis, he initially believed that asking for help and expressing his feelings were not options. This led to a conversation between the therapist and Julio about the disadvantages related to this rigid, all or nothing, understanding of masculinity. For example, expressing feelings and displaying emotions was perceived by Julio as acting like a coward because “men don’t cry, that’s for girls”. Julio was eventually able to become aware of his automatic thoughts and to see how suppressing the expression of feelings and talking (a sign of weakness) turned into anger, hatred, and aggression, and eventually into homicidal and suicidal ideation and threats. At that point, Julio viewed suicide as an opportunity to resolve all of his problems and end all the hatred and pain he felt.

These thoughts, which can be understood as a manifestation of toxic masculinity, were challenged and the advantages of expressing his feelings were explored and underscored. For example, using Socratic questioning such as, “Have you seen a man crying?”, and “How do you feel/what would you think if you saw a man expressing his feelings?” Julio was able to think of instances in which “good and respectful men” cried and expressed themselves without losing their manhood. Additionally, by identifying his reasons to live (e.g. enjoyment of sports and desire to become a professional ball player), an exercise to help delay aggressive behavioral responding (Stop, Think, and Act), and seeking social and emotional support among his friends and his friend’s family, he was able to develop a personal emergency/safety plan to prevent future suicidal crises.

Working to explore and understand his identity was the main goal at the first individual session (Identity Session). This exploration helped build the stage for working on gaining self-confidence and on effective communication further on. Re-framing the negative messages that he perceived from his family, focusing on who he really was at his core and his strengths, helped Julio gain self-confidence and openness to trying a different communication style. For example, in the identity session, the main objective was to discuss “Who am I?” where different aspects of his self-concept were explored (e.g. qualities, likes, ethnicity, spirituality, life goals etc.) and understood in context. The insight gained helped Julio further challenge and change his core-belief, from being a “chump”, if he didn’t act aggressively, to being a “fighter” referring to his resiliency in the face of adversity. He also challenged and changed the internalized belief and attribution of being the “bad one”, into an adaptive external attribution of “it’s not just me”.

At the communication session, the therapist and Julio worked on identifying his and his family’s main communication styles (aggressive and passive aggressive). Having a discussion about his gender identity, and cultural messages related to his avowed

masculinity, facilitated a conversation about how his socialization influenced thoughts such as, “They think I am a chump” and subsequent aggressive and passive-aggressive communication styles. Thus, his aggressive communication pattern was a way of demonstrating to his family that he was not a chump and that “no one messed” with him (e.g. school peers and personnel). Taking on the task of practicing assertive communication proved to be very challenging, particularly at home, as Julio believed that communication patterns in the family were so entrenched that they would never change; at one point sharing with his therapist, “if that changes, you guys are geniuses”. The idea that changes could start at any point was emphasized, and the therapist explained that even though all of them (the family) were part of a negative communication patterns, one person could act differently and provoke a different reaction in others. He added, “*Yo respeto si me respetan*”, “I respect if they respect me”. Using the cultural message of *Respeto* (respect for self and others) (Calzada, Fernandez, & Cortes, 2010), the therapist encouraged Julio to engage in a behavioral experiment in which he was asked to try to respond to communication challenges assertively and with respect for others in order to practice this skill and test whether he received a different response. Practicing assertive communication was also emphasized in a caregiver session (parenting styles), in which his mother acknowledged that this was an important family goal.

The Crisis module concluded with a decision-making session to help Julio develop healthy decision-making skills when responding to challenging situations. He and his therapist used the recent suicide attempt to help him think through options other than suicide that were at his disposal and the consequences for each option (both negative and/or positive). With this exercise, Julio was able to identify thoughts that informed the attempt including “*Me sentía demás*”, “I felt like an outsider/burden”, and “I wanted to end the pain”, and then generated a sizable list of adaptive alternatives that he could have engaged in instead. He selected reaching out to others (friends, therapist) for support as the best alternative to suicidal behavior, which was consistent with his personal emergency plan.

