

Commentary on Addressing Child Maltreatment by Infusing Multicultural, Feminist Tenets to Standard Clinical Approaches: The Cases of “Bashiir” and “Jaquann”

Working with Siblings in the Treatment of Traumatized Youth

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ABSTRACT

In their manuscript, “Addressing Child Maltreatment by Infusing Multicultural, Feminist Tenets to Standard Clinical Approaches: The Cases of ‘Bashiir’ and ‘Jaquann,’” Dr. Rachel Singer, Dr. Renee DeBoard-Lucas, and Dr. Milton Fuentes (2024) exemplified how clinicians can be cognizant and respectful of the many familial, socio-cultural, and systemic contexts that contribute to a client's difficulties and that must be considered for successful treatment. As such, they made relevant clinical adjustments to overcome possible barriers to treatment and to foster safe, culturally responsive therapeutic environments. In this Commentary, I propose another clinical adjustment, congruent with a multicultural feminist lens, that has the potential to be beneficial to families that face barriers to parental involvement in treatment: working with the sibling subsystem. While interventions with siblings have received minimal attention in the clinical literature, work with the sibling subsystem has the potential of benefiting individuals and families alike, particularly in the context of trauma-focused therapy with youth. To illustrate how clinicians can work jointly with siblings, I propose pivotal themes and junctures in therapy with Bashiir and Jacquann where sibling involvement may be beneficial.

Key words: sibling subsystem; refugee youth; African American youth; immigrant families; Posttraumatic Stress Disorder (PTSD); trauma-focused treatment; siblings in therapy; case study; clinical case study

INTRODUCTION

Using a multicultural, feminist lens, Dr. Singer and Dr. DeBoard-Lucas, the treating psychologists, met their respective clients, Bashiir and Jacquann, and their families with cultural humility and attention to the larger systems, socio-cultural context, familial factors, and intersecting identities that contributed to their clinical presentation and life experiences. They worked to share power in the treatment process, which allowed for co-creation of the therapeutic process, such that it more adequately met their client's needs. Their work was strengths-based

and exemplified the deliberate work of creating safe, culturally responsive therapeutic environments. This allowed their clients to benefit greatly from treatment. As such, I would like to start this Commentary by sharing my great respect for their clinical work and high regard for the multicultural, feminist lens that the three authors—Dr. Singer, Dr. DeBoard-Lucas, and Dr. Fuentes—shared with us readers in their manuscript: “Addressing Child Maltreatment by Infusing Multicultural, Feminist Tenets to Standard Clinical Approaches: The Cases of ‘Bashiir’ and ‘Jaquann.’”

As part of their work and congruent with a multicultural, feminist approach, the treating psychologists engaged in their own self-examination as therapists, which allowed them to approach the work with their clients from a higher level of cultural awareness. Their work invites us readers to reflect on our own intersecting identities and socio-cultural factors that impact not only the way we think about and interact with our fellow human beings, particularly those we serve in our professional capacities, but our reactions in reading Bashiir’s and Jacquann’s case. For me, this invitation serves as an opportunity to reflect on how my birth to middle-class parents in Rio de Janeiro, Brazil, in the mid-seventies during military dictatorship, intersects with aspects of my identity influenced by living in Puerto Rico, The Netherlands, and the continental United States growing up. My identity as a Latina cisgender woman who has resided in the United States for over three decades is connected to my professional identity as a psychologist practicing in the Washington D.C. area. My fluency in Portuguese, Spanish, and English, resulting from my transnational experiences, have allowed me to work extensively with immigrant and diverse populations, many of whom have a history of trauma, in various settings including non-profits, hospitals, community mental health clinics, and private practice. It is these intersecting identities, among others, that I bring to my work as a psychologist and to this Commentary.

OVERCOMING BARRIERS TO TREATMENT

In the cases of Bashiir and Jacquann the treating psychologists recognized and respected that parental involvement in their adolescent son’s treatment would need to be limited because of their work schedules. This type of structural barrier to parental involvement in treatment is prevalent in economically disadvantaged, ethnically underrepresented families (Yeh et al., 2003) as parents often work jobs that do not allow flexibility in their work hours (this was the case for Jacquann’s mom) and/or work multiple jobs allowing them little control over their work schedules (this was the case for Bashiir’s mom). In addition, many of the jobs that these families work do not afford them benefits, such as personal or sick leave, that they could use to attend therapy appointments. In response to this barrier, in both Bashiir’s and Jacquann’s cases, the treating clinician created a treatment plan that allowed their client to receive treatment despite limited parental participation.

