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How white non-Latino/a therapists perceive and address racial and cultural differences when working with Latino/a clients

Lisa C. Amato

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Lisa C. Amato
How White Non-Latino/a
Therapists Perceive and
Address Racial and Cultural
Differences When Working
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ABSTRACT

This study is intended to deepen and expand upon existing literature on cultural competence by offering a look at the views of White clinicians in the field who are working with communities of color, but who might not otherwise have thought about how they were engaging their clients and accounting for racial and cultural differences in their work. The project poses challenging questions and invites White clinicians to think honestly about salient issues around race, racism, culture, and ethnicity. One of its objectives is for the participants themselves, other clinicians, and readers of the thesis to think about how these issues might affect their work. For instance, whether or not taking an active stance around cross-cultural and racial matters has the potential to improve clinical practice and open dialogue as opposed to denying the presence of tensions which are considered by many to still be a very real impediment to cross-cultural and racial relationships in the US both in and out of the therapeutic context.

The project is also meant to promote the notion that the responsibility for anti-racism and anti-oppression work lies with the oppressor or those who benefit from unearned privileges, and argues that this begins with building internal awareness as a step toward ameliorating these endemic problems. It is rare that readers and students of cross-cultural practice get an opportunity to hear the anecdotal and raw stories and thoughts of

those who the field entrusts to practice cross-culturally. Through revealing the real practices of real clinicians we can understand how to build on and improve curriculum and research to better serve clients of color.

This particular study focuses in on these issues as they pertain to the Latino community and therefore folds in a host of other issues such as the impact of language difference and immigration experience. Significant increases in the Latino population in the US are reflected in the mental health client population. Yet, currently there is not a sufficient number of Latino/a therapists to accommodate the number of Latino/a clients in need of services and these clients are frequently being paired with non-Latino/a therapists. The implications of this are that cross-cultural and racial therapy is inevitable.

HOW WHITE NON-LATINO/A THERAPISTS PERCEIVE AND ADDRESS RACIAL
AND CULTURAL DIFFERENCES WHEN WORKING WITH LATINO/A CLIENTS

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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Thank you to all of the clinicians who participated in this project, for lending your time, thoughts, and experiences. This project could not have happened without you. Here's hoping it's all for something.

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Gracias

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CHAPTER I

INTRODUCTION

As a White non-Latina woman who has worked with various Latino communities (primarily Mexican, Dominican and Puerto Rican) in multiple capacities throughout my professional career, I find that my own views on cross-cultural interactions are continually changing and being redefined. This became even more evident upon entering the mental health field where my communication and relationship-building skills, as well as adeptness at understanding people from cultures different from my own have been consistently challenged.

There is ample literature on cultural competence and multiculturalism in therapy. Much of it, though both quantitatively and qualitatively tested, is written from primarily theoretical and methodological perspectives. I have come across an extremely limited amount of literature reflecting the experiences of White clinicians in their work with non-White clients. The absence of these voices has left me with questions about how clinicians are actually using, applying and understanding these theories and methodologies. Do they feel these guidelines are working for them or not and if not, why not? Are they even using them? Do they feel they are adequately trained, educated and engaged in dialogue around these issues? Do they see these issues as important and seek out dialogue and further training? Do differences in race, culture, and ethnicity change the way they approach their work or understand a client's presenting problem? What does it feel like to sit across from and in service to someone who has been oppressed by the same forces which have awarded them a certain degree of unearned privilege?

Through interviews with experienced clinicians, this research project sets out to answer these questions and keep this dialogue going. The project is being taken on under the assumption that therapists can benefit from hearing the views, growth processes, approaches, critiques, questions, and thoughts of peers in the field as they move toward understanding themselves and their work in the name of mitigating people's suffering and helping their clients to become their fullest and truest selves.

CHAPTER II

LITERATURE REVIEW

Introduction

This study will explore the experiences of White non-Latino/a therapists working cross-culturally with Latino/a clients. It postulates that there are certain social, political, and systemic issues, related to race and culture, which emerge both for the client as well as the clinician within this dyad that inform the therapeutic relationship. In addition, it questions whether or not these issues affect the quality of the client's treatment. Ultimately, this study is being undertaken to understand how White non-Latino/a therapists understand and approach cross-cultural therapy and methodology in their work with Latino/a clients.

In order to review these issues in the literature, the following topics are discussed. The first section provides a brief discussion of terms that are typically utilized in conversations about cross-cultural therapy with the Latino population, such as "Hispanic" and "Latino", as well as more general terms such as "culture," "race" and "ethnicity." I then provide general information about the demography and cultural characteristics of Latinos living in the United States as well as the mental health issues which affect them. Subsequently, I explore the intersections of therapy and culture (and the question of whether or not therapy is culturally-bound), and therapy and race (and what it means for White clinicians to hold white privilege while working cross-culturally, racially, and ethnically). Lastly, I look at research on cultural competence in multicultural therapy and

assessment and the way in which mental health providers understand clients from diverse backgrounds and work to employ culturally sensitive therapeutic methods.

Use and Definition of Terms

Hispanic vs. Latino

The terms *Hispanic* and *Latino* are often used interchangeably. The census-created term *Hispanic* (Marotta & Garcia, 2003) is classified by the Census Bureau as people whose ethnic roots can be traced back to Spain (Nather, 2002). The purpose of the label was to categorize people not by specific country of origin, but by a common language (Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002). Falicov (1998) noted that the term *Latino* is more representative of people from Latin America who have indigenous roots, whereas the term *Hispanic* excludes such influences. Because many Latin Americans are not of Spanish descent and because Spain's role in the history of Latin America has been one of colonization and imperialism, the word *Latino* has been adopted as an alternative, symbolizing independence from Spain.

Still, this term is less than ideal as it can be misleading and dismissive of the uniqueness of people from varying Latin American countries (as well as regions within the same country) to conflate distinct Latin American populations into one. To resolve this many Latinos prefer to be known by their national origin. As Nather (2002) points out, in the U.S., preference for one term over another also varies geographically. For example Mexican Americans in the Southwest United States often identify as *Chicanos*, a term introduced during the Mexican American civil rights movement of the 1960s and

which (though a complex and non-absolute term) carries with it the intention of conveying one's socioethnic as well as political identity (Duncan-Andrade, 2005).

Because of its common use in the Northeast and due to insufficient research pertaining to any one Latino group in this particular area of study, I will use the term *Latino* throughout this paper. When possible I will identify the specific nation of origin as reflected in the literature. I do this with the recognition that many of the ensuing statements will in some way fail to accurately convey the reality, perspective, or understanding of one or myriad Latino groups or individuals.

To the credit of those who are writing and publishing there is a notable increase in the amount of literature on Latinos; a reflection of population changes in the U.S. with Latinos now representing 13% of the total populace (Marotta & Garcia, 2003). Still more needs to be done to recognize that the experiences of a Puerto Rican migrant (from a U.S. colony in the Caribbean) are going to vary vastly from those of an undocumented Guatemalan escaping civil war, an Ecuadorian economic refugee, an Argentinean living in the U.S. on a student visa or a fifth-generation Mexican American. Identifying each of these people by the same name (*Latino*), and referring to the "Latino experience" has the affect of erasing these differences. It is important to convey the experiences of these individual groups, to record their histories and to understand them within their own social, economic, and political contexts.

Culture and Race

The word "culture" is another complex and tiered term that merits discussion and clarification. Researchers often equate and blur "race," "ethnicity" and "culture" in a

way which generates confusion (Garcia and Marotta, 2003; Park, 2005). Park (2005) proposes that in fact, “culture” (as one of the most complicated words in the English language) is used as a euphemism for “race” and “ethnicity” and is deployed as a marker of deficit. If, as Ramsdell (2004) asserts, “language is identity and identity is political,” then how one chooses to use these identifiers is important (p. 166). Park (2005) states that, “no usage of language can ever be considered neutral, impartial or apolitical acts” (p. 12). Therefore the misuse of terms or the failure to define them can be problematic in a field such as social work where “culture” is a primary topic of focus and where methods of teaching cultural competence are continually being explored and re-visited. Park (2005) states that there is an “underlying assumption...that culture is that which differentiates minorities, immigrants and refugees from the rest of society” (using the White mainstream as a point of comparison) and that the preservation of stereotypes is made possible by culture as a category defined by essential, fixable traits (p. 19). She goes on to say that the term has come to characterize “minority” or “person of color” and to reinforce a subjugating paradigm. Laird (1998) distills the study of culture within mental health into the idea that we educate ourselves about the characteristics of the “other” or those who are “different from” us. Like Park, however, she professes that “different from” often means “less than”.

Park’s arguments present a challenging, but important dilemma in the face of an immense body of literature addressing multiculturalism, cultural sensitivity, and cultural competence in clinical practice in which assumptions are perpetually made that there is a common, though unspoken definition and understanding of the word “culture.”

Unfortunately, a simple alternative is not readily available as similar if not deeper

conflicts arise with the use of terms such as “race” and “ethnicity.” It is with a profound respect for the issues raised by Park that I invite the reader to read on with her voice in mind and to think about how we might resolve this question as we further refine language and explore meaning.

Laird (1998) meets Park’s challenge by using Narrative ideas to explore meanings of cultural categorizations, arguing for the need to move beyond culture as a static notion and to see it instead as dynamic, performative, political, fluid, indefinable and immeasurable, and something which can be used as a point of intersection (meaning that parts of one’s identity may be more or less salient at different points in a person’s life).

While my own position falls somewhere between Laird and Park’s I have borrowed a more concrete, working definition of “culture” for the sake of this paper. Although, as Park (2005) indicates, Christensen’s (1992) definition fails to define the commonalities she refers to, I believe it does some justice to the word as it understands culture as something which is formed in a historical context. She says that, “Culture consists of commonalities around which people have developed values, norms, family values, social roles, and behaviors, in response to the historical, political, economic, and social realities they face” (p.86).