When reviewing the therapeutic gains made in the first phase of therapy, Julio recognized how his thoughts, feelings, and behaviors were interrelated. He was able to articulate that the first step in changing his behaviors and emotions was to become aware of his thoughts, and think through the different options in order to practice adaptive coping skills. He also acknowledged a shift in how he viewed himself, from all negative to more positive. Finally, he identified therapy as a place where he felt valued, respected and heard, and where he was given the space to vent his frustrations without having to fear judgment.

Summary of Crisis Module.—Some of the major challenges initially encountered in this module were gaining Julio’s trust and reducing his urges to die. As a response to these persistent urges, follow up calls after every session were incorporated into the treatment plan in order to help Julio practice and reinforce adaptive coping skills when experiencing suicidal ideation.

Developmental, ecological/family, and feminist perspectives were embedded in many of the interventions conducted when questioning and debating Julio's negative and inflexible thoughts (e.g. the toxic masculinity thoughts). The main focus was to shift the view

from “individual” problems to systemic ones that included acknowledging negative societal messages that interfered with personal well-being. The therapy itself was a place in which Julio could show his vulnerability while at the same time being respected as a young man affirming his burgeoning sense of healthy masculinity.

Emotional Regulation Module (4 sessions; 3 individual, 1 caregiver).—Julio had a volatile temper and had grown accustomed to reacting to challenging situations impulsively. As in the previous module, cultural elements, i.e., talking about the message of “hypermasculinity”, helped him understand how and why he tended to suppress most of his negative emotions, with the exception of anger. The emotional regulation module used examples from his life to facilitate the identification of difficult emotions to further develop adaptive affect regulation skills (e.g., listening to heavy metal music to relax). The main objective of this module were to first, increase awareness of how anger in particular affected his body, with the goal of identifying how these sensations escalate and placed him in his “danger zone”, i.e. the point at which he started to impulsively act out in anger, and second, learning specific skills to cool down.

Though difficult for him at first, the exercises in this module helped Julio identify anger-specific “body talk” (e.g., muscle tension, rapid breathing and heart palpitations), in order to engage in relaxation techniques to forestall further escalation leading to impulsive and aggressive behavior. The exercise that Julio found the most helpful was deep breathing as it helped him regulate his anger. Combining deep breathing with counting served as focal point anchoring his attention in the present moment, thereby shifting it from the thoughts that made him angry. Other strategies in this module were not as helpful, such as other relaxation techniques (i.e., progressive muscle relaxation and guided imagery) and mindfulness exercises. After Julio felt he had mastered his new “cool down plan”, both he and his therapist agreed to move on to the thoughts module, as he did not feel ready to move on to family communication.

Thoughts Module (5 individual sessions).—The objective of this module was to help Julio in identifying unhelpful thinking patterns and help him learn cognitive restructuring skills. The therapist had to simplify examples by making them very concrete and anchor them to situations in his life. As a result of an incident in school where he was about to be expelled, the therapist helped Julio identify how he used effective skills to deal with this situation. This exercise proved useful in helping him restructure his unhelpful thinking patterns and gave him a sense of personal efficacy (See Table 2 for some examples). Additionally, he was able to point out that others came to his defense when he was about to be expelled, challenging the thought that people did not care about him.

As the module progressed, Julio demonstrated the ability to challenge and restructure unhelpful thoughts by looking at the positive side of negative situations (e.g., “We live with my grandmother, but at least we are safe”, “My family has some bad aspects, but they also have some positive aspects”) leading to more flexible thinking. The therapist also used examples of thoughts related to sports, when he and his team faced a tough team. He was able to challenge thoughts related to his team’s skills compared to that of their opponents such as, “Although this team looks tough, we are also good at this game”. Importantly,

Julio identified that when he began to change his thoughts using cognitive restructuring, he noticed a change in his mood. At the end of this module, Julio was able to recognize and accept that what his family was doing was because they loved him, even though sometimes they had problems interacting. This was noticeable to others too; he was arguing and fighting less, thinking through his actions, challenging his unhelpful thoughts, and acting less impulsively.

