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CLINICAL APPROACHES TO WORKING WITH LATINO ADULTS

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As others in this handbook have noted, there exist several compelling reasons to identify and disseminate effective clinical approaches to working with Latinos. In particular, the Latino population in the United States has grown tremendously over the past 10 years, and census data predict that by 2050 the number of Latinos will exceed 125 million and represent more than one fourth of the U.S. population (Passel & Cohn, 2008). In addition, a large body of literature has documented pervasive health-care disparities affecting Latinos (U.S. Department of Health and Human Services [USDHHS], 2001), suggesting that existing clinical interventions may inadequately address the needs of Latinos.

However, despite the increased attention to the development and provision of culturally appropriate clinical services for Latinos, there remain significant disparities in the mental health care received by Latinos (Blanco et al., 2007; Vega et al., 2007). We suggest that one explanation for these continuing health-care disparities may be found in the difficulty the mental health field has had in conceptualizing how best to integrate cultural considerations into clinical work (Cardemil, 2008). In particular, while there exist many different perspectives in the literature on what constitutes acceptable integration of culture into

psychotherapy (e.g., Atkinson, Bui, & Mori, 2001; Bernal & Sáez-Santiago, 2006; Hall, 2001; La Roche, 2002; Whaley & Davis, 2007), there is no overarching framework into which to organize these different perspectives. For example, the American Psychological Association has published a set of guidelines for clinicians who work with individuals from ethnic, linguistic, and culturally diverse backgrounds (American Psychological Association [APA], 1993). These guidelines focus exclusively on therapist attitudes toward issues of diversity, knowledge about particular ethnic and cultural groups, and behaviors when working with individuals from different backgrounds. No mention is made, however, about the ways in which particular interventions may or may not need to be adapted for work with particular groups of individuals. As a result, many interested clinicians and scholars may remain unsure about how to proceed with efforts to consider cultural issues in their treatment approaches with Latinos.

In this chapter, we concretize a framework proposed by Cardemil (2008) in which different perspectives on how to incorporate conceptions of culture are organized according to a variety of assumptions regarding the active therapeutic ingredients and their relation to culture. We

begin by first briefly reviewing the mental health-care disparities that disproportionately affect Latino adults, in order to highlight the point that cultural considerations must begin at the systems level. Next, we describe three different perspectives on the integration of cultural considerations into clinical work with Latinos. We conclude with recommendations for clinical work and future research directions.

MENTAL HEALTH-CARE DISPARITIES AFFECTING LATINOS

Efforts to identify effective clinical approaches to working with Latinos must begin by understanding the mental health-care disparities that disproportionately affect Latinos. Considerable research has found that Latinos are less likely to receive formal mental health services (Alegría et al., 2002; Vega, Kolody, Aguilar-Gaxiola, & Catalano, 1999), especially if they are less acculturated or recent immigrants (Alegría et al., 2007; Cabassa, Zayas, & Hansen, 2006; Vega et al., 1999). Moreover, when low-income Latinos do seek services, they are more likely to prematurely terminate them (e.g., Organista, Muñoz, & González, 1994). With regard to pharmacotherapy, researchers have found that Latinos are less likely to use medication (Miranda & Cooper, 2004), as well as more likely to demonstrate worse treatment adherence to the medication regimen in disorders like depression (Sánchez-Lacay et al., 2001) and schizophrenia (Opolka, Rascati, Brown, & Gibson, 2003). Some research has even found poorer response to antidepressant medication among Latinos (Lesser et al., 2007). These disparities in use of formal mental health services have been found even when controlling for sociodemographic and clinical characteristics (Lagomasino et al., 2005; Padgett, Patrick, Burns, & Schlesinger, 1994), suggesting that mental health-care disparities are not simply the result of economic factors like poverty. Particularly troubling is that despite the increased recognition of these disparities, some recent research has found that mental health-care disparities for Latinos increased between the years 1993 and 2002 (Blanco et al., 2007).

Researchers have identified many reasons for these disparities in use of mental health services by Latinos (e.g., Alegría et al., 2002; Cabassa et al., 2006; Dwight-Johnson, Lagomasino, Aisenberg, & Hay, 2004). Some of the explanations have focused on systems-level barriers (e.g., dearth of Spanish-speaking service providers, lack of insurance), while others have focused on patient-level barriers (e.g., cultural differences in conceptions of mental health, concern regarding stigma; Harman, Edlund, & Fortney, 2004; López, 2002; USDHHS, 2001, 2005).

These mental health-care disparities are troubling and highlight the point that issues of culture are not limited to clinical work. That is, efforts to make clinical work culturally relevant to Latinos should begin at the level of the system and the organization, not merely at the level of the individual clinician. Some of these efforts could include innovative approaches to recruiting and retaining bilingual and bicultural providers, searching for funding sources to complement the insurance limitations that may exist in particular communities, and identifying mechanisms to overcome such common logistical obstacles as lack of transportation or child care. A more detailed examination of systems-level changes that could address the systems and organizational barriers that hinder the delivery of services to Latinos is beyond the scope of this paper. Nevertheless, they warrant mention, given the research documenting the effect of such barriers on Latinos' access to mental health services.

INTEGRATION OF CULTURAL CONSIDERATIONS INTO CLINICAL WORK WITH LATINOS

In addition to creating systemic changes to make treatment more accessible to Latinos, many scholars have argued that effective clinical work with Latinos is best accomplished through the consideration of culture in a variety of explicit ways (e.g., Arredondo & Perez, 2003; Bernal & Scharrón-del Río, 2001; Miranda et al., 2005). Given the surge in attention to these issues, it should not be surprising that there exists considerable variability in how scholars conceptualize the best way to integrate culture considerations into therapy. To date, this heterogeneity has gone relatively unexamined, leading to somewhat confusing and contradictory messages regarding what constitutes culturally sensitive treatment.

