Increasing Cultural Connection with Hispanic and Latinx Clients: Understanding the Cultural Needs of the Hispanic and Latinx Client

Highlights & Key Concepts

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Summary Ideas:

Cultural competence includes:

- an awareness of ourselves and of the individual we are working with.
- asking crucial questions that will help us discover our client's perspective.
- skills to know how to modify treatment interventions to increase efficacy.
- striving to overcome any challenges by potentially using the client's strengths.

Commonly shared identity characteristics for Hispanic and Latinx community members:

- Spanish language
- Cultural ideal of *personalismo* (personal contact)
- *Simpatia* (social engagement, charm)
- *Familismo* (familialism or collectivism)
- *Machismo* (manliness) and *marianismo* (womanliness)

Culture-related protective and risk factors for Hispanic and Latinx communities include:

- *Familismo* or the importance placed on family cohesion, closeness, and kinship networks.
- Acculturative stress which is experienced differently by different generations.
- Legal status issues; family separation due to immigration; issues of loss and trauma due to the immigration process.
- Loss of status in the community and loss of self-esteem due to undocumented immigrant status.

Cultural implications for practice with members of Latinx/Hispanic communities include:

- Some may be open to a holistic treatment experience involving spirituality and physical health treatment.
- Many community members are likely to trust a professional, follow their recommendations, and believe in the positive impact of mental health treatment.
- Hispanics and Latinos may describe symptoms of depression as feeling tired, having changes in their sleeping or eating patterns, or feeling nervous and restless.
- Hispanics and Latinos are more likely to believe that their symptoms are caused by external environmental, spiritual, or personal problems.
- Hispanics and Latinos are less likely to endorse a biological etiology of depression and mental illness, and they tend to view medication as addictive and harmful.
- Many may prefer counseling over medications.

Questions & Responses:

Q1 ***How did you bring this cultural aspect of care into your work and career? Or was it always present?***

A1 Often those of us that ended up in this field, sometimes we are chosen a little more than we volunteer. Early in my career, I was working in child welfare, and they needed somebody to speak on the Hispanic population, and I happened to be the only bilingual worker there. Even though I was a brand-new social worker, they tapped me on the shoulder because, as we know, often if you are from a population that is underrepresented, then you are expected to speak on behalf of that population and educate others. My grandparents are from Guadalajara, Mexico. My father was the first person actually born here. All of my aunts and uncles and cousins are immigrants. I grew up in a community that was 99% Hispanic and Evans is my married name. I began to realize more and more how important it is that the individuals that we serve have a voice. I dedicated my dissertation for my doctorate in social work to looking at ethnocultural empathy, which is literally what impact does the understanding of discrimination and oppression have in that ability to show empathy for someone who has been oppressed and discriminated against and is subject to stigma and bias every day? I recognize in our therapeutic services, without that understanding, we can't move forward, you know, and so that's just kept me going and it just really has provided a lot of meaning for me.

Q2 ***How does culture and attention to it affect therapeutic relationships?***

A2 Culture is the values, beliefs and norms of an individual. When you feel that someone understands what's important to you, your beliefs, and they accept them without challenging it, and they understand your norms, even though they might be different than everyone else in your community, that creates connection. And research shows that helps individuals stay in treatment and complete treatment. Because without that, people don't feel their clinician knows them, and they will prematurely drop out of treatment. I really believe it is the center of all therapeutic relationships and rapport.

Q3 ***What is a common misconception about culture that can lead to inequities in care?***

A3 So often we go to cultural competence trainings, and we believe that that's the end of the conversation— "I learned about Latinos. They like their families, a lot of them are religious, there you go." And so now I'm working with my client here who must love their family and go to church every week. And when there's something different, you don't hear it, you can't accept it, you have a hard time integrating it, or you end up pathologizing it. "Well, obviously, this is a Hispanic individual who is living out here in Seattle, while the rest of their family lives way out in Chicago. Obviously, there's something pathological about that." But if I see the exact same choices with a client who is a Caucasian individual, I might think, "This person values independence, how healthy." And so often that's where we can miss things, by thinking that by understanding the general kind of stereotypes we can apply those therapeutically when, in essence, it is really the individual. We can learn a lot about the

culture. But at the end of the day, we have to focus on the individual. And we have to realize that the majority of the impact of culture is actually about ourselves.

Q4 ***What about forms needed to access benefits, services, programs - the census, for example - that ask about race and ethnicity?***

A4 I do not have power over the U.S. Census, but I do have power over my organization. And so, looking at my organization's demographic forms: just saying it's always been like that and there's nothing we can do is not acceptable. In other words, making sure your organizations know how it feels to identify as someone that might be mixed race or might not be represented on your forms—that it's incredibly isolating and alienating. I think part of our work as social service providers is to challenge that. I was working with a kid the other day and we had one of those forms that I was helping him with. We had a conversation about his identity. I take the form as an opportunity to talk about what their identity is. I consistently fight against the "fit everybody in one box on the demographics forms" and I always express my discomfort with that—it's not acceptable today.

Resources:

- National Hispanic and Latino MHTTC
- Book: ¿Quiénes somos y de dónde venimos? A Historical Context to Inform Mental Health Services with Latinx Populations
- Addressing Latinx Health Disparities in the U.S.
- U.S. Census Bureau QuickFacts

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