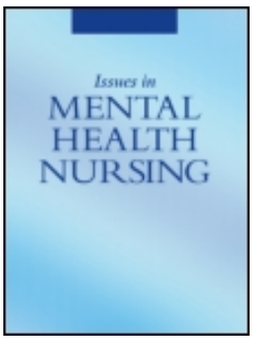

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FAMILY INTERVENTIONS WITH "TROUBLED" MEXICAN AMERICAN TEENS: AN EXTRAPOLATION FROM A REVIEW OF THE LITERATURE

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This article discusses therapeutic guidelines for family interventions with troubled Mexican American (MA) teenagers based on reports informing on MA teens and MA families. The typical MA teenager does not exist, and little is known about the complex variations in this population. What is known about some groups of MA teens is alarming and significant enough to provide some direction for serving this population. Existing data regarding teen social class levels, school performance, substance abuse, pregnancy and parenthood, and suicide are presented. Because knowledge about MA families is essential to guide interventions with MA teens in distress, the known traditional MA family is described, and the troubles that confront some MA families today are included. Findings from family cohesion studies, including those not involving MA teens in particular, are summarized to lend support to the guidelines presented. Associations found between family cohesion and various physical and psychiatric problems are noted to support the importance of the concept of cohesion in working with troubled teenagers and their families.

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The typical Mexican American (MA) teenager does not exist, and little is known about the complex variations present in this population (Castaneda, 1994; Ramirez, 1989). As a group, MA teens present differences in backgrounds, including differences in language, generational status, and social class levels, as well as individual differences such as gender and personality factors. What is known about some groups of MA teenagers is alarming and significant enough to provide some guidance for serving this population. Existing knowledge about MA teens and families is necessary to guide interventions that promote the well-being of troubled MA teens. Therefore, the purpose of this article is to suggest therapeutic guidelines for family interventions with troubled MA teens based on reports informing on MA teens and MA families. Findings from various family cohesion studies, although not involving MAs especially, are included to lend support to the guidelines presented.

In presenting this review of the research reports presented in this article, we caution the reader to remain aware of the limitations of correlational research. As all nurses learn in the introductory research courses, correlational data do not "suggest," "support," nor "find" simple unidirectional cause–effect conclusions. A correlation may represent two or many more effects from a single cause, or from a cluster of shared causes. Nor do correlations prove directionality of the cause–effect relationship, whether unidirectional, bidirectional, or interactive and mixed.

SOCIAL CLASS LEVEL

Many MA teenagers grow up in poverty. For example, half of the 27% of Hispanics in the United States who are living below the poverty line are under the age of 18. Hispanic children constitute 11% of the total number of children in the United States; however, they represent 21% (one fifth) of all the children living in poverty (U.S. Bureau of the Census, 1990). Hispanics are two and a half times as likely as non-Hispanics to live in poverty (Perez & De la Rosa Salazar, 1993). The average annual family income for Hispanics is $15,800, compared with $29,400 for Anglo Americans (AAs) and $15,400 for African Americans (AFAs) (U.S. Bureau of the Census, 1989). In 1991, 19% of MA households had incomes of less than $10,000 (Reddy, 1993) annually, compared with 10% for AA households.

SCHOOL PERFORMANCE AND SUBSTANCE USE

The U.S. Department of Education (1992) reported a school dropout rate of 35% for Hispanics in general, compared with 9% for AAs and

14% for AFAs. Although dropout rates for MAs vary from study to study, they are consistently the highest (Chapa & Valencia, 1993; Reddy, 1993), with only 44% of Hispanics (ages 26 and up) completing high school. For MA teenagers, dropping out of school has been associated with delinquency and substance abuse (Boles, Casas, Furlong, Gonzalez, & Morrison, 1994; Chavez, Oetting, & Swaim, 1994). Dreyfoos (1990) and Flowers (1988) have reported that MA teens are overrepresented among juveniles arrested. According to Flowers, incarceration of MA teenagers is double their proportion in the population.

In addition to delinquency and school dropout rates, the rate of substance abuse among MA adolescents is influenced by generational and acculturation factors (Boles et al., 1994; Swanson, Linskey, Quintero-Salinas, Pumariega, & Halzer, 1992), with rates of substance abuse among MA teenagers born in the United States more closely matching those of their AA peers and more recent MA teenage immigrants having lower rates of substance abuse than MA teens born in the United States.

TEEN PREGNANCY AND PARENTHOOD

High rates of teen pregnancy and parenthood demonstrate another alarming trend among some MA teenagers. The 1994 birth rate for MA teens in the United States was 116.2 births per 1000 women aged 15–19 years, compared with 40.4 and 107.7 per 1000 non-Hispanic AA and AFA females of the same age group, respectively (Ventura, Martin, Matthews, & Clarke, 1996). Although Hispanics made up only 19% of the 1994 population in Texas, Hispanic teens accounted for 42% of the teen births, with 22% attributed to AFA teens and 36% attributed to AA teens (Texas Department of Human Services, 1991). Teen parents frequently find themselves caught in a cycle of poverty from which it is difficult to separate.

