Clinical Applications of

CULTURAL ELEMENTS

When Working with Hispanic and Latino Populations

TRAINER'S GUIDE

National Hispanic and Latino

MHTTC

Mental Health Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

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The National Hispanic and Latino MHTTC recognize the complexities associated with gender and ethnic identification. With the intention of both facilitating a fluent reading of the text and supporting an inclusive and respectful language, this document uses terms that are linguistically neutral and inclusive of diverse gender groups and identities. In this document, we also use the term Latinx to encompass ethnic identity as well as non-binary gender identification.

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Institute of Research, Education, and Services in Addiction (IRESA)

The Institute of Research, Education, and Services in Addiction (IRESA) of the Universidad Central del Caribe leads the National Hispanic and Latino MHTTC. The Center serves as a national subject matter expert and a key resource for the workforce and communities seeking to address mental illness prevention, treatment, and recovery support to reduce health care disparities among Hispanic and Latino populations across the United States and its territories. In partnership with state and local governments, mental health providers, consumers and family organizations, Hispanic stakeholders, Substance Abuse Mental Health Services Administration (SAMHSA) regional administrators, and the MHTTC Network, the Center seeks to accelerate the adoption and implementation of mental health-related evidence-based practices.

National Hispanic and Latino Mental Health Technology Transfer Center

The mission of the National Hispanic and Latino Mental Health Technology Transfer Center is to provide high-quality training and technical assistance to improve the capacity of the workforce serving Hispanic and Latino communities in behavioral health prevention, treatment, and recovery. We disseminate and support the implementation of evidence-based and promising practices to enhance service delivery, promote the growth of a diverse, culturally competent workforce, and bridge access to quality behavioral health services. We are committed to increasing health equity and access to adequate culturally and linguistically grounded approaches.

The School-Based Mental Health Project (SMH)

The School-Based Mental Health Project (SMH) of the National Hispanic and Latino MHTTC works specifically with schools, organizations, and professionals to strengthen their capacity to provide culturally and linguistically responsive school mental health services. This initiative facilitates training, technical assistance, and capacity-building efforts led by experts in the field. Our goal is to increase awareness to attend to Latino students' mental health needs, promote the implementation of school mental health services that are culturally appropriate, encourage the use of promising and evidence-based practices, and disseminate information on practical strategies and implementation efforts of mental health services within a cultural context.

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INTRODUCTION
of Trainer Guide

Trainer Orientation

This guide was prepared by the National Hispanic and Latino Mental Health Technology Transfer Center. The goal of this guide is to increase the awareness and abilities of mental health care providers in their use of cultural elements by promoting the use of culturally appropriate formulations when treating Latinos with mental health disorders. This guide is informed by current research findings on the impact of cultural factors on the assessment and treatment of mental health disorders and on therapeutic relationships.

Culture is an enduring element, a tradition that is embedded in every human thought, emotion, and behavior. Culture is an element that is often complex to assess as it is ever changing as societal norms change. However, culture is the key factor that upholds normed belief patterns that maintain physical and psychological health as well as contributing to the tenacity of mental health disorders. This guide was developed for mental health care professionals interested in learning how to integrate the patient's cultural traditions and beliefs into effective clinical treatment with Hispanics and Latinos.

Goals and Objectives of this Training

Overall Learning Goal: To develop knowledge and skill in formulating culturally informed mental health assessments and treatment plans for Hispanic and Latino clients.

Objectives: Participants who complete the "Clinical Application of Cultural Elements for Hispanic and Latino Populations" training will be able to:

1) Distinguish culturally responsive approaches in mental health treatment.
2) Demonstrate knowledge, ability, and skill in formulating a culturally informed mental health treatment plan.
3) Identify Latino cultural syndromes upon symptom presentation when assessing mental health.
4) Identify risks of misdiagnosing.
5) Demonstrate knowledge and application of culturally informed therapeutic strategies to effectively engage Hispanic and Latino clients in mental health treatment.

Trainer's Knowledge, Skills and Abilities

Ideally, the leader facilitating this training should have the knowledge, experience, abilities, and skill to teach mental health care professionals and paraprofessionals. The ideal trainer should have the following minimum requirements:

1) Training, experience, and skills in professional presentations and training seminars in Latino mental health;
2) Ability to establish a teaching alliance with professional and paraprofessional audiences of varying health care disciplines;

3) A working knowledge of cultural responsiveness in mental health;
4) Direct clinical experience assessing and treating Hispanic and Latino clients with a variety of mental and behavioral disorders;
5) Ability to reflect and verbalize insight into one's own cultural development and identity;
6) Ability to identify and verbalize the impact that transference and countertransference has on the therapeutic relationship;
7) Knowledge of and experience in using the DSM-5 Cultural Formulation Interview and related diagnostic outline;
8) Knowledge of the impact that racism, prejudice, discrimination, and oppression have on individuals and on the collective psyche of Hispanic and Latino communities;
9) Some familiarity with the Spanish language, common Latino idioms, and expressions of grief and sorrow, joy and anger, and fatalism and resilience.

Trainer's Competencies

The delivery of successful training will highly depend on the trainers' knowledge and comfort with the subject matter. Trainers should have the following competencies:

1) A master's or doctoral degree with clinical licensure in social work, clinical psychology, marriage and family therapy, or in allied disciplines such as public health, nursing and psychiatry;
2) Experience and skill in providing individual, family, and group psychotherapy to Latinos and Hispanic populations in a variety of settings;
3) Experience providing professional training and clinical supervision to mental healthcare practitioners;
4) Clinical expertise in assessing and treating post-traumatic stress related to Latino immigration, acculturation, and assimilation;
5) Demonstrated experience in facilitating group discussions on sensitive issues related to race, ethnicity, gender and other matters of diversity.

Trainers must be familiar with and adhere to all laws and codes of ethics that govern professional conduct in mental health care. More than one trainer may be useful in delivering the material to large groups or to groups that need additional opportunities for application, as the co-trainer can help facilitate activities, provide additional examples of application, and provide support to the trainer and the audience.

Audience Considerations

This training is designed to benefit mental health care professionals, paraprofessionals and the general healthcare workforce who assess and treat Hispanic and Latino populations. This training includes knowledge and materials to provide an interactive experience for an audience to both learn and apply new skills during the training session.

It is recommended that training groups are large enough for small group interaction, yet small enough for participants to have an opportunity to engage and feel comfortable in sharing their lived experience. This training may be adapted to larger groups, if necessary, by adjusting application exercises to the size of the group. Ideally, participants will have at least a general knowledge of working with Hispanic and Latino individuals with mental health and co-occurring disorders.

The trainer should maintain an awareness of the comfort level of the group when discussing issues of culture with minority populations, and in discussing their own cultural identity development. The trainer should also be sensitive to the potential for conflict of ideas when discussing delicate issues of race, prejudice, gender, discrimination and oppression. Trainers should model a positive, empathic, and respectful attitude during the training. The trainer should maintain professionalism and an openness to sharing both experiences of success and of failure in order to demonstrate a model of lifelong learning and lifelong development as a culturally competent mental health care professional.

The trainer must gauge the comfort and experience level of the audience and adapt the training when necessary. The trainer may want to simplify clinical terms to make conceptualizations easier to understand [e.g. unconscious vs beyond awareness] or provide additional explanation by utilizing de-identified case material to provide application opportunities. Application exercises are provided within the training materials; these can be used to facilitate discussions with the audience in order to gauge their understanding of the central tenets of each module's lesson plan. High audience specificity and learner-centered teaching will lead to better retention of information, promote development of skills, and make training much more meaningful to the participants.

Using the Trainer Guide

This guide includes instructions for presenting five (5) modules on culturally responsive approaches. Each module is designed to be delivered over a 60-minute time period. This time may be impacted if the group is larger or less experienced and needs additional time for application. The modules are designed and best delivered in the sequential order listed, however, they may be offered independently as standalone teaching plans or blended with other training efforts.

Learning Approach

Trainers should remember that participants are coming to the training with various levels of skill, knowledge, and experiences with cultural diversity. Career minded adults seeking professional development may have different educational goals than graduate students still in school. Research demonstrates that adult students have different expectations and needs for engagement in the learning process (Taylor & Parsons, 2011). They typically arrive on time, are more prepared to receive instruction; they take copious notes, complete all assignments, and they contribute to the learning environment by asking questions, engaging the instructor and actively participating in class discussion. Adult students generally enjoy a more meaningful learning experience. Malcolm Knowles' Andragogy Model (Knowles, et al., 2011. p.63) focuses on the six assumptions of adult learning. This includes the following concepts:

Adults Need to Know

Adults need to know why a skill is going to be helpful to them before they can fully engage in the learning process. Understanding the value of the task being learned guides learners in realizing for themselves the difference between what they know and what they should know.

Self-Concept

Once adults accept that they are responsible for their own learning, they have a need to be viewed as able to be self-directed. An optimal environment allows for trainer/learner collaboration in the formation of new knowledge for all participants.

Prior Learning Experience

Adults typically have valuable prior learning experiences that may complement their formal education and training. Understanding that the trainer is not all knowing, and that participants can contribute equally to the learning environment is critical for helping learners construct new knowledge, develop increased problem-solving abilities, and elevate self-confidence and success.

Readiness to Learn

Timing is very important in learning, as adults learn best if they have a need to know. In professional development environments, many of your participants may be voluntary and want to increase their knowledge on a certain topic; however, others may be attending in order to gain Continuing Education Units for licensure. Relating information to each participant's discipline or field experience can be important in helping them understand and appreciate the need for high professional standards in delivering culturally competent mental health care.

Learning Orientation

Adults learn to recognize what they already know, what they need to know, and where to access that information through collaborations and group discussions. Especially in professional environments, professionals who are only exposed to one way of thinking may believe that it is the only and best way of going about task accomplishment. Exposure to other ways of thinking can increase understanding of competence and stimulate innovative thinking.

Motivation to Learn

Adults are motivated to learn best when personal goals, interests, attitudes, and beliefs are internally developed by the learner. Designing application exercises to meet the personal goals of the learners can have a positive effect on retention of material.

Knowles suggested multiple approaches for adult learning. A few relevant recommendations for adaptation for adult learners in a professional training are:

1) Prepare students by providing an overview of the course, encouraging participation, and by developing realistic and relevant objectives of the course.

2) Create an environment that is respectful of each person, and that encourages students to take responsibility for their learning, and where they can collaborate with others to construct learning.

3) Involve participants in planning the session, if possible, by discussing training objectives and how the group will work to achieve them.

4) Help participants consider their own objectives in completing the course by asking them what they hope to achieve, and by providing them with experiential opportunities, and opportunities to use prior knowledge to investigate an issue and collaborate with others to share knowledge and experience.

5) Involve participants in the evaluation of their learning experiences by discussing what has been accomplished and next steps that the participants want to take after the training is complete.

Discussion Method

Interactive discussions during professional training allow participants to become involved and interact with the material to synthesize, analyze, and apply prior learning with new learning. One of the most effective discussion methods is the Socratic Method. This is a manner of discourse which is geared to foster critical thinking by focusing the conversation to provide students with questions, not answers. The trainer should model an inquiring mind that aims to create logical reasoning with the constructed knowledge. This method is ideal with adult participants learning about culture as it allows each person to arrive at his or her own conclusion based on his or her experience, while also respecting the experience and reasoning of other participants. This is based on an understanding that all participants have an equal contribution to provide to the learning community. A Socratic questioner should keep the discussion focused, further the discussion through the addition of knowledge from multiple sources, stimulate the discussion with questions, periodically summarize what has and what has not been resolved, and attempt to have as many participants contribute to the discussion as possible.

Activities

Opportunities for application are offered in a variety of methods in this training. These activities are designed to allow each participant to apply what has been learned and to collaborate with others to continue building shared knowledge collaborate actively and be involved in insuring that each participant knows what the task is, and offer help as required based on the needs of the audience.

Adaptation

This training is designed to be adapted to a variety of different audiences and settings. Each module can be adapted to meet the needs of audiences working in specific fields by providing information on local demographics and resources. The training may also be adapted for larger or smaller audiences by making changes in activities or in time spent in specific areas of the training. Trainers are encouraged to use multiple modalities when offering this training (video, photos, resources) to increase the value to participants, and to allow participants with special learning needs to gain the most benefit from the training. The MHTTC network provides technical assistance and training support for trainers wishing to adapt this guide.

Training Space

A comfortable, well-lit training space can significantly enhance a participant's learning experience. Trainers should try to provide a space that will be large enough for the intended audience, with sufficient supplies required for activities. Arrange chairs for each session in a manner that allows each participant to see the primary speaker, but to also see and interact with each other during small group interactions and discussions. It is important that the training space is in an area that is away from high-traffic areas and distractions. The trainer should also assess the acoustics of the room to ensure that he or she has appropriate audio equipment, if necessary.

Equipment and Materials

It is recommended that the training area be as far in advance as possible to avoid technical problems, and to allow enough time to correct any problems, if necessary. Equipment such as a projector and computer are necessary to share PowerPoint slides. Microphones and other audio equipment may be necessary, depending on the size of the room and the size of the audience. Trainers should anticipate having audience members who may have diminished hearing abilities; using audio equipment ensures that all participants will be able to adequately hear the presentation. Additionally, trainers should practice using the audio equipment to ensure that he or she knows how to maximize its use.

Use of Materials

Each module includes slides and trainer notes to guide the discussion. It also includes in-depth resources to provide the trainer with background knowledge. The presentation is not a script but is designed to provide a cohesive flow through all the content required to provide the training. The audience and trainers should be encouraged to add their own prior learning, experience, and questions to the session to maximize the learning experience.

PowerPoint Slides and Handouts

PowerPoint Slides are included in this manual for each module. The slides may be formatted as a handout and distributed in paper format if desired. The slides are intended as points for discussion.

Training Structure

This guide is organized into five (5) modules. These modules may be presented in five one-hour modules, or in one five-hour training. These modules include:

1) Module 1: Hispanic and Latino Populations
2) Module 2: Cultural Case Formulation and Assessment using the DSM-5 Cultural Formulation Interview
3) Module 3: Considering Culture in the Assessment and Diagnosis of Mental Health Disorders with Hispanic and Latino Populations
4) Module 4: Developing Culturally Centered Interventions
5) Module 5: Engaging and Treating Hispanic and Latino Clients

Module 1: Hispanic and Latino Populations

Module One: Specific Preparation

Resources

Trainers should review the training guide before presenting, it may be helpful to have available in print or digital copy during the presentation at the trainer's discretion.

Presentation Instructions

This training guide provides a summary of the relevant information needed to deliver the training. References are also provided. The trainer should read the training material to gain a comfort level in presenting the information. The slides are provided in the same order that the material is given, and some notes are provided to guide the discussion during the presentation.

Handouts

Please refer to Appendix A for handouts associated with this module.

PowerPoint Slides

The trainer may distribute PowerPoint slides to the audience before the training if desired.

Trainer Tip

The training should be adapted to the length based on the audience's needs. The goal of this training is to provide an overview of specifics of Hispanic and Latino populations, and to provide education about common practices of individuals who self-identify as Hispanic or Latino or Latinx. It is not intended to promote stereotyping or profiling of these populations. A trainer should maintain an open mind to the many distinct types of experiences that Hispanic and Latino persons have had in their assimilation and acculturation process. A trainer that models this attitude that all perspectives are equally valid will avoid engaging in conflictual discussion as to the "right" way to understand Hispanic and Latino populations.

Module Agenda and Timeline (1 hour)

SAMPLE AGENDA

09:00 – 09:05	Welcome and Overview of Goals and Objectives
09:05 – 09:40	Session Presentation
09:40 – 09:55	Application Activity and Discussion
09:55 – 10:00	Summary/Conclusion

Welcome and Overview of the Session

Welcome participants to the training and thank them for attending. Introduce yourself and your relevant background working with Hispanic and Latino populations and other diverse cultures. Describe your experience working in mental health care, and your clinical experience assessing and treating mood disorders, trauma, substance use and other clinical issues. If appropriate, allow other individuals involved in the training to introduce themselves, including co-trainers and hosts. This is a good strategy and technique for the leader to establish subject matter expertise, establish the teaching and training alliance, and identify and understand the audience is training needs and level of experience.

