PSYCHO-CULTURAL ASSESSMENT and INTERVENTIONS : THE NEED FOR A CASE CONCEPTUALIZATION MODEL

Donald Meichenbaum, Ph.D.
Distinguished Professor Emeritus,
University of Waterloo,
Ontario, Canada

and

Research Director of
The Melissa Institute for Violence Prevention
Miami, Florida

www.melissainstitute.org

Contact Information

 Donald Meichenbaum
 dhmeich@aol.com

PROLOGUE
Donald Meichenbaum Ph.D.

In my capacity as Research Director of the Melissa Institute for Violence Prevention, I have multiple opportunities to consult to psychiatric settings and to various mental health personnel where the issues of ethnic and racial diversity come into play. For example, I have had occasion to work with:

(1) Native populations in both the U.S. and Canada and collaborated with indigenous health care providers;
(2) Mental health personal who work with torture victims who have now emigrated to the U.S. from various countries;
(3) Residential treatment centers who have clients from diverse ethnic and racial groups;
(4) Trauma victims who came from various cultural groups;
(5) Psychotherapy clients who come from varied religious and diverse cultural groups;

In each instance, I was challenged as a clinician to be culturally informed and competent in my clinical approach. But this is a challenge that all North American mental health personnel face. The following demographic data underscores this challenge. Just consider the following statistics.

Demographic Findings of the <u>Rapid</u> Cultural Diversification in the U.S.
(See reference list for the source of these statistics)

1. Currently, the U.S. population is estimated to be 306 million, of which some 45 million (15%-20%) constitute a minority population. These figures do not include the estimated 12 million undocumented immigrants in the U.S.

2. Some estimates predict an equal proportion of non-whites to whites by the year 2050. Less conservative estimates predict equal proportions much sooner.

3. Some 20% of the minority population currently live below the poverty line with all of the accompanying problems and stressors of high unemployment, high dropout rates from school, high rates of substance abuse, HIV infections, and psychiatric challenges.

4. These mental health difficulties may be exacerbated by the fact that there is a greater potential for <u>misdiagnosis</u> when clinicians do not take into consideration the cultural features of presenting problems and diverse patterns of health-seeking behaviors.

5. Members of minority populations are more likely to turn to primary care doctors or to faith-based healers before they turn to mental health personnel for assistance.

6. As a result, individuals from ethnic and racial minority groups are <u>underserved</u> and <u>underrepresented</u>, as both clients and as providers. Minority group members tend to underutilize mental health services and when they do obtain such services, they have a high drop-out rate.

7. Additional mental health concerns are raised by the findings that there is a higher risk of trauma experiences in minority populations than in non-minority populations, in part due to immigration experiences, racial discrimination, poverty and exposure to developmental victimizing "risk" factors.

8. Among those minority groups who have emigrated to the U.S., the incidence of mental health problems tend to increase over the length of their residence in the U.S.

9. To further illustrate these findings consider the largest minority group in the U.S., Latinos. It is estimated that by 2030, 20% (some 73 million) Latinos will make up the U.S. population. When considering the concept of Latino (or Hispanic), there is a need to keep in mind that this is a very heterogeneous population consisting of individuals from some 20 different Spanish-speaking countries including Central and South America, the Caribbean, Mexico, Puerto Rico, Cuba and Spain. Each Hispanic group has specific ethnic and cultural differences.

10. The U.S. Surgeon General's Report on Mental Health (DHHS, 1999) reports that there are only 29 Latino mental health providers for every 100,000 Hispanics in the U.S., as compared to 173 providers for every 100,000 non-Hispanic whites in the U.S.

11. The <u>good news</u>, however, is that there is encouraging data that when mental health treatment interventions are culturally modified, they are found to be significantly more effective. Meta-analytic reviews report that mental health treatments were 4X more effective when they were culturally modified for a specific group and when attention was tailored to cultural context and values. See examples by Anez et al. 2005, 2008; Hinton et al. 2000; Huey & Polo, 2008; Organista & Munoz 1996; Miranda et al. 2006; Szapocznik & Kurtines, 1993; Weisman, 2005. Griner and Smith, (2006) conducted a meta-analysis of 76 studies of culturally adjusted interventions and reported on Effect Size of d=.45 indicating a moderately strong benefit of culturally adapted interventions.