Our review of the literature has led us to identify at least three different emphases posited

by scholars who support the explicit consideration of culture in psychotherapy. The first focuses on the behavior of the therapist, with explicit recommendations on how to develop cultural competence. The second approach focuses on the treatment itself rather than the therapist and explores how to adapt specific treatments for particular racial, ethnic, and cultural groups. And the third perspective argues that the best way to integrate culture into psychotherapy is by developing novel therapeutic approaches that centralize culture. Each of these perspectives has intuitive appeal and some empirical support, and each has its strengths and limitations. In the following sections, we briefly describe these perspectives and review the literature as it relates specifically to Latinos.

Perspective 1: Culturally Competent Therapists

The first perspective on integrating culture into clinical work focuses primarily on the cultural sensitivity of the therapist and posits that therapists who are *culturally competent* will produce superior outcomes in therapy. Cultural competence has been defined in a variety of ways, but in general it is understood to be a therapist skill that consists of a variety of therapist attitudes, knowledge, and behaviors that allow for effective clinical work when working with culturally diverse populations (e.g., Sue, 1998; Helms & Cook, 1999; Whaley & Davis, 2007). This perspective is most consistent with those published by the APA (1993), which enumerate nine general guidelines related to conducting work with individuals from diverse ethnic, linguistic and cultural groups. In addition to highlighting the importance of self-awareness of how one's own cultural background, experiences, attitudes, values, and biases can influence clinical work, the guidelines also emphasize how critical it is to familiarize oneself with, and acquire relevant knowledge about, particular ethnic groups.

With regard to Latinos, then, cultural competence would include familiarity with and knowledge of the historical, cultural, and political experiences of the various Latino ethnic groups (e.g., Arredondo & Perez, 2003; Gloria, Ruiz, & Castillo, 2004; Mezzich, Ruiz, & Muñoz, 1999). Moreover, it is critical to understand that variability exists across Latinos in conceptions and experiences of mental health and illness, as well

as to be aware that some clients' expressions of emotion and idioms of distress may not match the European American conceptions of mental disorders (e.g. Guarnaccia & Rogler, 1999; Kleinman, 1982; Lewis-Fernández & Diaz, 2002; Rogler, Cortés, & Malgady, 1994). For instance, researchers have found strong evidence for the existence of a culture-specific syndrome, *ataques de nervios,* that is prevalent among Puerto Ricans and not adequately captured by the DSM nosological system (e.g., Guarnaccia, Lewis-Fernández, & Marano, 2003). Other idioms of distress among Latinos that have some empirical support include nostalgia, anger, and disillusionment among Puerto Ricans (Cortés, 2003), and the tendency to express somatically symptoms of mental illness in general and depression in particular (Snowden & Yamada, 2005).

Related to variability in conceptions of mental health and illness is the fact that scholars have noted that some Latinos attempt to make sense of illnesses through the use of nonmedical explanations, such as dream interpretation, spiritual and religious exploration, and supernatural perspectives (La Roche, 2002; Velásquez & Burton, 2004). Some Latinos may seek help from their own cultural healing traditions (e.g. priests, folk healers) in addition to connecting with standard medical-model forms (Delgado & Humm-Delgado, 1984; Rogler & Cortes, 1993; Mezzich et al., 1999). Although belief in these non-DSM and supernatural conceptions of mental health and illness is not uniform across all Latinos, an awareness of their existence can assist clinicians when working with Latinos who may not meet criteria for particular DSM disorders. Moreover, awareness of these perspectives can make it easier for clinicians to consider not adhering so rigidly to the medical model of mental health and illness, a perspective that some authors have suggested is not received well by many Latinos (Arredondo & Perez, 2003).

Many scholars have also noted the importance of understanding the role of Latino cultural values. Others in this book have described these values more fully; we mention them here to highlight their possible role in helping or hindering the treatment process. For example, some have suggested that adherence to the value of *fatalismo* (fatalism) may encourage passivity about overcoming mental health problems. This passivity may make some Latinos less likely to seek treatment (Schraufnagel, Wagner, Miranda,

& Roy-Byrne, 2006) and, among those who do seek treatment, may make them more likely to prefer directive forms of treatment. Others have discussed how the Latino cultural value of *familismo* (familism) might affect treatment seeking. Some have suggested that Latinos with a strong sense of *familismo* might be less likely to seek formal mental health services due to a desire to keep problems within the family (e.g., Vega & Alegría, 2001), while others have noted that Latinos might be particularly responsive to treatment approaches that incorporate family members (Cardemil, Kim, Pinedo, & Miller, 2005; Delgado & Humm-Delgado, 1984). Similarly, the gender roles of *machismo,* which encourages men to project images of strength and self-reliance (Torres, Solberg, & Carlstrom, 2002), and *marianismo,* which encourages women to assume the burden of suffering in the family (Chiriboga, Black, Aranda, & Markides, 2002; Gloria et al., 2004), may be at odds with some of the central goals of treatment, including seeking help, relying on others, and recognizing difficulties in one's life. Interian, Martinez, Guarnaccia, Vega, and Escobar (2007) found evidence that some cultural values (working hard, fighting against problems, *familismo*) contributed to negative attributions about antidepressant medication in a qualitative study of 30 Latino outpatients receiving antidepressant treatment. Again, as with the conceptions of health and sickness, it is important to note that variability exists in adherence to these values both across Latinos and within Latino families. Thus, a comprehensive cultural conceptualization of clients is important in order to understand each particular client's understanding of mental health and illness, the treatment process, and relevant values and worldviews.