Familiarize the participants with the training space by providing housekeeping information including the location of bathrooms, break rooms, and designated smoking areas. If the training session is longer than one hour, mentioning when breaks will be taken may be appropriate. Typically, breaks should be given to adult audiences every hour and a half. You may add other topics as appropriate. Also, invite participants to silence their phones or other electronics, and invite them to leave the room if they need to take a call.

Transition to the beginning of your session by stating, “While we all have opinions and perspectives of what culture is, as professionals it is important that we recognize that all perspectives are valuable. In this training, I invite you to share your experiences with the group.” Discuss if you would like individuals to offer their thoughts and questions as they have them, or if you would prefer if they waited until question-and-answer periods at the end of each section.

If you are training on Modules 1-5 on the same day, refer participants to the training agenda. Review the agenda, and state that the trainers will discuss Module 1: Hispanic and Latino Populations, Module 2: Cultural Case Formulation and Assessment using the DSM-5 Cultural Formulation Interview, and Module 3: Considering Culture in the Assessment and Diagnosis of Mental Health Disorders with Hispanic and Latino Populations before the mid-day break, and that Module 4: Developing Culturally Centered Interventions and Module 5: Engaging and Treating Hispanic and Latino Clients will be discussed after the mid-day break. This division of the modules provides a natural break between foundational assessment and diagnosis modules and the treatment planning and intervention adaptation modules. Ask if there are any questions about the agenda or coordination.

You may encourage participants to review their training materials, which should include a Trainer Guide and Participant Guide with slides. These materials contain everything they will need to facilitate training in the future.

Please note that copies of the training materials are available upon request from the National Hispanic and Latino Mental Health Technology Transfer Center and will be available at the Center’s website at: National Hispanic and Latino MHTTC | Mental Health Technology Transfer Center (MHTTC) Network (mhttcnetwork.org)

Goals and Objectives

Module Goal:

This module will provide a description of Hispanic and Latino populations and their mental health needs.

Module Objectives:

1) Participants will be able to identify elements that make up Hispanic and Latino populations.

2) Participants will be able to describe stereotypes that individuals within Hispanic and Latino populations have regarding mental health services.

3) Participants will be able to identify the strengths and challenges of the cultural norms of Hispanic and Latino populations.

Hispanic and Latino Populations: Context and Needs

In this section, you will review demographics of Hispanic and Latino populations to gain a greater understanding of their context and mental health needs. This will prepare the practitioner to provide Latino-centered culturally sensitive assessments and interventions.

Definitions: Cultural Norms, Culture, Hispanic and Latino

When considering the impact of culture on Hispanic and Latino populations, the definition of these concepts is important. A provider showing sensitivity and knowledge of ethnic diversity when assessing and treating clients of diverse cultures and traditions is said to be culturally competent.

Hispanic, Latino or Latinx?

According to the Merriam Webster Dictionary (Miriam-Webster, 2020), Hispanic and Latino mean the same thing, however, much more commonly the word Hispanic refers to people and things that have a connection to Spain. More commonly, Latino refers to people and things that have a connection to Latin America. The U.S (United States) Census Bureau (2010) defines the ethnicity of Hispanic or Latino as referring to "a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race." The Bureau does not define the two words differently. The U.S. Census Bureau considers Hispanic and Latino ethnicity. Per this census, Hispanic and Latino persons most commonly self-identify as being from the White race this has been changing in more recent years. The number of Latinos who say they are multiracial has increased dramatically. More than 20 million Latinos identified with more than one race on the 2020 census, up from just 3 million in 2010. This may be due in part to changes made in race questioning in the 2020 Census as well as an increase in those who identify as other races and changes in demographics. The second most common race is Native American or indigenous populations. Hispanic ancestry is considered connected to European ancestry (i.e. Spain). Therefore, Hispanic/Latino ancestry is defined solely as an ethnic designation. However, many individuals define Latino as geographic, which means that they have descended from Latin American countries, while Hispanic is commonly related to language, meaning someone coming from a Spanish-speaking country. Some individuals prefer to be called Latino, while others may prefer Hispanic, or prefer being titled with their nationality, such as Mexican or Cuban. Your client may feel differently about the definition, depending on the area of the country that you are in and the specific citizenship and generation of the individuals that you are interacting with. A client's ethnic designation contributes to their personal and collective identity and significantly contributes to the client's metaphorical expression of emotions, grief, and sorrow.

Latinx is a gender-neutral label that emerged during 2004. Data suggest that the term was developed by the LGBTTQ community as a way have a gender-neutral cultural identity. The dearth of literature regarding the significance of this emerging label for a large segment of the U.S. population has created a knowledge gap within higher education. While it may not be possible to pinpoint the exact time and place the term emerged, it appears to have been born out of the LGBTQIA community in the U.S. to resist the gender binary.

In terms of self-identification, a survey from the Pew Research Center found that while about one-in-four Latinos are aware of the term Latinx, just 3% say they use it to describe themselves, a share that is similar across all major demographic subgroups. The survey also found that the term is more commonly used among younger individuals and those with college degrees (Pew, 2020).
Providers of mental health care should be aware of these terms and provide a safe space to have a conversation with clients about self-identification. Furthermore, organizations should reflect the diverse identifications of individuals in their documentation.

Ambiculturalism
We call this cultural fluidity, or polymorphous cultural identity, ambicultural behavior. Latinos choose which cultural identity and preferences they display in various ecological cultural niches, such as the workplace, at home, schools, etc.

Hispanic and Latino Populations and the Needs for Services

The effective provision of services to underserved populations requires multiple strategies. Due to the breadth of diversity within Hispanic and Latino populations, identifying appropriate or needed services can be difficult. In addition to having a wide variety of representatives from different countries, there can also be differences among the national subcultures. However, similarities do exist. Some of the similarities across the different nationalities within the Hispanic culture include:

1) Use of the Spanish language;

2) Importance of family and religion in daily life;

3) Traditional gender roles;

4) Protocol in social relationships which can frequently be more elaborate than in casual mainstream America; and the

5) Personal nature of relationships, even business ones.

Even though there are similarities, individuals may be vastly different. They may hold positions, which vary from the commonly understood cultural similarities of the group. This is an important consideration as you assess your client’s cultural needs. While consideration of cultural similarities is essential, it is equally important to guard against the perpetuation of stereotypes.

When assessing the national origin and ethnicity of your client, there are a few general demographic questions that may help you assess your client’s acculturation and assimilation into a minority or majority culture. These questions include:

1) What part of the general population is Latinx (both number and percentage)?

2) Which Latinx subcultures are significantly present (e.g., Cubans, Mexicans, Puerto Ricans, Central or South Americans?)

3) In which neighborhoods do Latinos live? Are they concentrated in certain areas or counties?

4) To what extent are they literate in Spanish and English (consider verbal as well as written skills)?

5) What assistance are they now receiving and how have these programs reached them?

6) To what extent are Latinos with disabilities in your client's area getting needed services?

7) Do gaps in services in your area exist and if so, why?

The answers to these questions range from simple statistical data to more subjective responses. The purpose in gathering this information is to ascertain gaps and the reasons for them.

Statistical data are available from several sources:

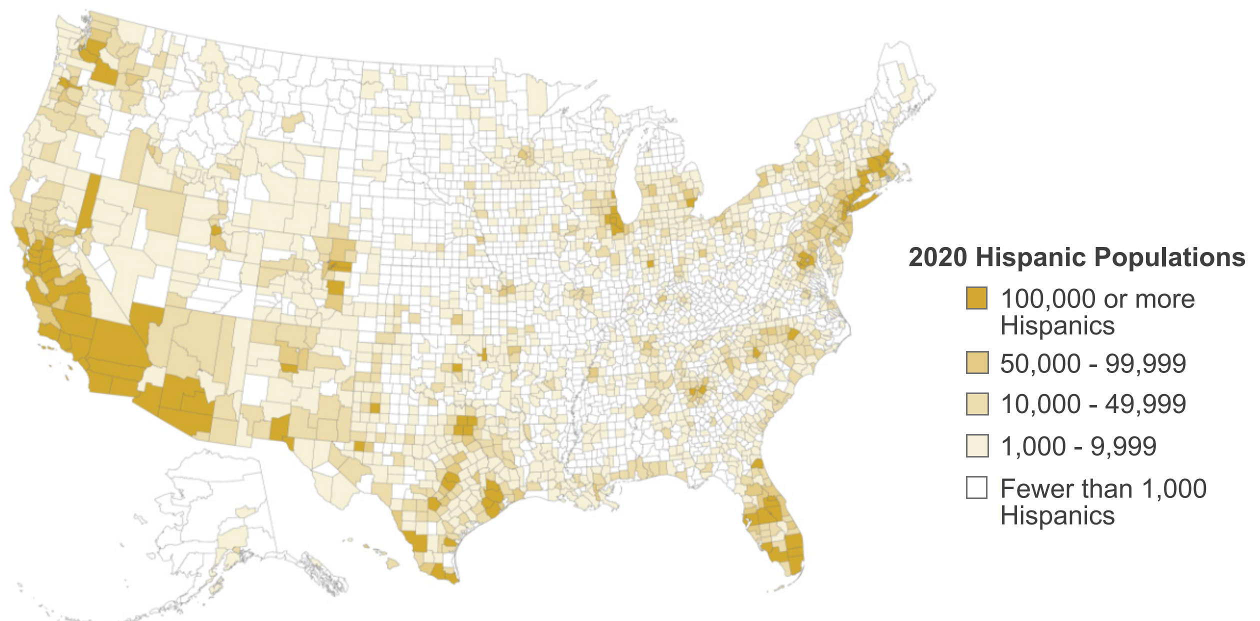
1) Statistical Abstract of the United States published annually by the U.S. Census Bureau provides information on a national level. Contact the U.S. Department of Commerce Census Bureau, Public Information Office (301-763-4040), or http://www.census.gov/compendia/statab/

2) State-level data can be found in the State Data Center Program Book, available from the State Data Center Program, Bureau of the Census (301-763-1580), or http://www.census.gov/sdc/

3) For area-specific information the County and City Data Book is available from the U.S. Printing Office (301-763-4100), or http://www.census.gov/statab/www/ccdb.html

Below, you will see the distribution from the most recent census of Hispanic or Latino Populations as a Percent of the Total Population by State: 2022. This information is informative regarding the amount of support that your client may be able to receive from family and culturally appropriate services. Hispanic Population by State 2022 (worldpopulationreview.com)

Table 1: Pew Research Center: Hispanic Population Growth and Dispersion Across U.S. Counties, 1980-2020 | Pew Research Center https://www.pewresearch.org/hispanic/interactives/hispanic-population-by-county/



Hispanic Population by State 2022 (worldpopulationreview.com) | https://worldpopulationreview.com/state-rankings/hispanic-population-by-state

The success of this approach can vary with the nationality but considering the answers to these mezzo questions can help you identify acculturation and assimilation concerns that might impact the client in his environment. Latinos with strong cultural ties to the community will be more effective spokespersons, while a Latino person who is a minority even within the Latino neighborhood may experience more discrimination. Additionally, when considering the services needed, the availability of interpreters, bilingual professionals, and funding also impact the capabilities of programs to successfully serve this population.

Hispanics and Latinos by Country of Origin

Although the term Hispanic and Latino is broad, each nationality has its own history of prejudice, discrimination, and oppression. Each nation has specific reasons why its people may immigrate to America. Below (Table 2) are the numbers regarding the Latino population, based on nationality.

Table 2: Hispanic origin groups in the U.S., 2021

Hispanic origin groups in the U.S., 2021

Origin group	Population	% among all U.S. Hispanics	% change 2010-2021
U.S. total	**62,530,000**	**100%**	**23%**
Mexican	37,235,000	59.5	13
Puerto Rican	5,800,000	9.3	24
Salvadoran	2,475,000	4.0	35
Cuban	2,400,000	3.8	28
Dominican	2,395,000	3.8	59
Guatemalan	1,770,000	2.8	53
Colombian	1,400,000	2.2	46
Honduran	1,150,000	1.8	57
Spaniard	995,000	1.6	43
Ecuadorian	815,000	1.3	25
Peruvian	720,000	1.2	20
Venezuelan	660,000	1.1	172
Nicaraguan	455,000	0.7	19
Argentinean	295,000	0.5	26
Panamanian	240,000	0.4	37
Costa Rican	190,000	0.3	44
Chilean	190,000	0.3	35
Bolivian	130,000	0.2	15
Uruguayan	65,000	0.1	9
Paraguayan	30,000	0.0	42
Other South American	40,000	0.1	62
Other Central American	30,000	0.0	1
All other Latinos	3,050,000	4.9	96

Notes: Hispanic origin is based on self-described ancestry, lineage, heritage, nationality group or country of birth. Population rounded to nearest 5,000. Listed in descending order of population size; differences between ranks may not be statistically significant. Rankings and percentages based on unrounded populations.
Source: Pew Research Center calculations based on the 2010 and 2021 American Community Surveys (U.S. Census Bureau).
PEW RESEARCH CENTER

Source: Pew Research Center 2019 Facts about U.S. Latinos for Hispanic Heritage Month | Pew Research Center https://www.pewresearch.org/fact-tank/2022/09/23/key-facts-about-u-s-latinos-for-national-hispanic-heritage-month/ft_2022-09-23_hispanickeyfacts_04/

Many Latin American immigrants have undergone significant political strife, poverty, and oppression in their home countries. Historical and social subgroup differences may impact the needs of immigrants. Central Americans may need mental health services due to political trauma experienced in their home countries. Puerto Rican and Mexican American children and adults may be at a higher risk than other immigrants due to their lower educational and economic resources. Immigrants who have arrived recently and who are adapting to life in the United States may have different stressors than long-term immigrants. Many of the individuals who are listed above may not have ever lived in a Latin American country but may be first- or second-generation immigrant that continues to speak Spanish and follow other cultural norms at home. Lastly, each nationality may have different strengths and weaknesses. For instance, Puerto Ricans have citizenship and therefore can access many services available to all United States citizens. Although Mexicans may or may not have citizenship, they may have strong cultural support and, because of their numbers, may have family or others in their community who share many cultural similarities who may support them. Immigrants who have experienced differing levels of political strife and oppression may have varying perceptions as to the availability of government support (Samson, 2014. p.489). These factors may impact the experience and values of Hispanic and Latino clients.

Beliefs and Stigma Held by Hispanics regarding Mental Illness, Substance Use Disorders, and Treatment

Mental illness is culturally defined. What is pathological in one culture (psychosis, hearing voices) may be spiritual in another (hearing the voice of God to serve). Mental illness is experienced differently based on an individual's cultural upbringing, family traditions, and beliefs about morality, health, illness, and cure. For instance, individuals from Hispanic and Latinos cultures tend to experience depression in the form of vague somatic complaints such as backaches, headaches, and stomach aches. Latino clients report changes to their sleeping or eating patterns. They may state that they feel "nervous" (nervioso) and "restless" (inquieto). Depending on the specific nationality, the cultural explanation of illness can vary. Latinos may believe that physical symptoms are more serious than mental health symptoms (Kouyoumdjjian, Zamboaga & Hansen, 2003). Latinos are more likely to believe that their symptoms are caused by outside environmental factors such as catching a cold in rainy cold weather. For many Latinos, depression is caused by loss of soul, substance use is caused by moral conflict, and trauma is caused by susto (fright). Latinos are less likely to endorse a biological etiology of depression and mental illness. Latinos are inclined to view psychotropic medication as addictive and harmful. Therefore, many Latinos prefer counseling over medications (Cooper et al., 2003; Givens et al., 2007; Karasz & Watkins, 2006). This is an important cultural element that supports the fact that Latinos engage and respond positively to psychotherapeutic interventions, especially family therapy, given Latinos' socio-centric nature.