12. When disparities in language and culture are reduced by the inclusion of bilingual and bicultural personnel, Latinos use of mental health services are similar to the rates of usage by non-minority clients.
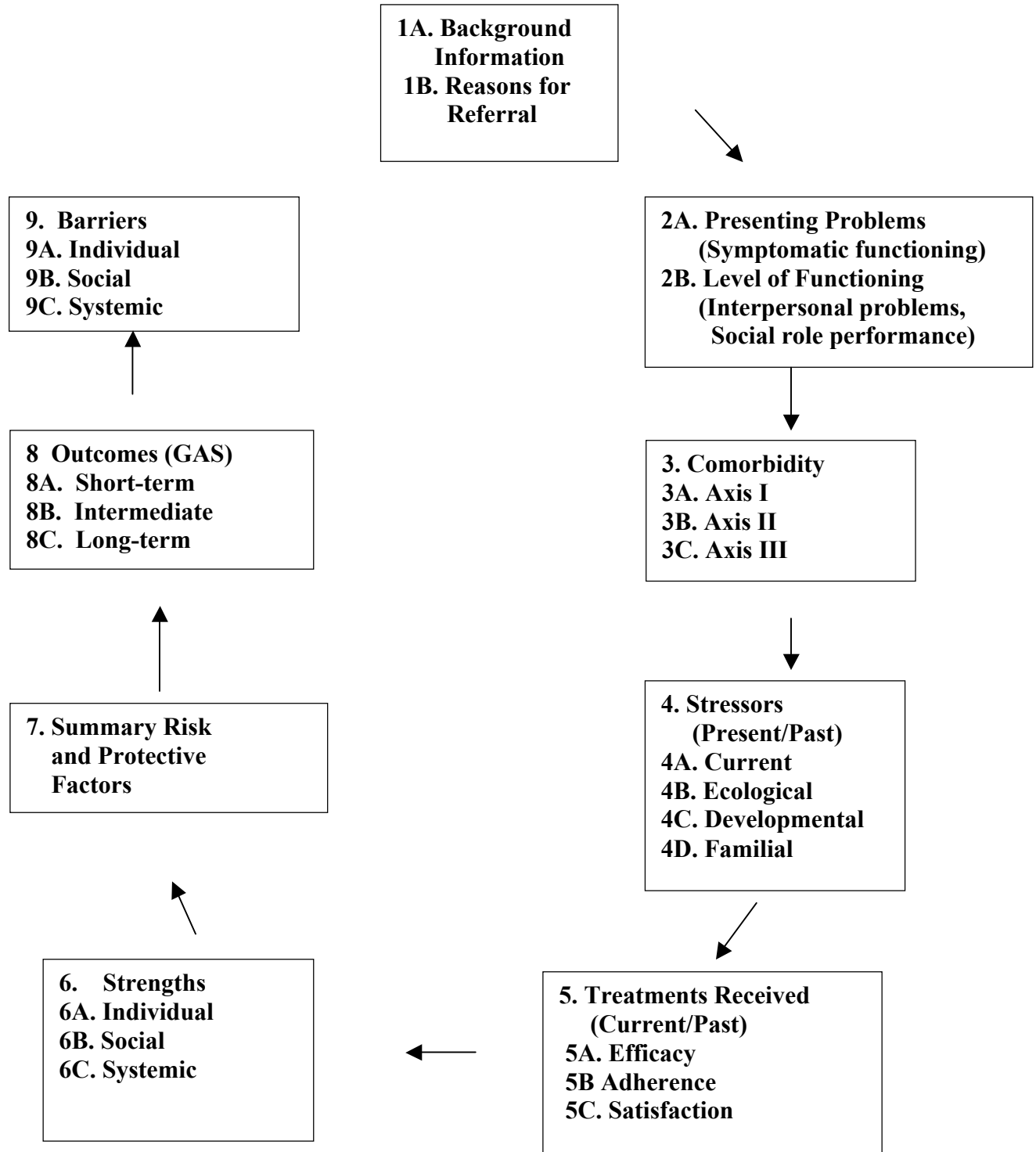
A CASE CONCEPTUALIZATION MODEL (CCM)

"A clinician without a Case Conceptualization Model is like a captain of a ship without a rudder, aimlessly floating about with little or no direction."

A well formulated Case Conceptualization Model (CCM) should:

1. identify developmental, precipitating and maintaining factors that contribute to maladaptive behaviors and adjustment difficulties and that reduce quality of life;

2. give direction to <u>both</u> assessment and treatment decision-making;

3. provide information about the developmental, familial, contextual risk and protective factors;

4. highlight cultural, racial and gender-specific risk and protective factors;

5. identify individual, social and cultural strengths that can be incorporated into the treatment/decision making;

6. provide a means to collaboratively establish the short-term, intermediate and long-term goals and the means by which they can be achieved;

7. identify, anticipate and address potential individual, social, and systemic barriers that may interfere with and undermine treatment effectiveness;

8. provide a means to assess the client's progress on a regular basis;

9. consider how each of these objectives need to be altered in a culturally, ethnically and racially sensitive fashion

GENERIC CASE CONCEPTUALIZATION MODEL

1A. Background Information
1B. Reasons for Referral

9. Barriers
9A. Individual
9B. Social
9C. Systemic

2A. Presenting Problems
(Symptomatic functioning)
2B. Level of Functioning
(Interpersonal problems,
Social role performance)

8 Outcomes (GAS)
8A. Short-term
8B. Intermediate
8C. Long-term

3. Comorbidity
3A. Axis I
3B. Axis II
3C. Axis III

7. Summary Risk and Protective Factors

4. Stressors
(Present/Past)
4A. Current
4B. Ecological
4C. Developmental
4D. Familial

6. Strengths
6A. Individual
6B. Social
6C. Systemic

5. Treatments Received
(Current/Past)
5A. Efficacy
5B Adherence
5C. Satisfaction

FEEDBACK SHEET ON CASE CONCEPTUALIZATION

Let me see if I understand:

BOXES 1& 2: REFERRAL SOURCES AND PRESENTING PROBLEMS

"What brings you here is ...? (distress, symptoms, present and in the past)"
"And is it particularly bad when..." "But it tends to improve when you..."
"And how is it affecting you (in terms of relationship, work, etc)"

BOX 3: COMORBIDITY

"In addition, you are also experiencing (struggling with)..."
"And the impact of this in terms of your day-to-day experience is..."