This cultural sensitivity or cultural competence must also take into consideration the socioeconomic difficulties that disproportionately affect Latinos. The life stressors that too often accompany financial difficulties (e.g., housing difficulties, exposure to violence, substandard medical care) are not characteristic of Latino culture per se, but they are common experiences of many Latinos living in the United States. Similarly, in order to be culturally competent with Latinos, clinicians must also understand the everyday experiences of prejudice, discrimination, and sense of disenfranchisement that many Latinos report living as a racial/ethnic minority in the United States. Because these experiences are neither limited to Latinos nor directly connected to Latino culture, they may be neglected in clinical work, since their consideration requires a broader conceptualization of the aspects of culture that should be included when attempting to be culturally competent.

Strengths of the Cultural Competence Perspective. The primary strength of this perspective on cultural competence is that it can be taught to and learned by a wide range of therapists from different theoretical orientations. It is true that some multicultural scholars have lamented the slow rate at which considerations of diversity and culture have been integrated into the overall training curricula of clinical psychology programs (e.g., Abreu, Chung, & Atkinson, 2000). Nevertheless, a perspective that limits the definition of cultural competence to the therapist is more readily disseminated than are perspectives of cultural competence that focus on adaptations to existing interventions or the development of novel interventions (see the following sections). Adherents of this perspective can reasonably expect that the numbers of culturally competent therapists will increase through the dissemination of information and opportunities in which to practice particular clinical skills in working with Latinos.

Limitations of the Cultural Competence Perspective. An important limitation of this perspective, however, is the dearth of attention to the relationship between cultural competence and active therapeutic ingredients that presumably differ by theoretical orientation. Although most scholars would likely suggest that cultural competence is necessary but not sufficient to produce positive results in therapy, very little attention has been given to how cultural competence might interact with (or in some cases, interfere with) the therapeutic approaches encouraged by traditional orientations. That is, because most of the major theoretical orientations were developed without consideration of culture, it may be simplistic to assume that they can easily accommodate changes in therapist attitudes and behaviors designed to reflect cultural competence. These incompatibilities can be seen in how therapists conceptualize client distress, as well as in therapist behaviors that emerge from that conceptualization. For example, most traditional therapy orientations

conceptualize distress intrapsychically (e.g., dysfunctional thoughts, unconscious conflicts), whereas models of cultural competence encourage therapists to acknowledge how societal structures can oppress individuals from particular sociodemographic groups. Thus, more reflection is needed regarding how to integrate these different worldviews. Similarly, most traditional therapy orientations have clearly prescribed and proscribed therapy behaviors that may be at odds with particular behaviors recommended by advocates of cultural competency (e.g., informality between therapist and patient, increased self-disclosure on the part of the therapist). The absence of a clear theory that provides a rationale for when to engage in particular behaviors is problematic, since therapists are left without a roadmap for choosing particular techniques and behaviors when conducting clinical work.

This lack of explicit attention to these issues is of concern on many levels, and it may be reflected in the lack of empirical support for the relationship between cultural competence and treatment outcome. That is, although it seems intuitive that greater cultural competence would be associated with improved treatment outcome, we are unaware of any published studies that have documented this association. We suggest that more attention to the congruence, or theoretical fit, between cultural competence and traditional therapy orientations will lead to thoughtfully designed research studies that can examine the relationships among the various therapy ingredients theorized to be related to treatment outcome.

Perspective 2: Cultural Adaptations

The second perspective on culture and therapy argues that the best way to integrate culture into treatment is to adapt existing treatments that have empirical support in ways that make them more culturally relevant and attractive to individuals from different cultures (e.g., Castro, Barrera, & Martinez, 2004; Lau, 2006; Miranda et al., 2005; Muñoz & Mendelsohn, 2005). Contained under the broad category of *cultural adaptations,* these generally include efforts to take established manual-based treatments and adapt them for Latinos. However, we also include in this category those efforts to develop novel treatments specifically for Latinos that are

based on traditional psychotherapeutic theories (e.g., cognitive-behavioral therapy).

Recently, scholars have begun to distinguish between two types of cultural adaptations that lie at the ends of a continuum (Castro et al., 2004; Resnicow, Soler, Braithwaite, Ahluwalia, & Butler, 2000). Superficial, or surface, modifications are those that consist of small changes to the intervention so as to match the delivery of the intervention to observable characteristics of the target population but that leave the vast majority of the original intervention intact. Castro and colleagues (2004) give the example of changing the ethnicity of role models or characters in an intervention so that they resemble more closely the ethnicity of the participants in the program. Another example of a surface-level modification might be the decision to deliver an intervention in a community church rather than in a mental health clinic. Conversely, core, or deep, modifications consist of changes to the intervention that result in more carefully taking into consideration central cultural aspects of the relevant ethnic group. Thus, core modifications might include finding ways to incorporate into program delivery many of the salient cultural values discussed earlier in the first perspective, using relevant cultural expressions, metaphors, and proverbs to convey important themes, and changing program content to be more relevant to the lives of the participants.

Despite the differences between surface and deep cultural adaptations, they are similar in that the cultural adaptations are not typically viewed as active ingredients that will directly contribute to improvement in the functioning of the client (Lau, 2006; Miranda et al., 2006; Muñoz & Mendelson, 2005). Indeed, Castro and colleagues (2004) point out the tension between fidelity and fit, making the case that cultural adaptations that deviate from the core ingredients of the original intervention run the risk of proving ineffective when implemented. As such, then, the cultural adaptations are conceptualized more as the means by which to make existing interventions more attractive and relevant to the participants. The assumption has been that making the interventions more attractive and relevant to participants will make it more likely that participants will stay engaged with the active ingredients of the intervention and thus have improved outcome.