Social Interactions (6 sessions; 5 individual (two crisis intervention), 1 caregiver).—

The objective of this module was to help Julio identify sources of social support, positive and negative relationships, and to understand how social interactions influenced his thoughts, emotions, and actions. Julio had many acquaintances through his involvement in sports but had very few friends. He had difficulty identifying positive relationships, mentioning that he did not trust others for fear of being betrayed. These cognitions affected his interactions and made him suspicious about others' intentions. Practicing problem solving and cognitive restructuring exercises helped him understand how his thoughts influenced whether he approached or avoided certain people. Julio was then able to identify several people as positive sources of support: his best friend, a woman who he identified as his "second" mother, his mother, one of his sisters, his coach, and God. This module helped Julio take actions that led to fewer negative consequences and helped him improve interactions with others. Before concluding this module, Julio experienced an instance of significant conflict with his grandmother and uncle. Despite this situation and experiencing a resurgence of automatic negative thoughts and go-to behavioral responses (e.g., aggression), at the end, Julio was able to manage the conflict in an adaptive manner (See Table 2, family systems approach). Namely, he used therapy sessions as a source of support, avoided family conflict, practiced cognitive restructuring skills, spent more time with friends, and engaged in sports as way to distract himself in order to avoid conflict. His mother was also a source of support during this period.

Family Communication (7 sessions; 3 individual -one crisis; 4 family).—The objective of this module was to help Julio and his family practice effective communication skills and improve their interactions. This was the only module in which all the immediate family members participated (mother, older sister, Julio, younger brother, and younger sister; all were teens). They all attended the four family sessions with exception of the younger brother who missed one. The interaction among all family members, including Julio and his siblings, appeared emotionally distant, but given that they were all sleeping in one room, there were constant clashes among them. However, Julio reported caring about them and they all recognized that there was a time when things were better among them. By the time, Julio started this module he exhibited significant improvement. However, he showed initial resistance and ambivalence about working with his family, even though he had stated that this was an important therapeutic goal. An individual session was held with Julio at the start and end of the module to assess his perception of his family's communication and interaction process. In the family sessions, family members identified their main communication style as aggressive and passive. Passive communication patterns in the family were maintained by thoughts like "they will not understand", and "they are hypocrites". Additionally, Julio shared that he was the only one in his family taking

medication and believed that some members of his family thought he was “crazy”, though they never spoke about this or the reason for his hospitalization.

The family exhibited difficulties in understanding each other’s perspective, which made the development of healthy family communication skills challenging. They engaged in blaming and pointing out each other’s flaws. After having identified this as an interaction pattern, the therapist pointed it out to the family and encouraged them to instead identify each other’s and the family’s strengths. Moreover, family members were taught to recognize the connection between thoughts, communication patterns and how they related to one another. The therapist helped them challenge and change negative and inflexible thoughts in order to improve their interactions.

Toward the end of this module, Julio continued to express ambivalence about family sessions because in his view “Things remain the same”. The therapist encouraged Julio to identify small changes gained by his family throughout the therapeutic process, in order to help challenge his beliefs. He responded by expressing willingness to practice in a final family problem-solving exercise. Upon concluding this module, the family agreed that communication at home continued to be a challenge, however, they reported listening to and communicating with one another more effectively, and showing more respect for one another. Julio reported, for example, that on one occasion he was insulting his brother and his brother responded by saying, “I’m not swearing at you and I respect you so you don’t have to talk to me like that”. This comment help Julio recognize his mistake and he apologized to his brother.

Follow-Up.—After terminating treatment Julio had one booster session two weeks after his treatment wrap-up session. In this session, Julio and his therapist went over the stressors experienced since treatment completion, and Julio’s response to these stressors. Here, his adaptive responses were assessed and reinforced, and a brief review of other strategies learned over the course of treatment was covered to inform future relapse prevention. At the conclusion of the clinical trial, after eight months of treatment, even though Julio still endorsed some clinical symptoms on self-report measures, he expressed benefits from treatment and did not want to continue in therapy with another provider. Instead, he was given a list of providers and health clinic options for future consideration.