In Bashiir's case, he initially received eight individual therapy sessions, during which time, Dr. Singer and the supervising team determined that Bashiir could benefit from group therapy with peers who were also immigrants from Somalia. In addition, Dr. Singer requested a family therapy session with Bashiir's parents to discuss issues related to his school attendance. In doing so, Dr. Singer was again met by structural barriers commonly present in the treatment of refugees (Abdi et al., 2022; Yeh et al., 2003), as it was challenging to reach his parents by phone. When she was able to reach Bashiir's parents, they requested to have Elders from their community attend the family therapy session. Instead of conceptualizing this as a barrier to treatment or denying their request because it does not fit Western models of who is included in the family therapy process, Dr. Singer welcomed the Elders to join. This resulted in a very helpful session where the Elders were able to find solutions to the family's childcare challenges, allowing Bashiir to attend school more regularly.

In Jaquann's case, Dr. DeBoard-Lucas, the treating psychologist, adjusted the delivery of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT; Cohen, 2012) in several ways to meet Jaquann's needs and his mother's limited availability to participate in his treatment. She conducted mainly individual sessions with Jaquann and updated his mom through email communication. Dr. DeBoard-Lucas also added modifications to the treatment to include focus on the client's experiences of discrimination and racism. Dr. DeBoard-Lucas was thoughtful about the fact that Jaquann's treatment would be interrupted by his upcoming three-month detention. As such, prior to his detention she worked on rapport and skill-building, as well as on preparing him for the detention. During the detention period, she maintained contact with him via email and after the detention she met with him and his mother jointly to help process the separation period and plan for the next phase of therapy. She waited to revisit past trauma until after the detention period when he was safely back home.

Dr. Singer's and Dr. DeBoard-Lucas' multiculturally attuned therapeutic adjustments to standard interventions helped their clients access and benefit from treatment. This type of adjustment to standard therapeutic interventions is exemplary of how clinicians can address barriers to treatment by being both cognizant of and respectful of the many socio-cultural, familial, and societal factors that contribute to client's difficulties and that must be considered for successful treatment. In this Commentary, I would like to propose another clinical adjustment, congruent with a multicultural feminist lens, that could be beneficial to families that face barriers to parental involvement in treatment: working with the sibling subsystem.

I will use the cases of Bashiir and Jaquann to anchor the discussion regarding working with siblings in therapy and to offer examples of how this could be done. The proposed interventions with the sibling subsystem in Bashiir's and Jaquann's cases are meant to inspire thought, dialogue, and research among clinicians working with traumatized youth on the possible benefits of working with the sibling subsystem, as opposed to being prescriptive.

WORKING WITH SIBLINGS IN THERAPY

A core principle in multicultural, feminist psychology is the idea that individual functioning is best understood in the context of the different systems within which the individual exists (David et al., 2014) and that interventions, when possible, should be systemic (Courtois, 2012). From this perspective, Bashiir and Jaquann's families can be understood as a system with two subsystems: the parental subsystem and the sibling subsystem. Bashiir's and Jaquann's individual functioning would hence be influenced by inter-system interactions or those between them and their parents, as well as intra-system interactions or those between them and their siblings. Likewise, interactions between their siblings and their parents, their siblings with each other, and the parents with each other, as well as interactions with extended family, would be considered important in understanding how the familial context influences Bashiir and Jaquann (Borkowsky, et al., 2002).

Using an ecological model (Bronfenbrenner, 1977) we can understand Bashiir's and Jaquann's sibling relationships within an even greater context than the microsystems described above (i.e., the family's subsystems and interactions between family members). These other systems would include: the neighborhood they live in, the schools they attend, cultural norms regarding sibling interactions, age, gender, and birth-order expectations, the influence of discrimination and oppression on sibling interactions, the threats to safety in the past and currently that have influenced sibling relationships, the parents' necessity to work long hours on the care-giving aspects of the sibling interactions, among many other levels of contextual influence on the sibling relationship (Whiteman et., 2011).

Sibling interactions have received minimal attention in the clinical and empirical literature, with a much greater focus placed on parent-child and marital interactions (Feinberg et al., 2012; Kramer, 2014; McHale et al., 2012; Milevsky, 2011). The available research does, however, support the notion that sibling relationships affect child/adolescent development (Bussell et al., 1999; Feinberg et al., 2012). In addition, intra-system and inter-system interactions are related to each other in families (Feinberg et al., 2012; McHale et al., 2012; Olivia & Arranz, 2005). In other words, interactions between siblings are related to the relationship between parents and between children and parents. As such, working with the sibling subsystem in therapy has the potential of positively affecting not only individual members, but also the entire family system (Bank & Khan, 1975; Feinberg, 2012; McHale et al., 2012).