TEEN SUICIDE

Suicide rates among MA teenagers have caught up with the suicide rates of their AA peers. The suicide rates for young people who are 15 to 24 years old have quadrupled, from 2.7 per 100,000 in 1950 to 13.1 per 100,000 in 1991 (National Center for Health Statistics, 1993). Wyche and Rotheram-Borus (1990) reported that teenage suicide rates have increased "across ethnic groups" for the last 30 years. For example, in Bexar County, Texas, a county known to be populated by at least 52% MAs, the suicide rates in the 15- to 19-year-old males from the three major ethnic groups (AAs, MAs, AFAs) have been almost identical over the last decade. The 1983–1993 rates in these age groups of male individuals were 23.7 per 100,000 (AAs), 23.0 per 100,000 (MAs), and 19.8

per 100,000 (AFAs) (Goldman, 1994). However, whereas the rate in 15- to 19-year-old AA males appears to have declined gradually from 32.0 per 100,000 in 1987 to 24.1 per 100,000 in 1993, the rate in their MA counterparts tended to climb, from 25.4 per 100,000 in 1987 to 26.6 per 100,000 in 1993, as did the rate of their AFA peers, from 26.2 per 100,000 in 1989 to 30.7 per 100,000 in 1993 (Goldman, 1994). Guiao and Esparza (1995) have reported that suicidality in MA teenagers is significantly influenced by many of the same risk factors consistently associated with suicide in AA teenagers, such as depression and poor coping with life stressors (Asarnow, Carlson, & Guthrie, 1987; Brent et al., 1993; Cole, 1989; Farberow, 1989; Garrison, Lewinsohn, Marsteller, Langhinrichsen, & Lann, 1991; Meneese & Yutrzenka, 1990; Peck, 1987; Rubenstein, Heeren, Housman, Rubin, & Stechler, 1989; Rudd, 1990; Spirito, Overholser, & Stark, 1989).

THE MEXICAN-AMERICAN FAMILY

Some studies on MA teenagers (Chavez et al., 1994; Guiao & Esparza, 1995; Munsch & Wampler, 1993; Ramirez, 1989) have suggested that the MA family may function as a source of strength, support, or constructive adaptation, and/or as a protective factor from engaging in the kinds of "troubling" behaviors noted above. Additionally, scholars on the MA family purport that the family remains a central and critical influence in the lives of its members, including teenagers (Falicov, 1982; Hampson, Beavers, & Halgus, 1990; Holtzman & Gilbert, 1987; Rueschenberg & Buriel, 1989; Sabogal, Marin, Otero-Sabogal, VanOss Marin, & Perez-Stable, 1987).

The Traditional Family

The literature recognizes a broad range of MA family structures and systems that interact with a variety of socioeconomic and acculturation factors. Some generalizations relative to major cultural values of the MA family have been consistently documented. Characteristics of MA families include large extended family and kinship networks; authoritarian and hierarchical structure; a high degree of cohesion, affiliation, and cooperation; valuing of the good of the family over the good of the individual; and acceptance of the individual family members' dependency needs (Falicov, 1982; Hampson et al., 1990; Holtzman & Gilbert, 1987; Knight, Cota, & Bernal, 1993; Markides, Boldt, & Ray, 1987; Ramirez, 1989; Rueschenberg & Buriel, 1989). These familial characteristics are descriptive of the concept of family cohesion.

The concept of family cohesion in MA families is noted by Falicov (1982, p. 138):

> Both a high degree of cohesion and hierarchical organization are normal for Mexican families. Patterns of interaction are characterized by general interdependence and loyalty to the family of origin, high levels of affective resonance, interpersonal involvement and controls, a tendency for individuals to live in families of origin, of procreation, or extended at every developmental stage, and the fact that all life cycle events and rituals are family celebrations and affirmations of their unity.

Within this context, family members are protected, and their dependency needs are shared and accommodated by the family as a whole.

The findings of Hampson et al. (1990) also suggest the cohesive structure of MA families. In their study of cross-ethnic family differences regarding family interaction, competence, and style, Hampson et al. reported that MAs are more attuned to and encouraging of dependency needs in their children, significantly more likely to describe themselves as close-knit (verbal expression of closeness), and significantly more discouraging of aggressive, defiant, or disruptive behavior from members (assertive/aggressive qualities) (p. 314). Delgado-Gaitan (1993) reported that observable parenting practices in the home between the parent and the child in MA families indicate a strong orientation toward respect and family ties.

According to Rueschenberg and Buriel (1989), the internal workings of the MA family seem to remain "unchanged during the acculturation process" (p. 241). In other words, *familialism*—that is, family cohesion and support—continues to be important through the succeeding generations here in the United States even as the family makes English its primary language, adopts U.S. customs, and becomes increasingly involved in its new community. This conclusion is supported by findings in other studies. Keefe and Padilla (1987) reported that extended family households continue despite decreasing cultural awareness and ethnic loyalty. Sabogal et al. (1987) found that perceived family support does not decline with acculturation. Vega et al. (1986) reported that family cohesion and adaptability are differentially related to acculturation.