Outcomes

During the Crisis Module Julio struggled with suicidal thoughts, but by the end of treatment, he had much better control over these thoughts by experiencing increased motivation to live and positive realistic thoughts about his life. A reliable clinical change index was observed on self-report measures of suicidal ideation (SIQ-JR; RCI = -2.64 : pre-score = 69 & post-score = 47), depressive symptoms (CDI; RCI = -2.34 : pre-score = 30 & post-score = 20), and hopelessness (HSC; RCI = -2.45 : pre-score = 11 and post-score = 6). However, post-treatment scores were still in the clinical range when compared with adolescent community samples. No change was observed in self-concept (PH; RCI = $.43$: pre-score = 36 and post-score = 38). At post-treatment evaluation, a final diagnosis based on

the DISC-IV concluded that Julio had a Partial Remission of his Recurrent Major Depressive Disorder diagnosis and full remission of his Disruptive Behavior NOS diagnosis.

Particularly important was Julio's reduction in impulsive aggression, which led to fewer arguments both in the home and at school. Julio was still struggling with his academic performance by the end of treatment. He was taking two summer courses, but was able to challenge his failure related thoughts and engage in proactive behavior to pass the classes. He was also able to challenge the thoughts that maintained and exacerbated his aggressive behavior. During the final session, a visualization exercise was completed in which a chain of stressful situations, based on the initial Chain Analysis exercise, was re-created in order to assess what he would do differently in the future. Julio was able to generate a list of skills that he would use in order to deal with stressful situations, rather than threatening to kill others and himself. He mentioned stopping to think through his options, looking for the positive in negative situations, and engaging in pleasant activities to distract himself. In addition to all the therapeutic gains Julio accomplished in therapy, the most clinically significant as it pertains to suicidal behaviors in his socio-cultural context was the realization that "he is not the problem", and that killing himself is not a solution to his problems.

Though the family had difficulties with communication even after completing the communication module, they did report instances in which Julio's new behaviors were helping them develop their own effective communication and decision making skills. This was a significant accomplishment because it indicated that they were starting to recognize Julio's, and their own, strengths. Moreover, from both his mother's and Julio's perspective, their views about each other shifted. His mother was better able to recognize Julio's positive qualities, and Julio was able to empathize with his mother and the sacrifices she had made for their family. However, there was no change in the family functioning (B-FAM) self-report instrument ($RCI = 1.01$). Finally, an exit interview revealed that Julio was very satisfied with treatment. He stated that he felt valued and heard in therapy sessions. His mother expressed that Julio was a "different person" and that he was managing his problems in healthier ways.

Complicating Factors

Among the many complicating factors in this case, the main one was Julio's conflict with family members, including his grandmother and uncle. Both were reported to use substances, which influenced their interactions with Julio. Due to the added stress of living with extended family in his grandmother's house, the treatment team intervened by providing a letter so that the family's housing application with social services be given priority, which had positive results.

Other complicating factors in this case were Julio's pervasive feelings of resentment and abandonment due to the absence of his father and the domestic violence perpetrated by his stepfather. These adverse experiences were a relevant and central factor in many of the maladaptive behaviors and cognitions Julio worked on in treatment. Despite the therapist's attempts to help him think about the importance of processing his feelings regarding these potentially traumatic experiences, Julio did not feel ready to complete the SCBT-SB trauma module. This is not unusual as studies have found that factors such as emotional readiness,

or lack thereof, may effect whether or not a person is willing to engage in trauma work (Hamblen et al., 2015; Stecker, Shiner, Watts, Jones, & Conner, 2013), especially among those who may not be seeking such treatment. Julio did, however, develop adaptive ways to manage his affect and learned cognitive restructuring and communication skills, perhaps influencing his readiness, and/or ability, to engage in trauma work in the future.

