Using Evidence-Based Practices in the Hispanic Community

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IN PART 4 OF THIS 6-PART SERIES ON LESSONS LEARNED from the GAIN Cultural Sensitivity Summit, we continue discussing the effective utilization of EBP with diverse clients. This article focuses on clinical service provision with Hispanic individuals living in the United States who may have substance use or mental health disorders.

People today who live in the United States who trace their lineage to Spain and its conquered areas are identified as "Hispanic" by the U.S. government, regardless of their race. This would include those from Mexico, Puerto Rico, Cuba, the Dominican Republic, Central or South America (with the exception of Brazil, which was colonized by Portugal), or other Spanish cultures. Although other terms, such as Latino or Chicano, are commonly used to describe the community of people who are the focus of this article, we have chosen to use the term Hispanic (Marín & Marín, 1991; Pollick, 2012).

What are some of these basic values and the implications for service delivery when working cross-culturally with Hispanic clients?

- *Allocentrism*. Also called collectivism, this is the orientation in which the needs, goals, values, points of view and expectations of the in-group are emphasized over those of the individual. When using the GAIN or other assessments to explore the client's reasons for change, a treatment provider can typically expect a Hispanic person's responses to be more related to community or family than to individual motivations. Treatment planning should reflect these collective motivations rather than focusing on individual benefits.
- *Simpatía*. This cultural value emphasizes the need for behaviors that promote smooth, pleasant and harmonious interpersonal relationships. Because simpatía is inherently tied to conflict avoidance, the

treatment provider may find that a higher level of sensitivity is needed to recognize when a client's response to EBP is intended to mask problems for the sake of avoiding conflict or offense to another person.

- *Familismo*. This value involves the individuals' strong attachment to and identification with their extended and nuclear families. Because of the importance of the family as a source of both material and emotional support, the therapist may need to consider more family involvement in the client's treatment. The client may even desire family members to attend sessions and contribute to discussions about problems and treatment options.
- *Personalismo*. This cultural value emphasizes the establishment of trust, friendship and rapport prior to engaging in any kind of business—personal or otherwise. Taking time up front to establish rapport in a friendly, easygoing manner is essential as is carefully and actively listening to the client.
- *Respeto*. This is the need for respect and maintenance of dignity in social relationships. *Respeto* implies deference to authority and knowing one's place in a hierarchical system. If the Hispanic client views the therapist as having greater social status or wielding more power, the desire to show respeto may cause clients to defer to the clinician rather than risk being disrespectful by disagreeing.
- *Machismo/Marianismo*. These are gender-specific values. *Machismo* refers to the man's responsibility to protect and provide for his family. In its more negative connotations, it can also refer to aggressiveness, dominance and arrogance. *Marianismo* encourages women to use the Virgin Mary as their role model, thus becoming spiritually strong, morally upright, nurturing and self-sacrificing.
- *Religion and spirituality*. Faith plays a central role in the lives of many Hispanic people. When working cross-culturally, the most effective clinicians will recognize and be sensitive to the role of spiritual explanations and remedies in the client's life.

As the Hispanic population grows, it is imperative that providers be prepared to assist Hispanic clients with treatment that is culturally informed. The GAIN Cultural Sensitivity Summit participants identified five competencies for treatment professionals who use evidence-based practices with diverse populations, which follow.

1. Recognize the Power of Historical Perspective

The Hispanic community has a long and varied presence in the United States, with some having been in the land destined to become the United States since the 1500s.

Spanish settlements like St. Augustine in present-day Florida, were established and growing in the mid- to late 1500s, predating the earliest English settlements in Virginia and Massachusetts. Many current day Hispanics can trace their ancestral heritage back to that time (http://usa.usembassy.de/society-hispanics.htm).

Following the conclusion of the Mexican-American War in 1848, Mexican citizens who lived in the ceded territory were promised U.S. citizenship. In more recent times, Mexicans have immigrated or otherwise entered the U.S. in search of employment and hopes for a better life, accepting low-skill, low-wage positions such as those found in agriculture and the service industries. Today, Mexico is by far the leading country of origin of U.S. immigrants (Passel & Cohn, 2009).

Puerto Rican people did not "migrate" to the United States, but were assimilated when the island of Puerto Rico became a territory of the United States at the conclusion of the Spanish-American War of 1898. In 1917, the people of Puerto Rico were granted U.S. citizenship. That, coupled with employment opportunities and low-cost travel between Puerto Rico and New York City, facilitated large-scale movement to the U.S. mainland in the 20th century.

Cubans migrated to the United States in several waves, with the first major wave occurring after Fidel Castro seized power in the island nation in 1959. During the 1980s, a large wave of Cuban immigration occurred through the Mariel boatlifts. The "boat people" were a mix of citizens desiring to flee communism along with criminals and mentally ill people whom Castro wished to send to the United States.