The cultural differences noted above are evident in the behavior of some MA teens. For example, in the Munsch and Wampler (1993) study of ethnic differences in early adolescents' coping with school stress, AFA teens and MA teens stated that they received "more problem-solving help than did AA teens" (p. 642). MA and AFA teens also named more adult relatives as "helpers" than did their AA peers.

Troubles in the Family

Troubled MA families have received scant attention in the literature. However, some researchers (Castaneda, 1994; Chavez et al., 1994; Ramirez, 1989) have linked troubled behaviors to family dysfunction. The 1985 National Family Resurvey (Strauss & Smith, 1990) found greater rates of violence in Hispanic families than in non-Hispanic AA families. Furthermore, the study reported that nearly 1 in 8 Hispanic husbands physically assaulted his wife during 1985. Strauss and Smith have suggested that this high rate of violence in Hispanic families can be explained by the relationship between violence and low income, urbanization, and youthfulness in the study respondents.

In their study on residents of battered women's shelters, Gondolf, Fisher, and McFerron (1988) reported that Hispanic women tend to marry younger, be less well educated, have larger families, and be poorer than their AA or AFA peers. Hispanic women in this study also tended to remain in violent relationships longer than did their AA peers. Torres (1991) compared MA and AA battered women and found that although the manifestations of wife abuse (nature of wife abuse) are generally similar for both groups, the MA wives tend to be more tolerant of abuse. In concert with the findings of the Gondolf et al. study, Torres also found that MA wives are less educated, and had larger families and lower income levels than their AA peers. Additionally, Torres noted that in MA families wife abuse frequently takes place in front of children or other relatives.

Violence in MA families may also include violent children or teenagers (usually male) (Adler, Ovando, & Hocevar, 1984; Belitz & Valdez, 1994; Morales, 1992). Family environment variables related to Hispanic youth gangs include family members who abuse alcohol or drugs; poverty; single-parent households, especially those headed by women; inadequate parenting or supervision of children and teenagers; inadequate housing; acculturation; and discrimination (Adler et al., 1984; Morales, 1992; Vigil, 1988).

FAMILY COHESION AND MENTAL HEALTH

Existing data on the relationship between family cohesion and the mental health of MA teens, albeit limited, are important. Adler et al. (1984) compared gang-member families and non-gang-member families and found that non-gang-member families had healthier family interactions and spent more time together. For example, non-gang-member families were more likely to be consistent in their discipline of the children, to express their affectionate feelings for each other, and to do

things together as families. Gang-member families, on the other hand, had little interaction with fathers, and mothers in these families tended to express negative feelings about their husbands.

Belitz and Valdez (1994) observed the following family dynamics in the families of the gang youth with whom they worked: The violent young men involved in gangs tended to come from families in which the parental male figure was the most powerful family member, using violence and intimidation to control the family and to gratify his needs. Mothers victimized by their husbands and too fearful to protect their children from the abuse of the father were perceived as passive and uncaring. This violent and seemingly uncaring family environment aroused intense feelings of abandonment and powerlessness in the young men, leading them to identify with the abusive father. As aggressive gang members, these young men discovered the power their fathers modeled for them, which they believed would prevent their further victimization (Belitz & Valdez, 1994). Thus, should these observations hold true for the larger population, violent behavior is passed from one generation to another.

Guiao and Esparza (1995) reported that perceived coping efficacy and family cohesion are related to decreased suicidality in MA teens. They posited that family cohesion in MA families may promote increased coping efficacy by allowing for family members to depend on the support of the family, reducing the risk of feelings of isolation and thereby decreasing feelings of helplessness or powerlessness that may lead to depression. Furthermore they suggested that family cohesion may offer the MA teenager a variety of alternatives and resources for coping with problems as family members engage in attempts to resolve the issue. Through discussion and interaction with other family members about a given problem, the teen may reframe his or her understanding of the problem in a constructive manner. Additionally, the mere knowledge or sense that the MA teenager can count on his or her family's support may reduce the risk of the development of depression and other suicide risk factors. Guiao and Esparza also found that family cohesion is also related to decreased levels of depression and increased levels of coping efficacy, although how these variables interact remains unknown. Such findings are consistent with the findings of other studies on teen depression and family functioning among mostly AA adolescents (Garrison, Addy, Jackson, McKeown, & Waller, 1992; Rubin et al., 1992).

The protective function of family cohesion in young people is supported by other mental health studies of mostly AA participants. Mollerstrom, Patchner, and Milner (1992) reported strong inverse relationships between family cohesion, family expressiveness, marital satisfaction, and child

abuse. A positive association between the family configurations of cohesion and adaptability and nonchronic juvenile offenders' level of ego development was found by Novy, Gaa, Frankiewicz, Liberman, and Amerikaner (1992). Better social adjustment in some schizophrenic patients has been found to be associated with less adaptable, more cohesive family functioning (King & Dixon, 1995).