Racial disparities in the use of mental health care are evident at all levels of services. Although there is evidence of a lack of access to care and to funding for care, often there are also differences in treatment preferences and in beliefs about mental health care that may pose challenges to effective treatment. There are multiple factors involved in the decision to seek help for mental health problems. One primary component is the individual's belief about the natural course of mental disorders and the effectiveness of treatment. These beliefs may be influenced by the availability of services or the perceived use of those services, or they may also be influenced by cultural beliefs (Anglin, Alberti, Link & Phelan, 2008).

Spirituality is the sine qua non of understanding the Latino psyche. Some Hispanic and Latino cultural groups believe in spiritual causality of emotional and psychological suffering ("why is God punishing me?" "What have I done to deserve my sorrow?"). Their troubles may be attributed to moral conflicts, guilt and shame over poor judgment, punishment from God for one's ancestors' indiscretions, or simply fatalism ("no hay otra vida" "Es mi destino"). These beliefs make it more likely that Hispanic and Latino individuals may seek spiritual or other healers as a first step in seeking help for their symptoms. Thus, it behooves the provider to understand, appreciate, and integrate in assessments and treatment plans the role that prayer and popular saints (Santos del Pueblo) have in managing mental illness and co-occurring disorders. Due to a cultural emphasis on "familismo" (familism), Latinos are more likely to seek help from someone that they know first such as a trusted family member, grandparents, a close relative, godparent, or a trusted priest from the local parish. When Latinos reach out to a professional, they are most likely to do so from someone they know and respect, such as a schoolteacher or long-time family doctor.

Myths Related to Mental Health Disorders

Hispanic and Latino individuals tend to be relational, family-centered, and sociocentric which can be a strength and a challenge in the assessment and treatment of mental illness and co-occurring disorders. A person who has harmed his family because of his mental illness and substance use may feel alienated and struggle to access resources due to sociological barriers. However, if his

agrees to provide support this may be a great resource. Often, Hispanic and Latino families struggle to understand the function and process of treatment for mental illness, primarily because they may not understand depression and co-occurring disorders are in fact illnesses deserving of compassion and support. Symptomatic behavior may cause the individual to become involved with local police, Court, Immigration and Customs Enforcement (ICE), and mandated social services, which may put the entire family at risk of deportation if the patient is undocumented.

Compared to White non-Hispanic patients, individuals from ethnic minority groups tend to avoid medication due to a belief that they are addictive, and are more likely to seek psychotherapy (Cooper, Gonzales, Gallo, Rost, Meredith, Rubenstein, Wang & Ford, 2003; Dwight-Johnson, Sherbourne, Liao, & Wells, 2000). However, while Hispanic and Latino patients may have positive beliefs about psychotherapy or individualized mental health treatment, they are less likely to seek treatment as they believe that mental health problems will improve on their own. Although differences in illness beliefs and treatment preferences may impact service delivery, the literature does not demonstrate that it is significant enough to explain all the racial disparities in the use of mental health care (Hunt, Sullivan, Chavira, Stein, Craske, Golinelli, Roy-Byrne, Sherbourne, 2013). Other considerations such as access to treatment, transportation, time, health insurance, and others must be taken into consideration.

Overall, once an individual is in treatment and has built a therapeutic rapport with a culturally responsive service provider, the individual will be more likely than his White counterparts to follow recommendations due to the respect given to professionals with perceived power and education. This can be a strength in meeting client outcomes.

Concepts Related to Cultural Sensitivity with Hispanic and Latino Populations

There are several key concepts that mental health care providers need to know when delivering culturally responsive services. Ongoing evaluation of these concepts will allow the provider to assess the impact of one's culture on the therapeutic process.

Culture

Culture as it is used in this training is defined as a system of enduring traditions that govern beliefs about health and illness, courtship and family composition, child rearing practices, intergenerational expressions of grief and suffering; and meaning making ability through music, ritual, spirituality and religion. Culture gives meaning to all aspects of one's lived experiences. Cultural traditions are so strongly ingrained psychologically that one may be unaware of the impact on daily life.

Cultural Humility

Cultural humility is the bedrock of developing a strong multicultural orientation and reflects the focus and title of this book (Hook et al., 2013). Cultural humility involves an awareness of one's limitations in understanding a client's cultural background and experience. Cultural humility also involves an interpersonal stance that is other-oriented rather than self-focused regarding the cultural background and experience of the client. The culturally humble therapist is interested in and open to exploring the client's cultural background and experience. The culturally humble therapist does not assume their cultural perspective is "the correct one;" rather, the culturally humble therapist recognizes that there are several valid ways of viewing the world and developing a sense of one's beliefs and values Cultural competence in mental health is defined as having appreciation, knowledge, skill, and experience to effectively assess and treat individuals and families from another ethnic or racial group different from the practitioner. (DiAngelis, 2015)

Goal of Cultural Humility Training

The goal in developing cultural humility in mental health practice is to be able to effectively assess and intervene with ethnically and racially diverse clients; to assist them to understand mental health issues and engage culturally sensitive therapeutic services to improve their therapeutic outcomes. Developing an understanding of the client's culture while also remaining aware of individual differences is integral to providing culturally competent care.

Cultural Competence

An **awareness** of ourselves and of the individual. Our knowledge of others occurs through our ongoing assessments. Many traditional psychological theories are particularistic rather than universal. Most traditional instruments were normed on dominant group participants, reflecting a worldview as well as a particular social context (Trickett, Watts, & Birman, 1994). Those individuals who more closely fit specific demographics will perform differently than those who deviate from them. Therefore, part of the assessment process must include an assessment of cultural factors that may affect how theories interact with the client's perspective.

Each individual dwells in a system of traditions, beliefs, rituals, and customs which is internalized, and in so doing contributes significantly to a personal and cultural identity formation. Problematic behaviors grow out of this system, and specifically from the individual's adherence to its values and principles. Latino clients can be assisted to learn and gain perspective by appropriately examining their cultural beliefs about health and illness, grief and sorrow, happiness and sadness, and the cure for their emotional and mental infirmities, i.e. therapy. We can enhance positive responses to mental interventions by incorporating these cultural beliefs and practices in the psychotherapy of Latino clients.

Accurate knowledge of a client's acculturation status gives us the opportunity to provide services in a way that the client will feel the most comfortable, and it increases the likelihood that they will continue with services upon discharge.

Cultural competence consists of **knowledge**: Providers need to have the knowledge of how to ask crucial questions that will help us discover the perspective of our client. It has been said that culture is like skin; it is only noticed when it is rubbing up against someone else's.
Lastly, cultural competence consists of skills: Providers need the skills to know how to modify our treatment interventions to increase efficacy. Once the assessment information is compiled, the provider can change specific interventions and behaviors to provide the client with the services that best fit his or her needs.

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Although this intention is commendable, training providers in becoming competent in various cultures presents the risk of stereotyping, stigmatizing, and othering patients and can foster implicit racist attitudes and behaviors. Further, by disregarding intersectionality, cultural competence trainings tend to undermine provider recognition that patients inhabit multiple social statuses that potentially shape their beliefs, values and behavior. To address these risks, we propose training providers in cultural humility, that is, an orientation to care that is based on self-reflexivity, appreciation of patients' lay expertise, openness to sharing power with patients, and to continue learning from one's patients (Luka, Pahl and Fuller-Lewis, 2020).

Health Disparities

The concept of cultural competence is linked to the movement to reduce health disparities. Health disparities are differences between groups of people that may impact individual access to health care. These health disparities may exist due to lack of funding, lack of ability to understand and communicate health information, or cultural factors which impact the beliefs and values of the receipt of healthcare. Mental health and substance use stigma or stereotypes held by treatment providers or clients can affect the delivery of services. Increasing cultural competence is designed to reduce health disparities by identifying specific cultural norms, values, and behaviors of the client, provider, and service system that impact the receipt of services.

Immigration Patterns

A concept that influences the cultural values and beliefs of Hispanic and Latino persons in immigration patterns. Immigration in this case, is when individuals move from their native country to the United States. Immigration changes the relationship between a Latino person and their environment. Latinos born in the United States and those with long-term residence have higher rates of mental illness, compared to recent immigrants. Additionally, higher rates of substance use are found among non-immigrants, when compared to immigrants (Grant, Stinson, Hasin, Dawson, Chou, and Anderson, 2004). The only ethnic group that has not demonstrated an increase in mental health issues compared to non-immigrants are Cuban Americans.

Immigration is frequently a source of stress for the family and the individual. Individuals who have immigrated frequently experience family dislocation and separation for a period of weeks to years. Individuals who have traveled without legal documentation have frequently been exposed to elevated levels of stress and may have been victims of abuse or manipulation. Immigrants may have suffered from poverty, discrimination, and oppression in their home country, thus prompting their immigration. Immigrants may experience decreased self-efficacy, low social interest, and a sense of alienation and feelings of vulnerability. This acculturative stress has a lifelong influence on the immigrant's psychological adjustment, decision-making abilities, occupational functioning, and physical and mental health (Smart and Smart, 1995). This leads to increased vulnerability to mental health and substance use disorders.

In addition to individual stress, immigrants may experience family discord as each family member acculturates to the new country at a different rate. Immigrant parents may experience a sense of role reversal when their more acculturated children participate as a translator in adult transactions. Additionally, children may not be able to communicate effectively with parents due to a lack of fluency in the language and diverse cultural beliefs and values. The family may or may not be aware of the stress on the family, and there may be differences in their comfort in talking about their immigration experience demonstrates that immigrants are often isolated due to a lack of health insurance, lack of knowledge of available services, and few Spanish-speaking providers.

Acculturation, Assimilation, and Biculturalism

Acculturation is the process in which members of one cultural group adopt the beliefs and behaviors of another group. Acculturation is mostly concerned with the individual and how he or she relates to his or her own group as a subgroup of the larger society. The acculturation process within Latino populations has been linked to fatalistic thinking and cultural distance, which may contribute to a sense of alienation and isolation. Many immigrants perceive acculturation as a negative experience which impacts their sense of identity (Bhugra & Becker, 2005. p.18).

Assimilation is the incorporation of one cultural group into another as evidenced by changes in language preferences and in changes in cultural values and attitudes. Assimilation is a

one-directional version of acculturation, in which only one side changes to fit into the other. Assimilation requires the individual or group to give up their cultural norms to be able to actively participate in the common society (South, Crowder, & Chavez, 2005. p.498).

More evidence has been available regarding the benefits of biculturalism. This is when an individual can retain the positive attributes of both cultures, and where diversity of beliefs and values are valued by the community. Bicultural Latinos are less likely to experience depression (Miranda and Umhoefer, 1998). Biculturality emphasizes the strengths of both cultures and does not require that the individual eliminate any elements of his identity.

Elements of Hispanic and Latino Populations that Impact Clinical Treatment

Hispanic and Latino populations bring many strengths, as well as challenges, to the treatment experience. Culturally responsive mental healthcare tries to overcome any potential challenges, hinderances to therapeutic interventions using the client's strengths.

Latinos' Cultural Strengths
Many Latinos have dedicated support systems in their family who are willing to attend relevant appointments and otherwise support the client. Some Latinos may also wish to involve a folk healer (curandero) and other holistic treatments. This may allow for holistic treatment experience. If a positive rapport is developed, Latinos are more likely to trust a professional and follow recommendations. Research has demonstrated that Latinos are more likely to believe in the positive impact of mental health treatment than their White counterparts. (Kouyoumdjjian, Zamboaga & Hansen, 2003).

Challenges
In addition to strengths, there are several challenges that clinicians may face when working with Latino populations. Stigma related to mental health and mental health treatment is one of these. Many Latinos only go to the doctor when something is wrong and when pain is unbearable (Rivera-Ramos & Buki, 2011). Latinos are more likely to seek help from a medical professional than a psychologist or psychiatrist due to the stigma associated with receiving mental health treatment. Latinos are more likely to see medical professionals as authority figures and are less likely to overtly disagree or express discomfort with a plan of action. As many Latinos hold the cultural ideal of "personalismo", they expect personal contact with the provider who is diagnosing and treating their condition. They may also expect more self-disclosure than non-Latinos (Bernal & Enchautegui-de-Jesus, 1994). If this does not occur, they may feel that they are not receiving diligent care and may prematurely terminate treatment.

Application - Case Example

The following is a case example designed to apply the concepts discussed in this module. Present the case, and then use the following questions to conduct either small or large group discussions about the case.

A report was received by the state Child Protective Services department regarding Gabriela and John. Gabriela is a 24-year-old Spanish-speaking Mexican woman who immigrated to the United States 6 months ago after she married John. John is a 43-year-old bilingual Mexican man who has lived in the United States for over 25 years and who is a United States citizen. A report was made by the police reporting that John had slapped Gabriela in front of her 4-year-old son, Samuel. Samuel is Gabriela's son from a previous relationship; she is also four months pregnant.

John and Gabriela met two years ago when John went to visit his family in Mexico, where he was introduced to Gabriela. He reports that he went to Mexico specifically to find a wife. He had previously been married to a Puerto Rican woman for 18 years but divorced. He has two children, ages 12 and 14, from this relationship, whom he has visitation with on a weekly basis. John owns a construction business and his house. John has a history of depression and alcohol use, but the specifics of his current use are unknown.

Gabriela reports that she is currently in the United States on a VISA, and she cannot work. Gabriela's family lives in Mexico, however, she has developed a strong relationship with her neighbors, and helps them out by cooking for them on a regular basis, which they pay her for. She has also developed relationships at the church and is on friendly terms with John's ex-wife. She reports feeling anxious, having trouble sleeping and loss of appetite for the last six months.

As a mental health care provider your goal is to sensitively assess and evaluate the individual's and family's psychological problems and emotional needs, and to create a culturally informed treatment plan to resolve the presenting problems. Please discuss the following:

1) What cultural beliefs, racial, ethnic, and gender stereotypes and assumptions might a mental health practitioner have while working with this family?
2) What racial, ethnic, and gender beliefs, stereotypes, and assumptions might Gabriela and John have when while with a mental health provider?
3) Based on the information provided in this scenario, what are the primary challenges facing this family?
4) Based on the information provided in this scenario, what are the family's primary strengths?
5) How might the agency or clinical supervisor support the practitioner in delivering culturally responsive services to this family?

Module 2: Cultural Case Formulation and Assessment Using the Cultural Formulation Interview

Module Two: Specific Preparation

Resources

Trainers should review the training guide before presenting, as many of them may be helpful to have available in print copy during the presentation at the trainer's discretion.

Presentation Instructions

This training guide provides a summary of the relevant information needed to deliver the training. References are also provided. The trainer should read the training material to gain a comfort level in presenting the information. The slides are provided in the same order that the material is given, and some notes are provided to guide the discussion during the presentation.

Handouts

Please refer to Appendix B for handouts associated with this module.

PowerPoint Slides

The trainer may distribute PowerPoint slides to the audience before the training if desired.

Trainer Tip

The training should be adapted to the length based on the audience's needs. The goal of this training is to provide an overview of specifics of Hispanic and Latino populations, and to provide education about common practices of Hispanic and Latino persons. It is not intended to promote stereotyping or profiling of Latinos. A trainer should maintain an open mind to the many distinct types of experiences that Hispanic and Latino persons have had in their assimilation and acculturation process. A trainer that models this attitude that all perspectives are equally valid will avoid engaging in conflictual discussion as to the "right" way to understand Hispanic and Latino populations.

Module Agenda and Timeline (1 hour)

SAMPLE AGENDA

09:00 – 09:05	Welcome and Overview of Goals and Objectives
09:05 – 09:40	Session Presentation
09:40 – 09:55	Application Activity and Discussion
09:55 – 10:00	Summary/Conclusion

Welcome and Overview of the Session

***********This section applies if you are using the module as a stand-alone tool.*************

Welcome participants to the training and thank them for attending. Introduce yourself and your relevant background working with Hispanic and Latino populations and other diverse cultures. Describe your experience working in mental health care, and your clinical experience assessing and treating mood disorders, trauma, substance use and other clinical issues. If appropriate, allow other individuals involved in the training to introduce themselves, including co-trainers and hosts. This is a good strategy and technique for the leader to establish subject matter expertise, establish the teaching and training alliance, and identify and understand the audience's training needs and level of experience.