McGoldrick (1993) speaks somewhat to these commonalities when she writes that “ethnicity patterns our thinking, feeling and behavior in both obvious and subtle ways, playing a major role in determining what we eat, how we work, how we relate, how we celebrate holiday and ritual, and how we feel about life, death, and illness” (p. 335). I will attempt to elucidate some of these commonalities (as they pertain to Latino culture) in the upcoming section about cultural characteristics of Latinos in the United States.

Adopting the theory that race is a construct, I have chosen to default to “culture” in lieu of “race” when referring to the differences between White clinicians and their Latino/a clients. However, I do believe that racial dynamics (white privilege) are prevalent between Anglo clinicians and Latino/a clients. It is important to note too that there are many overlapping and parallel hierarchies of privilege (including class, gender, sexual orientation, etc.). For instance, although white privilege might not be present in therapy between a White clinician and White client, class privilege may still permeate the relationship and affect the therapy in similar ways. Class differences, while not the focus of this paper, can be understood as a component of culture and a struggle which pervades, informs, and at times drives existing hierarchies, as exemplified in the following section outlining economic demographic data of Latinos in the U.S.

Latinos in the United States

Demographics

It is assumed that there is a significant margin of error in information gathered by the census. This can be contributed (among other factors) to a general lack of reporting, discrepancies in how people self-identify, and the presence of undocumented immigrants. The following population statistics are shared with this in mind. According to the US Census Bureau, in 2001 Latinos represented 12 percent (approximately 32 million) of the US population (US Census Bureau, 2001). Delgado (2000) categorizes “Hispanic” (with major categories in accordance with the census) as Mexican (at 62% of Latinos in the US), Puerto Rican (at 13%), Cuban (at 5%) and “other” originating from Central and South America (at 20%). He reports a growth in the Latino/a population by 59% from

1987 to 1998. Garcia and Marotta (2003) present slightly different numbers with Mexicans representing 58%, Puerto Ricans representing 10%, Cubans representing 4%, and Central and South Americans representing 28% of the population. By the year 2025 it is estimated that the Latino population in the United States will reach approximately 55 million and comprise the largest non-White population in the country (Falicov, 1998). These represent unprecedented changes in the U.S. population (Marotta & Garcia, 2003).

Nationally the percentage of people speaking Spanish in the home has increased from 7.5% to 10.7%. The average income for a family (if measured by number of family members) in the U.S. is \$26,641 as compared to \$15,415 for Latino families. 27% of Latinos live below the poverty level. At the college graduate level, unemployment rates for Latinos are at 3.6% compared to 2.3% for the total U.S. population. Sixty one percent of Latinos work in service, industrial and agricultural jobs. Within Latino groups Mexicans have lower employment in professional and managerial jobs than Puerto Ricans and Cubans. However, Puerto Ricans have an overall higher rate of unemployment. The proportion of Latinos with no more than a fifth-grade education is 17 times higher than non-Latino Whites (Marotta & Garcia, 2003). Of 10.8 million Latino/a children, 40% were poor compared to 15% of White children, while the school drop-out rate was 44% among Latinos compared to 15% among Whites (Delgado, 2000).

Cultural Characteristics

Delineating specific “Latino characteristics” can be complicated and precarious due to the risk of making overly broad generalizations and of merging distinct cultures into one. However, there are some characteristics of Latino cultures that most in the

literature agree upon and which can provide a useful framework for navigating the stories of Latino/a clients and the potentially culturally-engendered dichotomies they face living the US.

Research shows that Euro-Americans tend to favor individualism, whereas collectivism is characteristic of Latino cultures and immigrant generations (Raeff, Greenfield, Quiroz, 2000). In illustrating examples of collectivism and individualism within Latino and Anglo families, Falicov (2001) points out that it is much more common for grandparents to live with their children and for other relatives to share in daily life with Latino families. In fact, within Latino families the definition of kin has been expanded to include close friends, godparents, in-laws, distant relatives as well as immediate family members. Raeff, Greenfield, Quiroz (2000) define individualism and collectivism as “complex value systems that reflect different historically constituted standards for the interplay between independence and interdependence” (p. 59). They further define individualism in terms of independence, and collectivism in terms of interdependence and the assumption that people are primarily members of groups. “Whereas individualism views group membership and social relationships in terms of choice and mutual consent, collectivism treats social relationships as links that establish interdependence and reciprocal obligations (Raeff, Greenfield, Quiroz, 2000, p. 60).”

Familismo is one manifestation of Latino collectivism and example of a divergence from Anglo or European American culture. *Familismo* is defined as the interdependence of close family members and is believed by some to be the most important factor influencing the lives of Latinos (Coohey, 2001; Zayas & Palleja, 1988). It is a cultural value which has been described as a “traditional modality that emphasizes

the obligations and duties of family members to one another (Zayas & Palleja, 1988, p. 260).” Behaviors indicative of *familismo* include, obedience and respect toward authority figures, helpfulness, generosity and loyalty toward family members, and responsibility, hard work and sacrifice for the benefit of the family (Antshel, 2002). For many it is an important part of personal identity and a source of pride and strength. Even with a history of repeated migrations, *familismo* is a value which, for some, has been impervious to change despite acculturation pressure and influences of social and economic trends. However, research on Puerto Rican families shows second-generation adults to be less oriented toward *familismo* than their parents. (Zayas, 1988). As a component of *familismo*, Santiago-Rivera, Arredondo, and Gallardo-Cooper (2002) note that Latinos have a vertical communication style which reflects the hierarchy within the family and defines boundaries between authority figures and others.

Also of significance in various Latino cultures is *personalismo* and *respeto* (Antshel, 2002; Matos, Torres and Santiago, 2006; Sue & Sue, 2003). Delgado (2000) identifies additional traits such as *curanderismo* (folk medicine) and *compadrazgo* (reliance on godparents) as ways in which the Latino community has thus far been able to find and provide support to each independently of the external community. Other commonly shared elements of Latino culture include language, *espiritismo*, *simpatia*, and *fatalismo* (Antshel, 2002).

Antshel (2002) defines *personalismo* as a preference for personal over institutional relationships. This personal relationship might require less spatial distance between two people, more physical contact and an emphasis on trust and warmth. *Respeto* can be described as dictating deferential behavior towards others based on age,

gender and authority as well as a general respect and appreciation for Latino culture. The way in which *espiritismo* is viewed and lived varies significantly between Latino cultures, but generally speaking can be defined as a continuum of mind, body and spirit. Similar to *curanderismo* it involves spiritual healing, in Puerto Rico and Cuba carried out by *espiritistas* and in Mexico by *curanderas*. *Simpatia*, which is closely related to *personalismo*, emphasizes good manners and might entail avoidance of conflict (Antshel, 2002).

For many Latino groups, the Catholic religion is largely influential. The concept of *fatalismo* is part of the Latino culture and religion that is connected to a belief in fate; to the belief that things are the way they are because they are determined by God (Antshel, 2002). According to Sue and Sue (1999), the Catholic beliefs that sacrifice is helpful to salvation, charity is virtuous, and that injustice should be endured, lead to difficulty being assertive.

A common generalization about Latino cultures is that they are imbued by *machismo*. The underpinnings of this stereotype are that macho men are strong, virile, dominating, commanding, demanding, and sexual. There are also positive associations to the notion of *machismo*, which include courageous, proud, hard-working and family-oriented. Included in the *machismo* of Latino cultures, are the expectations of women to embody *La Virgen Maria* (The Virgin Mary). This is called *marianismo* and conveys the image of women as mother figures (self-sacrificing, religious, faithful, humble, modest and asexual except in relation to childbirth) (Falicov, 1998). There is also a stereotype of women as submissive to men, though some believe that Latina women assert their authority indirectly in order to maintain a facade of male control (Sue and Sue, 1999).

Falicov (1998) points out that this kind of gender typing brings about cycles of mutual reactivity and mutual control, precluding current progress and deviation from *machismo* and *marianismo* within contemporary societies.

Emphasis on one of these characteristics over another will obviously fluctuate depending on the specific country or region that a person is from and his/her relationship to the culture, family traditions, religion, gender, as well as economic and political position. These are the more common characteristics which, in numerous efforts to create culturally competent and integrative approaches toward working with a Latino client population, have been identified, observed, labeled, and analyzed in the literature relating to Latinos in the U.S. mental health system. Undoubtedly this is a superficial glance at these traits, and multiple exceptions can be made for each. Nonetheless, it provides a jumping off point for discussion.

Latino/a Mental Health

The increases in the Latino population are reflected in the mental health client population. Yet, currently there is not a sufficient number of Latino/a therapists to accommodate the number of Latino/a clients in need of services and these clients are frequently being paired with non-Latino/a therapists (Cervantes, 2005). The implications of this are that cross-cultural/racial/ethnic therapy is inevitable.

Falicov (1998) states that she does not believe in a “Latino therapy” or way of doing therapy, and maintains that the values of empathic listening and establishing a solid therapeutic alliance are the core and universal guiding principles for therapy with any population. While this may ultimately be a popular position among clinicians who work

with Latino clients, there is some data specific to the mental health of Latinos as well as their access to and receipt of services that might help to inform the clinical process.

It is important to note that, although this is changing, there has been a relative paucity of research on mental health issues affecting the Latino community. Additionally, it often seems that the research that is conducted is done so in response to problem or crisis. While much of the literature on mental health is pathology-driven there is the sense of conditions being significantly more dire for communities of color. On one hand this reflects the reality of what it means to be from a marginalized and oppressed community. On the other hand it echoes the undervaluing of Latino culture as one with strengths and values to borrow from.