The lack of attention to sibling interactions in the literature may be representative of Western values that place less emphasis on sibling relationships than other cultures (Bank & Khan, 1975). As such, giving attention to sibling relationships in therapy when working with clients from cultures where family relationships are a central value may be particularly

important. Likewise, working with the sibling subsystem within cultures where mental health is stigmatized can be beneficial as it takes away the focus from any one individual family member (Mak & Wieling, 2022).

The potential positive impact of working with siblings may also be particularly relevant in trauma-focused care. Trauma tends to impact the entire family either through direct impact on all members, through one member's trauma or posttraumatic reactions influencing other members, and/or through one member traumatizing other members (Figley, 1989). As such, if one sibling is suffering from effects of trauma, it is likely that other siblings are as well. In addition, how families cope with the challenges and stressors created by trauma impacts individual family members and how individuals cope with trauma impacts the family system (Kerig & Alexander, 2012; Johnson, 2019).

Family members may respond to trauma with differences along dimensions of nervous system arousal (i.e., hypo- versus hyper-arousal) and internalization versus externalization of distress (Kerig & Alexander, 2012). These differences can negatively impact relationships between family members creating another channel through which trauma continues to affect families both over time and over multiple generations (Kerig & Alexander, 2012; Sangalang & Vang, 2017). Given this reciprocal influence, taking a family systems approach to the treatment of trauma makes clinical sense (Figley, 1989; Kerig & Alexander, 2012; Johnson, 2019). When parental involvement in the therapy process is limited due to structural barriers, the clinician may consider working with the sibling subsystem to leverage the power of family support, increase positive relationships among family members and help the entire family through trauma-informed care.

Prior to engaging the siblings in therapy, the treating clinician would need to conduct a thorough assessment that would include not only information about the identified client (in this case Bashiir and Jaquann, in their respective cases), but also about the identified client's parents and siblings. It would be important for the clinician to gather information regarding siblings' interactions and family dynamics. The clinician should seek information regarding family and cultural norms that will help contextualize symptoms, as well as understand cultural and family norms regarding sibling interactions, especially as they relate to expectations based on gender, age, and birth order (American Psychological Association, 2017b; Updegraff, 2005). This information would help the treating clinician determine if working with the siblings would be clinically indicated and culturally congruent.

Therapists should carefully consider the relevant principles contained in the ethical codes governing their profession in thinking through the benefits and risks of including siblings in the therapy process (e.g., American Psychological Association, 2017a). In some cases, it may be deemed necessary for siblings to have their own therapist and therapy goals. The treating

therapists could then discuss the possibility of joint sessions with the siblings. Outlining clear therapy goals is advisable, as is going through the informed consent process with all participating family members, in an age-appropriate way.

WORKING WITH SIBLINGS IN BASHIIR'S CASE

Like many refugee families in the United States (Slobodin & de Jong, 2015), Bashiir and his family experienced traumatic events before, during, and after resettlement in the United States. Their experiences with civil war and instability in Somalia led them to flee their home country. In the process of doing so, they faced numerous and chronic threats to their safety and health at a refugee camp in Kenya where they resided for two years. Bashiir's experience upon resettlement in the United States did not free him and his family from experiences with violence and threats to their safety and well-being. Like many refugees in the United States (Frounfelker, et al., 2017), they resettled in a socio-economically disadvantaged community where violence is prevalent and where they face numerous daily stressors. In addition, their intersecting identities, including that of being Somali, Muslim, and first-generation immigrants, placed Bashiir at risk for racism, discrimination, and bullying, which he experienced at school (Scherr & Larson, 2009).

As a result of trauma and of the migration experience, refugee youth are at high risk for Posttraumatic Stress Disorder (PTSD); depression; and other emotional and behavioral difficulties (Bronstein & Montgomery, 2011; Fazel et al., 2005; Porter & Haslam, 2005). While Bashiir was referred to treatment due to frequent absenteeism from school, Dr. Singer determined through a thorough assessment that was attuned to Bashiir's experiences as a refugee that Bashiir was experiencing symptoms of PTSD. Given siblings have so many shared environments and experiences, it is clinically reasonable to assume that Bashiir's siblings were also at high risk for experiencing psychological distress as a result of their life experiences. Inclusion of siblings in the therapy process creates an opportunity for more immigrant youth to receive interventions to help prevent and/or address emotional distress that can often follow the migration experience (Bohnacker & Goldbeck, 2017). In addition, there is evidence that siblings in refugee families rely on each other for support as they navigate the challenges of being in a new country (Frounfelker et al., 2017). Clinicians can maximize this support by working with siblings jointly in therapy.