Familiarize the participants with the training space by providing housekeeping information including the location of bathrooms, break rooms, and designated smoking areas. If the training session is longer than one hour, mentioning when breaks will be taken may be appropriate. Typically, breaks should be given to adult audiences every hour and a half. You may add other topics as appropriate. Also, invite participants to silence their phones or other electronics, and invite them to leave the room if they need to take a call.

Transition to the beginning of your session by stating, "While we all have opinions and perspectives of what culture is, as professionals it is important that we recognize that all perspectives are valuable. In this training, I invite you to share your experiences with the group." Discuss if you would like individuals to offer their thoughts and questions as they have them, or if you would prefer if they waited until question-and-answer periods at the end of each section.

Refer participants to the training agenda. Review the agenda. Ask if there are any questions about the agenda or logistics.

You may encourage participants to review their training materials, which should include a Trainer guide and Participant Guide with slides. These materials contain everything they will need to facilitate training in the future.

Please note that copies of the training materials are available upon request from the National Hispanic and Latino Mental Health Technology Transfer Center and will be available at the Center's webpage: National Hispanic and Latino MHTTC | Mental Health Technology Transfer Center (MHTTC) Network (mhttcnetwork.org)

Goals and Objectives

Module Goal: This module will provide training on the development of an assessment and a cultural formulation using the DSM-5 Cultural Formulation Interview.

Module Objectives:

1) Participants will be able to define the five elements of the cultural formulation of the DSM-5;

2) Participants will be able to demonstrate the use of the Cultural Formulation Interview (CFI);

3) Participants will be able to apply the five elements of the cultural formulation to a case.

Outline for Cultural Formulation

The Diagnostic and Statistical Manual, Fifth Edition (APA, 2013), provides a cultural formulation that allows the provider to assess the cultural context of the illness experience. The DSM-5 defines culture as follows:

> Culture refers to systems of knowledge, concepts, rules, and practices that are learned and transmitted across generations. Culture includes language, religion, and spirituality, family structures, life-cycle stages, ceremonial rituals, and customs, as well as moral and legal systems. Cultures are open, dynamic systems that undergo continuous change over time; in the contemporary world, most individuals are exposed to multiple cultures, which they use to fashion their own identities and make sense of experience. P.749

Aspects of an individual's background, developmental experiences, and current social contexts may affect his or her perspective, such as geographical origin, migration, language, religion, sexual orientation, or race/ethnicity. Additionally, the influence of family, friends, and the individual's social network may have a significant impact on the individual's illness experience which is not readily seen by the provider.

DSM-5 provides an outline for a cultural formulation to supplement the diagnostic assessment. This allows the provider to assess the effect that cultural issues will have on treatment. The cultural formulation provides a framework to assess the cultural identity of the individual, the individual's cultural conceptualizations of distress, psychosocial stressors and cultural features of vulnerability and resilience, and cultural features of the relationship between the individual and the provider, and the overall cultural assessment for diagnosis and care.

Cultural Identity of the Individual

Within Hispanic and Latino communities, cultural identity cannot be assumed. Frequently, more than one race and nationality live within the same Hispanic household. Additionally, acculturation levels vary between generations of family members that can significantly impact their understanding of American treatment norms. Literature has documented a set of characteristics shared by most Latinos, including:

1) Spanish language

2) Cultural ideal of "personalismo" (personal contact)

3) "Simpatía" (social engagement, charm)

4) “Familismo” (familialism or collectivism)

5) “Machismo” (manliness) and “marianismo” (womanliness)

(Bernal et al., 2011)

These characteristics may impact the client’s relationship with others. Special consideration needs to be taken to consider the environment that the client lives in as well, as that environment may or may not support the client’s identity. The degree and kind of involvement that the individual has with his culture and with the majority culture may also impact his understanding of his identity and his relation to the greater world around him. Additionally, the individual’s history of connection with his or her environment and with the majority culture over her or her life span may also be significant. If the client has a history of social connectedness, he may have additional internal resources to reach out to support systems as an adult. Assessing these items may also assist the provider in identifying practical needs of the provider, such as the need for an interpreter or to invite additional family members into the therapeutic intervention.

Cultural Conceptualization of Distress

The cultural conceptualization of distress describes the cultural constructs that impact how the individual may experience illness and suffering. Depending on the specific nationality, the cultural explanation of distress can vary. The DSM 5 includes a Glossary of Cultural Concepts of Distress. Cultural groups experience, understand, and communicate suffering, behavior problems, or troubling thoughts and emotions differently. The DSM IV TR referred to cultural-bound syndromes, however, this term ignored the cultural explanations, terms, and experience of symptoms. DSM 5 more thoroughly explores and defines these syndromes.

Psychosocial Stressors and Cultural Features of Vulnerability and Resilience

Social stressors and access to social support are influenced by cultural interpretations of events and the role of family, social support, and religion. Statistics indicate that Latino ethnic groups are more likely to experience the following high-risk factors:

1) Poverty

2) Inadequate housing

3) High proportion of single parent families

4) Substance Use Disorders

5) Acculturative stress

6) Discrimination

7) Relatively low educational and economic status

8) History of conquest, oppression, defeat, and struggle for liberation

(Bernal & Saez-Santiago, 2010; Dana, 1998; U.S. Department of Health and Human Services, 2000).

Depending on their acculturation level and immigrant status, Hispanic and Latino individuals may also face barriers of:

1) English proficiency level
2) Legal status issues
3) Family separation due to immigration
4) Issues of loss and trauma due to the immigration process
5) Loss of status in the community and loss of self-esteem due to undocumented immigrant status

These are factors that may affect the second and third-generation immigrant as much as it affects the first-generation immigrant, depending on the intergenerational transmission of cultural norms and beliefs. Depending on the assimilation level of the individual, these barriers may not be readily apparent. Therefore, the provider needs to include an assessment of the client's ongoing awareness of issues of power, discrimination, oppression, and prejudice when assessing the client's access to support and resources. Levels of functioning and resilience should be assessed in relation to the client's cultural reference groups as well.

Overall Cultural Assessment

After the provider has assessed the cultural factors that might impact the client during treatment, the aggregate of these factors leads to an overall culturally appropriate assessment of the diagnosis, which in turn sets a solid foundation for treatment that will best meet the client's needs.

After assessing the client's cultural needs, the provider can determine the cultural elements of the relationship between the individual and the provider. The provider can begin to adapt treatment to increase the client's ability to gain the maximum benefit in treatment. Treatment models that do not consider racial cultural issues could leave ethnically diverse clients feeling invalidated or re-experiencing everyday racial-cultural traumas (Constantine et al., 2010). These factors could lead to premature treatment termination and aggravation of existing problems.

Cultural Formulation Interview (CFI)

The DSM-5's Cultural Formulation Interview (APA, 2013) is designed to help providers assess cultural factors that influence client's perspectives of symptoms and treatment options. It is written in a person-centered approach which seeks to elicit information from the client's point of view. By asking questions in an open-ended format, the client is given the opportunity to explain the problem as he or she sees it. The interview includes questions about a client's background that investigates his or her identity in terms of culture, race, ethnicity, religion and geographical origin. The questions provide an opportunity for an individual to define distress in his or her own words. By using this interview, the provider receives appropriate information that can be used in the development of the treatment plan.

CFI is a set of 16 questions that providers may use during an interview to assess the impact of culture on key aspects of an individual's clinical presentation and care (APA, 2013. p.750). This interview identifies four domains of assessment:

1) Cultural Definition of the Problem (Questions 1-3)
2) Cultural Perceptions of Cause, Context, and Support (Questions 4-10)

3) Cultural Factors Affecting Self-Coping and Past Help Seeking (Questions 11-13)

4) Cultural Factors Affecting Current Help Seeking (Questions 14-16)

This interview is intended to be a brief, semi structured interview that can be used with any individual. The questions can be integrated into an assessment format that is already used, or the interview can be used on its own.

CFI – Informant Version
In addition to the Cultural Formulation Interview, the Informant Version is also provided within the DSM-5. This version was created for when the client cannot be interviewed, or if additional information is sought. The interview follows the same format that the primary Cultural Formulation Interview follows. Hispanic and Latino individuals frequently desire to bring family members into the assessment process. This interview may be ideal in these situations, so that a more complete clinical picture is obtained.

Application - Case Example: Elena

The following is a case example designed to apply the concepts discussed in this module. Present the case, and then use the following questions to conduct either small or large group discussions about the case.

Elena is a 50-year-old Guatemalan woman, with a 6-year history of mental health treatment for Generalized Anxiety Disorder. Within the last 6 years, Elena has experienced the following symptoms: panic attacks, shortness of breath, tearfulness, and paranoid thoughts. She reports that in the last two weeks she has experienced sleeplessness, weight loss, obsessive thoughts, and "nervousness." She reports that within the last week, she has felt that she is being watched when she is alone and has a feeling of being out of control.

Elena was born in rural Guatemala. She completed her 2nd grade education. She immigrated to the United States 20 years ago to join her husband. He died 10 years ago in a car accident. Elena cleaned houses for the first 10 years that she lived in the United States. After her husband's death, she struggled to maintain employment. Elena has 2 children, a boy who is 28, and a girl that is 32. Her daughter currently lives in the home and helps care for her.

Elena has a poor history of medication compliance as she states that she has the feeling that her doctor is not trying to help her. She is currently receiving services at an outpatient Latino Clinic, where her symptoms of anxiety reassessed as ataque de nervios.

Questions
Based on the above example, identify how the Cultural Formulation Interview may be used:

What would you like to know about the client that you do not already know?

Which questions would be most helpful during your intake interview to identify her current treatment needs?

Imagine that Elena lives in your town. What cultural factors would need to be considered based on living in that social and political environment?

How might you use the Cultural Formulation Interview – Informant Version in Elena's assessment?

Module 3: Considering Culture in the Diagnosis of Mental Health Disorders with Hispanic and Latino Populations

Module Three: Specific Preparation

Resources

Trainers should review the training guide before presenting, as it may be helpful to have the guide available in print during the presentation at the trainer's discretion.

Presentation Instructions

This training guide provides a summary of the relevant information needed to deliver the training. Citations and references are also provided. The trainer should read the training material to gain a comfort level in presenting the information. The slides are provided in the same order that the material is given, and some notes are provided to guide the discussion during the presentation.

Handouts

Please refer to Appendix C for handouts associated with this module.

PowerPoint Slides

The trainer may distribute PowerPoint slides to the audience before the training if desired.

Trainer Tip

The training should be adapted in length based on the audience's level of experience, training, and needs. The goal of this training is to provide an overview of specifics of Hispanic and Latino populations, and to provide education about common practices of Hispanic and Latino persons. It is not intended to promote stereotyping or profiling of Latinos. A trainer should maintain an open mind to the many distinct types of experiences that Hispanic and Latino persons have had in their assimilation and acculturation process. A trainer that models this attitude that all perspectives are equally valid will avoid engaging in conflictual discussion as to the "right" way to understand Hispanic and Latino populations.

Module Agenda and Timeline (1 hour)

SAMPLE AGENDA

09:00 – 09:05	Welcome and Overview of Goals and Objectives
09:05 – 09:40	Session Presentation
09:40 – 09:55	Application Activity and Discussion
09:55 – 10:00	Summary/Conclusion

Welcome and Overview of the Session

***********This section applies if you are using the module as a stand-alone tool.*************

Welcome participants to the training and thank them for attending. Introduce yourself and your relevant background working with Hispanic and Latino populations and other diverse cultures. Describe your experience working in mental health care, and your clinical experience assessing and treating mood disorders, trauma, substance use and other clinical issues. If appropriate, allow other individuals involved in the training to introduce themselves, including co-trainers and hosts. This is a good strategy and technique for the leader to establish subject matter expertise, establish the teaching and training alliance, and identify and understand the audience's training needs and level of experience.

Familiarize the participants with the training facility by providing housekeeping information including the location of bathrooms, break rooms, and designated smoking areas. If the training session is longer than one hour, mentioning when breaks will be taken may be appropriate. Typically, breaks should be given to adult audiences every hour and a half. You may add other topics as appropriate. Also, invite participants to silence their phones or other electronics, and invite them to leave the room if they need to take a call.

Transition to the beginning of your session by stating, "While we all have opinions and perspectives of what culture is, as professionals it is important that we recognize that all perspectives are valuable. In this training, I invite you to share your experiences with the group." Discuss if you would like individuals to offer their thoughts and questions as they have them, or if you would prefer it if they waited until question-and-answer periods at the end of each section.

Refer participants to the training agenda. Review the agenda. Ask if there are any questions about the agenda or logistics.

You may encourage participants to review their training materials, which should include a Trainer guide and Participant Guide with slides. These materials contain everything they will need to facilitate training in the future.

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Goals and Objectives

Module Goal: This module will provide training on integrating Latino cultural factors into the assessment, evaluation, and diagnosis of emotional, psychological, and mental health disorders.

Module Objectives:

1) Participants will describe and discuss key cultural concepts central to understanding Latino grief, expressions of distress, and appropriate responses to treatment;

2) Participants will be able to identify, describe, and apply culturally informed diagnostic and treatment approaches to mental and substance use disorders with Hispanic and Latino clients

3) Participants will demonstrate an ability to conceptualize and create a basic culturally informed treatment plan.

The Impact of Cultural Concepts of Distress upon Hispanic and Latino Individuals Receiving Mental Health Treatment

As culture significantly impacts perception of experience, including the experience of distress and suffering, cultural factors may impact the experience of a Hispanic or Latino individual. These cultural concepts may be related to acculturation, discrimination, oppression, and the stigma related to substance use and mental illness. For example, traditional cultural values such as "personalismo" (emphasis on personal interactions with others) may impact a person with substance use disorders, as this is a value that may influence the individual's ability to reconnect with family, or to connect with a treatment provider. If an individual is depressed, anxious, or using substances, there may be an increased perception of suffering, as this inability to connect with others may be more strongly missed than in a culture that values independence and detachment.

The Impact of the Individual's Cultural Explanation of the Illness on Treatment

Cultural values impact perceptions of distress. Within Hispanic and Latino populations, the cultural values of "familismo," "machismo," and "personalismo" have been found to impact interpersonal and intrapersonal behaviors (Delgado, 2007). This may impact an individual's experience of depression, anxiety, alcohol or drug use. "Familismo" (familism) is a concept, which emphasizes an individual's dedication and enduring loyalty to the family above the needs of the individual. This cultural value may provide a client with a dedicated support system to help with healing and recovery and diminish feelings of being isolated and stigmatized. On the other hand, rejection from the family due to depression, anxiety, and substance use may be more strongly felt and understood by the client to be caused by moral or spiritual conflict or other metaphysical causality such as loss of soul (Mexican) or being possessed by bad spirits (Puerto Rican).

Machismo is a cultural concept that may be engrained in some Latino me. It has to do with protection and provision for the family while not promoting the healthy expression of emotions. For some men, and for a variety of reasons, this results in hypersexuality, misogynistic views, violence, and poor capacity to be emotionally vulnerable and receptive. A man who over identifies with this negative cultural image is likely to be resistant to mental health interventions that relies on self-disclosure, open expressions of grief, and direct communication.

Machismo also is applied to Latino men who adhere to family loyalty, good work ethic, and engaged parenting. Thus, a man in the psychological grip of this cultural image may either present as open and strong and feel responsible to care for the family, or he may isolate himself with the belief that he does not need help. (Torres, Solberg, & Carlstrom, 2002).

Lastly, the concept of personalismo. Personalismo places emphasis on personal relationships. Latinos are sociocentric and personalismo represents the core of Latino sociocentricity. Personalismo is a critical element in the therapeutic alliance. It is the central agent of change in any therapeutic interaction. Personalismo is a type of valued informality that conveys positive regard, genuineness, honesty, and deep respect for the person The strength of personalismo may be strain, devalue, and hinder therapy, or it may help treatment and facilitate a positive response by reconnecting to cultural beliefs that give meaning to the client's psychological and emotional problems.