BOX 4: STRESSORS

"Some of the factors (stresses) that you are currently experiencing that seem to maintain your problems are...or that seem to exacerbate (make worse) are... (Current/ecological stressors)"
"And it's not only now, but this has been going on for some time, as evidenced by..." (Developmental stressors)
"And it's not only something you have experienced, but your family members have also been experiencing (struggling with)..." "And the impact on you has been..." (Familial stressors and familial psychopathology)

BOX 5: TREATMENT RECEIVED

"For these problems the treatments that you have received were..." (note type, time, by whom)
"And what was most effective (worked best) was... as evidenced by..."
"But you had difficulty following through with the treatment as evidenced by..." (Obtain an adherence history)
"And some of the difficulties (barriers) in following the treatment were..."
"But you were specifically satisfied with...and would recommend or consider..."

BOX 6: STRENGTHS

"But in spite of...you have been able to..."
"Some of the strengths (signs of resilience) that you have evidenced or that you bring to the present situation are..."
"Moreover, some of the people (resources) you can call upon (access)are..." "And they can be helpful by doing..." (Social supports)

BOX 7: SUMMARY OF RISK AND PROTECTIVE FACTORS

"Have I captured what you were saying?" (Summarize risk and protective factors)
"Of these different areas, where do you think we should begin?" (Collaborate and negotiate with the patient a treatment plan. Do not become a "surrogate frontal lobe" for the patient)

BOX 8: OUTCOMES (GOAL ATTAINMENT SCALING PROCEDURES)

"Let's consider your expectations about the treatment. As a result of our working together, what would you like to see change (in the short-term)?"
"How are things now in your life? How would you like them to be? How can we work together to help you achieve these short-term, intermediate and long-term goals?"
"What has worked for you in the past?"
"How can our current efforts be informed by your past experience?"
"Moreover, if you achieve your goals, what would you see changed?"
"Who else would notice these changes?"

BOX 9: POSSIBLE BARRIERS

"Let me raise one last question, if I may. Can you envision, can you foresee, anything that might get in the way- any possible obstacles or barriers to your achieving your treatment goals?"
(Consider with the patient possible individual, social and systemic barriers. Do not address the potential barriers until some hope and resources have been addressed and documented.)
"Let's consider how we can anticipate, plan for, and address these potential barriers."
"Let us review once again..." (Go back over the Case Conceptualization and have the patient put the treatment plan in his/her own words. Involve significant others in the Case Conceptualization Model and treatment plan. Solicit their input and feedback. Reassess with the patient the treatment plan throughout treatment. Keep track of your treatment interventions using the coded activities (2A, 3B, 5B, 4C, 6B, etc) Maintain progress notes and share these with the patient and with other members of the treatment team.
"And some of the services you can access are..."

IMPACT of CULTURAL DIVERSITY on the CASE CONCEPTUALIZATION MODEL (CCM)

We can now consider how a consideration of cultural influences impact the Case Conceptualization Model.

Box 1 - Background Information and Reason for Referral
There is a need to consider information considering ethnic and racial factors. Obtain a migration history and present immigrant legal status. Focus on the degree of acculturation and the nature of acculturation stressors. Be sensitive to the impact and the nature of poverty, traumatic exposure (including exposure in country of origin) and the like. Consider help-seeking behavior - - reasons for referral. Assess focus on collectivism versus individualism.

Box 2 – Symptom Presentation and Adjustment Difficulties
Recognize the varied nature of symptom presentation, especially in the form of somatic complaints. Assess the client's perspective and definition of problem behaviors and his/her theory for change. Be sensitive to conduct risk assessment toward self and toward others. Consider Quality of Life functioning resulting from symptomatology and adjustment difficulties.

Box 3 – Presence of Comorbidity
Consider, once again, cultural variation in symptomatology. Be concerned about comorbid disorders of substance abuse and PTSD, depression and anger. Consider physical form of comorbidity such as HIV.

Box 4- Stressors
Highlight the role of emigration, acculturative stress. Consider the role of racism and discrimination and the nature of the loss of resources such as the loss of social supports. Intergenerational forms of stress need to be considered.

Box 5- Treatment History
Be sure to track the client's treatment history including the use of folk leaders and cultural traditional interventions.

Box 6- Signs of Resilience
Note the "in spite of" evidence of individual, social and systemic "strengths." Be sure to consider cultural beliefs and practices such as family and spiritual values. Use signs of resilience from forefathers (cultural resilience) and oral tradition. Highlight "survival skills."

Box 9- Potential Barriers
These may include individual obstacles such as language difficulties, limited literacy, lack of health insurance, mistrust, fear of stigmatization and fear of deportation, belief

that treatment will prove ineffective. <u>Social barriers</u> may include unsupportive family and the absence of social supports. <u>Systemic barriers</u> may include absence of transportation, distance, hours available for treatment services, mistrust between the client and the service providers, long waiting lists, uninviting treatment environment (Consider systematically assessing for such barriers).

The following Assessment Strategy illustrates how these diverse factors can be incorporated in a treatment plan.

ASSESSMENT STRATEGY WITH ETHNIC MINORITY CHILD POPULATIONS

*(See de Arellano, M. & Danielsen, C.K., 2008. <u>Cognitive and Behavioral Practice</u>, <u>15</u>, 53-66
and de Arellano et al. <u>Behavior Modification</u>, <u>29</u>, 130-155.)*

Using the acronym **INFORMED** de Arellano and his colleagues have provided a useful
assessment strategy that guides clinical practice. The acronym covers the following guidelines.