Since the migration experience inherently involves the separation from extended family, friends, and community, strengthening sibling relationships is particularly important. In the context of numerous losses, the connection to loved ones has the potential to serve as a protective factor (Bunn et al., 2022; Mak & Wieling, 2022). On the other hand, family relationships also have the potential to contribute to negative mental health outcomes for refugee youth when characterized by stress and conflict (Bunn et al., 2022; Frounfelker et al., 2017).

Given that refugee families face numerous stressors, not only because of the migration journey, but also because of the challenges associated with resettlement, working at a systemic level is important in helping family relationships be a source of resilience, as opposed to risk, for immigrant youth (Mak & Weiling, 2022). The inclusion of parents in family sessions may be ideal (Bunn et al., 2022), but when this is not possible clinicians can consider working with the sibling subsystem to help foster positive family interactions that are linked to strength and resilience.

Including Bashiir's siblings in therapy is also congruent with Somali culture where commitment to family is a strong cultural value (Suleiman et al., 2023) and where community interdependence is emphasized (Scuglik et al. 2007). A systemic approach is also aligned with the tendency of Somali families to approach any individual family member's problems as pertaining to the whole family. It can also help decrease stigma related to mental health, which is often a barrier to treatment for Somali families (Scuglik et al, 2007). Working with the sibling subsystem in therapy may also increase the effectiveness of family sessions with the parents. The therapist and the siblings can lay groundwork for the joint sessions with the parents.

Bashiir had six siblings, ages 1, 3, 4, 7, 11, and 14 years old. The youngest three may have been too young for therapy interventions without the presence of their parents. The 7-, 11-, and 14-year-old siblings, on the other hand, could potentially have been included in the therapy process. Given that I do not have information on Bashiir's siblings apart from their ages, I am going to propose potential ways in which Bashiir's siblings, ages 7, 11, and 14, may have been included in the therapy process.

As noted above, the inclusion of siblings in the therapy process is a clinical decision that bears consideration of multiple factors. A few additional factors to consider in Bashiir's case is his role as the oldest male sibling in the family and the gender of his other siblings, with focus on birth-order and gender-related expectations within the family system and sibling subsystem. The therapist would likely want to discuss with Bashiir how those roles may play out in the therapy setting. For example, it is possible that Bashiir could find it difficult to be vulnerable with his siblings given that he may want them to protect them and have them see him as a source of support for them. Should this be the case, the therapist would want to be respectful of these feelings and structure the therapy in a way that allows Bashiir to remain in his expected, culturally congruent role as the oldest male sibling.

Ellis et al. (2020) recommends addressing four core stressors in treatment with immigrant youth: isolation, trauma, acculturation, and resettlement. Following this recommendation, I will outline ways in which the inclusion of Bashiir's siblings in therapy could help address these stressors and facilitate some of Dr. Singer's treatment goals with Bashiir, which she outlined as: increasing attendance and engagement at school, reducing emotional dysregulation, identifying

resources to support the family system, and increasing positive coping strategies in response to trauma symptoms.

Initial Stages of Therapy and Isolation Stress

In the initial stages of therapy, the goal is to help the client feel comfortable with the therapy process and help establish trust between the therapist and the client. Given the therapeutic relationship emerges repeatedly in the empirical literature as a key factor to positive therapeutic outcomes (Lambert & Barley, 2001), Dr. Singer's investment in this process in early therapy was important. Dr. Singer noted that in the individual sessions Bashiir tended to be more reserved. The inclusion of Bashiir's siblings during the initial part of treatment may have helped Bashiir feel more comfortable with the therapy process, much like group therapy helped him feel more at ease and increased his engagement. In addition, the inclusion of siblings in the early stages of treatment may help address isolation stress, which so many immigrant youth face as a result of stigma and discrimination, as well as of limited support (Ellis et al., 2020). Siblings, given their shared environments, experiences, and overlapping identities, are in a unique position to provide support to each other, to understand each other's experiences, and to help each other as they face the challenges related to being refugees. This may be particularly true in families where parents must work long hours to financially support the family and older siblings provide care to younger siblings (Frounfelker et al., 2017).