Furthermore, family cohesion is negatively related to adolescent unemployment (Patton & Noller, 1991), borderline personality disorder (Feldman, Zelkowitz, Weiss, Vogel, & Heyman, 1995), and parental alcoholism and childhood sexual abuse (Yang, Tovey, Fogas, & Teegarden, 1992). Armbruster and Fallon (1994) reported low family cohesion as a predictor of attrition in a children's mental health clinic.

FAMILY COHESION AND PHYSICAL HEALTH

The significance of family cohesion in young individuals with physical illness has been demonstrated as well. Phipps and Mulhern (1995) found that family cohesion and expressiveness promote resilience to the stress of pediatric bone marrow transplant. Girls with recurrent ketoacidosis report higher levels of family conflict, and their parents report lower levels of family cohesion (Dumont et al., 1995). Active coping by children with sickle-cell disease is associated with a cohesive family environment (Kliewer & Lewis, 1995). Rait et al. (1992) found a positive association between adolescent malignant cancer survivors' perceived family cohesion and posttreatment psychological adjustment.

Weidner, Hutt, Connor, and Mendell (1992) examined children for relationships between family conflict and cohesion and plasma lipid profile and aggressiveness in the children. They found that family conflict as reported by the respondents' parents was associated with unfavorable lipid profile among the boy participants but not among the girls. Furthermore, they reported increased levels of aggression in boys whose family cohesion was low and that family conflict was associated with higher levels of aggressiveness in the girls. They concluded that stress in the family may play an important role in the development of coronary risk in male individuals who have histories of high blood lipid profile as children. It is equally possible that high lipid profiles contribute to aggressiveness in the child rather than being an effect of family conflict.

FAMILY INTERVENTIONS

The findings of the various studies described and characteristics of the MA family discussed should be considered a starting place from

which to individualize understanding of the complex factors that influence the MA teen and his or her family. The findings in the family cohesion studies, in particular, suggest that inclusion of the family in working with the troubled MA teenager is especially important. Enhancing family cohesion or minimizing family dysfunction is as crucial as addressing the problem behavior(s) of the adolescent; therefore, it is strongly recommended. Some general guidelines and strategies toward this end are described below.

Regarding Mexican American Family Structure and Dynamics

- Respect the traditional family age and sex hierarchies of power (Ramirez, 1989). However, keep in mind that the MA family is constantly changing, and more acculturated families may not exhibit the traditional family structure. For example, a recent study by Herrera and DelCampo (1995) of MA working class women in dual-earner families employed full-time found that women in such families do not subscribe to the superwoman myth. "Instead, they seem to endorse an expansion of the husbands' roles to include housework and child care" (p. 49). These women perceived themselves as "co-providers, with equal decision-making authority as the husband" (p. 57). These findings suggest that the MA family structure can display flexibility in gender roles. This is a positive trend concerning families in general that merits reinforcement to become more permanent in a changing MA family system.
- Recognize that the MA family is changing in its structure. MA families are increasingly single-parent households with mothers as the heads (Firestone & Harris, 1994). This structure does not fit the traditional nuclear family base described by Falicov (1982) and others. Assess how any single-parent home operates and whether extended family support is available to assist with parenting and other family tasks. The single mother of a troubled teen may need help to mobilize her dormant or potential support network.
- Accept that some members of the extended family (e.g., grandparents), because they care, have a right to interfere in the lives of their grandchildren. Assist the client in dealing with these significant others in a culturally appropriate manner that will enable him or her to manage the conflict effectively without breaking away from "interfering" significant others (Sandoval & De la Roza, 1986).
- Realize that, as family structures become more complex, especially through divorce and remarriage, blended MA families may have increasingly complex extended families and greater opportunities for conflict. Be creative in finding ways for these bigger and more com-

plex families to put into action the greater potential they have to give to one another rather than to conflict with each other. Keefe, Padilla, and Carlos (1978) stated that MAs tend to rely on relatives. From the MA culture perspective, this arrangement is natural, but before providing counseling to this effect, assess the acceptability of this norm to the client family, who may be in transition culturally or already nontraditional.