In order to investigate the extent to which researchers have developed and evaluated cultural

adaptations of existing interventions for Latino adults, we conducted a wide review of the empirical treatment literature. We included in our review those studies that focused specifically on Latinos, as well as studies that did not focus specifically on Latinos but included significant numbers of Latinos in the sample. Because of the limited attention clinical psychology has generally given to culture (e.g., La Roche & Christopher, 2008), research that has examined cultural adaptations of interventions with Latino adults is limited. Nevertheless, this limited research investigating the effectiveness of clinical interventions in Latinos has produced promising findings, particularly in the areas of depression and schizophrenia.

Depression. With regard to depression, the majority of interventions for Latino adults have been rooted in cognitive-behavioral approaches to the treatment of depression and demonstrate considerable overlap in the types of cultural adaptations made (e.g., Comas-Díaz, 1981, Miranda et al., 2003a; Miranda, Azocar, Organista, Dwyer, & Areán, 2003b; Muñoz et al., 1995). For example, Miranda and colleagues (2003a, 2003b, 2006) have conducted a variety of randomized, controlled trials to investigate the effectiveness of cognitive-behavioral treatment with low-income racial and ethnic minority women. Across the studies, the authors made similar cultural adaptations to the treatment, including the use of bilingual and bicultural providers, translation of all materials into Spanish, reduction in the number of therapy sessions, and the use of interaction styles that incorporate the Latino values of *respeto, simpatía,* and *personalismo.* In addition, the authors made considerable effort to assist the women in attending their treatment sessions, including intensive outreach, provision of transportation and child care, and encouragement to comply with treatment recommendations. In one study (Miranda et al., 2003a, 2006), the authors provided up to four sessions of an educational meeting in which the women met with their provider to discuss depression and its treatment. In another study (Miranda et al., 2003b), the authors explicitly incorporated case management into the treatment process. Results indicated that the cultural adaptations generally resulted in positive outcomes, particularly as compared with standard community care. Of note, adding the clinical case management appeared to enhance the effect of the cognitive-behavioral

treatment, as well as make it less likely for patients to drop out of therapy. A few other studies that have included Latinos have found similarly positive results with cognitive-behavioral therapy for depression (Areán & Miranda, 1996; Comas-Díaz, 1981, 1986; Organista et al., 1994).

In addition to depression treatment, there exists an emerging literature examining the efficacy of interventions in the prevention of depression. Muñoz and colleagues (Muñoz et al., 1995) conducted an eight-session cognitive-behavioral depression prevention program with a sample of low-income primary care patients, of whom approximately 24% were Latinos. Modifications to delivery (as compared to standard interventions) included the provision of both English- and Spanish-language manuals, as well as modification of vocabulary so as to reach individuals from different education levels. Modifications to content included the use of culturally relevant metaphors and stories as a means to convey key cognitive-behavioral principles, the identification and incorporation of cultural values into relevant intervention strategies (e.g., recognizing that the cultural value of *familismo* may make immigration especially difficult for those who have left family members in their country of origin), and explicit discussion of relevant issues like spirituality and religion, acculturation, and experiences with racism, discrimination, and prejudice (Muñoz & Mendelsohn, 2005). Results from this preventive intervention were generally positive: Participants randomized to the eight-session intervention reported significantly fewer depressive symptoms than those randomized to the control conditions through 1 year of follow-up assessments.

In a similar program, Vega, Valle, Kolody, & Hough (1987) developed a cognitive-behavioral intervention for Latina women defined as at risk by virtue of their status as low income, recently immigrated, and middle aged. The authors incorporated cultural considerations into the intervention in two primary ways. First, the authors identified specific cultural reasons to explain this at-risk status. For example, their research noted that many of these women were experiencing changing role expectations whereby they needed to assume greater responsibility for income, despite having minimal English-speaking ability. Similarly, many of these women had small social support networks due to their status as recent immigrants. In addition, due to the

cultural expectations for women's caregiving duties, many of these women were beginning to experience familial pressure to assist in the rearing and care of newly arriving grandchildren (Vega & Murphy, 1990). Second, the authors used *servidoras,* or indigenous Latina community helpers, to deliver the intervention to participants. In addition to having a no-intervention control condition, the research design had two active conditions: In one condition, the intervention was delivered on a one-to-one basis in the participant's home; in the second condition, the intervention was delivered in a group format in community locations, including churches, schools, and community centers. Both active interventions lasted approximately 12 weeks. Results from this intervention were also positive: Although conservative intent-to-treat analyses produced no significant effects of either intervention condition (as compared to the control conditions), subgroup analyses indicated that both active interventions produced a significant 6-month prevention effect in depressive symptoms among those participants who were initially low symptom at the start of the program (Vega & Murphy, 1990).

In a recently completed uncontrolled trial, Cardemil and colleagues (2005) reported preliminary findings from a six-session, group, cognitive-behavioral depression prevention program developed specifically for low-income Latina mothers. In addition to making many of the same cultural adaptations described earlier, this program was unique in that it explicitly recognized the importance of the family to Latinos by integrating two sessions of a brief family-based intervention with the larger group intervention. Results were promising, as participants in the program reported a significant reduction in symptoms over the course of the program. In addition, the researchers found that those participants who attended at least one family session reported significantly greater improvement in depressive symptoms than did those participants who did not attend any family sessions.

Although the overwhelming majority of cultural adaptations for Latinos have been rooted in cognitive-behavioral theory, our review of the literature identified three additional studies. Two investigated the efficacy of interpersonal psychotherapy (IPT) in samples of low-income, minority women (Spinelli & Endicott, 2003; Zlotnick, Miller, Pearlstein, Howard, & Sweeney, 2006), and one examined the adaptation of a

supportive and psychodynamic group therapy for socioeconomically disadvantaged Latino outpatients with a variety of diagnoses, including mood disorders (Olarte & Masnik, 1985). The two IPT studies both focused on depression during the perinatal period, with Spinelli and Endicott focusing on treating antepartum depression, while Zlotnick and colleagues attempted to prevent postpartum depression. Both studies reported generally favorable results; however, neither provided much information regarding the cultural adaptations.