Bashiir and his sibling(s) could play games together with the therapist, perhaps listen to songs they like, and engage in art together to help increase their level of comfort with the therapeutic process. From a strengths-based perspective, the therapist may invite conversation in this stage of treatment of how Bashiir and his siblings help and support each other. Siblings could be asked to share what they like most about each other or what they perceive to be their siblings' best qualities. Such interventions can help promote resilience and lower isolation stress by helping siblings build on their strengths, increase their connection to each other, as well as their sense of belonging in the family.

Traumatic Stress, Positive Coping, and Emotion Regulation

Trauma-focused treatment prioritizes, as the first phase of therapy, helping traumatized individuals increase their sense of safety in their lives, their relationships, and themselves (Herman, 2015; Cohen, 2012; Curtois, 2012; Harris, 2021; van der Kolk, 2014). In working with refugee youth, this work must include addressing socio-environmental stressors (Ellis et al., 2020). In Bashiir's case, Dr. Singer addressed such stressors by facilitating a session in which community Elders helped Bashiir's family find childcare support so that Bashiir could attend school more regularly. She also worked with his school counselor and increased his social support through participation in group therapy with other Somali immigrant youth. These interventions exemplify ways in which clinicians can take a socio-ecological approach to treating

immigrant youth as opposed to solely focusing on the treatment of posttraumatic symptomatology through psychological interventions with the individual. Linking the therapy to schools, other social service agencies, and family, peer, and community support can be imperative in increasing safety and stability in the life of immigrant youth (Ellis et al., 2020).

At an individual level, increasing a sense of safety is done in part by helping traumatized youth learn to observe and name their internal experiences (e.g., emotions, thoughts, and arousal) and regulate their emotions and nervous system, particularly in situations that trigger thoughts, feelings, and/or bodily experiences related to the trauma. Also critical is helping individuals develop and/or strengthen skills for managing painful and/or unwanted internal experiences and minimizing unhelpful responses to these, such as avoidance (Cohen, 2012; Harris, 2021). Psychoeducation is an important part of this treatment phase and can include helping clients understand the process of therapy, learn about trauma and the body's responses to it, as well as skills-based learning (Courtois, 2012). Utilizing a family systems perspective, we can understand that emotion dysregulation in one family member impacts others.

Bashiir and his siblings could have joint sessions in which they talk about what strategies they already use to help them in stressful situations and build on those strategies. They could learn from each other and from the therapist exercises that promote emotion regulation, self-soothing, and mindfulness of one's internal experiences. They could also practice these skills with each other in and out of session. Furthermore, work with siblings can not only help promote self-regulation, but allows for the opportunity for siblings to learn co-regulation, a process that has been emphasized in the parent-child clinical literature and that can also extend to siblings, especially in families where older siblings share care-taking responsibilities for younger siblings (Bank & Khan, 1975; Kramer, 2014). In a case study where three refugee children were jointly treated from trauma, the researchers found that siblings learned and imitated each other's coping strategies, highlighting the process of co-regulation that can happen between siblings (Bohnacker & Goldbeck, 2017). At this stage, the therapist could also slowly start to invite conversation about times of stress, conflict, or distress between the siblings, in the family, and at school. This could provide an opportunity to help siblings problem solve, support each other, and cope effectively with stressful situations, as well as with painful or unwanted emotional or somatic experiences that arise in the face of these situations (Courtois, 2012; Ellis et al., 2020; Herman, 2015).

Traumatic Stress: Construction of a Shared Narrative

In trauma-focused treatment, once clients have sufficient safety in themselves, their relationship, and their lives and can notice, name, and regulate their emotions and arousal states, a second phase of treatment can start. In this second part of trauma treatment, clients are encouraged to process past trauma more directly, to integrate past trauma into a cohesive life

narrative, and to relate to past traumatic events in ways that lower their impact. As such, a goal of this phase is for reminders of the traumatic events to no longer elicit overwhelming reactions (Cohen, 2012; Courtois, 2012; Gwozdziewicz & Mehl-Madrona, 2013). This phase generally involves some exposure work and, in many models, such as TF-CBT (Cohen, 2012) and Narrative Exposure Therapy (NET; Schauer et al., 2005), it involves the creation of a trauma narrative. In joint therapy with siblings, this invites the question of if and how a shared trauma narrative should be constructed.