- Take advantage of the MA family's commitment to the children in a variety of ways. For example, you may assist the teens or children in a family to voice their need for all the extended family members' support and love as well as their distress when various factions engage in hostile communication or behavior. You may also help feuding family members to identify common ground in their concern for the children or adolescents and remind family members of the damaging consequences for the children and adolescents when they grow up in an atmosphere of tension, anger, and distrust.
- Assess generational or acculturation and ethnic identity differences between family members, and between the troubled teen and his or her family. Family conflict and discord may surface when expectations differ between the spouses and between and among the parents and children. Address such differences by modeling recognition, support, and respect for those differences for the family (Ramirez, 1989). As in any family, unconditional respect and support are critical to the development of trust between client and therapist and to building or repairing the trust between family members. Furthermore, you should capitalize on the similarities of all concerned to help them deal in unison with the troubled member.
- Mediate gaps in levels of acculturation between the troubled teen and his or her parents. Initiation or domination of a therapeutic session by a teenage son or daughter may indicate a considerable gap between the parents' and childrens' levels of acculturation (Ramirez, 1989). Also note the language facility and preference of each family member. Help the family identify cultural strengths of all family members; they are important indicators of levels of acculturation. Assisting the family members to know and respect each other's circumstances and point of view can help the family to bridge acculturation gaps among the members. The development of therapeutic processes from structural and strategic family therapy approaches, which reflect appreciation for cultural difference and strength, is suggested (Soto-Fulp & DelCampo, 1994).
- Be cautious in challenging existing family structures. Rueschenberg and Buriel (1989) found that the process of acculturation had little

effect on internal family system variables such as cohesion, expressiveness, conflict, organization, and control. Therefore, instead of challenging the family system, you may find that teaching the family about itself and its unique system, and pointing to system problems can enable the family to create its own adaptive way of dealing with the issue(s) at hand.

Cross-Cultural Perspective on Treatment

- Be sensitive to the customs of the family. It is helpful to be bicultural and bilingual (Ramirez, 1989). However, the critical factor is to be attuned to the culture of the family members and to issues specific to that culture. Be curious about the family and how the family has fun, deals with conflict, celebrates special occasions, and lives day to day. You can thus better facilitate rapport with the client so that client self-disclosure can take place in good time.
- Encourage clients' self-disclosure. Although MAs disclose personal information slowly, you can facilitate self-disclosure through storytelling, anecdotes, humor, analogies, and proverbs (Falicov, 1982). MA family members frequently enjoy telling family stories as a way of sharing about themselves. You may also find that some judicious sharing about your own family may assist a family in connecting with you.
- Convey personal warmth and friendliness during all contacts with the family, especially during the initial face to face encounter with the family. Standing close to a person, exchanging a warm handshake, and placing a hand on a child client's shoulder facilitate openness in the early sessions (Ramirez, 1989). According to Ramirez, this strategy has its basis in *personalismo,* a Mexican American concept that denotes a preference for personal contact and individualized attention in social interactions. There are many opportunities to show interest in each family member and in the family as a whole. For example, taking care to remember how to pronounce family members' names (writing them phonetically may be helpful) and remembering the unique bits of personal information or family history that family members share indicate that you are truly interested in knowing who they are.
- Be meticulous in note taking. Keeping information about different family members, especially if the family is large or has a large extended family, can be a major task. You may find it useful to construct genograms or other family maps to keep straight who's who and what's what.

Regarding the Assumption that Traditional Families, in General, Are Natural and Cotherapeutic Support Systems

- Accept the family as both the most important support system and probably the greatest source of stress (Sandoval & De la Roza, 1986). Because MAs value their families so highly, a dysfunction in the family is a source of great stress. The stress level is especially high for a client who perceives himself or herself as alienated from the family or who is let down by the family in an important way, as in the case of an adolescent who experiences abuse at the hands of one or both parents. In this illustration, separation of the abused youth from the source of stress must be done with extreme caution and sensitivity to both the familial and safety needs of the youth. Provide options to choose to avoid further abuse. Uphold the teen's freedom to choose where to stay while in therapy. His or her decision must be respected and supported while you help him or her gain self-esteem, more effective coping skills, and psychological ammunition to avoid repeated abuse. The abusing parent(s) should be assessed and treated for factors and risks for abuse of children, as well as for dysfunction that may be arising from poverty and acculturation issues. The family's intention to stay together or separated should be respected and facilitated, with the needs of all concerned addressed. Be sensitive to ambivalence in decision making and counsel accordingly.
- When doing family therapy with youth gang members, consider the strategies Belitz and Valdez (1994) have found helpful with Hispanic gang youth: (a) Include a focus on family history of violence, abuse, neglect, secrets, and denial or concealment of violence, as well as on establishing honest communication of feelings and perceptions; 2) reframe as "learned abusive behavior resulting from the identification with the aggressor" (p. 65) the youth's gang membership and related activities; 3) explore family roles and redefine empowering parents as the adult decision makers, assisting them to establish developmentally appropriate expectations, guidelines, and consequences for their children's behavior; and 4) help the family identify cultural strengths and assist them to integrate these strengths to create more positive self and family identities.
- Turn into a family broker even when not exposed to all the family members, and use your expertise to enhance the positive aspects of the family and ameliorate the negative ones (Ramirez, 1989). Avoid interpretations of dysfunction or direct confrontations, which may be interpreted as disapproval (Ramirez, 1989) and could alienate the family to therapy. You are in a stronger position to be heard in the

family when the family members are convinced that you have their best interests at heart.