Delgado (2000) suggests that the US social services system has failed to provide adequate mental health services to Latino families. These include the need to deconstruct and debunk stereotypes, increase cultural competence, and ultimately to break down the disparities between the Latino and White populations. Latinos in the US suffer from relatively high levels of stress and are particularly vulnerable to mental health problems (Zayas & Solari, 1994; Berrios, 2003). This is due to a variety of factors such as socioeconomic pressure, racism and discrimination, language differences, problems adjusting to the host culture, and in this, the host culture's misinterpretation of traditional values, as well as demographic characteristics such as high rates of poverty, unemployment, and the school drop-out rate (Berrios, 2003).

Mental health practitioners can use their expertise to fulfill an important role as a positive and empowering mediator between one's traditional culture and the individualistic, modern, and unfamiliar society encountered in the U.S. Yet, historically

there has been a relative lack of utilization of mental health services by Latinos (Brettler Vandervort & D'ermano Melkus, 2003; Kouyoumdjian, Zamboanga, Byron, Hansen, 2003; Lasser, 2002, Rodriguez, 1987). There are numerous hypotheses for this trend.

Attempts to explain underutilization of services by Latinos have included the presence of language difficulties, poverty, limited access to transportation, and fear of discrimination or of being misunderstood culturally (Falicov, 1998). Antshel (2002) suggests that consideration of common elements of Latino culture is vital to improving treatment adherence among Latinos. These issues, encompassed by the "barrier theory," suggest that the client has a desire for services, but is impeded by something external or out of the individual's control, such as deportation (Rodriguez, 1987). Fear of deportation is another factor explaining underutilization and has been exacerbated by efforts such as legislation Proposition 187 in California which proposed that publicly funded health care facilities deny services to undocumented immigrants and report them to immigration authorities (Falicov, 1998). This type of movement has the power to simultaneously affect documented immigrants as well as Latino/a citizens by creating an image of U.S. government-supported facilities as unsafe and unwelcoming of the general Latino population.

The "alternative-resource" theory posits that there is a desire for help, but that the person in need draws from resources within his/her own community, consulting for instance, *curanderos*, *espiritistas*, friends, and family. In this case, internal supports might be sufficient for those who look to their families and communities for services which (among Whites or those from more individualistic and western cultures) have been professionalized, externalized and provided by strangers in the United States (Rodriguez,

1987). The tendency to distrust mental health providers also motivates Latinos to seek help through an extended family support network (Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002).

Falicov (1998) also suggests the presence of class and acculturation as factors contributing to underutilization. For instance, middle and upper middle class Mexican Americans who have lived in the U.S. for many generations make more use of private psychotherapy services than recent migrants do. At the same time, however, she notes that Mexican Americans who have more time in the U.S. still appreciate therapists who speak Spanish or who understand the Mexican way of thinking.

Migration and acculturation not only help to explain the underutilization of services, but can also be factors which contribute to the vulnerability of Latinos to mental health problems (Falicov, 1998; Zayas, 2005). Falicov (1998) posits that the assumption that acculturation benefits Latino mental health is arguable. Along these lines, Rogler (1991) hypothesizes that increases in acculturation can alienate a person from primary support groups and “facilitate the internalization of the host-society’s cultural norms,” such as prejudicial attitudes toward Latinos, leading to self-deprecation and a weakened ego structure as well as increased drug and alcohol use (p. 588). At the same time Rogler connects lack of acculturation to psychological distress pointing to increased isolation in those who experience the loss of their traditional support system and lack the time to reconstruct a similar network in the host- society. In addition, lack of acculturation can mean the absence of skills, such as mastery of the language, leading to low self-esteem and symptomatic behavior (Rogler, 1991). Research has shown that acculturative stress (including one’s degree of success with or resistance to acculturation) has been connected

to higher rates of suicide among Latinos in the U.S. than in their country of origin (Canino & Roberts, 2001). In his exploration of the high rates of suicide attempts among Latina teenagers, Zayas (2005) proposes that in addition to acculturation, socioeconomic disadvantage, traditional gender role socialization, and ethnic identity are also factors.

Themes of acculturation, immigration and political history, social and economic class, gender, religion, etc. are prevalent throughout the existing literature on Latino mental health. From group to group it appears that the emphasis on these factors fluctuates rather than the characteristics themselves. For example, being political is a significant part of Cuban identity. Additionally, with a complicated relationship to the U.S. Cubans have a unique acculturation experience. They are said to achieve higher levels of financial success in comparison to other Latinos, but still do not parallel their non-Latino/a White counterparts. Their success is in part attributed to the self-organization of cultural enclaves (Delgado-Romero & Rojas-Vilches, 2004).

Many, though not all, of the Salvadorans and Guatemalans who live in the U.S. are political refugees. While they also experience the challenges of migration, acculturation and discrimination that other Latinos face, their mental health is impacted significantly by war and trauma resulting in higher incidents of PTSD and trauma-related symptoms. It may be difficult for a person in exile to trust people in power and therapists may be viewed as such, especially a therapist from the U.S. which has a history of supporting their oppressive governments. Additionally, intergenerational issues might emerge such as the failure of parents and grandparents to share their cultural history with their children in an attempt to spare them or to move on themselves (Delgado-Romero & Rojas-Vilches, 2004).

South Americans represent about 4% of the U.S. Latino population and are mostly from Colombia, Ecuador, and Peru. Colombians face tremendous negative stereotypes in the U.S. and like Salvadorans and Guatemalans, have a history of civil war and large-scale death tolls. According to Delgado-Romero & Rojas-Vilches (2004), there is nothing written on the strengths of Colombian immigrants nor is there literature which addresses their normal developmental challenges. The literature that is available relates mostly to stress and anxiety connected to involvement with substance use, HIV, and risk behavior.

According to Arbona's (2004) writings on counseling Puerto Ricans, existing research shows that the prevalence of mental health disorders in Puerto Rico is similar to that of populations in the U.S. However, there were higher rates of depression for Puerto Ricans living in the U.S. than in those living in Puerto Rico.

Emphasizing the roles of acculturation and intermarriage, Cervantes (2004) notes that among Mexican Americans, emotional, behavioral, and family difficulties are the results of various social forces, but attributes centuries of psychological and spiritual distress, as well as loss of identity and life purpose to a loss of spiritual heritage.

Therapy and Culture

Therapy as Culturally-Bound

Sue and Sue (2003) suggest that at the onset of the therapeutic relationship the theoretical orientation of mental health providers is often culturally-bound. Likewise, the major psychodynamic psychologies are often critiqued for failing to fully account for the social, political, and class context of their time. These theories and methods for practice are developed in a certain time and place by individuals who are observing, experiencing,

and (advertently and inadvertently) absorbing the culture of their particular society—a culture which is affected by the engrained and historically specific characteristics of its environment. Therefore, it is only natural to conclude that the theories and methods being developed are going to be infused with these characteristics, such as beliefs about how an individual functions, how problems develop, and how change is actualized. A White professional in the U.S., for instance, might assess the beliefs or behavior of a working class Ecuadorian as dysfunctional if assuming his/her ideas to be universally applicable. The concepts and the debates which have ensued around the idea that therapy is culturally-bound have opened discussion around these types of chasms in psychological theory and methodology.

The example of Margaret Mahler's theory of separation-individuation is commonly used to illustrate this rift. Mahler describes separation-individuation as the process whereby a child transitions from being symbiotically fused with the mother to a state of individuation, in which the "I" is differentiated from the "not-I," and the child becomes aware of his/her physical as well as emotional separateness from the mother. The child ultimately achieves this autonomy by attaining object constancy whereby the maternal image becomes intrapsychically available (Mahler, 1968). Though Mahler's research on separation-individuation was developed in the context of her research with infants and young children, it is a concept that therapists frequently pull from in their work with adults as they assess the developmental achievements and delays of their clients.

The question has been posed as to whether or not it is appropriate to apply separation-individuation theory (conceived by a privileged White European woman) to

people from collectivist societies, in which the development of the child and the context in which s(he) is raised differs substantially from those observed by Mahler. In other words, can it be assumed that separation-individuation is a universal paradigm or do the influences of culture and ethnicity pose irreconcilable challenges to this school of thought? Though today some put separation-individuation forth as a prerequisite for mental health, others argue that doing so disregards the “psychological value of relatedness and interdependence, critical to the lives of many ethnic minorities and essential to women’s psychological development” (Choi, 2002, p. 468).

Choi (2002) goes on to say that often independence is equated with advanced development and interdependence with developmental delay or immaturity. Notably, societies which are portrayed as individualistic are often wealthy European or Anglo societies, while societies which are described as collectivist tend to refer to those comprising people of color from third world or developing nations. Even on this global political level a parallel can be drawn about the assumption that separation-individuation is a universal goal of the individual’s psychological development, as it is the goal of developing nations to become “developed” and therefore, “independent.” Perhaps, the question is not whether or not to become independent, but how one goes about achieving independence, or on a more basic level, how one defines independence.

There is no definitive answer to this question and therapists have to practice across cultures without the benefit of one. One might have an opinion informed by his/her education, by an awareness or lack of awareness of cultural differences or by his/her own upbringing. Inevitably, however, the temptation is to lean in one direction or

another; one that privileges individuation and independence, or one that privileges a sustained attachment to the primary support group.

Variance in attachment style can be observed in language. In Spanish the word for “clingy” is *pegado*, which literally means attached and in Latin America does not have the negative connotation that “clingy” has in the United States. In Puerto Rico, a child might colloquially be referred to as a *faldero*. The word for skirt in Spanish is *falda*, and a *faldero* is a boy who is seen close to his mother’s skirt. This is known in English as being “tied to his mother’s apron strings,” defined by the Cambridge Idioms Dictionary (2006) as follows: “If someone, usually a man, is tied to their mother's apron strings, they still need their mother and cannot think or act independently” (p. 425). However, it is not derogatory to refer to a Puerto Rican child as a *faldero*. To the contrary, this usually means that he is well-attached, (L. Mattei, personal communication, October 13, 2006). In “How culture-bound is therapy?” Gonzalez (1993) puts these differences in perspective when she states that “each culture has a unique order that defines what is seen as deviant and curative” (p. 3).