In contrast, Olarte and Masnik (1985) described in considerable detail how they incorporated cultural elements into the group process in order to enhance cohesion among group members. Participants were welcome to bring traditional dishes or musical instruments to group meetings during relevant holidays, encouraged to bring gifts for other group members and the therapists, and provided with an opportunity to consider the congruence of the group goals with their own cultural values. Although not empirically evaluated, Olarte and Masnik (1985) note that the group therapy was well received by participants and suggest that it is a cost-effective approach that can lead to improvements in functioning among the participants, healthier family environments, and decreased use of emergency rooms for treatment.

Schizophrenia. In addition to cultural adaptations of interventions for depression, a few other adaptations have begun to emerge in the area of schizophrenia. In general, the early psychosocial interventions for schizophrenia were rooted in the research demonstrating that particular forms of family communication around emotion are related to relapse rates (Butzlaff & Hooley, 1998). This research led to a variety of interventions that were highly effective at reducing family conflict through communication training and psychoeducation and subsequently reducing risk for relapse (Mari & Streiner, 1994).

Given the promising nature of these family-based psychosocial interventions for schizophrenia, researchers began to explore their utility with Latinos. Telles and colleagues (1995) conducted one of the first efforts to adapt a standard family-based intervention for Latinos. The authors modified Behavioral Family Management (BFM), a family-based intervention that focuses on psychoeducation, communication training, and problem solving (Falloon, Boyd, &

McGill, 1984). This adaptation could be conceptualized as surface level, since the modifications consisted primarily of "socioculturally appropriate translations and adaptations of the educational and instructional materials" (Telles et al., 1995, p. 474). Results indicated an interesting moderation effect of acculturation. There was no significant effect of the treatment for those Latino participants who were highly acculturated; instead, the best predictor of outcome was medication compliance. Conversely, for the less acculturated Latinos, participation in the BFM was associated with greater likelihood of relapse. The authors suggested that BFM may include activities and exercises that are incongruent with some aspects of Latino culture. They highlight in particular the communication exercises that consisted of speaking directly and assertively with parental figures as at odds with the hierarchical nature of Latino families.

The generally negative findings of BFM with Latinos is consistent with emerging research suggesting that family processes may be differentially related to the course of schizophrenia for Mexican American and Anglo American families (López et al., 2004). In particular, López and colleagues found that for Mexican American families, expressions of familial warmth were a protective factor against relapse, while for Anglo Americans, expressed criticism was a risk factor. Thus, it is plausible that adaptations of standard family-focused interventions for Latinos should pay as much attention to strengthening familial relationships and creating more positive relations as to reducing expressed criticism.

At least partly in response to these ideas, Weisman and colleagues (Weisman, 2005; Weisman, Duarte, Koneru, & Wasserman, 2006) have developed and are beginning the evaluation process of a novel, family-focused, culturally informed therapy for schizophrenia (CIT-S). This approach explicitly integrates three modules of standard family-focused techniques (i.e., psychoeducation, communication training, and problem solving) with two more culturally congruent components (family cohesion and spirituality). CIT-S aims to increase familial empathy, to lower levels of critical and hostile attitudes from family members toward the patient with schizophrenia, and to provide a more realistic set of expectations for the course of the disorder. Results from a randomized controlled trial are still pending.

One research group has taken a different approach to reducing relapse rates with schizophrenia. Kopelowicz, Zarate, Smith, Mintz, and Liberman (2003) used a social-skills training program that has been shown to be effective in schizophrenia and adapted it for Latinos. These adaptations were primarily surface-level ones, including careful translations of the material that considered relevant dialects and colloquialisms, the use of bilingual and bicultural staff, and the emphasis on an informal, friendly interaction style between therapists and patients. One deeper-level adaptation was the inclusion of family members rather than clinicians as aides to help in the generalization of skills. Results indicated that Latinos who were randomly assigned to the cultural adaptation of the social skills training had more improved outcomes than those assigned to a customary outpatient control condition. This advantage for the social skills intervention was found on symptoms, skill acquisition, level of functioning, and rates of rehospitalization.

Strengths of the Cultural Adaptation Perspective. In summary, there is increasing support for the cultural adaptation perspective, particularly in the areas of depression and schizophrenia. Among the studies that provided descriptions, the adaptations generally included both surface and deep structural adaptations in that they modified both the delivery and the content of the program (see Castro et al, 2004). Most of the studies readily identified efforts made regarding the intervention delivery, including having bilingual and bicultural therapists, attending to such cultural values as *familismo* and *personalismo,* and integrating outreach and support programs that facilitate participation in treatment (e.g., child care and transportation). Many of the studies also explicitly noted how they modified the content, or focus, of the intervention by applying the therapeutic techniques to culturally relevant life experiences, such as immigration and acculturative stress, financial stress, and racism and discrimination. Importantly, though, none of the interventions described ways in which fundamental changes were made to the underlying cognitive-behavioral or interpersonal approaches to treating or preventing depression.

A strength of this perspective is that there exists an emerging empirical base supporting

the notion that culturally adapted interventions can produce effective outcome. In fact, Griner and Smith's (2006) meta-analysis of 76 studies found a generally positive effect of participating in a culturally adapted intervention ($d = 0.45$). Although the studies in this meta-analysis included participants from a variety of racial/ethnic backgrounds, findings indicated that those studies with high numbers of Latino participants had particularly stronger effects. Moreover, among studies that focused on Latinos only, those that were focused on less acculturated participants did better than those that were focused on more acculturated participants. Thus, increasing empirical support is emerging for the notion that culturally adapted interventions can be efficacious with Latinos. As a result, these interventions may be particularly well suited to address the health-care disparities discussed earlier, since they may have more legitimacy in the eyes of health-care providers, given the evidence of their efficacy.