Trauma narratives in most models of therapy are constructed through individual work with a therapist. For example, TF-CBT when delivered in a group format has each group participant work individually with a therapist on their trauma narrative (Deblinger et al., 2016). This is done to protect individual's privacy around the details of their trauma, as well as to prevent exposing children to the trauma of other children. In trauma-focused family therapy, caution is also employed in having family members jointly create a trauma narrative (e.g., Kerig & Alexander, 2012). Likewise, in NET—a model that has demonstrated effectiveness in treatment of refugees, in part because of its capacity to include numerous traumatic events which often characterize the process of migration—the trauma narrative is conducted individually with a therapist or in group formats where the ratio of therapist to group members allows individualization in trauma narrative work (Gwozdziewicz & Mehl-Madrona, 2013; Robjant & Fazel, 2010; Ruf et al., 2010; Schauer et al., 2005).

In addition, there is current debate in the clinical literature as to whether a formal component of exposure to past trauma is a necessary factor for successful treatment (Rubenstein et al., 2024), with some evidence that treatment can be effective even in the absence of a trauma narrative (e.g., Deblinger et al., 2011). Furthermore, for many clients who continue to experience trauma or significant resettlement stressors, reprocessing past trauma is not indicated (Courtois, 2012; Herman, 2015). In such situations, the focus of therapy remains in increasing safety, coping, and regulation. In the context of family therapy, there is also a focus on increasing positive relationships and support between family members.

Taken together these findings suggest that doing trauma narrative work jointly with Bashiir and his siblings would warrant significant caution and clinical consideration. Until more research is conducted on the use of trauma narratives in joint sibling therapy, as was effectively done in the case study by Bohnacker and Goldbeck (2017), it may be best for therapists to conduct trauma narrative work individually with family members or to adjust the task of creating a narrative in the context of families. For example, Kerig and Alexander (2012) suggest having family members write narratives that focus on the impact of trauma in their lives, as opposed to detailing the trauma itself.

Bashiir and his siblings could construct a shared narrative about their strengths as a family, highlighting each individual family member's strengths. This narrative could be facilitated using art, toys, poetry, storytelling, movement, or a combination of all these methods (Ruf et al., 2010). While this narrative would not be intended to help family members process past trauma, it has the potential to change the meaning of those events by helping family members connect with their strengths. Such interventions may lead to cognitive reappraisal of traumatic events, which has been linked with a decrease in posttraumatic symptoms (Boden et al., 2012).

Acculturative Stress and Resettlement Stress

Another area of work that would likely be beneficial to Bashiir and his siblings would be talking about the process of adapting to a new culture. This process is best referred to as "cultural negotiation," as opposed to the acculturation, to account for its nonlinearity, for its ongoing, fluid, and context-dependent nature, as well as for the diverse ways in which immigrants negotiate creating multiple identities that encompasses more than one culture (Bhatia & Ram, 2001). Research suggests that stress related to cultural negotiation is linked to mental health difficulties in Somali immigrant youth (Lincoln et al, 2016), as well as in refugee youth from other countries (Revollo et al., 2011; Suarez-Morales & Lopez, 2009).

Stress related to cultural negotiation appears to be, at least in part, related to differences in how family members engage in the process of adapting to new culture (Telzer, 2011). For example, in qualitative interviews with Somali Bantu youth, Frounfelker et al. (2017) found that stress and parent-child conflict was related to parents perceiving the youth as rejecting the customs of their native culture. Youth refugees, on the other hand, expressed pressure to take on the host country's culture to fit in with peers and protect themselves from discrimination and bullying. They expressed guilt and stress in disappointing their parents, as well as hesitation to share with their parents their reasons for taking on the customs of the host culture, out of fear that this would further upset their parents who were already tasked with so many resettlement challenges of their own. While these differences led to strains in the parent-child relationship, it fostered closeness between siblings as they leaned on each other for understanding and support, with older siblings often serving as mediators between younger siblings and their parents (Frounfelker et al., 2017).

Work with Bashiir and his siblings could facilitate conversation about what the process of cultural negotiation is like for themselves, for their parents, and for other family members. This type of conversation can help promote greater understanding between the siblings and potentially between the siblings and their parents. This type of work has the potential to lower acculturative stress not only for individual family members, but within the family system itself. Likewise, conversations about how family members' intersecting identities impact their experiences at

school and with peers could also be helpful to Bashiir and his siblings. The therapist could help Bashiir and his siblings support each other and problem solve how to manage some of the stress and challenges that come along with the process of cultural negotiation, both inside and outside of the home. For example, they could talk about ways to handle bullying at school and ways to talk to their parents and to school staff about their experiences. This type of work with siblings can also prime conversations for family therapy sessions in which parents are able to participate.