Investigate the target population—consult experts and members of the cultural group

Navigate new ways of delivering assessment services—build trust, addressing language
and logistical barriers

Further assess extended family members and significant others

Organize background assessment using culturally sensitive measures and also assess the
role of spiritual beliefs and level of acculturation

Recognize and broaden the range of traumatic events to be assessed (e.g., immigration-
related stressors, racism, discrimination)

Modify types of trauma-related sequelae being assessed (e.g., consider culturally specific
symptomatology, expression of somatic complaints, level of functioning in schools)

Evaluate the effectiveness of modified assessments (e.g., obtain patient satisfaction
measures, conduct assessments over time since family and home composition may
change; conduct assessment in homes and other settings)

Develop the assessment based on the evaluation results (Be specific in the questions to be
asked—see Appendix in de Arellano & Danielson, 2008 article pp. 63-65)

For an example of the application of this model see De Arellano, M.A. et al. (2005). Community
outreach program for child victims of traumatic events: A community-based project for
underserved populations. Behavior Modification, 29, 130-155.
http://www.musc.edu/outreach/programs/outreachprograms.html#cope

A "TO DO" LIST

How many of the following <u>culturally</u>-<u>informed</u> <u>activities</u> do you engage in your clinical practice?

Please put a <u>check mark</u> next to each activity that you presently engage in. What do you think are the <u>barriers</u> that prevent you or your clinical setting from engaging in each culturally-informed activity? For example, is it a <u>lack of</u> knowledge, skills, opportunities, resources- - both financial and social support, interest - - judgement that they are not relevant to your population, other reasons.

Please <u>choose</u> <u>two</u> <u>activities</u> from the **TO DO LIST** that you are <u>presently</u> <u>not</u> <u>doing</u> and that you believe you could try and that you judge <u>is</u> <u>doable</u> and that will likely make your clinical practice more culturally sensitive. Now, share this choice with a fellow conference attendee or a colleague and indicate the reasons why doing so would be worth implementing.

Can you anticipate any obstacles/barriers that may get in the way of your incorporating such culturally-sensitive clinical activities? How could you judge if implementing these practices were effective in improving your clinical outcomes? For example, could you include client feedback and satisfaction measures, indicators of improved therapeutic alliance indicators, lower drop-out rates, treatment adherence measures, treatment outcome data, changed therapist behaviors, and other indicators.

HOW MANY OF THE FOLLOWING CLINICAL ACTIVITIES DO YOU PRESENTLY ENGAGE IN?

Culturally-sensitive Assessment Practices

_____ Use open-ended questions that are culturally-specific (***See examples below***)

_____ Incorporate culturally specific concepts as part of the assessment process (***See list below for examples***)

_____ Use assessment tools that have been culturally normed

_____ Obtain a migration history that includes a time-line of dates and the circumstances concerning migration (life before migration, decision process to migrate- - forced, voluntary, change in life status, family left behind, stressors and "strengths" since migration, network of social supports).

_____ Assess for the degree of acculturation (identity with culture of origin, language proficiency, bicultural competence, acculturative stress)

_____ Assess for exposure to racism and discrimination (for example, administer Schedule of Racial Events, Landrine & Klonoff, 1996). Be respectful of the client's "healthy cultural suspicion" and ask if the client wishes to discuss the role of racism and experiences with discrimination. (Franklin et al., 2006). Do <u>not</u> debate whether racism is involved.

_____ Assess for the clients' worldview and explanatory concepts of presenting problems and their theories of causation and possible interventions.

_____ Assess for possible barriers to treatment and possible protective factors (network of social supports).

_____ Assess for the role of spiritual/religious and cultural beliefs that can be included into treatment.

_____ Use a Case Conceptualization Model that guides your treatment decision-making.

Presently Engage In?

CULTURALLY INFORMED CLINICAL PRACTICES

_____ Ensure that the client's basic needs (shelter, food, safety, welfare, and family connections) are being met.

_____ Focus on developing a therapeutic alliance and assessing the quality of this relationship throughout therapy. The therapist should be warm and welcoming, respectful and "down to earth." Be sure to address everyone present. Ask adults how they would like to be addressed. Avoid using first names unless they give permission.

_____ Use open-ended questions to solicit the client's story or narrative. For example, the therapist can ask:
> *"Tell me more about that"*
> *"A lot of people I see tell me ....."*
> *"A lot of people report that..."*

_____ In cross-racial therapeutic interactions, ask how the client feels discussing the issue of racism with a therapist of a different race/ethnic background.

_____ Psychotherapeutic interventions should build upon the client's, family's, communities', strengths, survival skills, and cultural resilience and "social capital." Use the language of possibilities. *("Hope is in the struggle" "Those are tears of strength and love" "The funeral was a celebration of life")*

_____ Engage in culturally-informed treatments (Adapt Evidence-based practices in a culturally sensitive fashion). For example, see Bernal & Domensch (in press), Miranda et al. (2005), and Sue (1998).

_____ Recognize that there is a need to alter the ways in which you develop a therapeutic alliance in a culturally sensitive fashion. (***See examples below***)

_____ Arrange for cultural training of clinical staff. Have cultural consultants evaluate treatment manuals, assessment tools and videotapes of treatment sessions.

_____ Run focus groups of clients to obtain their feedback of clinical setting in their community and use feedback to alter outreach programs.

_____ Have an active outreach program to recruit and serve underserved minority populations.

_____ Include on your answering machine bilingual messages. Be respectful of diverse cultural groups. Close on special cultural holidays, include cultural art in clinic/office.