- In the absence or unavailability of biological parents, mobilize the support of the extended family network—for example, godparents or coparents (Martinez, 1986), grandparents, uncles, and aunts—in providing for the familial needs of the troubled adolescent. Surrogate family in the form of adult friends or mentors are also powerful caregivers. Be prepared to assist the adolescent in the formation and development of these kinds of relationships when necessary.

CONCLUSION

This article includes a review of the broad variation of issues faced by MA teenagers and their families in the United States today. Cultural family strengths and evidence of family dysfunction are reviewed, especially as they apply to troubled teens. Family interventions with MA adolescents to improve family cohesion and suggestions to decrease perceptions of family conflict, as well as some approaches that may meet the familial needs of the distressed MA youth, are presented.

Much remains to be known about MA families and teenagers. However, a common theme throughout the literature review is the importance of family in the MA culture and its pivotal importance to the therapy of MA teens for problems common to many American adolescents today. Differences in language, generational status, socioeconomic level, and other individual and familial factors can greatly influence the circumstances and treatment specific for each MA teenaged client and his or her family.

REFERENCES

Adler, P., Ovando, C., & Hocevar, D. (1984). Familiar correlates of gang membership: An exploratory study of Mexican-American youth. *Hispanic Journal of Behavioral Sciences, 6,* 65–76.

Armbruster, P., & Fallon, T. (1994). Clinical, sociodemographic, and systems risk factors for attrition in a children's mental health clinic. *American Journal of Orthopsychiatry, 64,* 577–585.

Asarnow, J. R., Carlson, G. A., & Guthrie, D. (1987). Coping strategies, self-perceptions, hopelessness, and perceived family environments in depressed and suicidal children. *Journal of Consulting and Clinical Psychology, 55,* 361–366.

Belitz, J., & Valdez, D. (1994). Clinical issues in the treatment of Chicano male gang youth. *Hispanic Journal of Behavioral Sciences, 16,* 57–74.

Boles, S., Casas, J. M., Furlong, M., Gonzalez, G., & Morrison, G. (1994). Alcohol and other drug use patterns among Mexican-American, Mexican, and Caucasian adolescents: New directions for assessment and research. *Journal of Clinical Child Psychology, 23,* 39–46.

Brent, D. A., Perper, J. A., Moritz, G., Allman, C. J., Friend, A., Roth, C., Schweers, J., Balach, L., & Baugher, M. (1993). Psychiatric risk factors for adolescent suicide: A case control study. *Journal of the American Academy of Child and Adolescent Psychiatry, 32,* 521–529.

Castaneda, D. M. (1994). A research agenda for Mexican-American adolescent mental health. *Adolescence, 29,* 225–239.

Chapa, J., & Valencia, R. R. (1993). Latino population growth, demographic characteristics, and educational stagnation: An examination of recent trends. *Journal of Hispanic Behavioral Sciences, 15,* 165–187.

Chavez, E. L., Oetting, E. R., & Swaim, R. C. (1994). Dropout and delinquency: Mexican-American and Caucasian non-Hispanic youth. *Journal of Clinical Child Psychology, 23,* 47–55.

Cole, D. A. (1989). Psychopathology of adolescent suicide: Hopelessness, coping beliefs, and depression. *Journal of Abnormal Psychology, 98,* 248–255.

Delgado-Gaitan, C. (1993). Parenting in two generations of Mexican American families. *International Journal of Behavioral Development, 6,* 409–427.

Dreyfoos, J. G. (1990). *Adolescents at risk.* New York: Oxford University Press.

Dumont, R. H., Jacobson, A. M., Cole, C., Hauser, S. T., Wolfsdorf, J. I., Willett, J. B., Milley, J. E., & Wertlieb, D. (1995). Psychological predictions of acute complications of diabetes in youth. *Diabetic Medicine, 12,* 612–618.

Falicov, C. J. (1982). Mexican families. In M. McGoldrick, J. K. Pearce, & J. Giordano (Eds.), *Ethnicity and family therapy* (pp. 134–163). New York: Guilford Press.

Farberow, N. L. (1989). Preparatory and prior suicidal behavior factors. In *Alcohol, drug abuse, and mental health administration,* Report of the Secretary's Task Force on Youth Suicide, Vol. 2: Risk Factors For Youth Suicide (DHHS Publication NO. ADM 89-1622, pp. 34–55). Washington, DC: U.S. Government Printing Office.

Feldman, R. B., Zelkowitz, P., Weiss, M., Vogel, J., & Heyman, M. (1995). A comparison of the families of mothers with borderline and nonborderline personality disorders. *Comprehensive Psychiatry, 36,* 157–163.

Firestone, J. M., & Harris, R. J. (1994). Hispanic women in Texas: An increasing portion of the underclass. *Hispanic Journal of Behavioral Sciences, 16,* 176–185.

Flowers, R. B. (1988). *Minorities and criminality.* New York: Greenwood Press.