WORKING WITH SIBLINGS IN JAQUANN'S CASE

Jaquann, a 15-year-old African American male, has two younger siblings who live with him and his mom. Since the age of his siblings is not contained in Jaquann's case study, I will base my suggestions for their inclusion in treatment as if they are school-aged or older. In addition, I will make treatment recommendations based on the assumption that Jaquann and his siblings share the same mother and father and have lived together since birth. Additionally, I will make treatment suggestions that are based on the following: 1) a thorough clinical interview with Jaquann and his mom that determined the clinical appropriateness of sibling inclusion; 2) the decision to include siblings having been made in collaboration with Jaquann and his mom; and 3) that all family members agreed and provided consent.

TF-CBT With Siblings

Given that Dr. DeBoard-Lucas utilized TF-CBT (Cohen et al., 2012) as a treatment model in Jaquann's case, the question arises as to whether TF-CBT can be adjusted to include joint sibling work. In this research-supported treatment model, siblings are not seen jointly, but rather are seen individually by a therapist and in conjoint sessions with one or more parents or caretakers (e.g., Deblinger et al., 2017; Thornback & Muller, 2015). A case study conducted with a refugee mother and her three children successfully adapted TF-CBT such that treatment was provided jointly to the three siblings, with participation of their mother in accordance with the TF-CBT protocol. After 18 treatment sessions, all three siblings no longer met criteria for PTSD (Bohnacker & Goldbeck, 2017). Additional studies are needed to replicate this finding and to extend TF-CBT to treat siblings jointly.

The successful extension of TF-CBT to group format indicates that, at least under certain circumstances, TF-CBT can be successfully delivered to more than one child/adolescent at a time, with added benefits such as peer support, de-stigmatization of trauma, opportunities to practice skills with peers, a larger number of children accessing treatment, and cost-effectiveness (Deblinger et al., 2016). Working jointly with siblings in TF-CBT could lead to some of these same benefits. The extension of TF-CBT to include joint work with siblings would need to address the issue of if and how to implement the trauma narrative portion of the treatment (Bohnacker & Goldbeck, 2017). The discussion above regarding the creation of a trauma narrative with Bashiir and his siblings may also be relevant here.

While working with siblings jointly in trauma-focused work has potential to be very beneficial and may have been applicable in Jaquann's case, there are many other ways in which working with the sibling subsystem can occur in the process of therapy. Attachment based therapies, such as Emotionally Focused Family Therapy (EFFT; Johnson, 2019), offer a helpful framework to working with the sibling subsystem in the treatment of youth, as it helps the therapist attune to attachment themes and needs. Using such a framework, I will propose two key points in Jaquann's treatment where the inclusion of his siblings could have been beneficial in addressing attachment themes: in preparation for his departure to a three-month detention and upon his return home.

Preparation for Detention

Jaquann and his siblings faced separation from their father due to his incarceration. Separation from a parent due to parental incarceration can be very difficult, if not traumatic, and is related to negative mental health outcomes for children and adolescents (Eddy & Reid, 2003; Morgan-Mullane, 2017; Murray & Murray, 2010). From an ecological perspective, parental incarceration places children at risk for numerous types of intersecting traumas due to the multiplicity of ways that incarceration affects children and families (Arditti, 2005), including placing youth of incarcerated parents at greater risk for incarceration themselves, as was the case for Jaquann (Roettger & Swisher, 2011). From an attachment perspective, parental incarceration is seen as a major and traumatic disruption to the parent-child relationship that can impact children's sense of security and their related attachment strategies (Murray & Murray, 2010).

At the time Jaquann started therapy, he was preparing for yet another separation from a parent due to being mandated to serve a three-month sentence at a juvenile detention center after being found guilty of possession of an unregistered firearm, the same charge that led to his father's incarceration. Through a multicultural and systemic lens, we can understand Jaquann's upcoming detention as a second forced parental separation related to being a Black male in a society characterized by systemic and structural racism that causes and perpetuates trauma and oppression through its criminal justice system (Braveman et al, 2022; Roettger & Swisher, 2011). Through an attachment lens, we can see this separation as a key event that can be worked on in therapy to help minimize its negative impact on Jaquann, his siblings, and mother.