For example, is it appropriate for an Anglo therapist treating an adult Latino male client who is living with his mother to set departure from his mother’s home as a goal for the client because (s)he believes that the client’s living situation is a symptom of his/her failure to individuate? Is there any reason to believe that an adult can not be individuated and also live with his/her family of origin? Furthermore, can one be individuated and still be closely tied to the family, even dependent on family for help in times of stress or economic need, or simply because one wants his child’s education and upbringing to extend beyond what (s)he alone is able to offer? Do we understand the decision of a

single mother to live with her parents in order to alleviate financial burden as poorly individuated? Or do we understand it as pragmatic?

Falicov (1998) presents the case of a family for whom “family connectedness is valued over individuation (and) interdependence over autonomy” (p. 25). The attending therapist in this case has determined that the client is “pathologically attached” to his mother. Without disregarding separation-individuation theory, nor with disregard for the cultural context of the client, Falicov (1998) ultimately concludes that it is the client’s need for parental approval which is the core issue. Therefore, perhaps it is not the theory itself, but how it is understood, interpreted or used in practice, which determines whether or not it is culturally-bound.

This is only one illustration of the many ways in which therapy might be considered culturally-bound. Gonzalez (1997) offers an example in which she proposes the use of the genogram (a drawn exercise similar to a family tree and a tool often used in family therapy) and is consequently asked by her client whether or not “family” refers only to legally sanctioned relationships. In this case, she decides to abandon the genogram realizing that “its underlying assumptions were based on the Western European experience of immigration, which contrasted drastically with the Puerto Rican experience of colonization and domination” (p. 3).

Falicov (1998) holds the complexity of this issue by simultaneously acknowledging that each person deals concurrently with universal as well as idiosyncratic experiences, solutions and “ethnic-specific views.” She also sites multiculturalism as one of the mechanisms which challenges what particular theories are considered to be universal. At the same time, she posits that what is truly universal and essential to the

practice of cross-cultural therapy is the value of empathic listening and of establishing a therapeutic alliance.

Although I have presented the concept of theories being culturally-bound as a potential deficiency in the way in which we see and understand intrapsychic development, there is another way in which the concept may be understood, as demonstrated in the Glossary of Culture-Bound Syndromes in appendix I of the DSM-IV. In the introduction to this section, the Group on Culture and Diagnosis defines the term “culture-bound syndrome” as a syndrome “denoting recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category.” It states that these patterns are usually described as illnesses or afflictions, often have local names and are restricted to specific societies or cultural areas as well as being “localized, folk, diagnostic categories that frame coherent meanings for certain repetitive, patterned, and troubling sets of experiences and observations” (First and Tasman, 2004, p. 844). Rather than viewing the concept of “culture-bound” as a way of critiquing the psychological theory, the DSM presents it as a way of understanding the diagnosis or the individual and his/her symptomatology. In other words, it is implied that the syndrome is rooted in the culture or even caused by the culture.

Guarnaccia and Rogler’s (1999) investigation of the DSM-defined Latino-Caribbean cultural syndrome *ataques de nervios* raises important questions about this definition of culturally-bound and suggests a need for more comprehensive research on such “syndromes”. First and Tasman’s (2004) description of *ataques de nervios* from the

Glossary of Culture-Bound Syndromes in DSM-IV provides an orientation to this syndrome:

Ataque de nervios [is] an idiom of distress principally reported among Latinos from the Caribbean, but recognized among many Latin American and Latin Mediterranean groups...Symptoms include uncontrollable shouting, attacks of crying, trembling... and verbal or physical aggression. Dissociative experiences, seizure-like or fainting episodes, and suicidal gestures are prominent in some *ataques* but absent in others. A general feature of an *ataque de nervios* is a sense of being out of control. *Ataques de nervios* frequently occur as a direct result of a stressful event relating to the family (e.g., news of the death of a close relative, a separation or divorce from a spouse, conflicts with a spouse or children, or witnessing an accident involving a family member). (p. 845)

Guarnaccia and Rogler (1999) state that this is a cultural idiom that expresses suffering and signifies a plea for help and they set the “syndrome” apart from western psychiatric disorders. The distinctions between an *ataque de nervios* and the various anxiety or depressive disorders are somewhat vague. Nonetheless, Guarnaccia and Rogler state that those who suffer from the “syndrome” often comorbidly suffer from psychiatric disorders and are 3.5 times more likely to suffer from an anxiety disorder. They use this logic to argue for looking at *ataques de nervios* in the context of comorbidity rather than viewing it as its own diagnostic category. One might understand the identification of this syndrome in the DSM as an attempt by the APA to recognize the role of culture in mental health and acknowledge the fact that people from specific cultures, races, ethnicities, or parts of the world suffer from syndromes which are unique to them. While the underlying events of an *ataque de nervios* (grief, loss, divorce, familial conflict) are universal, it is the response, or manner of expressing the response which might be unique to the culture.

Anne Fadiman (1997) writes about the role of culture in understanding or defining a syndrome in her telling of the story of a Hmong child who is diagnosed with epilepsy in a California hospital. The child's parents, however, believed that her seizures were caused by the flight of her soul from her body and identified her condition by its Hmong name: *qaug dab peg* ("the spirit catches you and you fall down"). The incident, which due to cultural misunderstandings results in tragedy, seems to be a testament to the fact that physical and mental health professionals, are still in the midst of the process of understanding how "syndromes" are translated, understood, and treated across cultures and borders.

Therapy and Race: White Clinicians Holding White Privilege

I have not come across a discussion in the literature regarding the theory of white privilege as it relates specifically to Latinos. Additionally, it is important to note that (although this paper looks specifically at non-White Latinos) there are Latinos who identify as White. In fact, Latinos can also be Black, Asian, Indigenous, *Mestizo*, or any combination of these. Falicov (1998) notes that it wasn't until 1954 that Hispanic was classified as a race in the United States. In 1990, 52% of Latinos identified as White (most of whom were said to be *Mestizos* or multiracial African, Indo-American and European), 3.4% identified as Black and 42% identified as "other" (Falicov, 1998). Nonetheless, it is my belief that for the most part racism and white privilege exist within cross-cultural therapy interactions with Latino clients. Comas-Diaz (2000) states that racism and political repression of people of color can traumatize an entire society. She writes that:

Racial terrorism's emotional and psychological effects include depression, shame, rage, and post-traumatic and post-colonization stress disorders. The effects on cognitive schema include alterations in perceptions of self, others, and the world as a just place, as well as changes in the sense of trust, power, and safety. (p.1320)

Considering the implications of this statement for Latino/a clients and in light of the power and affect that racism and white privilege hold, this section examines what it means for White clinicians to hold this kind of privilege while working cross-culturally, racially, and ethnically.

White privilege is the privilege not to consider what it means to be White (McIntosh, 1990). In McIntosh's (1990) words it is the "unearned entitlements" and "unearned advantage" of Whites. Sue and Sue (2003) identify this inadvertent behavior as one of the most dangerous forms of racism defining unintentional racism as the propensity to be unaware of one's biases, perceive oneself as moral and incapable of racism and lack a sense of one's whiteness. Pinderhughes (1984) suggests that social work students should be provided with an opportunity in their training to identify and acknowledge their biases, and grapple with them privately or through direct interaction among classmates as a manner of achieving self-awareness before entering into the field.

In assessing the self-reported multicultural counseling competence of White family therapists, Constantine, Juby and Liang (2001) found that significant inconsistencies in self-perceived competence could be attributed to racism and White racial identity attitudes. Their study included 57 male and 56 female participants ranging in age from 25 to 78 years old, 84% of whom held master's degrees and 16% of whom held doctoral degrees with an average number of 18 years counseling experience. 63% of

participants reported having taken at least one course related to multicultural counseling. Participants completed a demographic survey as well as the Multicultural Counseling Knowledge and Awareness Scale, the White or Visible Racial/Ethnic Identity Attitude Scale, the Marlowe-Crowne Social Desirability Scale, and the New Racism scale. The study revealed that therapists who expressed a high need for social approval presented some discrepancies in reporting (due to discomfort reporting limitations) and tended to be less aware of cultural variables in counseling. In addition, those clinicians who had taken courses on multicultural counseling perceived themselves as highly competent in cross cultural therapy though this was not necessarily reflected in their practice. Therapists with higher levels of racism were found to be less aware of cultural issues in counseling which was predicted to lead to decreased therapeutic effectiveness.

Sue and Sue (2003) suggest that the failure to understand that cross-cultural therapy methods can be harmful is one way in which white privilege plays out within the therapeutic relationship. They see white liberalism as being motivated by white guilt, with white guilt and privilege coming at a cost to people of color (McIntosh, 2001; Sue and Sue, 2003). In this lies the desire of White therapists to work with the “disadvantaged” and to see people of color as “other”—or as “those” people who need help. While the authors suggest that it is impossible not to inherit bias and prejudice, they interpret the decision of Whites to work with minority clients and assuage their white guilt in part as an attempt to repress and deny their racism (McIntosh, 2001).

Johnson (2001) offers a list of ways in which white privilege is experienced, but often unrecognized by Whites. Many of these examples are relevant to cross-cultural/racial therapy. For instance, he says that “Whites can choose whether or not to be

conscious of their racial identity or to ignore it and regard themselves as simply human beings” (p.28). In the room with a Latino/a client, therefore, a White clinician by not being conscious of his/her racial identity could easily fail to recognize the importance of racial identity to the client. On the other hand, with increased awareness around issues of racial identity the therapist may choose to broach this subject with the client in order to learn how the client’s racial identity and social context might inform their every day lives and experiences.