Not all Hispanics and Latinos are acculturated at the same level. Differential acculturation may change the emphasis placed on traditional values, which may raise or lower the significance of these factors. A significant difference in acculturation between community or family members may raise the stress level in the family and community. This may increase the level of acculturation distress felt, in addition to the distress of the disorder itself. (Torres, Kaplan, & Valdez, 2011). Research has demonstrated that Hispanic and Latino's use of the Spanish language with family, rather than language proficiency, appears to be a stronger indicator of social assimilation (Canino, Vega, Sribney, Warner, & Alegría, 2008). When the element of social assimilation is considered, it is evident that elements of the assimilation process can be protective or risk factors. The experience of distress is embedded within this context of assimilation.

Overall, this expression of distress may increase the psychosocial stress felt if it is not received effectively by a treatment provider. Language barriers and differences in expectations for treatment can impact the experience of substance use disorders and mental health issues.

Forms of Expression of Distress and Illness

The client forms their perception of their distress based on their beliefs about illness, their context, and through the support and influence of individuals around them. Once that perception is formed, it is experienced and then expressed.

According to the DSM 5 (APA, 2013), cultural concepts of distress are expressed through three concepts:

1) **Cultural syndromes:** Groups of symptoms that co-occur among individuals in specific cultural groups, communities, and contexts;

2) **Cultural idioms of distress:** Ways that symptoms are expressed which provide a collective, shared ways of experiencing and talking about personal and social concerns;

3) **Cultural explanations (perceived causes):** Labels, attributions, or features of an explanatory model that indicate culturally recognized meaning or etiology for symptoms, illness, or distress (APA, 2013. p.758).

Cultural Syndromes: Meaning and Impact of the Severity of Symptoms in Relation to Cultural Norms

The term cultural syndrome involves groups of symptoms that co-occur among individuals in specific cultural groups, communities, and contexts. Medical anthropology has demonstrated that culture and biology impact each other, and that all psychological distress is culture bound. Cultural Syndromes differ from idioms, as they are the dominant perspective or thought map which influences how the specific symptom is experienced. The idiom describes the specific condition that is experienced.

"Nervios"

"Nervios" - There are several distinct levels of "nervios" which may indicate a worsening of symptoms. The beginning of the spectrum includes "ser una persona nerviosa" or being a nervous person. "Padecer de los nervios" (suffering from nerves) implies more pervasive symptoms. "Ataques de nervios" (attacks of nerves) are more severe, and may include violent acts toward others, somatic distress, or loss of control of behaviors. Extremely severe nerves may lead to locura (madness). Forty percent of Mexicans that expressed that they had "nervios" stated that they also had thoughts that were stuck to their mind (England & Gallegos, 2007).

"Ataque de nervios"

In studies on Hispanics and Latinos expressing that they have symptoms of "nervios", "ataques de nervios" these included: symptoms of panic attacks and panic disorder. They are separate, however, as triggering episodes are typically interpersonal disputes, they include dissociative features, and an experience of relief comes after the "ataque". These disorders typically include physical health problems including neurological complaints and other impairment that are not common in psychiatric disorders. (Guarnaccia, Lewis-Fernández, & Marano, 2003).

"Susto"

"Susto" is an idiom which typically refers to a frightening event that causes the soul to leave the body. The symptoms are frequently unhappiness and sickness. It is linked with increased stress and physical distress. It is typically related to a particular incident. "Susto" has been found to be associated with an increased risk of a physical and psychiatric diagnosis (Baer et al., 2003). "Susto" is related to "nervios" as it may be the cause of it, or "nervios" may be the cause of "susto". Incidents that cause "susto" frequently have a thread of helplessness involved.

"Mal de Ojo"

"Mal de ojo" (the evil eye) is an illness transmitted by making eye contact with someone, as it is received through the eyes of the intended recipient. When the illness is passed it heats the blood of the victim, causing multiple gastrointestinal problems.

Cultural Idioms of Distress: Cultural Expressions of Distress Unique to Hispanic and Latino Cultures

Hispanic and Latino persons may use expressions that are consistent with the symptoms that they experience. These expressions support the framework of their understanding of their illness and are important to note during assessment and treatment.

"Nervios" starts with a "persistent idea that is stuck" ("idea pegada a la mente"). The individual may find it difficult to think about other things, or they find their thoughts consistently returning to the idea. (Salgado de Snyder, de Jesus Diaz-Perez, & Ojeda, 2000).

“Coraje” (anger) is the most infrequently researched and identified idiom of distress. Researchers have found “coraje” to be associated with “nervios”, “susto”, and depression (Bender, 2003). Although it is translated as anger, research found that it was experienced differently than the English equivalent of anger. “Coraje” was found to be attributed to prolonged experiences of trauma. Both “susto” and “coraje” were found to have associated physical symptoms.

Hispanic and Latino individuals may also use phraseology that indicates the spiritual or physical element of their experience of distress.

Cultural Explanations: Perceived Causes and Explanatory Models

The literature demonstrates several common themes that may impact Hispanic and Latino clients in these areas. Regarding their illness, Hispanic and Latinos individuals are more likely to believe that their symptoms are caused by outside environmental, spiritual, or personal problems (Kouyoumdjjian, Zamboaga & Hansen, 2003). They are less likely to endorse a biological etiology of depression and mental illness and they tend to view medication as addictive and harmful. Therefore, many prefer counseling over medications (Cooper et al., 2003; Givens et al., 2007; Karasz & Watkins, 2006). Endorsing the belief that depression is a chronic condition is negatively associated with individuals’ sense of treatment and personal control over their illness (Cabassa, Lagomasino, Dwight-Johnson, Hansen & Xie, 2008). Lastly, Hispanic and Latino individuals may believe that physical symptoms are more serious than mental health symptoms (Kouyoumdjjian, Zamboaga & Hansen, 2003). This may impact substance use or mental health treatment as when symptoms are resolved, the client may feel that treatment should be ended. When treating Hispanic and Latino individuals, the assessment of the level of severity and potential coping behaviors should be considered considering the individual’s cultural reference group’s understanding of distress.

Research has also found that perceived discrimination is correlated with adverse mental health outcomes among Hispanic and Latino individuals. Acculturative stress mediated the perceived discrimination-psychological distress relationship. The link between perceived discrimination and acculturative stress was moderated by Anglo mental orientation but not Latino mental orientation. This reinforces the idea that the environment and feeling of belongingness impacts the perception of distress.

The literature on cultural concepts of distress and psychiatric disorders currently tends to be inconsistent in its identification and description of cultural concepts of distress. Many studies lack consistent descriptions of concepts, and the studies do not report key factors of explanatory models (Kohrt, et al., 2014). This continues to be an area for future research.

Help Seeking Plans for Recovery

In addition to the assessment of cultural idioms, the DSM-5 (APA, 2013) encourages an assessment of cultural factors affecting self-coping and past help seeking behavior. These specific questions assess the client’s support system, and where they typically seek help.

The more assimilated the Hispanic or Latino individual is, the more likely he or she is to seek help from a psychiatrist or psychologist. Individuals from Spain and recently arrived Latino migrants were more likely to seek non-medical sources to support them, such as relatives and religious personnel.

Regression analysis demonstrated that lower educational attainment was associated with the use of “susto.” This demonstrates that individuals have multiple models of distress, even within the Hispanic and Latino population, and that everyone must be evaluated based on their individual, communal, and national culture (Durá-Vilá & Hodes, 2012).

Application - Case Example: María

The following is a case example designed to apply the concepts discussed in this module. Present the case, and then use the following questions to conduct either small or large group discussions about the case.

María is a 33-year-old Cuban woman. She has an 8-year history of Major Depressive Disorder, which began after she arrived in the United States. Although she has never been suicidal, she experiences the following symptoms: lack of appetite with significant weight loss, insomnia, irritability and rage, and nightmares. At times, she will go months without symptoms, but then will have several months of debilitating symptoms which have caused her to miss several days of work at a time due to depression and insomnia. During the assessment, she was well groomed and well spoken, but tearful when discussing her symptoms.

María was born in Cuba. She completed a 12th education, and some college. She reported that she was married and divorced in Cuba, and after the divorce, she decided to live with her sister in the US (United States). To do so, she had to leave her now 13-year-old daughter with her ex-husband. Although she feels that her ex-husband was an adequate father, her daughter, when she was 6, had an accident a year after she left Cuba. This accident caused her daughter to be paralyzed, and her daughter is not able to communicate. Her daughter is cared for by her ex-husband’s family. Maria continually feels that this accident was her fault and that there are “bad spirits” over her family as she abandoned her daughter. Maria can communicate with her ex-husband and daughter via video; however, her daughter cannot communicate and does not appear to recognize María.

María continues to live with her sister’s family, and she works in a downtown office as a secretary. Her English is good; however, she frequently does not feel accepted by the other office workers. She feels that sometimes they do not understand her. Maria spends most of her free time in the Cuban neighborhood and speaks Spanish in her sister’s home. She has considered returning to Cuba, however, her parents passed away over a decade ago, and her sister is her primary support system. Maria reports that she enjoys spending time with her neighbors when she is feeling good. However, whenever she is feeling good, she feels that something bad is around the corner, and so she never feels that she can totally be comfortable. Maria’s general practitioner prescribed her an anti-anxiety medication; Maria reports that sometimes she takes more than she is prescribed so that she can go to work. She has fallen asleep at work on more than one occasion after taking too much; her employer did not find out, but Maria is afraid that if her employer discovered her sleeping at work she would be fired.

María attempted counseling with an agency close to her work, however, the provider told her that she needed to move on and seek an independent life. Maria did not feel that she was able to do so. Maria wants to figure out what she needs to do to move forward, but also feels that her symptoms are her punishment for what happened to her daughter.

Question

Based on the example, identify how the cultural expressions of distress may be impacting María:

1) What would you like to know about the client that you do not already know?

2) How might an understanding of cultural syndromes help the assessment and treatment plan for María?

3) How might an understanding of cultural idioms of distress help María's treatment?

4) How might cultural explanations of illness impact María's commitment and motivation for treatment?

Module 4: Developing Culturally Centered Interventions

Module Four: Specific Preparation

Resources

Trainers should review the training guide before presenting, as it may be helpful to have the guide available in print during the presentation at the trainer's discretion.

Presentation Instructions

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Handouts

Please refer to Appendix D for handouts associated with this module.

PowerPoint Slides

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Trainer Tip

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Module Agenda and Timeline (1 hour)

SAMPLE AGENDA

09:00 – 09:05	Welcome and Overview of Goals and Objectives
09:05 – 09:40	Session Presentation
09:40 – 09:55	Application Activity and Discussion
09:55 – 10:00	Summary/Conclusion

Welcome and Overview of the Session

***********This section applies if you are using the module as a stand-alone tool.*************

Welcome participants to the training and thank them for attending. Introduce yourself and your relevant background working with Hispanic and Latino populations and other diverse cultures. Describe your experience working in mental health care, and your clinical experience assessing and treating mood disorders, trauma, substance use and other clinical issues. If appropriate, allow other individuals involved in the training to introduce themselves, including co-trainers and hosts. This is a good strategy and technique for the leader to establish subject matter expertise, establish the teaching and training alliance, and identify and understand the audience's training needs and level of experience.

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Transition to the beginning of your session by stating, "While we all have opinions and perspectives of what culture is, as professionals it is important that we recognize that all perspectives are valuable. In this training, I invite you to share your experiences with the group." Discuss if you would like individuals to offer their thoughts and questions as they have them, or if you would prefer it if they waited until question-and-answer periods at the end of each section.

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Goals and Objectives

Module Goal: This module will provide training on the integration of culturally centered interventions in mental health and substance use treatment.

Module Objectives:

1) Participants will be able to apply culturally centered interventions when working with Hispanic and Latino individuals;

2) Participants will be able to discuss the eight areas of culturally centered interventions, and will be able to identify specific elements of Hispanic and Latino populations which may need special attention;

3) Participants will be able to demonstrate the use of the eight culturally centered intervention modifications.

Beliefs about the Origin of Illness

When determining interventions that will best meet the client's needs, the client's belief about the cause of illness must be considered. There are three primary belief systems that can impact the client's response to treatment. If the client does not belief that the intervention will work, they will not be invested in the treatment, and thus they are at a higher risk of not following recommendations.

Personalistic

Hispanic and Latino individuals may hold a personalistic system of beliefs. This is when the illness is believed to be caused by the intervention of a divine being or a human with special powers. This may be someone currently alive, or an ancestor. Often, it is believed that the illness is caused in retaliation for sins committed, or for disrespect to an ancestor. Lastly, illness is believed to be bad luck or bad karma. Recovery from an illness with personalistic causes may involve the use of ritual and symbolism, often by natural or spiritual healers.

Naturalistic

In a system of naturalistic beliefs, human health is closely tied to the natural environment. Harmony and balance are sought in maintaining health and well-being. When there is no balance, illness results. There may be a humoral approach, which focuses on attention to appropriate diet and activity. Ayurveda integrates preparations made from herbs and minerals to build a healthy metabolic system. Ayuerveda also focuses on exercise, yoga, meditation, and massage. In the United States, the National Institute of Health funds research on Ayurvedic medicine research. Lastly, vitalism is a belief that disease is the result of an imbalance in vital energies. Illness results when a person's energy is disrupted. Yoga or other treatments may be used to restore balanced energy.

Biomedicine

Lastly, biomedicine is a system of beliefs that is summarized by a "body-as-machine" metaphor. This metaphor is frequently used in western medicine. An assumption is that diagnosis and treatment should be based on scientific data. Biomedicine tends to focus on the theory, knowledge, and research of illness to advance treatment options.

The health beliefs of cultures all the world are established by some combination of these belief systems. Theories of health and illness help clients understand their experience with illness, and it

thus impacts their expression of distress and their idea of what will help them to feel better. Through communication, clients and providers can develop an understanding of the impact of the client's illness on their life so that they can best develop a treatment plan. Although western practitioners are trained in biomedicine, having an open and nonjudgmental mindset toward other ideas will help explain illness and treatment to the client to achieve a mutual commitment to wellness.

The client's belief about the cause of illness should be considered when developing culturally appropriate interventions. The client's belief system informs his or her understanding of the problem, the client's response to treatment recommendations, and the client's goals and evaluation of treatment. This understanding of the cause of illness sets the foundation to implement culturally adapted interventions.

Culturally Adapted Interventions

To integrate the client's understanding of the cause of illness into their goals in the treatment plan, interventions must be planned in a way that integrates the client's concept of health, concept of distress, cultural values, and with the diagnosis and assessment of the provider. The first known framework that was developed for this purpose is the ecological validity model (Bernal, et al., 2005). Nicolas, Arntz, Hirsch, and Schmiedigen (2009) have demonstrated positive support for the use of this model with ethnic minorities. Other research has found that interventions that have been culturally adapted (client-provider ethnic matching or services in ethnic-specific agencies) have lowered rates of premature drop out (Flaskerund & Liu, 1991; Takeuchi, Sue & Yeh, 1995).

The term, culture centered, is used to encourage the use of a "cultural lens" as a central focus of professional behavior. In culture centered practices, all individuals, including the treatment provider, express cultural norms and beliefs throughout the interaction. Often, the challenging task is to identify those norms and beliefs so that they can be used in the therapeutic process.

The best approach to working within a culture-centered context is to have some knowledge about specific cultures with a "not knowing" stance that incorporates cultural and personal beliefs and values. When this is combined, the provider can see the specific individual or family norms that impact the individual. This may or may not be congruent with the person's color, class, ethnicity, and gender. Simultaneously, the provider can recognize and respect culture-specific differences that exist due to color, class, ethnicity, and gender. The goal of ethnically sensitive treatment is to recognize and express the existence of cultural differences between the client and provider, while also having a knowledge of the client's culture. The provider must distinguish between culture and pathology in the assessment phase, and then modify the treatment as necessary to accommodate the client's individual culture (Zayas, Torres, Malcolm, and DesRosios, 2006).