Limitations of the Cultural Adaptation Perspective. This perspective has important limitations, however. One primary limitation is the general absence of empirical evidence demonstrating that the provision of adapted treatments produce better outcomes than the standard versions of the treatments with individuals from the targeted cultural groups in general and, in this case, with Latinos in particular (Lakes, López, & Garro, 2006). Thus, although evidence exists that these adapted interventions may be efficacious, it is not clear that they produce better outcomes than standard interventions. For example, the Griner and Smith (2006) meta-analysis did not examine the sizes of the differences in effects between adapted interventions and standard interventions but focused instead on the effect sizes of the adapted interventions only. Comparing the effectiveness of adapted interventions with standard interventions will likely be an important comparison to make, since the implementation of different versions of a treatment is costly for health-care providers. It is plausible that the adapted treatments will demonstrate superior symptom reduction compared to standard interventions; however, it is much more likely that the advantage of the adapted interventions will be found in the domains of treatment acceptability, retention, and adherence. Such an outcome would be important,

as it could make significant inroads into the mental health-care disparities described earlier.

A second important limitation is the fact that very few culturally adapted interventions are based on empirical research (Lau, 2006). That is, there has been little consideration of how basic research on risk and resiliency factors in Latinos might directly inform the adaptation of existing treatments or development of novel treatments. Instead, most adaptations have focused on enhancing the attractiveness of the intervention for potential participants (surface-structure adaptations). Even those that have incorporated deep-structure adaptations (e.g., incorporation of culturally relevant metaphors, idioms, and interaction styles) have generally not connected these adaptations to considerations of risk and resilience. The one notable exception is the Weisman (Weisman 2005; Weisman et al., 2006) work with CIT-S. In this approach, the incorporation of the culturally components of family cohesion and spirituality were made in response to the literature documenting some differences in the risk and protective factors between schizophrenia in Latinos and in Caucasians. Weisman's work can serve as a model for a theoretically and empirically guided approach to the development of cultural adaptations of treatments. Given the recent attention to this limitation (e.g., Castro et al., 2004; Lau, 2006), we are looking forward to the next generation of cultural adaptations.

Perspective 3: Culturally Centered Therapies

The third perspective on the integration of cultural considerations into therapy is by far the most comprehensive and has been termed *culturally centered therapies* by some scholars (Bernal & Sáez-Santiago, 2006; Pedersen, 1997). From this perspective, attempts to impose traditional forms of psychotherapy upon individuals from non-European cultures are built upon faulty assumptions of universality and essentialism (Atkinson, et al., 2001; Bernal & Scharrón-del Río, 2001). Concretely, this perspective argues that it would be theoretically incongruent to provide a traditional form of psychotherapy for culturally specific expressions of distress (e.g., *ataques de nervios,* somatic symptoms). Even adaptations of traditional forms of psychotherapy would be unlikely to be effective, as they are ultimately rooted in universal conceptions of health and illness.

Further, even when programs that have been adapted for particular cultural groups have been found to be efficacious, they are inherently limited in their abilities to empower individuals to overcome societal structural obstacles. That is, because adapted interventions are rooted in traditional models of psychotherapy, they can only conceptualize health and illness from within that framework. Thus, they are less able to recognize how societal structures, like the therapeutic endeavor itself, can promote the status quo in the service of distress management. For these reasons, adherents of this perspective suggest that there is more to gain by developing novel therapeutic approaches that centralize culture in the treatment process, by working from particular cultural conceptions and idioms of distress, utilizing culture-specific traditions of pathways to health and sickness, and explicitly addressing societal structure issues in treatment (e.g., race, gender, class, sexual orientation). A culturally centered therapy need not address all of the aforementioned issues, but it must at least conceptualize distress and treatment from culturally relevant perspectives.

The most commonly cited example of a culturally centered therapy is *cuento therapy,* an approach that uses cultural folktales to increase children's connections both with their parents and with their Puerto Rican culture and heritage (Costantino, Malgady, & Rogler, 1986). Another excellent example of a culturally centered therapy is *bicultural effectiveness training* (BET; Szapocznik et al., 1986). BET was developed to improve family functioning through the explicit consideration and working through of cultural conflict that arises between family members as a result of differences in acculturation level. Both of these examples make central the culturally salient goal of developing increased connection to family and culture, and both use culturally relevant treatment approaches (family connections) to reach the goal. Thus, the entire therapy endeavor remains culturally congruent from the outset.

With regard to Latino adults, we identified several studies that could be considered culturally centered therapies. Szapocznik and colleagues (1981, 1982) described their development of life enhancement counseling for elderly Latinos, a therapeutic approach designed to address the loss of meaning and purpose in life that occurs to many individuals as they age. In both its development and implementation, life enhancement counseling is both developmentally and culturally centered, as both its goal and its methods of achieving them are relevant to elderly Latinos. The model's two primary techniques are (1) the life review and (2) ecological assessment and intervention. The life review consists of having participants describe important life events and experiences, with a particular focus on enhancing the meaning of positive memories, facilitating acceptance of unresolved events, and the rediscovery of past strengths. The ecological assessment and intervention consist of identifying current environmental sources of stress for participants and then identifying ways to change the participant-environment transactions that are causing stress. Results from an open pilot trial were positive, as significant improvements occurred over the course of the intervention on a range of outcome measures, including depression and anxious symptoms, social isolation, and general functioning (Szapocznik et al., 1981). Unfortunately, more rigorous analyses of life enhancement counseling with Latino elders have not been published.