_____ Consult with and work with cultural/folk leaders and indigenous religious healers, "prayer Warriors."

_____ Include extended family members, and non-blood family members where this is indicated. Be flexible in terms of including significant others in the healing process. Include collective/community healing ceremonies.

_____ Encourage clients to identify and access spiritual and cultural group activities, practices, rituals and beliefs.

_____ Use Motivational Interviewing procedures to engage clients. Engage clients in collaborative goal-setting.

_____ Address barriers to treatment that may include concerns about stigma and shame of obtaining help, as well as practical barriers to obtaining help (transportation, child care, hours of availability, lack of insurance, and the like). Provide extra services to remove such barriers

_____ Engage in advocacy activities on behalf of clients with regard to various other agencies.

_____ Train translators and work with them to learn the nuances of the cultural group.

_____ Analyze your own beliefs, attitudes, biases and those of your colleagues toward varied cultural groups.

_____ Include "cultural consultants" by including ethnically and culturally diverse services providers.

BE FAMILIAR WITH CULTURAL CONSTRUCTS: AN EXAMPLE FROM LATINO POPULATIONS

A good example of how clinicians can become more culturally informed and sensitive comes from the work with Latino populations. While the Latino/Hispanic population is quite heterogeneous, there are several cultural constructs that when adhered to by therapists can help guide client decision-making and behaviors.

The literature has identified the existence of various culture-specific concepts that can potentially impact a client's thoughts, beliefs, behaviors and activities that can be incorporated into the treatment framework (Anez, 2005, 2008; Bracero, 1998; Falicov, 1998; Santiago-Rivera et al., 2002; Triandis et al., 1984).

Concept	Definition
Respeto	Demonstration and receipt of respect for age, gender, experience and title
Confianza	Trustworthiness and intimacy in relationships
Personalismo (simpatica)	Avoidance of direct conflict and preference for personal relationships over formal rules and regulations
Familismo	Characterized by family loyalty, reciprocity and solidarity
Fatalismo	Sense of fatalism and preordained destiny, often manifested by the expression of "el destino" and/or "si dios quiere," alluding to a sense of lack of control over one's destiny. Dichos such as "God helps those who help themselves" (Ayundara y Dios te agudara) can be used to help clients with "fatalismo."
Marianismo	Cultural belief that women in families should be home-oriented, nurturing and self-sacrificing
Aguantarse	Ability to withstand stressful situations during difficult times
Use of Dichos (Sayings)	These are popular sayings (like proverbs)

<u>For example</u>:

> *"Tell me the company you keep and I will tell who you are."*
> *"God helps those who help themselves."*
> *"God uses struggles to build virtue and patience."*
> *"God throws blocks in the road to make us stronger."*

For further examples see the Website http://www.hablemos.samhsa.gov.

The impact of these cultural concepts on the development and maintenance of a therapeutic alliance is worth highlighting. A number of the authors who are listed in the reference list highlight the need for the psychotherapist or mental health worker to be sure to use:

-Elements of Motivational Interviewing (Miller & Rollnick, 2002) such as Reflective
   Listening Skills, Open-ended questions, Summary Statements (Check comprehension),
   and Affirmations.

-Be respectful of the client's desire to limit self-disclosure.

-Assess client's theory of causation and treatment. Conduct psychoeducation.

-Demystify treatment. Use "journey of healing" metaphor.

-Ask the client how he/she would like to be addressed.

-Use personal connections (e.g., use small talk, escort the client to and from waiting
   room to your office).

-Maintain appropriate physical spacing and greeting.

-Ask about what language the client prefers to use.

-Convey that seeing client is "more than a job, but it is more of a personal mission."

-Introduce the client to new personnel, especially if transferring the client.

-Ask the client about his/her gender preference of the psychotherapist.

-Ask the client if he/she wishes to involve family members as part of treatment
   (obtain a genogram). Note, in regard to Latinos a genogram may be useful in that clients
   often include individuals who are considered to be family members such as "compadres"
   and "camadres" who are <u>not</u> blood relatives. This is often the case for those individuals
   who have migrated from their countries of origin and created pseudo-families here in the

U.S. The role of family members are especially salient when developing a therapeutic alliance with Latino children. Asking questions can provide significant information regarding the family's perception of shared responsibility and the role of the clinician. For example, "If I was your madrina, padrino (Godparents), how do you think I could be Helpful?"

-Incorporate cultural concepts and the role of spirituality. Note, regarding Latinos, spirituality often takes the form of religiosity, but it can also have elements of indigenous beliefs, such as Curandismo, Espiritismo and Santierea. This is often regionally determined and consultation between mental health personnel and spiritual leaders is highly recommended in situations where clients have strong religious beliefs.

-Recognize that clients may give gifts. Consider that the issues of boundaries varies across cultural groups. Note, that gift giving is very common in Latino groups, specifically, gifts of food as a sign of appreciation and gratitude.

-Highlight strengths and signs of survival and resilience. Nurture hope. Validate the experience and normative stress resulting from moving to a new country and losing their support system.

The following provides examples of how these cultural constructs can be translated into clinical questions and into ways to establish and maintain a therapeutic alliance.

EXAMPLES OF CULTURALLY-SENSITIVE OPEN-ENDED QUESTIONS WITH LATINO CLIENTS

(These examples were offered by Anez and his colleagues 2005, 2008. For additional information contact Luis.aneznava@yale.edu)

Each set of questions reflect ways to tap specific cultural concepts that are central to Latino beliefs.