The ecological validity model conceptualizes eight dimensions of interventions. It was originally conceptualized for Latino populations; however, it has been researched with several other populations. Roselló and Bernal (1999; Rosselló, Bernal, & Rivera, 2008) conducted two trials that used this model to adapt Cognitive Mental Therapy to include the cultural adaptations of content and methods with Puerto Rican adolescents with depression. This study found increased positive outcomes when those adaptations were used. The ecological model has also been used in parent-child interaction therapy (Mateos, et al. 2006).

Language

Definition
Language includes the actual language (Spanish, English), but it also includes local colloquialisms and idioms that impact the expression and understanding of what is occurring. It is often a carrier of culture. Language provides a communication tool for the speaker to communicate concepts that are valued by that culture. Individuals are not likely to think of ideas that they cannot express within their culture. (Saari, 1991.) Treatment delivered in the native language assumes integration of ethnic culture, but it may not consider individual culture. However, knowledge of the language usually implies greater cultural knowledge.

Importance to Hispanic and Latino Clients
For Hispanic and Latino individuals, language is related to culture and to the expression of emotional experience. Due to the increased familiarity with vocabulary and linguistic nuances, clients can express themselves better in their native language. Additionally, local "dichos", or idioms, can connect cultural metaphors with the client's experience to increase an understanding of the concepts that are discussed. Lastly, language can also indicate acculturation or assimilation levels, and can have meaning between generations. Often, the younger generations fail to acquire Spanish, which can lead to misunderstandings between family members, and a feeling of loss.

Specific Modifications for Hispanic and Latino Cultures
Language-appropriate interventions require more than the mechanical translation of a particular intervention. The provider needs to understand the importance of the concept of language, and how it impacts interactions with family members. Issues of who is using language and in what context are also important in understanding meaning between family members.

Narrative therapy has been suggested to be helpful in working with minority populations as this therapy allows the client to explore their cultural assumptions to understand their racial identity and contextual influences (Edwards & Pedrotti, 2004; Semmler & Williams, 2000; Yuen & White, 2007). Much of the work in this therapy revolves around the reconstruction of story and metaphor, however, it also involves naming experiences to understand them. Narrative therapy incorporates language as an empowerment tool to help clients change their experience.

Persons

Definition
This concept refers to the individuals that the client expects to be involved in their treatment, and the significance of each of the persons. This can mean the significance of the individuals involved in the client's care, including family members, holistic healers, and extended family. It also refers to the client-provider relationship during the intervention.

Importance to Hispanic and Latino Clients
Culturally centered interventions consider the role of ethnic and racial similarities and differences in the client-provider dyad. Hispanic and Latino individuals frequently place a high value on "personalismo," which is a formal friendliness. Hispanic and Latino clients are more likely to place an elevated level of trust in one professional, and to go to that individual for many or all their concerns, instead of relying on the advice of multiple specialists. If they are confronted with the business-like relationship of a western medical professional, a Hispanic or Latino client may perceive the individual as not helpful or not motivated to help them. However, due to the elevated level of trust in the provider as an expert, the client may not always express disagreement or that they are

uncomfortable with treatment recommendations, and instead they may fail to follow the treatment.

Specific Modifications for Hispanic and Latino Cultures

In treatment, the provider needs to focus on developing rapport with the patient. Treatment may include multiple members of the patient-defined family. Additionally, treatment should include patient empowerment with a firm plan of action, with the provider as a guide. The provider must remain mindful of the reverent power that he or she has as a member of the professional community to be aware of the client's wishes and needs in treatment.

Metaphors

Definition

Metaphors are symbols and concepts shared by a particular group. These metaphors may conceptualize beliefs of that group. Metaphors help individuals make meanings of new situations based on previous experiences that they have had. "Este hombre esta de pelos" ("This man is all hair") i.e. "This man is very angry." "Me volteó la tortilla" ("He flipped the tortilla on me") e.g. "He changed the topic."

Importance to Hispanic and Latino Clients

Hispanic and Latino individuals may have had experiences with individuals in power that negatively impact their ability to build rapport. If they have been oppressed by their home government, individuals of power may symbolize oppression or prejudice. Additionally, symbols of the United States may be symbols of hope, or they may be symbols of loss of their home country. A provider that is attentive to these variables will be able to identify the positive symbols that are helpful for the individual and minimize symbols that negatively impact treatment.

Specific Modifications for Hispanic and Latino Cultures

Treatment needs to explore the patient's story as understood by the patient. Dr. Celia Falicov identified a multidimensional framework that appreciates culture as defined by the shared world views, meanings, and adaptive behaviors of the individual within their family and environmental context (Falicov, 1995. p. 383.) Within this framework, it is the provider's role to assist the individual or family in exploring their unique cultural meanings and metaphors through dialogue. This provides an empowering and respectful environment where the family may explore their cultural narrative. The provider may best support this by maintaining a supportive, curious, and imaginative stance that acknowledges the individual's cultural constraints and resources (Falicov, 1995.) Additionally, the provider may incorporate symbols and objects of the client's culture in the office. The linguistic use of dichos (sayings) may help the client understand and express nuanced meanings. Throughout the treatment, the provider must be aware of the differences in the personal involvement (or meaning) of the provider and client as an individual or family goes through changes. Narratives may be incorporated to assist providers with the integration of change concerning self-awareness about all human diversity variables. For instance, Domenech Rodríguez (2008) adapted a parent management training for Mexican American families with children who exhibit behavior problems. She integrated the use of "dichos" and expressions in educational materials and incorporated and encouraged respeto (respect) and buena educación (well mannered) as goals of the intervention. Preliminary findings found a good retention of parents and better improvements than with the control group.

Content

Definition

Content refers to cultural knowledge about values, customs, and traditions. Although knowledge of cultural content is important, a client may still have unique cultural factors that impact their cultural values and beliefs.

Importance to Hispanic and Latino Clients

Hispanic and Latino individuals have unique values, customs and traditions that connect them to their native countries and to their families. Being conscious of this content can allow the provider to hear the specific problems and concerns that their clients have to address them efficiently.

Specific Modifications for Hispanic and Latino Cultures

In making modifications, treatment needs to be holistic and may need to incorporate spiritual or other elements from the patient's culture. Additionally, incorporating values, customs, and traditions will increase the amount of comfort and familiarity that the client has with the behavior that he or she is asked to perform. An understanding of the client's cultural content is an essential starting point for sharing experiences in a therapeutic context.

Concepts

Definition

Concepts refer to the constructs of the theoretical model that is to be used in treatment. It incorporates the provider's conceptualization of the client's problem, and it involves the client's understanding of that same problem. If the provider does not effectively communicate the concepts that he understands to be the issue, the client may not understand enough to be an effective partner in the treatment.

Importance to Hispanic and Latino Clients

There are multiple theories and techniques that can be used for a wide range of concerns, and that allow room to incorporate concepts central to culturally competent care. Providers should use a theory that allows for the integration of the individual's cultural values and beliefs so that they can understand and accept the framework of their problem. For instance, a client's understanding of how his illness occurred is a concept that, if it is incongruent with the theory of the framework being used, will prevent him from fully participating in treatment.

Specific Modifications for Hispanic and Latino Cultures

When choosing a theoretical framework to use, ensure that it is consistent with the cultural concepts of the individual that is being served. Be open-minded to changing the concepts used in treatment to better meet the individual's needs.

CFI of the DSM-5 is an example of a tool that has been specifically created to integrate cultural concepts into the assessment and treatment planning process. This tool provides a framework for assessment that allows the provider and client to explore the cultural concepts that impact the problem and interventions, including the client's definition of the problem, the cause, context, and support, and other factors that impact coping and help seeking currently and historically.

Goals

Definition

Goals should reflect the client's and provider's understanding of the problem and of the solution. They should be specific to the client's problem, attainable for the client by using his current supports and resources, relevant to the client's understanding of his problem, and offered at the right time, based on the client's schedule. Additionally, the goals must be congruent with the client's cultural values.

Importance to Hispanic and Latino Clients

If a client does not have the understanding that the goal is worthwhile, he may not fully engage in services. For instance, due to the concept of respeto (respect), Hispanic and Latino clients may not directly tell a professional that they do not feel that an intervention will be helpful. Instead, they may not attend appointments, not follow through, or otherwise not participate in the recommended treatment. If a provider understands the power imbalance in the relationship and works to involve the client in goal setting, there is a higher likelihood that the client will participate in the interventions willingly.

Specific Modifications for Hispanic and Latino Cultures

The provider needs to take into consideration specific values, customs, and traditions that are integrated into the client's understanding of the problem and continue to carry these concepts into the goal-setting process. Often, it is within these concepts that the client's strengths and resources may be identified. The incorporation of this cultural knowledge will provide the client with an opportunity to integrate new goal behaviors into existing beliefs. An example of a culturally modified goal would be to focus on familismo (familism) and respeto in a family therapy session to strengthen family dynamics, improve emotional support and validation, and increase communication and problem-solving strategies among family members.

Methods

Definition

Methods are the procedures to follow to achieve therapeutic goals. This incorporates the theory used, but it also incorporates the provision of the assessment, the use of transference and countertransference in the relationship, and the use of specific interventions, such as group or individual treatment. (These concepts are expounded upon on page 113-114 of this manual).

Importance to Hispanic and Latino Clients

Depending on the context, Hispanic and Latino clients may already feel alienated if services are offered in a manner that they are unaccustomed to. If the client has not had previous experience with services, providing them with methods that are familiar will help increase their comfort. For instance, offering services in a central location in the community, or located in the schools that their children attend will help increase the feeling of "personalismo."

In treatment, the experience, expression, and explanation of symptomatology is bound to the provider's and client's intersubjective perspective, which is impacted by each person's culture. (Hardy, Cahill, & Barkham, 2007). The provider's misunderstanding of the communication methods of the client or vice versa can cause barriers to progress. If the client is uncomfortable with the methods of the provider because they are different than what was expected, progress may be slowed or stopped until communication and understanding can be improved.

Context

Definition

Context considers the client's broader social, economic, and political contexts. It also includes the client's understanding of themselves within their environmental context. This impacts their priorities in completing tasks and in if and how they follow treatment recommendations.

Hispanic and Latino cultures are high-context cultures. This means that, for Hispanic and Latino individuals, the context is highly relevant in the understanding of messages and expectations. The US tends to have a low-context culture, and so the context is perceived differently. Many Hispanic and Latino countries tend to have high context cultures. Anthropologist Edward Hall (1976) discovered specific key contextual factors within cultures that impact perception.

Table 1: High Context versus Low Context Factors Retrieved from http://changingminds.org/explanations/culture/hall_culture.htm

Factor	High-context culture	Low-context culture
Overtness of messages	Many covert and implicit messages, with use of metaphor and reading between the lines.	Many overt and explicit messages that are simple and clear.
Locus of control and attribution for failure	Inner locus of control and personal acceptance for failure	Outer locus of control and blame of others for failure
Use of non-verbal communication	Much nonverbal communication	More focus on verbal communication than body language
Expression of reaction	Reserved, inward reactions	Visible, external, outward reaction
Cohesion and separation of groups	Strong diistinction between ingroup and outgroup. Strong sense of family.	Flexible and open grouping patterns, changing as needed
People bonds	Strong people bonds with affiliation to family and community	Fragile bonds between people with little sense of loyalty.
Level of commitment to relationships	High commitment to long-term relationships. Relationship more important than task.	Low commitment to relationship. Task more important than relationships.
Flexibility of time	Time is open and flexible. Process is more important than product	Time is highly organized. Product is more important than process

Importance to Hispanic and Latino Clients

This factor is significant to Hispanic and Latino clients as it impacts their understanding of the subliminal meanings that are communicated in everyday interactions in the mental health setting. Often, due to the lower priority set on being on time, Hispanic and Latino clients may struggle to understand the need to follow the strict attendance guidelines of treatment providers. Additionally, clients may present with an elevated level of non-verbal cues that providers are not conscious of. Lastly, if the provider does not understand the social, environmental, and economic context of the client, the intervention may include recommendations that put the client at risk, or that are impossible based on the client's social, environmental, and economic resources.

Specific Modifications for Hispanic and Latino Cultures

Treatment needs to focus on developing rapport with the patient. Treatment needs to consider the client's understanding of their acculturation, immigration, the client's stage of development, social support, and relationship with their country of origin. In considering these factors, the client's context can be better understood so that interventions are appropriately developed. Additionally, if there are significant differences in the expectations of the client and agency, these issues should be identified and discussed with the client to minimize misunderstandings.

Application - Case Example

You have been assigned to develop and lead a mandated group of individuals that have been convicted of driving under the influence of alcohol. The population that will attend your group is primarily Mexican men, most who have immigrated to the United States within the last 15 years. In the group that you are leading, you have found that a considerable number of the men show depressive symptoms and have evidence of Post-Traumatic Stress Disorder. This group is offered by a substance abuse agency in a large metropolitan area in the United States. Your task is to identify culturally appropriate interventions for the group.

1) How will you identify the cultural needs of the group?
2) Based on the ecological validity model, name four adaptations that you can make in providing the group.
3) How will you measure if these adaptations have been effective?
4) How will you balance the cultural needs of the group with the requirements of the Department of Transportation authorized curriculum?

Module 5: Engaging and Treating Hispanic and Latino Clients

Module Five: Specific Preparation

Resources

Trainers should review the training guide before presenting, as it may be helpful to have the guide available in print during the presentation at the trainer's discretion.

Presentation Instructions

This training guide provides a summary of the relevant information needed to deliver the training. Citations and references are also provided. The trainer should read the training material to gain a comfort level in presenting the information. The slides are provided in the same order that the material is given, and some notes are provided to guide the discussion during the presentation.

Handouts

Please refer to Appendix E for handouts associated with this module.

PowerPoint Slides

The trainer may distribute PowerPoint slides to the audience before the training if desired. The slides are formatted as a participant handbook.

Trainer Tip

The training should be adapted to the length based on the audience's needs. The goal of this training is to provide an overview of the specifics of Hispanic and Latino populations, and to provide education about common practices of Hispanic and Latino persons. It is not intended to promote stereotyping or profiling of Latinos. A trainer should maintain an open mind to the many distinct types of experiences that Hispanic and Latino persons have had in their assimilation and acculturation process. A trainer that models this attitude that all perspectives are equally valid will avoid engaging in conflictual discussion as to the "right" way to understand Hispanic and Latino populations.

Module Agenda and Timeline (1 hour)

SAMPLE AGENDA

09:00 – 09:05	Welcome and Overview of Goals and Objectives
09:05 – 09:40	Session Presentation
09:40 – 09:55	Application Activity and Discussion
09:55 – 10:00	Summary/Conclusion

Welcome and Overview of the Session

*********This section applies if you are using the module as a stand-alone tool.***********

Welcome participants to the training and thank them for attending. Introduce yourself and your relevant background working with Hispanic and Latino populations and other diverse cultures. Describe your experience working in mental health care, and your clinical experience assessing and treating mood disorders, trauma, substance use and other clinical issues. If appropriate, allow other individuals involved in the training to introduce themselves, including co-trainers and hosts. This is a good strategy and technique for the leader to establish subject matter expertise, establish the teaching and training alliance, and identify and understand the audience's training needs and level of experience.

Familiarize the participants with the training space by providing housekeeping information including the location of bathrooms, break rooms, and others. If the training session is longer than one hour, mentioning when breaks will be taken may be appropriate. Typically, breaks should be given to adult audiences every hour and a half. You may add other topics as appropriate. Also, invite participants to silence their phones or other electronics, and invite them to leave the room if they need to take a call.

Transition to the beginning of your session by stating, "While we all have opinions and perspectives of what culture is, as professionals it is important that we recognize that all perspectives are valuable. In this training, I invite you to share your experiences with the group." Discuss if you would like individuals to offer their thoughts and questions as they have them, or if you would prefer it if they waited until question-and-answer periods at the end of each section.

Refer participants to the training agenda. Review the agenda. Ask if there are any questions about the agenda or logistics.

You may encourage participants to review their training materials, which should include a Trainer guide and Participant Guide with slides. These materials contain everything they will need to facilitate training in the future.