If a therapist accepts the existence of white privilege, then (s)he might inquire (internally or externally as appropriate) as to what it is like to be counseled by one’s oppressor/someone who benefits from this privilege—in essence from racism—especially if (s)he prescribes to the belief that within the therapeutic alliance, the therapist is already in a position of power. Understanding racism as a construct and relating it to the concept of conquest, Falicov (1998) states that for Latinos “therapy itself can represent a form of conquest, pushing families toward a new way of relating and living that conforms to the values of a more powerful therapist” (p. 95). The client must manage both this subordinate position as well as that of being a person of color confiding in someone from the dominant culture. Johnson (2001) writes that being aware of one’s privilege also means being aware of the social reality that shapes our lives. He aptly observes that while multicultural methodologies often address the need to be aware of one’s biases they usually fail to address the need for recognition of one’s privilege.

Comas-Diaz (2000) suggests that an ethno-political model can provide a basis for therapists to work with people who have suffered racism, discrimination, and repression. In fact, ethno-political theory names this experience “post-colonization stress disorder” as

the result of “contending with racism and cultural imperialism, whereby the mainstream culture is imposed as dominant and superior” (p.1320). Comas-Diaz asserts that racism is a tool of terrorism which dismantles individual and collective identities.

This dismantling can occur in seemingly subtle forms, such as in what Johnson (2001) describes as the tendency of Whites to be “more likely to control conversations and be allowed to get away with it, and to have their ideas and contributions taken seriously, including those that were suggested previously by a person of color and dismissed” (p. 28). For therapists this perhaps unconscious, usually unacknowledged action comes in direct conflict with the goals of therapy. Furthermore, with the potential for internalized racism¹ also at play, a Winnicottian therapist, for instance, might have difficulty working with the client toward the emergence of his/her “True Self.”²

In addition to the internal and relational issues at play are the global and sociopolitical implications of white privilege. Johnson (2001) mentions that “Whites are not segregated into communities that isolate them from the best job opportunities, schools, and community services” (p. 29). Failing to recognize this dynamic, a White clinician by simply encouraging the client to draw from his/her inner strengths and failing to recognize the external systemic issues at play, might (consciously or unconsciously, directly or indirectly) blame the client for not succeeding. This theory is further

¹ Padilla (2004) defines internalized racism as the experience of unresolved pain that leads to the realization of distress patterns which get directed both toward members of one’s own group as well as inward through feelings of “self-invalidation, self-doubt, isolation, fear, powerlessness and despair” (p. 15).

² Flanagan (2002) describes Winnicott’s belief in the “True Self” as “the repository of individuality, uniqueness, difference.” She goes on to say that “the True Self can not emerge if the [child] feels that she must be exclusively attuned to the needs of others in the family system and if she needs to be a certain way in order to be recognized and acknowledged” (p.140).

strengthened by the fact that “if a white person works hard and plays by the rules, they will get what they deserve and feel justified complaining if they don’t (Johnson, 2001, p. 30).” Would the same grievance voiced by a Latino/a client be supported or would it be viewed as fear of success or self-sabotage? Conversely, “Whites can succeed without others being surprised (Johnson, 2001, p. 29).” What message would the clinician send if (s)he showed surprise when a Latino/a client succeeded?

Luepnitz (2002) discusses the dilemma of white privilege within her therapeutic relationship with a Jamaican client named Pearl. She recounts an incident in which she charges Pearl one hundred dollars for missing an appointment. Pearl responds by talking about the value of money and how hard people in certain parts of the world have to work to earn that amount of money. She expresses feeling that Luepnitz could not understand this coming from her background. Pearl says to Luepnitz (2002), “It just hurts somehow that even with someone like you, there comes a limit between Black and White, a limit of understanding” (p.192). Luepnitz recognizes this interaction as an opportunity to confront her own racism and sees it as an inroad into thinking about other times when Pearl might have felt this limit in their work. She theorizes that Pearl’s response was based on the truth that a White person can not know the experience of a person of color, but counters this too with the belief that no therapist can understand any patient fully, even when from similar race and class backgrounds. Ultimately she affirms that race does matter, and that therapists err when they fail to recognize racial differences.

Simultaneously, Luepnitz scrutinizes this incident with Pearl through the lens of the “rescue fantasies” that Whites have when working with people of color. She remembers asking herself how she could charge this “poor Black woman” for a missed

session and wonders whether or not she might contribute to leveling the playing field for people of color if she would forgo the charge. However, she also questions whether or not doing so would be to the detriment of the client; a missed opportunity to explore Pearl's no-shows and possibly any resentment that Pearl was feeling that might have caused her to neglect appointments. In the end, Luepnitz concludes that in this world issues around race permeate people at all levels and walks of life, that it would still have had a role in her therapy if Pearl had worked with a Black therapist and that it even has a role when both client and therapist are White.

Zayas, a Puerto Rican therapist writing about an encounter with a Puerto Rican adolescent male client (Jose) describes a discussion of racial difference, in which Jose makes the assumption that Zayas is a non-Latino White. Zayas (2001) comments that, "upon realizing that I was Puerto Rican he seemed to go through a visible shift in his relation to me" (p. 269). It becomes clear that Jose's racial and ethnic identity are important to him and crucial to the therapeutic process when he expresses the feeling that "therapy like other activities in life was intended to deprive him of who he was, including his strong sense of ethnic affiliation" (Zayas, 2001, p.269).

There are other factors to consider when looking at the affects of white privilege on Latinos. Taylor, Gambourg, Rivera, and Laureano (2006) note that in Latin American countries social class is more predominant than issues of race, whereas in the U.S. Latinos give more importance to issues of race. They also conclude that clinicians working with Latino families notice culture clashes mostly around gender and power, immigration and acculturation rather than race. While this does not negate the presence

and power of White privilege with Latino/a clients, it does reveal new and varied dimensions of the issue that are unique to certain populations.

Cultural Competence in Therapy and Assessment

Definition and Need for Cultural Competence

As the field of mental health treatment evolves, there is increased emphasis on the importance of cultural competence, recognizing race and political power within the therapeutic relationship, and understanding cultural, racial and ethnic identity development. Cultural competence can be viewed as the recognition and navigation of differences (not exclusively cultural) within the therapeutic relationship. A more expansive list of differences might include racial, ethnic, economic, age, language, disability, gender, educational, physique, and sexual orientation (Weinrach & Thomas, 2001).

There is insufficient research evaluating culturally competent treatment outcomes for ethnic populations (Berrios, 2003). Campinha-Bacote (1995) defines cultural competence as an ongoing process of seeking cultural awareness, knowledge, skill, and encounters. Lo and Fung (2003) divide cultural competence into two categories. One they call “generic cultural competence” and define as the knowledge and skill set needed in any cross-cultural therapeutic encounter. The other is called “specific cultural competence” and enables clinicians to work effectively with a specific ethnocultural community. Taylor, Gambourg, Rivera, and Laureano (2006) define cultural competence as the duty of the therapist to be aware of assumptions and presumptions about the clients’ cultural narratives in building a therapeutic alliance that depends on

understanding the cultural meaning behind nationality, socioeconomic status, immigration, and acculturation. Perhaps as progress is made in these realms, mental health services will be more accessible to, perceived differently by, and better serve Latino communities in the US.

Recent critiques suggest that sufficient attention is not awarded to cultural dynamics in therapy with people of color (Hamilton-Mason, 2004). In addition, Latinos have expressed resentment about the services that they receive from social workers who do not always understand cultural differences and who in their assessments frequently overlook strengths such as their aspirations and hopes (Quinones-Mayo, 2005).

According to Gonzalez-Ramos, Zayas and Cohen (1998), Latina mothers in particular are inclined to emphasize the relational aspects of the parenting values that they adopt which may not be in accordance with the non-Latino/a or acculturated clinicians' perspective. These expressions of dissatisfaction speak both to the growing need for culturally competent clinicians as well as to problems between points of view that might not be reconcilable. In addition, it begs the question as to how discordant frames of reference are resolved within the therapeutic relationship. Might it be possible for instance, to use this dissonance as a springboard for better understanding of one's self, of the relationship and of the ways in which culture informs the client's presentation?

Zimmerman's (1991) college paradigm offers a pertinent example of conflicting culturally-informed positions. Within this model Latino parents encourage their children to attend community colleges for the purpose of staying close to the family. Conversely, in the United States, people often value opportunities for children to go away to college and see this transitional period as a stepping stone toward living independently. In the

U.S. it is commonly viewed as a weakness when a college graduate “returns to the nest.” A Euro-centrally trained mental health practitioner might see the decision of a Latino/a child to attend a college close to home as the manifestation of his/her impaired individuation or as the family’s failure to consider the best interest of the child. On the other hand, a Latino/a practitioner or someone employing culturally sensitive practices might focus on understanding the cultural context of this request on the part of the parent.

Working clinically across cultures can have many meanings and implications which also manifest in concrete forms. It may require translation, treatment modification, and openness on the part of researchers to take suggestions from participants with regard to culturally important adjustments (Matos, Torres and Santiago, 2006). Much of the research conducted in the US has been developed for white English-speaking clients (despite the prevalence and growth of the Latino and Spanish-speaking population, now the largest minority group in the US) and may not be easily applicable to members of the Latino community. In addition, there is a dearth of Spanish-speaking clinicians available to Latinos with limited English proficiency. According to the surgeon general, 40 percent of Latinos report limited fluency in English with an estimated 29 Latino mental health professionals for every 100,000 Latinos in the US, compared to 173 White mental health professionals per 100,000 Whites (US Department of Health and Human Services, 2001). While there are culturally competent clinical methods being developed these statistics are clear indicators of the need for Spanish-speaking professionals in the field. This can be accomplished both through the integration of Spanish language education into related curriculum, as well as through the recruitment of Latinos into the field.