Latino Concept of Respeto - - demonstration and receipt of respect due to age, gender, experience and title.

"How important is Respeto to you?

"In what ways can a person demonstrate respeto for another person?"
"How would you like me to refer to you?" (Ask about the use of the formal "Usted" versus the more familiar use of "tu.")

> *"Please tell me about a time when you felt as if you were not getting the Respeto that you deserved. How did that affect you? What, if anything did you do?"*

Latino concept of <u>Confianza</u>- trustworthiness and intimacy in relationships.

"I understand that confianza can be very important for some individuals. How important is it for you?"

"What does it take for you to develop confianza with someone?"

"How important is confianza to you, especially when you are first getting to know someone?"

"Please describe a person of confidence (confianza) in your life."

"What does it take for you to develop confianza with someone?"

"Tell me about a time when your confianza with someone was violated."

"To help us work together, I am wondering how we can develop confianza in our relationship?"

"What helps to make you feel comfortable when you are first getting to meet someone?"

"How do you handle conflict or express disagreements?"

"I am wondering how would I know if you are disagreeing with something I said or something I did, or what I did <u>not</u> say or did <u>not</u> do?"

"On a scale of 0 to 10, with 0 being the lowest and 10 being the highest, how much confianza (referring to the individual's level of trust in the therapeutic process) do you have in our relationship?" If the person responds with the number 3, for example, then the question that would follow after appropriate reflections and open-ended questions would be to explore why a rating of 3 and not a rating of 1 (reflecting some confianza in the relationship). The questions that would then follow would be on what we would have to do to reach a level 5 rating?

"What do you think we have to do together to improve our joint confianza?"

"What do you think it will take to move from a rating of 3 to 8?"

"What helps to make you feel comfortable when you are getting to know someone?"

"How do you handle conflict and express disagreement?"

Latino Concept of Familismo

"What does your family think about your being here?

"What might they say if they knew you were coming here for help?"

"What were you told about coming here?"

"How important is family to you?"

"How important is your family's opinion when you make a decision?"

"What do you think is causing this problem?"

"How have you tried to solve it in the past?"

"What do you think should be tried now?"

"What is different between your current support system and the one you had in your home country?"

"What other people would you like to involve in your treatment?"

"Some folks like to include family members in treatment. Could you see any benefit/advantage of including your family in treatment?" (Note: There is a need to obtain relevant release of information early on in treatment).

FURTHER EXAMPLES OF WAYS TO INTEGRATE CULTURAL CONCEPTS INTO PSYCHOTHERAPY: LATINO HEALING

Lillian Comas-Diaz (2006) has observed that "spirituality permeates Latino life." Latino everyday language is filled with invocations of God, angels and saints with multiple references to "God willing". Spirituality which is communal in Latino culture can provide sustenance, hope, a sense of belonging, and a reason to live. Comas-Diaz provides a number of examples of Latino healing procedures that culturally-sensitive and culturally –competent psychotherapists can include in order to help clients develop spiritual resilience and move from being "sufferers to seekers." These healing procedures may include:

➢ Use of culturally relevant <u>imagery</u> and <u>fantasy</u> in therapy. For example, De Rios (1997) used "magical realism," which is a mixture of <u>reality and fantasy.</u> Cultural heroes and heroines were used to help <u>traumatized Latino children</u> image safety and refigure traumatic events.

➢ Use <u>religious rituals</u> such as a visit to a sanctuary, engage in communal rosaries, novenas, posadas, peregrinations, purification ceremonies that seek to destroy the "sick existence" and experience a new life, and find comfort and meaning in Our Lady of Guadalupe, reinforcing a cosmic locus of control expressed in reference to "God's decisions."

➢ <u>Call upon spiritual and existential wisdom</u> -- "sabiduria." Honor ancestors and value intergenerational wisdom. In Latino culture there is boundary permeability that may extend beyond death. The deceased can continue a relationship with the living through dreams, visions, visitation, and through the intercession of folk healers.

➢ As noted, use of <u>Spanish proverbs</u> or "Dichos" which are culturally accepted communications that discourage the expression of negative feelings and can act as learning tools for cognitive restructuring. Dichos foster cultural resilience, transcendence and rebirth. Life's setbacks are viewed as opportunities for spiritual development.

> Illustrative Dichos (Sayings)
>
> *"When one door closes another one opens."*
>
> *"A bad thing can turn into something good."*
>
> *"God helps those who help themselves."*

➢ Use <u>storyteller icons, folktales, folk tapestries</u> to create personal narratives that lead to healing and transformation.

➢ <u>Reaffirm bonds</u> to one's group, ancestors and offspring. Attend celebrations, ceremonies, communicate with dead relatives, repeat story of namesake. Comas-Diaz indicates that Latino clients may invite the psychotherapist to attend and participate in such celebrations.

➢ <u>Conduct dream analysis and use art expressive practices</u> (See Cane, 2000).

➢ <u>Conduct culturally-appropriate burial rites.</u>

➢ <u>Consult a folk healer</u> who may act as an adjunct to the psychotherapist in order to nurture a sense of harmony in the client's mind, body and spirit. The folk healer may use purifications rituals, herbs, prayer, community ceremonial activities to foster healing. The

client may choose to communicate with God directly without the intercession of a folk healer.

These varied activities indicate that "**spirituality is at the base of Latino healing.**" Boyd-Franklin (2003, 2008) has highlighted the role spirituality plays in the healing process of African American families and the role that the home and family play as a "refuge from a harsh world."