Please note that copies of the training materials are available upon request from the National Hispanic and Latino Mental Health Technology Transfer Center and will be available at the Center's webpage: National Hispanic and Latino MHTTC | Mental Health Technology Transfer Center (MHTTC) Network (mhttcnetwork.org)

Goals and Objectives

Module Goal: This module will provide training on best practices in the engagement and treatment phase of mental health treatment with Hispanic and Latino clients.

Module Objectives:

1) Participants will be able to identify three cultural elements that inform mental health assessment and treatment interventions with Hispanic and Latino individuals.

2) Participants will be able to list and discuss at least two specific evidence-based interventions and techniques in Latino mental health.

3) Participants will be able to demonstrate two culturally informed assessment and treatment techniques shown to be effective with Latino clients.

Cultural Values of Hispanic and Latino Populations that Impact the Engagement Phase

Cultural values are embedded in every interaction that we have with our clients. It influences our perceptions, our feelings, and our actions throughout the life of the case. The assessment and treatment planning phases are important; however, they only make up a small portion of the treatment process. Engagement and treatment occur for the rest of the life of the case.

Providers need to be familiar with normative cultural values that affect interactions with clients from Hispanic and Latino cultures. Even if the provider is Hispanic or Latino, cultural biases about their own ethnicity may prevent them from seeing the cultural nuances that impact their client's experience. It is impossible to know everything about any culture, therefore, using consultation, professional development, published references, and by speaking to interpreters and community members, a provider can continue to increase their knowledge about culture.

To develop a culturally competent perspective, a provider needs to understand his or her own health beliefs and behaviors first to understand his or her biases and perspective. Factors such as socioeconomics, education, language, and degree of assimilation impact health beliefs and behaviors. In addition to those visible factors, there are also several invisible factors that impact a client's ability to engage in treatment. Following is a list of frequently seen values in Hispanic and Latino individuals and families. Although these values may be present in a person's belief system, they may occur to differing degrees, and they may change over the life of the case as the client continues to assimilate.

Confianza – Trust (Element of Therapeutic Alliance – True Agent of Change)
Confianza, or trust, is a form of mutual emotional reciprocity for many Hispanic and Latino individuals. In a particularistic culture, having trust in a professional means having faith that individual will help you to the best of their ability, and that person will work to give you the best service because you have developed a relationship with trust. Within European and US cultures, there is less of a reliance of trust and personalismo in the therapeutic relationship as there is more of an importance placed on codes of ethics, professional conduct, and explicitly stated formal rules that dictate how a professional will behave. It is important to acknowledge and appreciate that professional, ethical conduct and personalismo are powerful when yoked together by the Therapeutic Alliance, which is often considered the true agent of change in any psychotherapy. In Latin American cultures, there may be more of an emphasis placed on the mutual reciprocity of the relationship. Social obligations

are based on social relationships with others, which extends into therapeutic relationships as well. Additionally, small self-disclosures may be helpful in establishing trust (Falicov, 1982.)

Personalismo – Formal Friendliness (Element of Therapeutic Alliance – True Agent of Change)
"Confianza" discusses the relationship between two people; "personalismo" refers to how one behaves within that relationship. Hispanic and Latino individuals expect health care providers to demonstrate simpatia (kindness) and personalismo. If these values are not expressed, the Hispanic or Latino individual may feel slighted and mistrusting, and leave treatment prematurely against professional advice. This reduces the likelihood of compliance with the treatment protocol and may hinder the successful resolution of the presenting issue.

Familismo – Familism
Hispanic and Latino individuals tend to be focused on family and their community group as a source of identity and support. Often, these individuals may report that they have few friends outside of their family, extended family, and close family friends. In the case of the immigrant, if there is no family immediately in the area, they may still connect closely with other individuals from their town or area where they immigrated from, or they may connect closely with individuals that their extended family knows, even if they do not know the individual personally. All individuals, including adolescents, are expected to support the family financially and to support one another during tough times. As individuals frequently consult their family regarding decisions, providers who do not recognize the importance of family may encounter conflicts and failure to follow through with treatment. Within the formal relationship of provider and client, and between family members, it is important to recognize the flexible boundaries within the Hispanic and Latino families to avoid pathologizing these boundaries as enmeshed. Research has demonstrated that Latino/a mental health providers that primarily serve Latina/o client frequently implement a flexible understanding of boundaries, and view families holistically when developing an assessment of the family (Manoleas et al., 2000.) Involving the family early in the treatment process may help build Confianza (trust) between the individual, family, and provider. This perspective may help the provider to avoid cultural loading and pathologizing what may be a cultural strength of the client and family.

Respeto – Respect
Hispanic and Latino individuals tend to expect status differences between professionals and non-professionals, which is different than the culture in the United States. There is a high value placed on demonstrating respeto (respect) in interactions with others. Healthcare professionals are seen and experienced as authority figures. This may mean that Hispanic and Latino individuals may hesitate to ask questions about psychotherapy or disagree with the clinician's observations and opinions as it may be perceived as disrespectful. Respeto is expected on a reciprocal basis when healthcare professionals work with older Hispanic or Latino clients. The expectation is that the younger healthcare professional should behave in a formal manner, using appropriate titles such as Doctora Rodriguez. Doña Maria, Señora Maria. Ask, "How do you want me to address you?"

Cultural Values of Hispanic and Latino Populations that Impact the Treatment Phase

Although cultural values can impact any period of treatment, there are a few specific values that most affect the treatment phase due to the pervasive way that these values impact the client's perception of identity.

Machismo
Machismo is the male gender construction that influences sociocultural conditions and the identity development of males in Hispanic and Latin American countries. It is a form of masculinity that promotes male dominance and superiority. It also refers to having pride, being courageous, and being valorous. Machismo is typically used in a negative way to refer to extreme masculinity and to promote dominance. However, it can also be used in a positive way to refer to having positive self-pride and taking responsibility for one's family and responsibilities. Often, men who have been socialized to be "machos" struggle with accepting appropriate emotions and vulnerability and may participate in demeaning ways toward women. This may be socially acceptable and even encouraged in their families, which may have a double standard for male and female children. In treatment, this may mean that the client minimizes symptoms or avoid routine care all together. If a diagnosis is perceived as a weakness, the client may not be willing to request support from family members as it would impact how they are perceived by family members. Therefore, men are more likely to function while living with a substance use disorder and may go longer without mental health treatment with the goal of avoiding asking for help (Fragoso, 2000; Rivera-Ramos, & Buki, 2011; Sobralske, 2006.) The provider should maintain a stance that accepts strength and weakness, and that provides respect for the client at all stages of illness.

Marianismo
Marianismo is the female equivalent of machismo. It is rooted in the image of the Virgin Mary, and incorporates the concepts of saintliness, submissiveness, and feminine behavior. Marianismo expects women to accept their roles as mothers and wives, and to be humble, pure, kind, unassertive, and vulnerable. However, marianismo can also be interpreted as being a provider to one's children, and as having the strength necessary to care for one's family. This characteristic may impact treatment as the client may minimize symptoms or neglect treatment to care for her family and handle responsibilities of her family. The provider should be open to the client's priorities in managing her illness to develop a plan that will consider the client's values regarding her treatment (Kouymdjjian, Zamboaga, & Hansen, 2003.)

Fatalismo/Spirituality Resilience
Many Hispanic and Latino individuals are very spiritual, and many are also deeply religious. The term fatalismo (fatalism) expresses the belief that the individual cannot do much to alter their fate. Idioms expressed as "Si no hay otra," (There is no other life"), "Asi es la vida," ("That's how life is") "Siempre sudando la gota gorda," ("Always sweating the fat drop.") Hispanic and Latino individuals may believe that their illness is a spiritual punishment, and therefore, they may be less likely to seek treatment for symptoms and instead rely on prayer, confession, or forgiveness to relieve their distress. They may also decline new and aggressive therapies. The Latino culture tends to tolerate more uncertainty than the majority culture in the United States and is more comfortable with the unknown.

In addition to fatalismo, individuals from this culture may have a lower drive to access and manage their own healthcare, as Hispanic and Latino individuals tend to have a stronger belief that what happens to them is in the hands of their higher power. Routine appointments may not make sense to people that believe that fate oversees their health.

Overall, it is important to respect the individual beliefs of clients, while also offering them education and options for wellness. Understanding the above values can help providers begin this understanding.

Therapeutic Elements of the Engagement Phase

Development of the Therapeutic Relationship
During the engagement phase, the provider can develop the therapeutic relationship that will support the therapeutic interventions. Cultural differences between the individual and the provider may also impact the level of communication. If the provider is not aware of these differences, they may impact diagnosis and treatment. Differing experiences of justice, oppression and discrimination can impact the establishment of therapeutic rapport.

Cultural differences may also affect the client's expectations about the treatment experience. Misunderstandings of these expectations and the expression of values may lead to difficulties for the provider in soliciting symptoms, difficulties in developing needed therapeutic rapport, and a misunderstanding of the significance of symptoms. The provider must consider the client's values, but the provider must also suspend judgment in order not to assume cultural norms. The areas that are most impacted in the engagement and treatment phase are in the expression of empathy, transference, and countertransference.

In the development of the therapeutic relationship, the provider must be clear on the nature of the relationship, expectations of the provider, and potential confidentiality issues, and must have a good understanding of the expectations of the client. Additionally, the provider must maintain an open but attentive stance to identify potential ethical issues or conflicts of interest that may impact the relationship. Expressing to the client any concerns or misunderstandings provides the respect required to maintain a therapeutic rapport.

Expression of Empathy
In its most simple form, empathy is defined as "feeling in oneself the feeling of others" (Strayer, 1987). As each participant in cross-cultural communication is a member of their own social and cultural context, the therapeutic intervention may be impacted by the same issues that impact interethnic relations in the larger society (Blue and Gonzalez, 1992). "By encouraging the elaboration of ethnoculturally-focused devaluing concepts and feelings, the provider can offer patients a richer opportunity to know and resolve their own ethnocultural and racial conflicts" (Comas-Días, 1991). This interpretation stems from the provider's ability to empathize with the client regarding their cultural experiences and their culturally based perspective. An initial goal in a therapeutic relationship is to build rapport and demonstrate empathy, warmth, and genuineness (Gilbert and Leahy, 2007). According to Wang et al., (2003) ethnocultural empathy involves three instrumental aspects: intellectual empathy, empathic emotions, and the communication of those two elements. If the provider is not able to understand the situation of the client from a knowledge base of his or her culture, identify the provider's own emotions about those factors, and then express these concepts in a constructive way to the client, the client will not feel that the provider utterly understands them and "feels" for them.

Transference
Understanding the process of ethnocultural transference can help the client understand and accept parts of his identity which he has not been able to integrate, which may lead to a deeper therapeutic experience (Wang et al., 2003.) Transference is defined as the unconscious redirection of feelings from one person to another. Within the therapeutic relationship, this means that the client may be attributing unconscious thoughts and feelings toward the provider. According to Comas-Dias and Jacobsen (1991), patients' racial and ethnic remarks in therapy are often attributed to a defensive shift away from underlying conflict. This approach hinders the exploration of conflicts related to ethnicity and culture (p.392). When the provider can accept and acknowledge the client's racial and

ethnocultural transference, these concepts can be dealt with in a way that increases the client's ability to resolve conflicts.

Countertransference

During the therapeutic session, the experience, expression, and explanation of symptomatology is bound to the provider's and client's intersubjective perspective, which is impacted by each person's culture. (Hardy, Cahill, & Barkham, 2007). This intersubjective experience is communicated in the session through cross cultural communication. This communication constantly occurs between the provider and client; once it is received, it is interpreted, and then is re-communicated to continue to influence the perceptions of both the client and provider. This interpretation, plus the provider's experience of empathy or lack of empathy, leads to ethnocultural countertransference, which is defined by Lilian Comas-Diaz and Frederick Jacobsen as the provider's own repressed feelings in reaction to the emotions, experiences, or problems of a person undergoing treatment, as specifically related to the race and ethnicity of the provider and client (Comas-Diaz & Jacobsen, 1991). Qureshi (2011) defined ethnocultural countertransference as "the unconscious projection of ethnic and racial prejudice onto the patient, which has a direct impact on diagnosis and the development of the therapeutic relationship" (p.1798). In both cases, the potential impact of the provider's perception and communication of racial and ethnic norms significantly impacts the client. As with all countertransference, the primary goal is for the provider to be aware of his or her own biases and to explore the impact of those biases in supervision in order to avoid a negative impact on the client.

Impact of an Intracultural Relationship

Although client-provider matching is frequently cited as a positive service to offer, providers may be less attuned to cultural conflict as they assume that the client shares the same cultural values. According to Comas-Díaz and Jacobsen (1991), there are several countertransference reactions that may impact the relationship. These may include: overidentification with the client, the feeling of "us and them," distancing oneself from the client, cultural myopia of not seeing any cultural conflict, ambivalence about the client's situation, anger toward the client regarding the cultural conflict, survivor's guilt, or hope and despair regarding cultural conflict and struggle.

The client may struggle with similar issues. Comas-Díaz and Jacobsen also hypothesized that the client may participate in a complete idealization of the provider as omniscient and omnipotent. This may impair communication if the client is not open with the provider as he believes that the provider knows everything. The opposite of this is if the client feels that the provider is a traitor for his success, and therefore the client does not trust the provider. The client may also experience feelings of auto racism, in which the client does not want to work with a provider of his own race because of their own negative feelings about their race. Lastly, they may feel ambivalence of initial comfort with the provider but also fear too much closeness. These transferential issues may impact the development of the therapeutic rapport, and progression in treatment.

Impact of an Intercultural Relationship

An intercultural relationship between a client and provider who are racially and ethnically dissimilar may present challenges, according to Comas-Díaz and Jacobsen (1991). The provider may deny ethnocultural differences and hold that all clients should be treated the same. The provider may endorse color-blindness, or just deny that issues of ethnicity and race are important for that specific client. Conversely, the provider may appear overly interested and become a clinical anthropologist. This is when the provider spends an inordinate time in treatment discussing the impact of cultural

occurring. Additionally, the provider may feel guilt or pity, or even aggression toward the client due to institutional racism that the client experiences. Lastly, the provider may feel ambivalence due to a lack of clarity regarding his or her own cultural experiences, and therefore the provider may struggle to recognize the client's experience.

The client may also experience intercultural transference in four primary ways. This may include over-compliance and friendliness, as when there is a social power differential that causes a client to be overly compliant in an attempt not to reinforce negative stereotypes. This may also cause a denial of ethnicity and culture to avoid their own internal racial conflict or perceived racial conflict with others. Mistrust, suspicion, and hostility can also occur, as the client may not perceive that the provider can understand her, and then behave in a hostile manner. Lastly, there may be ambivalence, as the client may have negative feelings, but may not know productive ways to discuss them or to process them (Comas-Díaz & Jacobsen, 1991).

Ethnocultural issues are woven within every therapeutic interaction; acknowledging them does not diminish the unique individual or relationship that develops between the client and the provider. As the provider, we must be aware of our communication and the impact of our ethnicity on the expression of our ideas and meanings. Additionally, we must recognize our own level of cultural knowledge and ethnocultural empathy and how we communicate ideas regarding ethnicity, race, and identity. Also, we need to be aware of the ethnocultural transference and countertransference, and the impact of those factors on the provider/client relationship.

The Impact of Evidence Based Therapies on the Engagement and Treatment Phase with Hispanic and Latino Populations

One of the primary tools to incorporating cultural values and concepts into culturally competent treatment is by using a therapy that is Evidence-Based, and that can be adapted to incorporate the client's cultural experience into the treatment. Following are three therapies that have been reviewed by SAMHSA, and that are effective with substance affected Hispanic and Latino families.

Cognitive Mental Therapies

A Cultural Adaptation of Cognitive Mental Therapy (CBT) for Puerto Rican Youth is a short-term intervention that was developed for adolescents with severe depression. This adaptation considers and adapts cultural developmental, and socioeconomic factors. It includes adaptation regarding all the ecological validity framework addressed by Bernal, Jiménez-Chafey, and Domenech Rodríguez (2009).