Situations surrounding one's "coming to America" can be traumatic, either in migrating or immigrating. In the United States, many Hispanic people have experienced economic or social barriers and numerous forms of discrimination. A person's historical experience with discrimination and their fears of revictimization (in the case of undocumented individuals or those from war-torn countries) can manifest as mistrust and reticence toward helping professionals, especially those who are not Hispanic themselves. The possibility of misinterpretation or overdiagnosis of certain behaviors exists if the client's justifiable mistrust is treated like a personality disorder or symptom of paranoid schizophrenia. Clinicians who use EBP like the GAIN or other evidence-based protocols are wise to inquire and take note of any culturally-related historical experiences of clients and their families to administer and interpret an evidence-based protocol with cultural sensitivity.

2. Appreciate the Impact of Cultural Explanations and Stigmas

Cultural beliefs and attitudes concerning substance use can have a significant influence on a client's reasons for seeking substance abuse treatment, the responses to intervention and prevention efforts, as well as barriers to treatment (Santisteban & Szapocznik, 1982). Summit participants emphasized that for Hispanic communities, culturally-based explanations for substance abuse and mental health problems are often rooted in strong spiritual and religious values.

Several culture-bound syndromes of the Hispanic community worldwide are described in the current volume of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision (DSM-IV-TR; APA 2000). For example, "ataque de nervios" is triggered by a stressful event related to the family (e.g., news of a death, divorce or separation). Symptoms include uncontrollable shouting, attacks of crying, trembling, heat in the chest rising into the head, and verbal and physical aggression.

When a client describes their problems in cultural terms and expresses connection to their culture's religious traditions around healing, therapists are encouraged to involve the client's priest, minister or curandera in the treatment plan. For example, Hispanic veterans diagnosed with PTSD have been found to frequently seek the advice and healing power of a curandera (Canive & Castillo, 1997), and symbolic rituals such as burning a representation of a traumatic event are seen as a way to cleanse the soul.

If the client's spiritual beliefs and practices differ from those of the clinician, there is a risk of overinterpreting or pathologizing culturally normative activity. In the Hispanic community, this behavior could include talking to deceased loved ones or recognizing ghosts or spirits. Without a cultural framework and collateral input from others, a clinician could misinterpret this as psychosis. For example, one item in the GAIN-I asks if the person has had significant problems with "seeing or hearing things that no one else could see or hear or feeling that someone else could hear or control your thoughts." This is one of 12 items in the instrument's Anxiety and Fear Symptom Scale with items that contribute to measuring internal mental distress. At the summit, a GAIN interviewer told of a 16-year-old Hispanic male who endorsed "seeing or hearing things that no one else could see or hear." While this would be a non-normative experience in the clinician's culture, it was indeed normal for the client's family and was not problematic for the client. The GAIN interviewer was able to contextualize this to the client's culture to avoid overdiagnosing the client. This emphasizes the importance of clarifying with the client and family whether a particular behavior is within the norm for their family or community.

Paniagua (2005, p. 67) notes that Hispanic clients tend to expect a clinician to discuss spiritual factors that

may be related to emotional problems. Spiritual explanations include the "mal puesto" or hex; the "susto" or magical fright; and the "mal de ojo" or evil eye. The first session or initial assessment is a good time to explore the client's beliefs and begin to consider how to integrate those beliefs into EBP.

In Hispanic communities, mental illness is often experienced shamefully for a family. In fact, stigma is believed to be one of the major reasons for underutilization or lack of medication compliance (Interian et al., 2007). Alcohol use, however, is generally more accepted. Underage consumption of alcohol may be allowed at family celebrations, such as weddings, birthdays, sporting events and religious ceremonies such as baptisms. Tolerant views on using illicit drugs for medicinal purposes are also common in many Hispanic communities. For example, it is not uncommon for marijuana to be soaked in alcohol and used for the treatment of arthritis. Cultural practices such as this can make it very difficult for some families to comprehend the meaning of illicit drug use and may make it necessary to incorporate more educational content into service delivery.

3. Respect Cultural Variations in Communication, Expectations, and Norms and Values

For Hispanic clients, there are two levels of variation to consider related to cultural distinctions in communication, expectations, norms and values. Those two levels are intergroup diversity and intragroup diversity.

In this article, intergroup diversity refers to cultural differences between the treatment professional and the client, which has already been discussed. Intragroup diversity refers to differences between groups of Hispanics. Intragroup diversity is important because Hispanic diversity goes far beyond the limitations of a geographic landmark and the similarities of language. Summit participants noted that the common struggle among nearly all Hispanics who are newer to the United States revolves around the issue of acculturation and cultural adjustment. Peter Bell (2002) provides a description of cultural adjustment issues that many clients of color need to address to maximize the chances of successful recovery from substance use disorders. On the assimilation continuum, a person may choose to either: (1) remain culturally separate from the more prevalent group; (2) integrate into it by maintaining bridges between both the culture of origin and the new culture; or (3) fully assimilate into the new culture with little to no connection with the culture of origin.

Hispanics generally hold strong loyalties to their countries of origin and may be apprehensive about emersion into a new society (Woodward, Dwinell, & Arons, 1992). Often, the result is stress, depression and other problems. These issues are further compounded by the effects of discrimination, poverty, low-income communities, low paying jobs, a sense of powerlessness and limited access to quality health care in Hispanic communities (Terrel, 1993).