Garrison, C. Z., Addy, C. L., Jackson, K. L., McKeown, R. E., & Waller, J. L. (1992). Major depressive disorder and dysthymia in young adolescents. *American Journal of Epidemiology, 135,* 792–802.

Garrison, C. Z., Lewinsohn, P. M., Marsteller, F., Langhinrichsen, J., & Lann, I. (1991). The assessment of suicidal behavior in adolescents. *Suicide and Life Threatening Behavior, 21,* 217–230.

Goldman, D. A. (1994). The epigram computer program for analyzing mortality and population data sets. *Public Health Reports, 109,* 118–124.

Gondolf, E. W., Fisher, E., & McFerron, R. (1988). Racial differences among shelter residents: A comparison of Anglo, Black, and Hispanic battered women. *Journal of Family Violence, 3,* 39–51.

Guiao, I. Z., & Esparza, D. (1995). Suicidality correlates in Mexican-American teens. *Issues in Mental Health Nursing, 16,* 461–479.

Hampson, R. B., Beavers, W. R., & Halgus, Y. (1990). Cross-ethnic family differences: Interactional assessment of White, Black and Mexican American families. *Journal of Marital and Family Therapy, 16,* 307–319.

Herrera, R. S., & DelCampo, R. L. (1995). Beyond the superwoman syndrome: Work satisfaction and family functioning among working-class, Mexican American women. *Hispanic Journal of Behavioral Sciences, 17,* 49–60.

Holtzman, E. H., & Gilbert, L. A. (1987). Social support networks for parenting and psychological well-being among dual-earner Mexican American families. *Journal of Community Psychology, 15,* 176–186.

Keefe, S. E., & Padilla, A. M. (1987). *Chicano ethnicity.* Albuquerque: University of New Mexico Press.

Keefe, S. E., Padilla, A. M., & Carlos, M. L. (1978). The Mexican American extended family as an emotional support system. *Spanish Speaking Mental Health Research Center Monograph Series, 7,* 49–67.

King, S., & Dixon, M. J. (1995). Expressed emotion, family dynamics, and symptom severity in a predictive model of social adjustment for schizophrenic young adults. *Schizophrenia Research, 14,* 121–132.

Kliewer, W., & Lewis, H. (1995). Family influence on coping process in children and adolescents with sickle cell disease. *Journal of Pediatric Psychology, 20,* 511–525.

Knight, G. P., Cota, M. K., & Bernal, M. E. (1993). The socialization of cooperative, competitive, and individualistic preferences among Mexican American children: The mediating role of ethnic identity. *Hispanic Journal of Behavioral Sciences, 15,* 291–309.

Markides, K. S., Boldt, J. S., & Ray, L. A. (1987). Sources of helping and intergenerational solidarity: A three-generation study of Mexican Americans. *Journal of Gerontology, 41,* 506–511.

Martinez, C. (1986). Hispanic psychiatric issues. In C. B. Wilkinson (Ed.), *Ethnic psychiatry* (pp. 61–88). New York: Plenum Medical.

Meneese, W. B., & Yutrzenka, B. A. (1990). Correlates of suicidal ideation among rural adolescents. *Suicide and Life-Threatening Behavior, 20,* 206–212.

Mollerstrom, W. W., Patchner, M. A., & Milner, J. S. (1992). Family functioning and child abuse potential. *Journal of Clinical Psychology, 48,* 445–454.

Morales, A. T. (1992). Latino youth gangs: Causes and clinical intervention. In L. A. Vargas & J. Koss-Chioino (Eds.), *Working with culture: Psychotherapeutic intervention with ethnic minority children and adolescents* (pp. 129–154). San Francisco: Jossey-Bass.

Munsch, J., & Wampler, R. S. (1993). Ethnic differences in early adolescents' coping with school stress. *American Journal of Orthopsychiatry, 63,* 633–646.

National Center for Health Statistics (1991). *Monthly vital statistics report: Advance report of final natality statistics, 1989.* Hyattsville, MD: Author.

National Center for Health Statistics (1993). Advance report of final mortality statistics, 1991. *NCHS Monthly Vital Statistics Report, 42* (2, suppl.). Hyattsville, MD: Author.

Novy, D. M., Gaa, J. P., Frankiewicz, R. G., Liberman, D., & Amerikaner, M. (1992). The association between patterns of functioning and ego development of the juvenile offender. *Adolescence, 27,* 25–35.

Patton, W., & Noller, P. (1991). The family and unemployed adolescent. *Journal of Adolescence, 14,* 343–361.

Peck, D. L. (1987). Social-psychological correlates of adolescent and youthful suicide. *Adolescence, 22,* 863–878.

Perez, S. M., & De la Rosa Salazar, D. (1993). Economic, labor force, and social implications of Latino educational and population trends. *Journal of Hispanic Behavioral Sciences, 15,* 188–229.

Phipps, S., & Mulhern, R. K. (1995). Family cohesion and expressiveness promote resilience to the stress of pediatric bone marrow transplant. A preliminary report. *Journal of Developmental and Behavioral Pediatrics, 16,* 254–268.

