Implementation of Beardslee Intervention In Different Cultures Helsinki, Finland 27 November 2006 (PM)

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Adapting PIP to Latino Families: Why PIP?

- Need: high depression prevalence, high risk (poverty, trauma, racism, marginalization, losses, environment stresses)
- Need for evidence-based prevention intervention for Latino children
- Improving access quality interventions
- Family and strength focus useful with multi-stressed families
- Flexibility of the model open to adaptation
- Previous work adapting PIP for urban, low income families

Latinos in the US

- At the end of 2004, 40.4 million Hispanics lived in this country
- 14 percent of the total U.S. population.
- Latinos are now not only the nation's fastest-growing minority group, but also its largest
- They are expected to grow from one in seven to one in four by 2050.
- Highly heterogeneous

Pew Hispanic Center 2005

A population that defies generalizations

- The very term Latino has meaning only in reference to the U.S. experience.
- Outside the U.S., Latinos speak of Mexicans, Cubans, Colombians, Salvadorians, Puerto Ricans and so forth.
- The term Latino glosses over the contradictions, tensions, and fissures that often separate us.
- The vectors of race and color, gender, socio-economic status, language, immigrant status and mode of incorporation into the United States shape our experiences.

Suarez-Orozco & Paez, 2002.

Findings from the ECS and NCS Studies (DHHS, 2001) and other studies

- Being born in the United States or living there 13 years or more increases the prevalence rate for mental health problems among Mexican-Americans and those from Puerto Rico
- Depression is one of the greatest mental health problems within the Latino communities
- Lifetime prevalence rates for other psychiatric disorders among different Latino groups were comparable to those of non-Latino whites
- Many other studies have found that Latinos have higher rates of depression or distress than whites.
- Two other large studies: Depressive symptoms may measure distress rather than disorder for economically disadvantage Hispanics (Cho et. al, 1993)

Module 1: Establishing the Therapeutic Relationship & Constructing the Family History of Depression

- **Establish therapeutic alliance & collaborative nature of the intervention**
- **Orienting the family to the intervention**
- **To construct the family history of the parental depression**

Cultural Adaptations

- **The process of establishing and maintaining the therapeutic relationship is central**
  - **Personalismo: warm, personal, informal style**
  - **Respeto: acknowledging and valuing the authority of the parent**
  - **Confianza (trust) result from the first two**
- **A collaborative, rather than a hierarchical relationship with parents but respecting the hierarchical relationship between parents and children**

Module 1: Establishing the Therapeutic Relationship & Constructing the Family History of Depression (continued)

Cultural Adaptations (continued)

- **Definition of family. Who is included?**
- **Spouse/partner involvement?**
- **“Secrets” may need to be considered (e.g., illegal status, etc)**
- **Confidentiality becomes a major focus**
- **Safety**
- **Family history of depression, using family’s understanding of depression, and names used for sadness and depression. Listen for issues regarding stigma**

Module 2: Experience of Depression and Psycho-education

- Review previous session: discuss reactions, questions and goals
- Continue to elicit history of family's experience with affective illness, with particular attention to spouse's/partner's experience
- Psychoeducation about the etiology, symptoms, and treatment of the pertinent affective disorder
- Help parents review child's current functioning and their worries about their children
- Help parent prepare child for meeting with clinician (i.e. worries about the interview)

Cultural Adaptations

- *Not having a spouse modifies Module II*
- *Depression not seen as a illness, we needed to modify how we used the term with this sample*
- *Different understanding of depression and its etiology. Difficulties translating resilience*
- *Psycho-education not limited to depression*
- *Many parents reported "kids don't know I am depressed" which required that preparation of the children be adapted.*

Module 2: Illness Experience and Psycho-education

<u>Adaptations</u> (continued):

- Discussion about parenting beliefs and what makes a good parent (be aware of your own parental beliefs arising from a different culture and keep an open mind).

- Inquire about parents worries and perspectives about raising children in this country and these communities.

- Keep in mind the challenges of raising kids in cultural borderlands, with limited social power.

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Module 3: The Meeting with the Child

- To acknowledge the importance of the child's perspective & to develop a rapport with him/her
- Assess child's current functioning & understanding/response to parental depression
- Help the child articulate questions or concerns for family meeting
- When appropriate, impart information about depression geared to child's concerns and developmental level

Cultural adaptation:

- *Brief meeting with child and parent to review purpose of meeting and obtain parental sanction*
- *Emphasis on worries and concerns on self-and parent not limited to depression*
- *Psycho-education about topics related to family concerns in addition to depression*
- *Listen to children's requests for assistance in negotiating generational differences without betraying parents best intentions.*
- *Interview all the children*

Module 5: The Family Meeting: Facilitating the Creation of a Shared Understanding of the Parental Depression

- To review with the family the purpose of the family meeting(s) & information from last session about depression & resiliency
- Facilitate the creation of a shared understanding of parental illness, incorporating the affective experience of all family members
- Empower parents to conceptualize & present the depression to their children as an [illness] that may have affected the family in various ways & can now be discussed

Cultural adaptations:

- Family conversation is the most important factor of the intervention keeping focus on strengths.
- The conversation does not always focus on depression but on the associated risks.
- Constructing a shared understanding about issues of common concern. Families learn each other's experiences, their contexts and meanings

What helps parents cope with depression?

- Focus on the children

- Visualizations. Envisioning a better future

- Prayer, songs, religion, church community, spiritual healing

- Support groups
- Helping others, sharing information
- Focusing in the present: *"viviendo de dia a dia" (living day to day)*
- Not giving up: "*seguir la lucha"*
- Alternative medicine
- **Humor: "al mal tiempo buena cara" "yo no lloro, yo me rio"**
- **Aguantar (mixed reports-may be a problem)**

Parental concerns, worries and experiences

- Concern about the kids' future: wanted a better life than theirs for their children, with less suffering, and for them to take advantage of the opportunities offered in this country, to study and to eventually develop better relationships with partners.

- Concern about the impact of absent fathers

- Parents felt isolated in this country but stayed for the opportunities for their children. Kids difficulties (disobedience, school problems) associated with fear dreams will not come true and sacrifice will be in vain. Often depressive feelings were associated with these fears.

What helps kids build resilience?

- Faith in God and in my children
- *Darles animo* (*give encouragement*)
- Meeting their needs
- Discipline and setting limits
- School support and emphasis on education
- Activities:
  - Structured activities, preferably after school related (less trust about other activities)
  - Providing games, activities they can enjoy
- Working and providing them with what they need
- *Buen ejemplo- good example*