Culturally Competent Assessment

One of the most important pieces of becoming culturally competent is learning how to properly evaluate clients from other cultures. According to McGoldrick (1998), questions about how families are located in their communities are becoming routine in assessment. Comas-Diaz (1989) tells the story of Sara, a mother of a three, who announces to her therapist that all of her problems are rooted in her living outside of Puerto Rico. It is when Sara expresses the feeling that her children are being corrupted in the US that her therapist decides to perform an ethno-cultural assessment. One of the most interesting and illuminating issues in this analysis was the gentle reminder that Sara had to hold many identities at once; that not only of mother, but of Puerto Rican, non-White, migrant, wife, employee, and so on.

One way to overcome cultural barriers to an accurate psychosocial evaluation is to allow the client to be a participant in his/her assessment. Hamilton-Mason (2004) is one of the few who offers a tangible assessment tool which includes the voices of his clients. In developing this tool he specifically had in mind those who suffer from oppressive social structures, thereby acknowledging their dual existence as well as the centrality of racial identity to the life of a person of color. This assessment entails understanding one's own cultural biases and becoming free of them, listening to the client openly and with an ear for psychosocial affects of oppression, working with the client on creating a positive identity and actively working toward social justice (Hamilton-Mason, 2004). This last component is of particular interest and begs further research and discussion because while it attempts to merge micro and macro practice, and comes close, it is the one piece that can not be performed in conjunction with the client. If the

client is to be privileged in the relationship, then the clinician's fight for social justice can be used to *inform* the relationship, but in practical terms will likely be kept separate from the clinical dyad. In addition the clinician might also be wary of not centralizing the client's "oppressed" identity if the client does not feel this part of his/her identity to be fundamental to treatment. Most important is awareness and the open-mindedness of practice so that it is not mono-cultural and ethnocentric.

This propensity to underestimate the intellectual capacity of clients or their ability to be self-reflective is one form of pathologizing them. For Latino/a clients this is particularly salient. There is a great deal of debate around the pathologizing of Latino/a clients. One form this takes on is in the labeling of Latinos from collectivist cultures as 'enmeshed.' Research indicates a prevalence of separation anxiety and reactive attachment disorders among immigrant Latino children (Berrios, 2003), which might in part explain the tendency to perceive Latino families in this way. However, within this, there is also discussion of the failure of the therapist to employ culturally sensitive strategies to her practice. Therapists who recognize this issue may apply a multicultural assessment theory that includes an understanding of one's own cultural biases and incorporates other world views (Hamilton-Mason, 2004). Taylor, Gambourg, Rivera, and Laureano (2006) state that, "It is hard to use West-European theories when working with Latino families. The notion of enmeshment cannot be used with this population that has a strong sense of family connectedness as cultural pride" (p. 441). On the other hand, there are those who purport that there is a universal definition of "healthy development" which is blind to cultural differences (Sue and Sue, 2003). Interestingly, regardless of cultural context, if one looks at diagnostic categories or interpretations of problems it is easy to

understand how a psychodynamic assessment might be perceived as judgmental. For instance, is there a way of shedding the negative connotation elicited by being named “pathologically enmeshed” or “excessively dependent?” While the same conclusions about a White client from an individualistic culture would come across as equally demeaning, for the Latino/a client, there are clear issues around racial and ethnic identity development that must be understood within the therapeutic relationship. These issues emerge as we examine whether or not it is appropriate to apply theories such as separation-individuation to a person whose experience is based more on collectivist culture and *familismo* than on individualism. This is one place where different cultures are susceptible to conflict and clash with each other. Specific examples of culture clashes in therapy can be seen in challenges to conventional therapy in which clients’ culturally-based expectations might defy traditional definitions of therapeutic boundaries such as the convention that therapists decline gifts, or cut off contact after termination (Fung and Lo, 2003). Through knowledge and the ability to perform a proper assessment, therapists may be able to make clinically-attuned adjustments, such as choosing to maintain a link with clients after termination of the treatment relationship, by defining appropriate circumstances in which they might re-consult (Fung and Lo, 2003).

Culturally Competent Treatment

Bean, Perry, and Bedell (2001) performed a content analysis to examine existing literature on culturally competent treatment of Latinos. They found and supported (with some qualifiers) guidelines that emerged consistently regarding therapeutic work with Latino families. These included a preference for family treatment as a modality,

collaboration with folk healers, serving as an advocate and broker between the family and other agencies, assessing for levels of acculturation, bilingualism, respect of the patriarchy, conducting separate interviews with family subsystems, accepting existing family dynamics rather than forcing change, offering concrete suggestions, and lastly, engaging in therapy with warmth and *personalismo*. The authors suggest, however, that many of these principles are specific to immigrant groups of low-economic status. This means both that the guidelines are applicable to other groups who fall into these categories, and that they might not all be applicable to Latinos who belong to the middle or upper classes, or who are far removed from their immigration history.

In thinking about and critiquing multicultural therapy and its various theoretical orientations, Hamilton-Mason (2004) takes the position that while it is important to recognize that classical theories may not apply or may need to be adjusted to fit people from different cultures, it is also important within that process not to undermine the capacity of the client to think and be understood intrapsychically. Rothe (2004), for instance, states that “Hispanics are not interested in and are unfamiliar with long-term therapies for the purpose of personal growth,” claiming that Latinos might become “confused” or “disillusioned” with the therapeutic process (p. 274). Consequently, he proposes short-term, present-oriented and time-limited therapy which outlines identifiable problems and measurable goals. Sue and Sue (1999) also recommend concrete, goal-directed and structured treatment strategies (such as assertiveness training with Mexican American women or folklore therapy with children). Interestingly and sometimes unfortunately, there are many who theorize that ethnic minorities do not

always value personal insight or the ability to talk about the deepest and most intimate parts of one's life (Park, 2005).

Using a strength-based approach, Carey and Manuppelli (2000) implemented participatory ethnographic interviews in order to extract the personal stories of therapists and their use of cultural competence methodologies with their Latino clients. Their work epitomizes the postmodern resolve because their research methodology itself reflects the values and practices of what they understand to be culturally competent therapy. They diminished their own assumptions and prejudices by cultivating a collaborative, “not-knowing” predisposition in relation to their interviewees. This encourages rich narratives to emerge in developing ideas around cultural competency. Carey and Manuppelli (2000) recommend that therapists use this same approach when working with Latino clients. Laird (1998) builds on this and takes a stance of “informed not-knowing” stating that “only if we become as informed as possible—about ourselves and those whom we perceive as different—will we be able to listen in a way that has the potential for surfacing our own cultural biases and recognizing the cultural narratives of others” (p. 23).

The concept of a client-centered approach is being revisited and gaining momentum as diversity training is reassessed. Weinrach and Thomas (2001) encourage clinicians to centralize the client by integrating his/her frame of reference, self-definition, or belief system in the creation of a treatment plan. Similarly, Dyche and Zayas (2001) recommend a client-centered versus clinician-centered approach which emphasizes empathy as a tool to achieve openness to diversity and knowledge of the culture. They suggest that this “attitude-knowledge dilemma” can be resolved by empathic responses

(emotional and intellectual resonance achieved by listening and receptivity) which transcend cultural differences. Dyche and Zayas suggest that, while important, integration of knowledge about specific cultures can create dissonance within training programs. For instance psychodynamically-oriented programs might emphasize countertransference, while family-systems therapy focuses on specific cultures. Similarly, some view culture as a mask that can obfuscate attempts at problem-solving, suggesting that by simply being a good listener what is important about culture will emerge (Laird, 1998).

Alternatively, rather than setting the transcendence of cultural differences as a goal, Sue and Sue (1999) emphasize the between and within-group differences in working with Latino populations. Though Weinrach and Thomas (2001) warn against privileging between-group differences over within-group differences, Sue and Sue (1999) maintain that information about between-group differences in terms of values, acculturation level, and problems is vital to treatment. In accordance with contemporary trends, they suggest that development of an individual treatment plan include client input and a thorough assessment of environmental factors as well as family and group therapy modalities which respect family tradition, unity and loyalty as important aspects of the lives of Latinos. Furthermore, they stress respect and warmth (or *personalismo*), correct name pronunciation, transparency with regard to therapeutic process, deference to the client's description of the presenting problem, an assessment of available resources, and assistance with prioritization of problems.

Falicov (1998) devised MECA, (Multicultural Ecosystemic Comparative Approach) as a means to incorporate cultural considerations into the theory and practice of family psychotherapy. She describes culture as a multidimensional belief, hope, and

thought system which possesses both emotional elements as well as cognitive interpretations of reality. Culture in this framework encompasses numerous ecological contexts (which can be experienced as spheres of entitlement as well as powerlessness) and perspectives which, over time, inform a family's values. The comparative approach refers to that which allows the comparison of similarities and differences across cultures.

MECA utilizes four domains, all of which allow for distinctions between "how the family and the therapist make sense of experience" (Falicov, 1998, p. 18). These domains, known as "cultural maps," (also referred to by Falicov as one's world views or ideologies) paint a picture of the clients' journey of migration and culture change, ecological context, family organization, and family life cycle. The cultural map is intended to serve as a tool to help the therapist navigate the uncharted territory of a family's culture. In order to locate oneself and the client, and to provide comparison, the therapist might also generate his/her own map as a part of this approach (Falicov, 1998).