Dialectical Behavior Therapy (DBT) is an approach developed from cognitive-mental principles. DBT focuses on capability enhancement, motivational enhancement, and generalization to outside environments. As this therapy focuses on changing specific thoughts in the individual's specific environment, it can be adapted to integrate elements of the individual's culture to increase the effectiveness of treatment (Fuchs et al., 2013).

Motivational Enhancement Therapy

Motivational Enhancement Therapy was adapted from motivational interviewing. As it incorporates a normative assessment, it can be adapted to include the client's perception of norms based on their cultural experience. This uses an empathic and strategic approach in which works to increase intrinsic motivation to change substance use behaviors by using the client's motivation and commitment to change. This can be adapted to integrate the client's personal beliefs, family support, and specific environmental strengths to maximize the benefit of treatment (Miller, 1995; 1994).

Trauma Informed Therapies

Seeking Safety is an evidence-based counseling model used to help clients who have experienced trauma and substance abuse. The primary goal is helping the clients attain safety in their relationships, thinking, behavior, and emotions through integrated treatment, a focus on ideals, a focus on cognitive, mental, interpersonal, and case management, and a focus on the clinician's process as it impacts the treatment. This model has been proven effective with Hispanic and Latino populations as it is highly flexible in incorporating the client's perspective and values, while also considering the impact of the clinician's processes (Najavits, 2001).

The Trauma Recovery and Empowerment Model (TREM) is a group treatment designed to empower, provide trauma education, and to provide opportunities for skill-building. As this treatment also focuses on understanding the client's environment and values to increase their experiences, it is highly adaptable to Hispanic and Latino populations (Harris, 1998).

Family Therapies

There are also multiple family therapies that have been found to be effective with Hispanic and Latino populations with mental health and substance use disorders, especially when one considers that Latino families are sociocentric making family therapy a treatment choice with relevance to Latino cultures. These include Celebrating Families, which is a parenting skills program for parents in the initial stages of recovery, Family Support Network, which includes elements of Motivational Enhancement Therapy/Cognitive Mental Therapy, Functional Family Therapy for Adolescent Alcohol and Drug use, Multidimensional Family Therapy, and Network Therapy. All these therapies have provided evidence that they are effective with substance use disorders and that they are readily adaptable to the client's cultural needs (Dennis, et al., 2004; Liddle, et al., 2008; Pratt, 2000; Waldron, et al., 2013).

Lastly, in addition to the above treatments is Brief Strategic Family Therapy (BSFT). This treatment is an evidence-based, family-focused intervention that improves family interaction and reduces delinquency and drug use. The therapist engages both the individual and the family system separately and jointly to identify interactional patterns. Research has demonstrated BSFT and other family therapies such as Structural Family Therapy developed by Latino psychoanalyst turned family therapist, Salvador Minuchin, MD, to be highly effective with the Hispanic and Latino population (Santisteban, et al., 2003; Minuchin, 1960).

Although there are multiple theories that have been proven to be evidence based and effective with Hispanic and Latino clients, the challenge to the provider is to move beyond their own belief system to culturally meet with sensitivity the client where they are in the context of the therapeutic relationship. Within an evidence-based treatment framework that allows for cultural sensitivity, the provider can meet the client where he or she is in order to develop and engage the client effectively.

Application: Provider Self-Assessment and Reflection

Self-assessment is an ongoing process that everyone must participate in so that he may develop cultural humility in a variety of contexts and with a variety of populations. In this activity, the group will complete Cultural Humility Scale (2013).

TI-ROC_Cultural_Humility_Scale_FINAL.pdf

1) Where did you find your greatest strengths in your cultural humility?

2) Based on our discussion today and the assessment, what is one thing that you can change in your practice to increase your cultural humility?

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APPENDIX A – MODULE ONE PARTICIPANT HANDOUT

A report was received by the state Child Protective Services department regarding Gabriela and John. Gabriela is a 24-year-old Spanish speaking Mexican woman who immigrated to the United States 6 months ago after she married John. John is a 43-year-old bilingual Mexican man who has lived in the United States for over 25 years and who is a United States citizen. A report was made by police reporting that John had slapped Gabriela in front of her 4-year-old son, Samuel. Samuel is Gabriela's son from a previous relationship; she is also four months pregnant.

John and Gabriela met two years ago when John went to visit family in Mexico, where he was introduced to Gabriela. He reports that he went to Mexico specifically to find a wife. He had previously been married to a Puerto Rican woman for 18 years but divorced. He has two children, ages 12 and 14, from this relationship, whom he has visitation with on a weekly basis. John owns a construction business and his house. John has a history of depression and alcohol use, but the specifics of his current use are unknown.

Gabriela reports that she is currently in the United States on a VISA, and she cannot work. Gabriela's family lives in Mexico, however, she has developed a strong relationship with her neighbors, and helps them out by cooking for them on a regular basis, which they pay her for. She has also developed relationships at the church and is on friendly terms with John's ex-wife. She reports feeling anxious, having trouble sleeping and loss of appetite for the last six months.

As a child welfare agency, your goal is to assess the family's needs and create a plan to resolve the current issues. Please discuss the following:

1) What beliefs, stereotypes, and assumptions might a worker have when approaching this family?
2) What beliefs, stereotypes, and assumptions might Gabriela and John have about Child Welfare Services when working with the agency?
3) Based on the information provided in this scenario, what are the primary challenges facing this family?
4) Based on the information provided in this scenario, what are the primary strengths facing this family?
5) How might the worker's supervisor support the worker in delivering culturally competent services to this family?

APPENDIX B – MODULE TWO PARTICIPANT HANDOUT

The Case of Elena

Elena is a 50-year-old Guatemalan woman, with a 6-year history of mental health treatment for Generalized Anxiety Disorder. Within the last 6 years, Elena has experienced the following symptoms: panic attacks, shortness of breath, tearfulness, and paranoid thoughts. She reports that in the last two weeks she has experienced sleeplessness, weight loss, obsessive thoughts, and "nervousness." She reports that within the last week, she has felt that she is being watched when she is alone and has a feeling of being out of control.

Elena was born in rural Guatemala. She completed a 2nd grade education. She immigrated to the United States 20 years ago to join her husband. He died 10 years ago in a car accident. Elena cleaned houses for the first 10 years that she lived in the United States. After her husband's death, she struggled to maintain employment. Elena has 2 children, a boy who is 28, and a girl that is 32. Her daughter currently lives in the home and helps care for her.

Elena has a history of poor medication compliance as she states that she has the feeling that her doctor is not trying to help her. She is currently receiving services at an outpatient Latino Clinic, where her symptoms of anxiety reassessed as "ataque de nervios".

Questions:

1) What would you like to know about the client that you do not already know?
2) Which questions would be most helpful during your intake interview to identify her current treatment needs?
3) Imagine that Elena lives in your town. What cultural factors would need to be considered based on living in that social and political environment?
4) How might you use the Cultural Formulation Interview – Informant Version in Elena's assessment?

APPENDIX C - MODULE THREE PARTICIPANT HANDOUT

The Case of María

María is a 33-year-old Cuban woman. She has an 8-year history of Major Depressive Disorder, which began after she arrived in the United States. Although she has never been suicidal, she experiences the following symptoms: lack of appetite with significant weight loss, insomnia, irritability and rage, and nightmares. At times, she will go months without symptoms, but then will have several months of debilitating symptoms which have caused her to miss several days of work at a time due to depression and insomnia. During the assessment, she was well groomed and well spoken, but tearful when discussing her symptoms.

María was born in Cuba. She completed a 12th grade education, and some college. She reported that she was married and divorced in Cuba, and after the divorce she decided to live with her sister in America. To do so, she had to leave her now 13-year-old daughter with her ex-husband. Although she feels that her ex-husband was an adequate father, her daughter, when she was 6, had an accident a year after she left Cuba. This accident caused her daughter to be paralyzed, and her daughter is not able to communicate. Her daughter is cared for by her ex-husband's family. Maria continually feels that this accident was her fault, and that there are "bad spirits" over her family as she abandoned her daughter. Maria can communicate with her ex-husband and daughter via video, however, her daughter cannot communicate and does not appear to recognize María.

María continues to live with her sister's family, and she works in a downtown office as a secretary. Her English is good; however, she frequently does not feel accepted by the other office workers. She feels that sometimes they do not understand her. Maria spends most of her free time in the Cuban neighborhood and speaks Spanish in her sister's home. She has considered returning to Cuba, however, her parents passed away over a decade ago, and her sister is her primary support system. Maria reports that she enjoys spending time with her neighbors, when she is feeling good. However, whenever she is feeling good, she feels that something bad is around the corner, and so she never feels that she can totally be comfortable. Maria's general practitioner prescribed her an anti-anxiety medication; Maria reports that sometimes she takes more than she is prescribed so that she can go to work. She has fallen asleep at work on more than one occasion after taking too much; her employer did not find out, but Maria is afraid that if her employer discovered her sleeping at work that she would be fired.

María attempted counseling with an agency close to her work, however, the provider told her that she needed to move on and become independent. Maria did not feel that she was able to do so. Maria wants to figure out what she needs to do to move forward, but also feels that her symptoms are her punishment for what happened to her daughter.

Questions

Based on the example, identify how the cultural expressions of distress may be impacting María:

1) What would you like to know about the client that you do not already know?
2) How might an understanding of cultural syndromes help the assessment and treatment plan for María?
3) How might an understanding of cultural idioms of distress help María's treatment?
4) How might cultural explanations of illness impact María's commitment and motivation for treatment?

APPENDIX D - MODULE FOUR PARTICIPANT HANDOUT

You have been assigned to develop and lead a mandated group of individuals that have been convicted of driving under the influence of alcohol. The population that will attend your group are primarily Mexican men, most who have immigrated to the United States within the last 15 years. In the group that you are leading, you have found that a significant number of the men show depressive symptoms and have evidence of Post-Traumatic Stress Disorder. This group is offered by a substance abuse agency in a large metropolitan area in the United States. Your task is to identify culturally appropriate interventions for the group.

1) How will you identify the cultural needs of the group?

2) Based on the ecological validity model, name four adaptations that you can make in providing the group.

3) How will you measure if these adaptations have been effective?

4) How will you balance the cultural needs of the group with the requirements of the Department of Transportation authorized curriculum?

APPENDIX E – MODULE FIVE PARTICIPANT HANDOUT

PROMOTING CULTURAL AND LINGUISTIC COMPETENCY

Self-Assessment Checklist for Personnel Providing Primary Health Care Services

Tawara D. Goode

National Center for Cultural Competence ▪ Georgetown University Center for Child & Human Development▪ University Center for Excellence in Developmental Disabilities, Education, Research & Service ▪ Adapted Promoting Cultural Competence and Cultural Diversity for Personnel Providing Services and Supports to Children with Special Health Care Needs and their Families ▪ June 1989 (Revised 2009)

Directions: Please select A, B, or C for each item listed below.

A = Things I do frequently, or statement applies to me to a great degree
B = Things I do occasionally, or statement applies to me to a moderate degree
C = Things I do rarely or never, or statement applies to me to minimal degree or not at all

PHYSICAL ENVIRONMENT, MATERIALS & RESOURCES

_____ 1. I display pictures, posters, artwork and other decor that reflect the cultures and ethnic backgrounds of clients served by my program or agency.
_____ 2. I ensure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different cultures and languages of individuals and families served by my program or agency.
_____ 3. When using videos, films or other media resources for health education, treatment or other interventions, I ensure that they reflect the culture and ethnic backgrounds of individuals and families served by my program or agency.
_____4. I ensure that printed information disseminated by my agency or program takes into account the average literacy levels of individuals and families receiving services.

COMMUNICATION STYLES

5. When interacting with individuals and families who have limited English proficiency I always keep in mind that: _____ * limitations in English proficiency are in no way a reflection of their level of intellectual functioning. _____ * their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin. _____ * they may neither be literate in their language of origin nor in English.
_____ 6. I use bilingual/bicultural or multilingual/multicultural staff, and/or personnel and volunteers who are skilled or certified in the provision of medical interpretation services during treatment, interventions, meetings or other events for individuals and families who need or prefer this level of assistance.
_____ 7. For individuals and families who speak languages or dialects other than English, I attempt to learn and use key words so that I am better able to communicate with them during assessment, treatment or other interventions.
_____ 8. I attempt to determine any familial colloquialisms used by individuals or families that may impact on assessment, treatment, health promotion and education or other interventions.
_____ 9. For those who request or need this service, I ensure that all notices and communiqués to individuals and families are written in their language of origin.
_____ 10. I understand that it may be necessary to use alternatives to written communications for some individuals and families, as word of mouth may be a preferred method of receiving information.

_____ 11. I understand the principles and practices of linguistic competency and: _____ * apply them within my program or agency. _____ * advocate for them within my program or agency.
_____ 12. I understand the implications of health literacy within the context of my roles and responsibilities.
_____ 13. I use alternative formats and varied approaches to communicate and share information with individuals and/or their family members who experience disability.

VALUES & ATTITUDES

_____ 14. I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.
_____ 15. I screen books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with individuals and families served by my program or agency.
_____ 16. I intervene in an appropriate manner when I observe other staff or clients within my program or agency engaging in behaviors that show cultural insensitivity, racial biases, and prejudice.
_____ 17. I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture.
_____ 18. I understand and accept that family is defined differently by different cultures (e.g. extended family members, fictive kin, godparents).
_____ 19. I accept and respect that male-female roles may vary significantly among different cultures (e.g. who makes major decisions for the family).
_____ 20. I understand that age and life cycle factors must be considered in interactions with individuals and families (e.g. high value placed on the decision of elders, the role of eldest male or female in families, or roles and expectation of children within the family).
_____ 21. Even though my professional or moral viewpoints may differ, I accept individuals and families as the ultimate decision makers for services and supports impacting their lives.
_____ 22. I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures.
_____ 23. I accept that religion and other beliefs may influence how individuals and families respond to illnesses, disease, and death.
_____ 24. I understand that the perception of health, wellness, and preventive health services have different meanings to different cultural groups.
_____ 25. I recognize and understand that beliefs and concepts of emotional well-being vary significantly from culture to culture.
_____ 26. I understand that beliefs about mental illness and emotional disability are culturally based. I accept that responses to these conditions and related treatment/interventions are heavily influenced by culture.
_____ 27. I recognize and accept that folk and religious beliefs may influence an individual's or family's reaction and approach to a child born with a disability, or later diagnosed with a disability, genetic disorder, or special health care needs.
_____ 28. I understand that grief and bereavement are influenced by culture.
_____ 29. I accept and respect that customs and beliefs about food, its value, preparation, and use are different from culture to culture.
_____ 30. I seek information from individuals, families or other key community informants that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse groups served by my program or agency.
_____ 31. Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs, and expectations that are unique to the culturally diverse groups served by my program or agency.
_____ 32. I keep abreast of the major health and mental health concerns and issues for ethnically and racially diverse client populations residing in the geographic locale served by my program or agency.
_____ 33. I am aware of specific health and mental health disparities and their prevalence within the communities served by my program or agency.
_____ 34. I am aware of the socio-economic and environmental risk factors that contribute to health and mental health disparities or other major health problems of culturally and linguistically diverse populations served by my program or agency.

_____ 35. I am well versed in the most current and proven practices, treatments, and interventions for the delivery of health and mental health care to specific racial, ethnic, cultural and linguistic groups within the geographic locale served by my agency or program.

_____ 36. I avail myself to professional development and training to enhance my knowledge and skills in the provision of services and supports to culturally, and linguistically diverse groups.

_____ 37. I advocate for the review of my program's or agency's mission statement, goals, policies, and procedures to ensure that they incorporate principles and practices that promote cultural and linguistic competence.

This checklist is intended to heighten the awareness and sensitivity of personnel to the importance of cultural and linguistic cultural competence in health, mental health and human service settings. It provides concrete examples of the kinds of beliefs, attitudes, values and practices which foster cultural and linguistic competence at the individual or practitioner level. There is no answer key with correct responses. However, if you frequently responded "C", you may not necessarily demonstrate beliefs, attitudes, values and practices that promote cultural and linguistic competence within health and mental health care.

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