Aviera (1996) described the development of a *dichos therapy* group for hospitalized Spanish-speaking psychiatric patients. Building on the work of others who have used *dichos* (proverbs, idioms, or metaphors) to help facilitate the therapy process with Latinos (e.g., Zuñiga, 1991, 1992), Aviera developed a group in which the consideration and discussion of dichos was the explicit focus of the group and the conceptualized active ingredient. The dichos group was part of a multimodal treatment approach that included a variety of other disciplines (e.g., psychiatric, social work, rehabilitation therapy). Participants in the dichos group were patients in a state psychiatric hospital with a variety of psychotic disorders. Aviera noted that most of the participants had limited coping skills, strained or limited family relationships, and were struggling to adapt to life in the United States. Published data supporting the efficacy of the dichos group were limited to clinical observation, but Aviera suggested that the dichos group had a variety of positive effects on both attitudes toward therapy (e.g., decreased defensiveness, increased motivation for therapy), and individual functioning (e.g., improved self-esteem, enhanced attention and emotional exploration).

More recently, Guinn and Vincent (2002) described the development and preliminary evaluation of a novel educational intervention

to enhance Latina spiritual well-being. Building on the work of an already established educational health promotion program, the authors described a participatory action approach in which the community participated in the initiation, development, implementation, and evaluation of a holistic approach to enhancing Latinas' spiritual well-being. The intervention is described as consisting of two sets of educational sessions: personal growth and entrepreneurial intervention. Personal growth sessions included sessions on a range of psychological, health, and social topics, including spiritual issues, parenting and child development, safety, hygiene, and domestic violence. Entrepreneurial interventions included sessions on elder care, GED attainment, citizenship procedures, and other vocational skill development. One-time comparisons between participants in the intervention and community controls revealed higher religious and existential well-being scores among those Latina women who had participated in the intervention.

Some other examples of this perspective with adults, although not Latinos in particular, can be found in the counseling psychology tradition, which has historically focused less on resolving pathology and more on promoting developmental well-being. The scholars who have developed therapies that centralize multiculturalism in both mental health and treatment have tended to give attention to the relationship between the client and therapist, as well as a variety of sociocultural developmental issues, including racial and ethnic identity, spirituality and religion, and social class struggles (e.g., Atkinson, Morten, & Sue, 1998; Sue, Ivey, & Pedersen, 1996).

Strengths of the Culturally Centered Perspective. Although less attention has been given to treatment approaches that fall into this perspective, the examples we found have considerable appeal. Unlike the examples from the other two perspectives, all of the treatment approaches provided compelling descriptions of the culturally specific problems they were attempting to help (e.g., parent-child problems, loss of meaning and purpose with advancing age, difficulty adjusting to U.S. culture). Because there was very little mention of diagnostic categories, the treatments were free to address psychosocial stressors that were relevant to the lives of the participants in that particular cultural moment. Moreover, these approaches generally tended to

be less pathology focused, and more focused on enhancing the well-being of their participants.

Another important strength of this perspective is the coherence between the cultural conceptualization of the problem and the resultant approach to treating the problem. Treatment approaches varied and included the use of culturally salient cuentos, dichos, life reviews, and psychoeducational workshops. Because these treatment approaches were conceptualized as the active ingredient or mechanism of change, the concern about potential incongruities between cultural elements and theoretically active elements is not relevant.

Limitations of the Culturally Centered Perspective. Despite the obvious strength of centralization of culture within the treatment paradigm, this perspective has several notable weaknesses. Primarily, the dearth of examples of this approach speaks to the difficulty of developing a treatment that stands outside of Western conceptions of health and sickness. Because these treatments were developed for highly specific situations, they are less easily transported and disseminated to other locations. As a result, it is unlikely that these approaches will be on the front line of reducing the mental health-care disparities described earlier.

Further, although it centralizes culture in both the conception of illness and in the route to wellness, this perspective offers little guidance on working with individuals who may prefer a standard treatment approach or who may not be presenting with culturally influenced distress. For instance, it is plausible that culturally centered therapies would work less well with more assimilated individuals, who may not resonate with approaches that utilize traditional healing pathways. Very little guidance is given to help with these determinations.

Summary and Recommendations

In sum, our review of the literature on clinical work with Latino adults suggests that there are important differences in the centrality with which scholars believe that attention should be given to culture. The first perspective views the integration of culture as a process that happens through the attitudes, knowledge, and behavior of the therapist; the second sees the integration of culture as best occurring through the adaptation of existing therapies for particular cultural

groups; and the third conceptualizes the integration of culture as a process that is central to the entire therapeutic endeavor.

As we have noted throughout, each of these perspectives has important strengths and limitations, and the body of research is still in its relatively early stages. Thus, we remain uncommitted regarding which perspective might ultimately prove most useful in reducing health-care disparities and increasing treatment opportunities for Latinos. Of course, our own experiences lie in the area of cultural adaptations because we believe that the strengths of this perspective are considerable. However, we also recognize that the overwhelming majority of therapists do not work with culturally adapted interventions, and so training in the development of cultural competence with Latinos would likely produce considerable benefit. Similarly, we see that culturally centered interventions offer the most promise for the long term in helping develop novel theoretical approaches to conceptualizing and treating distress that explicitly incorporate culture.

Importantly, despite distinct differences across these perspectives, several commonalities warrant mention because they lead directly to concrete clinical and research recommendations.

1. Acquire the relevant cultural knowledge, and modify therapist behavior accordingly.

There was broad consistency across studies regarding the importance of the incorporation of Latino cultural values into the treatment process. Moreover, many authors noted that clinicians should also be familiar with the specific cultural conceptualizations of mental health and illness of the Latino ethnic groups with whom they are working. Importantly, several authors also described concrete changes to traditional therapist behavior in response to this knowledge. For example, a few studies suggested that they attempted to create an informal approach to therapy, in recognition of the cultural value *personalismo*. Others described how they encourage more self-disclosure from therapists than is typically sanctioned by traditional therapy approaches. In our prevention work with Latina mothers, we have found that our groups work well when we balance a less formal approach to therapy that includes more self-disclosure with the formality in how we address our participants (e.g., use of the formal second

person, *Ud.,* rather than the informal second person, *Tu*). These concrete modifications were described more fully with regard to the cultural values, but it is not difficult to imagine therapists explicitly discussing traditional views of mental health and illness as a way to increase rapport and trust in the treatment process. Thus, cultural sensitivity requires more than just an awareness of the values and culturally specific conceptions of mental health; it requires that the therapist's behavior be congruent with those values and conceptions.