Another way for the therapist to use him/herself in the therapy and an equally necessary component of practicing multiculturalism is for clinicians to examine their cultural countertransference and the subjectivity that they bring into the room (Perez-Foster, 1998). With regard to the client, this can be realized in the form of idealization of the other, in assuming a position of cultural superiority or in minimizing cultural differences in order to appear less discriminating (Fung and Lo, 2003). Multicultural practice or cultural empathy requires that the investigator not make assumptions, but is aware of the presence of culture, ethnicity, race, gender, sexuality, and his/her own racism, internalized racism, sexism, etc. Based on Perez-Foster's (1998) contributions, it seems to follow that failure to do so is one of the many ways in which cultural

countertransference might play a significant part and potentially generate bias and influence the outcome of the research. For instance, if a therapist walks into a room feeling that (s)he does not have a cultural identity, (s)he might unconsciously misuse the time with the client to satisfy curiosity and yearning, thereby focusing too much on culture. At the same time, lack of knowledge about the client's cultural context or a denial of differences might hinder the therapist from properly understanding, interpreting information, or guiding the client. How might a non-Latino/a clinician address these issues without a deep-rooted understanding of the client's predicament? What if the inclination of a White family therapist with engrained values (s)he might not even be aware of is to privilege the perspective of an acculturated Latino/a child over that of a parent still rooted in the traditions of his/her country of origin?

Lo and Fung's (2003) model for culturally competent treatment emphasizes the importance of establishing goals collaboratively, performing a cultural analysis, and communicating effectively. In some cases effective communication might require the use of the client's native language as well as English, leaving room to switch between languages according to the client's comfort level. Language is also valuable for the employment of *dichos* (popular sayings and wisdoms) and folktales in therapy with Latino families which serve both to decrease client opposition as well as increase comfort (Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002). Constantino, Malgady and Rogler (1994) developed and tested a culture-specific modality in their work with Puerto Ricans which incorporated the use of traditional folktales as a way of enhancing cultural pride, as well as educating about cultural values and behavioral standards. These methods will not always be feasible in therapy with monolingual therapists and while

some clients use family members or professional translators within sessions, this practice can lead to detrimental miscommunications caused by a loss of privacy, flaws in the interpreter's translation skills, or lack of psychiatric knowledge (Sue and Sue, 1999).

Lo and Fung suggest that Chinese clients might choose to talk about subjects such as sex in English rather than Chinese. Correspondingly, they propose that cultural differences between therapist and client in some cases have a positive transference effect that assists rather than hinders therapy, as for example with an Asian client who may feel that a Western therapist will respond less judgmentally than a culturally matched therapist in discussing subjects prohibited in their culture, such as homosexuality. On the other hand, clients may feel apprehensive about consulting a therapist from a culture that has oppressed them, or they may dismiss cultural issues, feeling that they are fully acculturated (Fung and Lo, 2003). In these cases Fung and Lo suggest open discussion about the discrepancy in power as a means of facilitating therapy.

In practicing cultural competence with Latino/a clients Taylor, Gambourg, Rivera, and Laureano (2006) suggest utilizing postmodern perspectives such as a Narrative theoretical approach. With a focus on gaining mutual understanding over time, as well as negotiating and constructing meaning with clients, they believe that these approaches can lead to improved relationships with clients through contextual and fluid factors which eventually recognize power relations and the discourses that organize peoples' lives. By this standard, cultural competence is not global or measurable, but a socially constructed idea that is influenced by the social locations of the therapist and the client.

There is an evolving recognition and need within the psychotherapy community to think beyond the individual. Inherent in this is the growing importance of dissent and

the ability of professionals to tolerate disagreement regarding evolving methodological approaches (Weinrach & Thomas, 2001). The demographic shift toward cultures, such as Latinos, in which the family unit is central, is promoting changes, not just for Latinos, in how counseling is provided (Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002).

The MCCs (multicultural counseling competencies) were developed as guidelines for ethnic groups as a product of the Association of Multicultural Counseling and Development of the American Counseling Association (Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002). The three essential building blocks to the MCCs are that counselors possess awareness of competency-based models, knowledge about historical and political context and Latino-specific frameworks, and the skills to implement the MCCs and identify community or institutional resources. Some other tenets include, that racial awareness is important to identity and that counselors be aware of issues such as immigration, poverty, language difference, racism, and stereotyping. The MCCs also provided the basis for the Latino-Specific Competencies and include a Latino Dimensions of Personal Identity Model that can assist in conceptualizing the individual and Latino family experience. Santiago-Rivera, Arredondo, and Gallardo-Cooper (2002) offer the following specific guidelines for Latino family counseling. They include: preparing the family for the counseling process in order to ensure treatment adherence, defining one's role as a mediator (or *padrino/madrina* meaning godparent in Spanish) and someone the family can respect, admire and trust, assuming the role of a humble expert, focusing on the relationship, using the family narrative to define difficulties, determining the family's style of seeking help, learning vital cultural-familial themes, assessing loss and grief, evaluating levels of acculturation, veering away from the use of

diagnosis, reframing acculturation dilemmas as “culture-conflicts” rather than family problems, setting the achievement of biculturalism as a goal, incorporating the family belief system, maximizing resources, avoiding gender stereotypes and stereotypes of *machismo*, and incorporating spirituality in the healing process when applicable.

Conclusion

There is a vast amount of literature on cultural competence within the mental health profession. Phrases such as “culturally sensitive practice,” “cultural diversity,” and “multiculturalism,” have become buzz words in the field (Laird, 1998). Though discussion of race, ethnicity and culture have spanned most of the past century, definitions, methods of practice, and language relating to this subject area have changed substantially over time. My criteria for inclusion in this literature review have incorporated the more prolific and well-known spokespeople in the clinical arena for the importance of cultural and racial dimensions in therapy. In addition, I gave preference to authors who specifically addressed work with Latinos in their writings about cultural competence.

As stated earlier, there is almost no literature that reflects the experiences of the White clinicians who are being trained in and applying these methods, as well as grappling with an exploration of their own racial, cultural, and ethnic identity, though this is commonly suggested to White clinicians who choose to commit themselves to cross-cultural work (Sue & Sue, 1993). Experiential accounts of the therapists who are using these techniques and the clients who are participating in them have the potential to inform theorists about the aftermath of their methods.

As McGoldrick (1998) states, how a society defines and understands race, culture, gender, and class relationships is critical to understanding the structure of family processes and therefore to how therapists are able to facilitate healing within these structures.

CHAPTER III

METHODOLOGY

Research Design

The purpose of this investigation was to elucidate the ways in which White clinicians perceive and address issues of race/culture/ethnicity and racial/cultural difference when working with Latino clients. The study utilized an exploratory, qualitative, cross-sectional, research design which employed the use of in-person interviews conducted with twelve participants.

The research relied on the use of standardized open-ended interview questions, establishing wording and sequence prior to the interview for purposes of increased validity while still allowing flexibility for open-ended discussion. Participants also completed a brief demographic questionnaire with questions including: age, race and ethnicity, years in the field, years working with Latino/a clients, experience working with Latino populations outside of mental health, country of origin of Latino/a clients, clinical degree received, Spanish fluency, and whether or not the therapist received cultural competency training or continues to seek out such trainings.

Participants were a sample of convenience recruited through word of mouth. The researcher directly approached colleagues working in the mental health field in Western Massachusetts, requesting their participation in the study with a written document detailing eligibility requirements as well as the purpose of the study (see Appendix D). Upon expression of interest, the researcher conducted a brief interview with potential

subjects to ensure that they met eligibility requirements. The researcher reiterated the topic of exploration during this brief interview.

Sample

Selection criteria included that participants self-identify as White with at least one year of clinical work with Latino/a clients. Prior to recruitment a human subject review board application (see Appendix A) including measures and consents used for this study were reviewed and approved by the researcher's thesis advisor and the Smith School for Social Work's Human Subject Review Board Committee (see Appendix E).

Participants in this study consisted of a total of twelve White clinicians (including six social workers, two psychologists, one marriage and family therapist, one PHD in family systems therapy, one MA in counseling, and one MA in expressive arts therapy), all working with Latino/a clients of various ages in Western Massachusetts. Eight of the twelve participants were women. Eleven of the twelve participants worked in outpatient mental health clinics and one worked on an inpatient psychiatric unit of a hospital. Participants' ages ranged between twenty-nine and sixty-four.

Participants self-identified race and ethnicity included: six White and Jewish (of these Jewish participants three identified as Caucasian/Jewish, one identified as Caucasian/Ashkenazi Jewish, and two identified as White/Jewish), one White American and Italian, one Caucasian and Italian, two Caucasian, one White and Italian/Eastern European, one Euro-American White and German/French/Belgian/Irish.

Ten of the twelve participants had worked with Latino/a clients for as long as they had worked in the field. Only one participant had less than three years of experience. One

third of the participant pool had between one and three years of experience. One sixth had between eight and twelve years and one third had substantial experience ranging between nineteen and twenty-nine years. Of the twelve all had worked with Latino/a clients since the inception of their careers. Of the remaining participants one had worked with Latino/a clients for two out of six years total experience and one for twelve out of twenty-five. Six out the twelve said that they had had experience interacting with Latino people outside of mental health. Four reported no Spanish language skills and of the remaining eight, half reported intermediate levels of fluency and the other half reported high levels of fluency. All twelve participants reported that the majority of their Latino/a clients were Puerto Rican. Clients' countries of origin also included: Dominican Republic, Mexico, Ecuador, Peru, Cuba, Guatemala, Uruguay, Colombia, and Venezuela. Four participants reported that Latinos comprised between 20-35% of their caseload. Five reported between 40-65%, and 3 reported between 65-80%.

All twelve participants reported having received cultural competency trainings either from their graduate programs or from their agencies, but with varying degrees of success. All stated that they continue to seek out culturally competency trainings. One reported that she was a teacher of cultural sensitivity at a local college.