Rait, D. S., Ostroff, J. S., Smith, K., Cella, D. F., Tan, C., & Lesko, L. M. (1992). Liver in a balance: Perceived family functioning and the psychological adjustment of adolescent cancer survivors. *Family Practice, 31,* 383–397.

Ramirez, O. (1989). Mexican American children and adolescents. In J. T. Gibbs, L. N. Huang, & Associates (Eds.), *Children of color: Psychological interventions with minority youth* (pp. 224–250). San Francisco: Jossey Bass.

Reddy, M. A. (1993). *Statistical record of Hispanic Americans.* Detroit, MI: Gale Research, Inc.

Rubenstein, J. L., Heeren, T., Housman, D., Rubin, C., & Stechler, G. (1989). Suicidal behavior in normal adolescents: Risk and protective factors. *American Journal of Orthopsychiatry, 59,* 59–71.

Rubin, C., Rubenstein, J. L., Stechler, G., Heeren, T., Halton, A., Housman, D., & Kasten, L. (1992). Depressive effect in "normal" adolescents: Relationship to life stress, family, and friends. *American Journal of Orthopsychiatry, 62,* 430–441.

Rudd, M. D. (1990). An integrative model of suicidal ideation. *Suicide and Life Threatening Behavior, 20,* 16–30.

Rueschenberg, E., & Buriel, R. (1989). Mexican American family functioning and acculturation: A family systems perspective. *Hispanic Journal of Behavioral Sciences, 11,* 232–244.

Sabogal, F., Marin, G., Otero-Sabogal, R., VanOss Marin, B., & Perez-Stable, E. J. (1987). Hispanic familism and acculturation: What changes and what doesn't. *Hispanic Journal of Behavioral Sciences, 9,* 397–412.

Sandoval, M. E., & De la Roza, M. E. (1986). A cultural perspective for serving the Hispanic client. In H. P. Lefley & P. B. Pedersen (Eds.), *Cross-cultural training for mental health professionals.* Springfield, IL: Charles C Thomas.

Soto-Fulp, S., & DelCampo, R. L. (1994). Structural family therapy with Mexican-American family systems. *Contemporary Family Therapy, 16,* 349–362.

Spirito, A., Overholser, J., & Stark, L. J. (1989). Common problems and coping strategies II: Findings with adolescent suicide attempters. *Journal of Abnormal Child Psychology, 17,* 213–221.

Strauss, M. A., & Smith, C. (1990). *Physical violence in American families.* New Brunswick, NJ: Transaction.

Swanson, J. W., Linskey, A. O., Quintero-Salinas, R., Pumariega, A. J., & Halzer, C. E. (1992). A binational school survey of depressive symptoms, drug use, and suicidal ideation. *Journal of the American Academy of Child and Adolescent Psychiatry, 31,* 669–678.

Texas Department of Human Services (1991). *Teen birth data and statistics in 254 Texas counties.* Austin, TX: The University of Texas, Center for Social Work Research, School-Age Pregnancy and Prevention Clearinghouse.

Torres, S. (1991). A comparison of wife abuse between two cultures: Perceptions, attitudes, nature, and extent. *Issues in Mental Health Nursing, 12,* 113–131.

U.S. Bureau of Census (1989). *The March 1988 current population survey.* Washington, DC: U.S. Government Printing Office.

U.S. Bureau of the Census. (1990). *The Hispanic population in the United States, March 1989* (Series P-20, No. 444). Washington, DC: U.S. Government Printing Office.

U.S. Department of Education, National Center for Education Statistics (1992). *Digest of education statistics 1992.* Washington, DC: U.S. Government Printing Office.

Vega, W. A., Patterson, T., Salis, J., Nader, P., Atkins, C., & Abramson, I. (1986). Cohesion and adaptability in Mexican and Anglo families. *Journal of Marriage and the Family, 48,* 857–867.

Ventura, S. J., Martin, J. A., Mathews, T. J., & Clarke, S. C. (1996). Advance report of final natality statistics, 1994: Monthly Vital Statistics Report, 44, supp. Hyattsville, MD: National Center for Health Statistics.

Vigil, J. D. (1988). Group processes and street identity: Adolescent Chicano gang members. *Ethos, 16,* 421–445.

Weidner, G., Hutt, J., Connor, S. L., & Mendell, N. R. (1992). Family stress and coronary risk in children. *Psychosomatic Medicine, 54,* 471–479.

Wyche, K. F., & Rotheram-Borus, M. J. (1990). Suicidal behavior among minority youth in the United States. In A. R. Stiffman & L. E. Davis (Eds.), *Ethnic issues in adolescent mental health* (pp. 323–338). Newbury Park, CA: Sage.

Yang, M. F., Tovey, S. L., Fogas, B. S., & Teegarden, L. A. (1992). Joint consequences of parental alcoholism and childhood sexual abuse, and their partial mediation by family environment. *Violence & Victims, 7,* 313–325.