Differences may exist between Hispanics of different national origins. Geert Hofstede's international research on cultural values in the workplace (2001; Hofstede, Hofstede, & Minkov, 2010) shows how values differ among people from various countries. Inherent in those distinctions are many unique characteristics related to values, communication and norms. One such difference concerns expectations about obligations. Some Hispanic cultures have very fluid expectations about obligations, while others have less flexibility. In the Dominican Republic, for instance, adherence to laws and rules tends to be flexible to suit specific situations. (Hofstede, 2001; Hofstede, Hofstede, & Minkov, 2010). These clients may have an expectation of flexibility that treatment systems are not accustomed to providing. On the other hand, Mexico and the majority of Latin American countries have a high preference for structure, convention and minimizing uncertainty. In these cultures, security is an important motivator and there is great need for rules, precision and punctuality. Treatment providers who understand these distinctions will be positioned for greater responsiveness to a client's culturally based expectations.

Another area of cultural variation concerns how a culture defines success. American society is typically driven by comparative achievement where success is defined by an objective, competitive measure and the winner is considered to be the "best" contender. This is the case in Mexico and Venezuela. Compare this value system to that in Panama, Chile or Costa Rica where the dominant values are more nurturing and society is less assertive or competitive. Standing out as the

best at the expense of others is not highly regarded. Recognizing the differences in these culturally driven values can help clinicians develop or select EBPs with motivational enhancement interventions that are congruent with client values. Understanding cultural distinctions can also help treatment professionals who interpret clinical assessments like the GAIN to consider the values that inform client attitudes about quality of life and environment satisfaction.

4. Create an Atmosphere of Cultural Safety

People in the Hispanic community continue to desperately desire the "American Dream." The pursuit of this dream has often been slowed by discrimination, immigration challenges and a feeling of invisibility. As a result, many turn to the use of alcohol and other drugs for relief. The need for effective, culturally competent care is pervasive, but must expand beyond the notion of having a Spanish-speaking staff person on the treatment team. Studies suggest that Hispanics are roughly six times more likely to use specialty mental health services if the environment is culturally friendly (Woodward et al., 1992).

Summit participants noted that providing a culturally sensitive atmosphere can increase the effectiveness of treatment. They also emphasized the need for therapists to understand the client's untold stories and begin to nurture trust by placing emphasis on the core values of *simpatía* and *personalismo*. Treatment providers who have been trained in strict adherence to a highly structured EBP protocol may not realize the potential damage to client rapport with Hispanic clients. The ideal environment will focus on the establishment of trust, friendship and rapport prior to a business encounter or any other such transaction. If these values become standard practice in a treatment setting, the organization is creating an atmosphere of cultural safety for Hispanic clients.

5. Show Adaptability and Flexibility

Terrel (1993) points out that treatment providers should take into consideration six key elements when developing curriculum to be used with Hispanics:

1. *The curriculum should include content that involves cultural experiences.*
2. *Training materials should be based on the specific experiences and values of a given culture rather than using "cookie cutter" materials.*
3. *Trainers themselves should be members of that culture.*
4. *Incorporating cultural values will add credibility and convey the competence of the program.*
5. *Inclusion of culturally salient materials will offset culturally based treatment barriers.*
6. *Address the role of the family in Hispanic communities.*

Santisteban, Mena, and McCabe (2011) note that if treatment providers were to (1) utilize treatment that focuses on cultural characteristics, (2) avoid a "one-size-fits-all" approach and (3) target family processes, then treatment for Hispanics would be effective.

Using evidence-based assessments in the client's choice of language is another way to accommodate Hispanic clients. In 2005, staff at the GAIN Coordinating Center started receiving requests from the field for Spanish language GAIN instruments. A Translation Advisory Group was formed to lead the adaptation, both culturally and linguistically, through state-of-the-art translation methods. The group was composed of substance abuse and mental health professionals from the major Spanish-speaking communities in the United States—Mexican, Puerto Rican and Cuban—along with a representative from South America. The goal was to create a Spanish language instrument that preserved the meaning and intent of the original English items but also incorporated any necessary adaptations to make items culturally relevant.

Given that the Spanish GAIN-I (the Valoración Global de Necesidades Individuales-Inicial, or VGNI-I) was to be used in the United States, the backdrop culture would still be "American"; thus items having to do with federal services or the criminal justice system would not need to be culturally adapted. However, there are subtle differences in terms used in Mexican, Puerto Rican and Cuban communities. Yes, they are all "Spanish-speaking,"

but variations by community exist. For items where reliable differences in terms existed, variations were included in parentheses.

Last, summit participants noted that attention to staffing patterns is often overlooked. Few treatment providers are bilingual-bicultural and culturally competent with an array of diverse populations. Hispanic treatment providers are often overutilized (i.e., translating for other therapists, translating materials and managing higher caseloads because they are the only Spanish speaking therapist in the office). Program directors and supervisors can help their staff members by understanding that additional time and energy are required for a staff person to provide adequate and appropriate services in two languages. Most important, treatment providers will be most effective when cultural sensitivity training and supervision are regularly incorporated into staff development activities.

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