Dr. DeBoard-Lucas was attuned to Jaquann's feelings regarding his upcoming detention and appropriately adjusted therapy to allow space to help Jaquann process his feelings and prepare for the upcoming separation from his mother, siblings, extended family, friends, home, school, and daily life. Joint session(s) with Jaquann and his siblings at this juncture in therapy could allow the siblings to talk about and prepare for this upcoming separation. The therapeutic goals here would include providing the siblings space to share with each other their thoughts and feelings about the separation, allow them to emotionally prepare for the separation, and discuss

strategies to help them cope while they are apart. The use of art, games, and music could be used to facilitate this work, with the therapist taking cues from Jaquann and his siblings, their ages, personalities, relationships, dynamics, history, culture, and broader context in regard to what interventions to utilize. For example, siblings could have made a drawing for Jaquann to take to the detention center with him. Jaquann could have selected a song that the siblings could listen to in his absence to remember that he would be back. The siblings could also have worked on a count-down calendar that they could use to mark down the days to Jaquann's return. This work could also have been extended to include a session with their mother, if possible.

Conversations about their father's incarceration may have emerged during sibling sessions related to Jaquann's upcoming detention as the two events bear resemblance. Here there could be numerous points of interventions to minimize the psychological impact of Jaquann's upcoming detention on him and his family.

For example, the therapist could help Jaquann and his siblings with the similarities and differences of this detention from his father's incarceration. While Jaquann's father had been detained for several years and did not maintain much contact with the family, Jaquann would be back home after three months and would maintain as regular contact as possible with his mom and siblings. The therapist could create space here for Jaquann and his siblings to talk about their experience of parental separation and for grief work. This work would be trauma-informed and the therapist would need to make sure that Jaquann and his siblings were able to talk about this without experiencing overwhelming emotions or nervous system activation. Should that happen, the therapist could help Jaquann and his siblings use strategies to help reduce autonomic nervous system arousal and increase emotion regulation. The therapist could also help shift the focus of the therapy session to the family's present experiences so as not to re-process trauma without the groundwork necessary to safely do so.

These types of intervention with the sibling group would be congruent with the first phase of TF-CBT treatment, which focuses on stabilization and skills building, and which Dr. DeBoard-Lucas was already working on with Jaquann (Cohen, 2012). As noted earlier, possible benefits of joint sibling interventions is the opportunity for siblings to support each other, learn from each other, and practice learned skills together, as well as to be able to co-regulate (Kramer, 2014; Bohnacker & Goldbeck, 2017).

Return From Detention

A joint sibling session may also have been helpful in the reunification process. Return from detention is a transitional and vulnerable time for youth and best navigated with increased support at different systemic levels (Anthony et al., 2010). Dr. DeBoard-Lucas conducted a joint session with Jaquann and his mom to help in this transition. A joint session with Jaquann and his siblings (and his mother if possible) could also be helpful in providing additional support to

Jaquann and his siblings in his return home. Such sessions would allow siblings space to talk about what the period of separation was like for them, to normalize challenges that may arise in adjusting to being together again and to problem-solve through these challenges, if necessary, as well as to increase positive relationships between the siblings.

A few topics that the therapist can be attuned to here would include shame around incarceration, fears related to future incarcerations and/or separations, cognitions and emotions around the detention, and posttraumatic experiences related to the incarceration/separation (Anthony et al., 2010). From an attachment lens, this work fosters connection and support after a period of forced separation, aiming to reestablish a sense of safety and belonging in the family system.

CONCLUSION

Siblings are an integral part of families, yet they have been neglected from the clinical literature, with little attention given to working jointly with the sibling subsystem in the therapy process (Feinberg et al., 2012; McHale et al., 2012). The shared environments of siblings, their numerous interactions, as well as their enormous potential to be a source of support for each other and to foster a sense of belonging, places siblings in a unique position to facilitate positive outcomes in the therapy process, especially when parental involvement is limited. The potential positive outcomes of working jointly with siblings may be especially relevant when treating traumatized youth as trauma affects the entire family system and is best healed in the context of safe and caring relationships (Johnson, 2019).

Work with siblings may also be particularly relevant in treating youth from cultures where the importance of family is emphasized (McHale et al., 2005, McHale et al., 2007). Finding the therapeutic power of siblings in the therapy process also allows us to expand our clinical horizons as we continue to move away from Western, individualistic models of treatment to those embedded in ecological, systemic, multicultural and feminist theories, such as the treatments Dr. Singer, Dr. DeBoard-Lucas, and Dr. Fuentes generously shared with us through their case studies of Bashiir and Jacquann.

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