2. Attempt to understand culturally relevant life stressors.

We found that the majority of examples in the literature conceptualized Latino culture very complexly in that they recognized the importance of attending to life events that are commonly reported by Latinos living in the United States. Some of these life events include the stressors associated with the immigration and acculturation process, issues related to socioeconomic status, and issues related to minority status. These life events and experiences are not specific to Latino culture, as many individuals from other low-income and racial/ethnic minority backgrounds have similar experiences. Moreover, some of these life events are not likely to be found among Latinos living in Latin America (e.g., immigration stress, minority status). However, because they are so commonly experienced by Latinos living in the United States, it is important that clinicians understand both the general sociocultural contexts, as well as the particular life experiences, of their Latino clients.

3. Acknowledge the importance of religion and spirituality.

Several authors discussed the centrality of religion and spirituality in the lives of Latinos and suggested that clinicians make efforts to acknowledge this fact. One culturally adapted intervention went so far as to specifically create a module that focused on spirituality, and one of the culturally centered interventions specifically targeted spirituality. However, unlike the other Latino cultural values, considerably less attention has been given to the integration of religion and spirituality into the treatment process, most

likely due to the traditionally secular stance of psychotherapy. The consistently positive experiences reported by the authors who have attempted to integrate religion and spirituality suggest that some minimum acknowledgment of this aspect of Latinos' lives could increase rapport with clients.

4. Conceptualize clinical work more broadly than is traditionally done.

We also found considerable agreement across studies in their recognition of the serious mental health-care disparities affecting Latinos. Thus, many researchers explicitly documented ways in which their approaches to treatment included elements not traditionally thought of as therapy. For example, several authors noted that they provided transportation and childcare accommodations for their participants in recognition of the financial stressors many faced. Some of the authors described providing more psychoeducation regarding mental health and psychotherapy for their Latino clients, many of whom may not have had prior experience with therapy. Miranda and colleagues (2003a, 2003b, 2006) formalized the provision of this information, allowing as many as to four sessions of psychoeducation prior to starting treatment. Finally, a few authors described the utility of formal case management that was useful in supplementing the therapy itself. Taken as a whole, it seems that the successful treatment approaches were those that sought out creative ways to help their Latino clients overcome common instrumental barriers to treatment.

5. Consider integrating family members into the treatment process.

Interestingly, few of the studies we reviewed explicitly incorporated family members into the treatment process, despite the general recognition that many Latinos consider the family very important. The few that did reported considerable success regarding both participation from family and acceptance of the familial treatment approach (e.g., Cardemil et al., 2005). We suspect the reason so few treatments explicitly incorporate family members is that there is a general lack of familiarity with family-based treatment approaches. Some support for this explanation can be seen in the fact that the overwhelming

majority of treatments in the cultural adaptation perspective were individually focused (either cognitive-behavioral or interpersonal). We believe that there are many potential benefits from the integration of family members into treatment, including reduction of family resistance to treatment, increasing familial emotional support for the client, and modifying familial problem-solving and communication patterns. In our prevention work with Latina mothers, we have consistently found increased attendance and participation when we have met other family members (e.g., husband, mother, siblings). Thus, we recommend that clinicians and researchers consider the formal inclusion of family members in some portion of the treatment process.

6. Recognize that many Latinos use alternate sources of health care.

Several scholars noted that many Latinos seek out help for mental health problems from traditional sources rather than from formal mental health services. These traditional providers can include religious leaders and traditional cultural healers as well as family members. In much the same way that clinicians should be aware that some of their clients may be receiving several different treatments from different providers (e.g., pharmacotherapy, psychotherapy, family therapy), clinicians working with Latinos should be cognizant of the fact that some may be seeking help from informal and traditional sources. Validation of these help-seeking behaviors, rather than dismissal of them as ineffective, could lead to a strengthening of the rapport between clinicians and their clients.

7. Whenever possible, use bilingual and bicultural clinicians.

Finally, the overwhelming majority of the studies we reviewed had bicultural and bilingual clinicians deliver the treatment, highlighting the importance of depth of familiarity with Latino culture. Given the wide variability among Latinos in Spanish- and English-speaking ability, it is important that health centers have the versatility to provide services in either Spanish or English, and ideally have bilingual and bicultural clinical health providers. Relatedly, Latino scholars were involved in the development and conceptualization of the treatments in many of

the studies we reviewed. This speaks to the importance of continuing to support Latino students and early career professionals who are entering the field. It is unlikely that we would have had so much literature to review without the impressive work of those Latino scholars who began to question the general absence of attention to Latino populations and issues.

CONCLUDING THOUGHTS

In this chapter, we have reviewed the literature on clinical approaches to working with Latinos. We have placed our review in the context of the troubling mental health-care disparities that currently exist in the United States and that in some cases appear to be increasing (Blanco et al., 2007). Of course, there exist many economic, political, and social structural reasons for the continuing disparities. However, we believe that more explicit attention to the heterogeneity in the literature regarding clinical work with Latinos can provide some clarity to the occasionally contradictory recommendations that currently exist. Our hope has been to increase the awareness of the heterogeneity in approaches that currently exist in the literature. A better understanding of this variability, along with careful consideration of the strengths and weaknesses of each perspective, can serve only to advance the literature on clinical work with Latinos.

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