Several other psychotherapists who work with Latino populations have also demonstrated that treatment can be culturally adapted and involve spiritual elements. For example:

➢ Organista et al (1994) and Munoz and Mendelson (2005) have culturally adapted cognitive behavior therapy to treat Latino depressed outpatients.

➢ Costantino et al (1986, 1994) have used story-telling and folktales (Cuento Therapy) with Puerto Rican children.

➢ Koss-Chioino and Vargas (1999) have demonstrated how restoring a spiritual connection helped Latino youth who were struggling with psychological and acculturative distress, alienation and substance abuse.

➢ Other examples of culturally adapted interventions have been offered by Bernal and Domench (in press), Hwang et al. (2006), Interian et al. (2008), Lau, (2006), Rosello & Bernal (1999, 2005).

➢ For an example of a Treatment Manual that has been adapted to depressed Peurto Rican adolescents see: ***http://ipsi.uprrp.edu/recursos.html***

REFERENCES

American Psychological Association (1993). Guidelines for providers of psychological services
      to ethnic, linguistic and culturally diverse populations. Washington, DC: Author.

Andres-Hyman, R.C., Ortiz, J., Anez, L.M., Paris, M, & Davidson, L. (2006). Culture and
      clinical practice: Recommendations for working with Puerto Ricans and other
      Latinas(os) in the United States. Professional Psychology, 37, 694-701.

Anez, L.M., Paris, M., Bedregal, L.E., Davidson, L. & Grilo, C.M. (2005). Application of
      cultural constructs in the case of first generation Latino clients in a Community Mental
      Health Setting. Journal of Psychiatric Research, 4, 221-230.

Anez, L.M., Silva, M.A., Paris, M. & Bedregal, L.E. (2008). Engaging Latinos through the
      integration of cultural values and motivational interviewing principles. Professional
      Psychology: Research and Practice, 39, 153-159.

Bernal, G., Bonilla, J., Padillo-Cotto & Perry-Prado, E.M. (1998). Factors associated to outcome
      in psychotherapy: An effectiveness study in Puerto Rico. Journal of Clinical Psychology,
      51, 329-342.

Bernal, G. & Domench Rodriguez, M. (in press). Cultural adaptation: Tools for evidence-based
      practice with diverse populations. Washington, D.C.: American Psychological
      Association Press.

Bernal, G. & Scharran-Del-Rio, M.R. (2001). Are empirically supported treatments valid for
      ethnic minorities? Toward an alternative approach to treatment research. Cultural
      Diversity & Ethnic Minority Psychology, 7, 328-342.

Boyd-Franklin, N. (2003). Black families in therapy. (2nd ed.) New York: Guilford Press.

Boyd-Franklin, N. (2008). Working with African-Americans and trauma: Lessons for clinicians
      from Hurricane Katrina. In M. McGoldrick & K. Hardy (Eds.), Re-visioning family
      therapy (2nd ed.). New York: Guilford Press.

Bracero, W. (1998). Intimidades: Confianza, gender and hierarchy in the construction of Latino
      therapeutic relationships. Cultural Diversity and Mental Health, 4, 264-277.

Cane, P. (2000). Trauma, healing and transformations: Awakening a new heart with Body Mind
      Spirit practices. Watsonville, CA: Capacitor Inc.

Cohen, A.B. (2009). Many forms of culture. American Psychologist, 64, 194-204.

Comas-Diaz, L. (2006). Latino healing: The integration of ethnic psychology into
      psychotherapy. Psychotherapy, 43, 436-453.

Comas-Diaz, L. & Greene, B. (Eds.) (1994). Women of color: Integrating ethnic and gender
      identities in psychotherapy. New York: Guilford Press.

Costantino, G., Malgady, R. G. & Rogler, L. H. (1986). Cuento therapy: A culturally sensitive
      modality for Puerto Rican children. Journal of Consulting at Clinical Psychology, 54,
      639-645.

Costantino, G., Malgady, R. G. & Rogler, L. H. (1994). Storytelling through pictures: Culturally
      sensitive psychotherapy for Hispanic children and adolescents. Journal of Clinical Child
      Psychology, 23, 13-20.

De Rios, M. D. (1997). Magical realism; A cultural intervention for traumatized Hispanic
      children. Cultural Diversity and Mental Health, 3, 159-170.

Falicov, C.J. (1998). Latino families in therapy. New York: Guilford Press.

Franklin, A.J., Boyd-Franklin, N. & Kelly, S. (2006). Racism and invisibility: Emotional abuse and psychological trauma for people of color. Journal of Emotional Abuse, 6, 9-30.

Griner, D. & Smith, T.B. (2006). Culturally-adapted mental health interventions: A meta-analytic review. Psychotherapy: Theory, Research, Practice, Training, 43, 531-548.

Hays, P.A., & Iwamasa, G.Y. (2006). Culturally responsive cognitive-behavioral therapy. Washington, DC: American Psychological Association.

Hinton, D.E., Pich, V., Chhean, Safren, S.A. & Pollock, M.H. (2006). Somatic-focused therapy for traumatized refugees: Treating Posttraumatic Stress Disorder and comorbid neck-focused panic attacks among Cambodian refugees. Psychotherapy, 43, 471-505.

Huey, S.J. & Polo, A.J. (2008). Evidence-based psychosocial treatments for ethnic minority youth: A review and meta-analysis. Journal of Clinical Child and Adolescent Psychology, 37, 262-301.