Financial and transportation stressors were other barriers to care as Julio's mother had difficulty on occasion making it to sessions due to lack of transportation. Another barrier was the unwillingness of extended family members to engage in treatment and work together in a collaborative way to help Julio reach his treatment goals. Conflicts between Julio, his grandmother and his uncle, and even between his mother and grandmother, made it difficult to engage and include extended family members in sessions. This conflict was exacerbated by his grandmother's and uncle's substance use. Despite this, Julio's mother and his siblings completed the family communication module. Although change in communication was limited as not all members of the family participated, the immediate family continued to work on ways to improve their communication at the conclusion of treatment. From a family-systems perspective, a change in one aspect of the system can influence positive change in the unit as a whole.

Conclusion

This case study is an attempt to address a gap in the literature related to treating Latino adolescents who engage in suicidal ideation and attempts. Studies focused on understanding the familial and social-cultural contexts that influence suicidal thoughts and behavior in Latinos are rare. Treatment for Latino adolescents with a history of suicidal and aggressive behaviors can be challenging due to gender socialization, as well as cultural stigma against treatment seeking and treatment engagement. One way to conceptualize low treatment engagement and help seeking stigma is to understand the role of gender-norm socialization. Gender researchers posit that male socialization reinforces the belief that asking for and/or receiving help, and/or being "vulnerable", can be seen as antithetical to being masculine (Creighton & Oliffe, 2010). Thus, masculinity-based beliefs may likely negatively affect male adolescent's openness to seek, or engage in therapy (Creighton & Oliffe, 2010).

Culturally-informed interventions, compared to non-culturally tailored interventions, may be more likely to provide the conditions necessary for developing therapeutic rapport, a collaborative working alliance, and establishing trust between client and therapist (Huey, Tilley, Jones, & Smith, 2014; Perez Benitez et al., 2013; Wampold, 2015). CBT interventions that are culturally-adapted and responsive to a client's individual presentation, such as Latinx values, are associated with treatment acceptability, retention, clinically significant treatment gains, and increased quality of life (Perez Benitez, et al., 2013). These factors seem to have been operating in Julio's case and led to clinically significant gains and an improved quality of life for him.

The socio-cognitive behavioral model approach to the treatment of suicidality provided the conceptual framework and guidelines to reduce Julio's suicide risk. From a feminist perspective, an open discussion of gender norms and beliefs around masculinity was crucial

to facilitate a healthy masculine identity. Re-framing his male identity and beliefs about expected male behavior, allowed him the opportunity to break the aggressive cycle, try a different communication style, which ultimately initiated a change in his environment while still holding on to his avowed gender identity. A systemic approach, in which aggressive communication and behaviors were conceptualized as a cycle in which all family members were involved provided some relief for Julio. Additionally, it provoked an important cognitive shift, from viewing himself as the family scapegoat to viewing himself as one component in a shared family problem. From an ecological perspective, a therapeutic atmosphere of respect and understanding of the socio-cultural context helped him feel affirmed and safe early on treatment.

Julio also had important protective factors that worked in his favor, such as good insight and athletic abilities, which promoted a sense of self-efficacy in an important area of his life. Furthermore, Julio's mother's willingness to support his treatment and her positive attitude toward therapist recommendations helped her make modifications to her own behavior and consequently helped improve Julio's negative thoughts about his family. This case underscores the relevance of using a skills-based approach within a culturally informed comprehensive framework like the SCBT-SB model, to treat Latino adolescents with suicidality.

Lessons Learned

One of the main triggers for Julio was his conflict-laden relationship with members of his extended family, namely his grandmother. Although attempts were made to include his grandmother in family sessions, this was not accomplished. Family interactions that may result from mixed-generational households, in addition to the complicated dynamics that can result when a family member(s) engages in substance use, can make it difficult to negotiate treatment engagement. Therefore, special attention should be paid early on in treatment to address the motivation of family members, although it is not always feasible or productive. Nonetheless, increasing buy-in from adolescents and families who are referred for treatment post-hospitalization is very important. It is also important to assess motivation and engagement at various points during treatment. For this particular intervention, given its modular approach, motivation and engagement can be assessed and addressed at the end of each module. These check-ins can also serve to further tailor interventions to each individual case on an on-going basis. In the case of Julio, and possibly other Latinos, using the fighter image and the notion of internal strength associated with masculinity, but in a healthy way, was an effective way to cognitively reframe Julio's unhealthy ideas about masculinity, and may have helped keep him engaged in treatment.