Hwang, W., Wood, J.J., Lin, K. & Cheung, F. (2006). Cognitive-behavioral therapy with Chinese Americans: Research, theory and clinical practice. Cognitive and Behavioral Practice. 13, 293-303.

Interian, A., Allen, L., Gara, M. & Escobar, J. (2008). A pilot study of culturally adapted cognitive-behavior therapy for Hispanics with major depression. Cognitive Behavior Practice, 15, 67-75.

Jose, A. & Goldfried, M. (2008). A transtheoretical approach to case formulation. Cognitive and Behavioral Practice, 15, 212-222.

Koss-Chioino, J. D. & Vargas, L. A. (1999). Working with Latino youth: Culture, development and context. San Francisco: Jossey- Bass.

Lau, A.S. (2006). Making the case for selective and directed cultural adaptations of evidence-based treatments: Examples from parent training. Clinical Psychology: Science and Practice, 13, 295-310.

Landrine, H. & Klonoff, E.A. (1996). The Schedule of Racist Events: A measure of racist discrimination and a study of its negative physical and mental health consequences. Journal of Black Psychology, 22, 144-168.

Marsella, A.J., Freedman, M.J., Gerrity, E.T. & Scurfield, R.M. (Eds.). (1996). Ethnocultural aspects of post-traumatic disorder: Issues, research and clinical applications. Washington, DC: American Psychological Association.

McGoldrick, M., Pearce, J.K., & Giordano, J. (Eds.). (1996). Ethnicity and family therapy. New York: Guilford Press.

Miller, W.R. & Rollnick, S. (2002). Motivational interviewing: Preparing people for change. (2nd ed.). New York: Guilford Press.

Miranda, J., Bernal, G., Lau, A., Kohn, L., Kwang, W.C. & La Fromboise, T. (2005). State of the science in psychosocial interventions for ethnic minorities. Annual Review of Clinical Psychology, 67, 734-745.

Munoz, R. F. & Mendelson, T. (2005). Toward evidence-based interventions for diverse populations; The San Francisco General Hospital prevention and treatment manual. Journal of Clinical and Consulting Psychology, 73, 790-799.

Nader, K., Dubrow, N. & Stamm, B. (Eds.) (1999). Honoring differences: Cultural issues in the treatment of trauma and loss. Philadelphia: Taylor & Francis.

Nezu, A.M., Nezu, C.M. & Lombordo, E. (2004). Cognitive-behavioral formulation and
         treatment design: A problem-solving approach. New York: Springer.
Organista, K. C. Munoz, R. F. & Gonzales, G. (1994). Cognitive behavior therapy for depression
         in low income and minority medical outpatients. Cognitive Therapy and Research, 18,
         241-259.
Organista, K.C., & Munoz, R.F. (1996). Cognitive behavioral therapy with Latinos. Cognitive
         and Behavioral Practice, 3, 255-270.
Panaigua, F.A. (1994). Assessing and treating culturally diverse clients. Thousand Oaks: CA:
         Sage.
Persons, J.B. (1989). Cognitive therapy in practice: A case formulation approach. New York:
         Norton.
Rastogin, M. & Weiling, E. (Eds.) (2004). Voices of color: First person accounts of ethnic
         minority therapists. Thousand Oaks, CA: Sage Publications.
Rossello, J. & Bernal, G. (1999). The efficacy of cognitive-behavioral and interpersonal
         treatments for depression in Puerto Rican adolescents. Journal of Consulting and Clinical
         Psychology, 67, 734-745.
Rossello, J. & Bernal, G. (2005). New developments in cognitive-behavioral and interpersonnal
         treatments for depressed Puerto Rican adolescents. In E.D. Hibbs & P.S. Jensen (Eds.),
         Psychosocial treatment for child and adolescent disorders: Empirically-based strategies
         for clinical practice (2nd ed.) (pp. 187-217). Washington, DC: American Psychological
         Association.
Santiago-Rivera, A., Arrendo, P. & Gallardo-Cooper, M. (2002). Counseling Latinos and la
         familia. Thousand Oaks, CA: Sage Publications.
Smith, T. (2004). Practicing multiculturalism: Affirming diversity in counseling and psychology.
         Boston: Pearson Education.
Sue, D.W., Bingham, P.R., Porche-Burke, L. & Vasquez, M. (1999). The diversification of
         psychology: A multicultural revolution. American Psychologist, 54, 1061-1069.
Sue, D.W. & Sue, D. (2003). Counselling the culturally diverse: Theory and practice. 4th ed.
         New York: John Wiley & Sons.
Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. American
         Psychologist, 53, 440-448.
Szapocznik, J. & Kurtines, W. (1993). Family psychology and cultural diversity. American
         Psychologist, 48, 400-407.
Triandis, H.C., Marin, G., Lisonsky, J. & Betancourt, H. (1984). Simpatica as a cultural script of
         Hispanics. Journal of Personality and Social Psychology, 47, 1363-1375.
U.S. Department of Health and Human Services (1999). Mental health: A report of the Surgeon
         General. Rockville, MD: National Institute of Mental Health.
Weisman, A. (2005). Integrating culturally based approaches with existing interventions for
         Hispanic/Latino families coping with schizophrenia. Psychotherapy: Theory, Research,
         Practice, Training, 42, 178-197.
Wilson, J.P. & Tang, C.S. (2007). Cross-cultural assessment and psychological trauma and
         PTSD. New York: Springer.