Limitations and future direction

This case was selected from a sample of adolescents taking part in a study that is in the early stage of the treatment development process according to the Stage Model of Behavioral Therapies research (Rounsaville, Carroll, & Onken, 2001). The cultural relevance of the treatment components were assessed throughout the treatment development process, including consulting the literature on evidence based practice among Latinx individuals, clinical expertise, and mentoring/consultation with experts in the field. Culture-based

outcome measures were not incorporated during treatment development because the main purpose of this phase was to treatment refinement and determination of treatment feasibility and client satisfaction. Currently, a pilot RCT is underway stateside with Latinx youth to assess the feasibility of further conducting a larger study to assess SCBT-SB efficacy (K23 MH097772–05, PI: Duarte-Velez, Y). Possible psycho-social risk factors relevant to Latinx youth and families in the contiguous U.S., such as acculturation conflicts, ethnic identity, discrimination, and spirituality were incorporated in the above mentioned study to assess their impact on suicidality. Finally, even though the SCBT-SB was develop for Latinx, specifically Puerto Ricans adolescents, other ethnic groups may benefit as well from a developmental, feminist, and ecological/systemic approach.

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Table 1
Therapy modules and objectives matched to areas of need

Therapy module	Objectives	Areas of Need
Crisis (CORE) (1 family, 5 individual, 2 caregivers)	Stabilization of the crisis & Conceptualization	Coping skills, emergency/safety plans, & understanding of the crisis
Understanding the suicidal crisis		
*Identity		
*Chain Analysis		
*Cognitive restructuring		
*Decision making		
*Communication skills		
^a Parenting skills		
^o Communication skills		
Thoughts (4 individual & 1 family)	Manage thoughts about a healthier life	Low self-esteem; negative thoughts; hopelessness
Emotional Regulation (3 individual & 1 family)	Regulate emotions to have a healthier life	Impulsivity; aggressiveness Rapid mood swings
Family Communication (4 family)	Improve communication and increase positive interactions	Communication problems or family conflicts
Social Interactions (3 individual & 1 family)	Develop healthier social interactions	Problems with friends or forming relationships
Activity (2 individual & 1 family)	Plan activities to have a healthier life	Loneliness; Few pleasant activities
Trauma (3 individual & 1 family)	Beginning to manage the traumatic experience/s	Traumatic event that caused severe emotional pain
Substance (to be tested)	Gain control over substance use	Problems with addictive substances
Identity (to be tested)	Explore and affirm sexual and gender identity	Problems with understanding, "Who am I?"

Note. The number of sessions in each module can vary depending on the needs of the adolescent/family; sessions can take place over two visits when necessary

* = The beginning of each individual teen session name

^o = The beginning of caregivers session name. Substance and Identity Module were not used with any teen during the open trial.

Table 2
Cognitive re-structuring interventions from a feminist and systemic approach

Cognitive Re-structuring (ABCDE)	Feminist Approach	Family System Approach
Activating Event	The teacher was harsh on me.	My grandmother blames me for something I didn't do.
Belief (Core Negative/Inflexible)	If I don't act aggressively I will be seen as weak and a chump.	I am always the bad one in my family. Things will never change in my family.
Consequence	Disappointment and anger → impulsive and aggressive behaviors	hopelessness and anger → impulsive and aggressive behaviors (within family fights)
Discussion	The societal norm of who is strong (particularly for men) is not always correct. To be assertive you have to be brave.	I am a good person. I have been good to others. This is not just on me. <u>We</u> have been like this for so long, but I have other options.
Effect	Breathe, cool down, don't explode	I walked away to avoid problems.