Data Collection

Participants were given an informed consent agreement (see Appendix B) prior to being interviewed. The agreement, abiding by federal research guidelines, reviewed the topic of exploration for the study. The agreement also notified participants of their rights, including the right not to answer particular questions and to withdraw from the study

prior to April 1, 2007. Participants were given a copy of the consent agreement for their personal records.

Twelve digitally-recorded interviews ranging between 40-60 minutes were conducted. According to the requests of the participants, three of the interviews were held at the researcher's home, one was held at the participant's home, and the remaining eight were held in the participants' offices. Participants were assigned coded numbers in lieu of identifying information for the purpose of labeling equipment such as minidisks and demographic questionnaires.

Data Analysis

Interviews were transcribed by the principal researcher who then analyzed transcripts for emergent themes in the data. Analysis employed the constant comparative method and looked for repeating examples within inductive observations in order to generate ideas and theories based on those patterns. This was conducted with multiple cases comparing new observations to original concepts and hypotheses. Coding of words and phrases were used as the units of measure for the purposes of data reduction. In order to protect participant privacy, descriptive quotes used for publication were reported without connection to identifying information. All case material was disguised in order to provide confidentiality for both participants and their clients. As per federal regulations, all data including cassettes and transcripts will be kept in a locked box and secured for three years. After this time material will be destroyed.

CHAPTER IV

FINDINGS

In this chapter, thematic analysis was used to categorize ideas and patterns in responses to the interview questions. Participant's responses to interview questions, which address more than one theme, are identified separately. Responses are either paraphrased or illustrated through direct quotations. The following sections are categorized according to the nine core questions which were asked of the interviewees. Fictitious names have been assigned to participants to insure confidentiality and improve readability.

Meaning and Identification of Cultural Sensitivity

In the beginning of the interview participants were asked to define cultural sensitivity and talk about whether or not they identified as culturally sensitive therapists. As evidenced in the succeeding responses this question also revealed participants' definitions of culture. Although interviewees were not specifically asked to define culture the responses seem noteworthy. Definitions included culture as belief systems (including values, ethics and morals), family structures and dynamics, race, ethnicity, religion, gender, education level, past experiences and immigration history, sex and sexual orientation, and class background.

Of the twelve participants, nine identified themselves as culturally sensitive while two said that cultural sensitivity was something that one needed to continually work toward. Genevieve, an art therapist, stood alone in delineating cultural sensitivity as being "at risk of having your feelings hurt or insulted in some way because of there being

so many differences, comments, and attitudes that different culture groups have toward other groups.” According to this definition Genevieve stated that she did not view herself as culturally sensitive. In addition, she offered a unique characterization of culture within a global perspective.

I don't see myself at risk of being insulted by names and things like that which are stereotypically the way people are insulted because as a sociometrist, my culture group is actually a global perspective. So I feel my culture is insulted by situations where blinders are put up and there is a refusal to pay attention to the whole global perspective, that there is more of what I call a caveman attitude instead of a 21st century acceptance of reality of the world. I don't think there are foreign countries anymore. There are far away places, but in terms of integration everything is interwoven, the stockmarket and all of that, commerce, industry.

The following quote is a statement made by Sabina, a doctoral student in social work and one of the two participants who felt that cultural sensitivity was not something that one could arrive at, but something that one should continually worked toward.

I don't know if cultural sensitivity is something that can even be attained. I certainly hope I will always be in the process of attaining it. I think that there's so much even if I study that I continue to be blinded by my own particular experiences. Even if I think I am catching a lot of assumptions or am tuned into different potential expressions of culture, I am just sure there are so many things that I miss on a regular basis.

Cedric, another doctoral student in social work, echoed this sentiment stating, “I think there's always room to grow. There's a never ending source of things to learn about other cultures and about ourselves. Our cultural sensitivity is something that changes continually over time.”

What follows are the varied definitions of the nine who identified unequivocally as culturally sensitive. The themes of these responses include possessing knowledge, being able to communicate well about cultural issues (listening and talking), being aware

of sociopolitical issues surrounding culture, and not making assumptions about people and their culture.

Sabina defined cultural sensitivity as “attunement and attention paid, being aware of assumptions, having knowledge about specific cultures, and being aware of the affects that the power of a formal institution might have on someone from a marginalized culture.” She also reported that she “continually puts her own practices under a microscope to make sure that they are not diminishing of people’s experiences.”

Julia, a social worker, said that it meant being sensitive to circumstances around family dynamics as well as ways of interpreting a client’s presentation, such as understanding that the hearing of voices might not be an indication of psychosis or pathology, but a part of one’s culture.

Various clinicians discussed the importance of being open to, comfortable with, and versed in one’s own and other cultures. To Cedric this meant having the education, experience, and ability to converse, “not just talk, but communicate, know limits, know that one is biased, and be aware of one’s biases towards oneself and others.”

For some of the participants being aware of biases implied a comfort in asking questions, bringing culture up, and exploring it in a session. For instance, Nikko, a psychologist, expressed the following:

For me the idea of cultural competence is if you have that sensitivity and awareness then you can usually pretty smoothly move in and ask, inquire, tell me about the cultural piece in this. How does that impact you?

Several participants discussed perceptions, being mindful of where another person is coming from, how one perceives the client and is perceived by the client. In discussing

this and the importance of empathy and openness in cross-cultural relationships Izzy, who holds a Master's degree in counseling, offered the following example.

We were taking a group of kids camping and people were pairing up and being assigned to their tents and it didn't dawn on me that this Black kid would see it as racist that no one wanted to pair up with him, because mostly at that point everyone was thrilled when they got their own tent. I think I thought I was colorblind and now realize was that I was being insensitive to interpretations he might have of other people's behavior.

The majority of participants talked about how a person's belief system factors into his/her culture and the importance of being aware of varying world views, perspectives, values, morals, and ethics. One psychologist named Sirius conceded that early in his career he was more apt to impose his own beliefs onto his clients.

It just doesn't bother me anymore, when clients tell me that they work under the table so that they don't have to report their income to social security. I now see that as a reasonable thing that they do. At first I took the George Bush approach and said, "You shouldn't be doing that." But when you look at it from their perspective, they really don't have much choice.

Chiara, a marriage and family therapist, recounted a conversation she had had with an African American client at her agency about differences in belief systems between White therapists and Black clients.

There's a woman, she's Black and she said, you know all these White therapists they tell us to tell our kids that they need a time out and that's just not how we do it. If they deserve a spanking they deserve a spanking and they have to understand that there are different cultural beliefs around how to raise our children and these White therapists can't be coming in here and saying this. I was taking in what she was saying and it's true that there are clashes. So I have to decide if I am going to come in with my own belief system about what to do or if am I going to help support them in finding ways to shift a little bit. It's so sensitive, because often its generation to generation of doing things the same way.

Although she identified as culturally sensitive, she had some reservations about the characterization.

I would say that I am culturally sensitive. However, I don't think it's at the forefront of my thinking and I don't think it's at the forefront of their thinking. They just want help. Maybe they are looking at me like some White woman, but for the most part we are just trying to deal with whatever is before us.

Other themes that emerged among several participants in defining cultural sensitivity included considering each person as unique, understanding that a person's culture is not their race or ethnicity, but their experiences growing up, really thinking about where a person comes from, as well as their immigration history, and keeping a spectrum of differences in mind, such as class, sexual orientation, race, gender, ethnicity, and education level.

Differences between Latino/a and White Clients

The second question asked participants to offer examples of observed differences between their White and Latino/a clients. Three of the participants clarified that there was too much diversity within the Latino community to generalize, but were willing to do so with that disclaimer. The remaining nine put forth the differences they had identified. Many of the differences noted were characterized by sociopolitical and economic themes such as class, immigration, acculturation, imperialism, and violence, as well as cultural characteristics such as the role of family, language, religion, and personality.

With the majority of her Latino/a clients coming from Puerto Rico, Genevieve conveyed that there is a sense of victimization and disadvantage that her clients carry that comes from being from an occupied country.

Puerto Rico is a country that has been occupied many times and there is this flavor of victimization that has been over and over again endorsed and enhanced. The people I see from Puerto Rico haven't been able to manage well there. Puerto Rico is a beautiful island and people don't generally say they want to leave this paradise and freeze their butts off in the middle of a drug dealing city. They are thinking they might have resources they can't get there so they'd better bite the bullet and go and so we get a lot of the people who can't seem to survive well and they seem to be a large group of disadvantaged people.

Four participants raised class as a difference, stating that generally speaking their Latino/a clients were in lower economic classes. Sabina mentioned that this sometimes had benefits such as better health insurance plans and the ability to receive follow-up services. Sirius felt that Latinos had lower expectations in terms of income.

When you have grown up in poverty all your life it's very hard to go to a different level. Latinos do with what they have better than a lot of White folks do, but I don't see a lot of them crawling over themselves to climb the economic ladder, so to speak, and some do tend to make do with disability checks and welfare.

Also thinking within a global framework, Sabina raised issues of histories of immigration and acculturation.

I see clashes between generations between ways that are familiar of doing things or thinking about things for parents, that are different for their children who are really focused maybe on trying to assimilate, getting encouragement to assimilate, but then really adopting other ways of understanding things.

Julia seemed to feel that culture was a more prominent issue with her Latino/a clients than it was with her White clients, stating that "with White clients, I don't think about it. It's just therapy and culture doesn't come into it."

Most of the participants discussed the differences between family roles, relationships, and networks, citing Latinos as being more interdependent and placing

more emphasis and importance on family. This included more reverence for the elderly within the family and more integration of the kids into the family as well. Julia hypothesized that among Latinos there is more reticence about entering into therapy or “extenuating circumstances which bring them in” since they get the support that they need from their families. This was also extended into perceptions of Latinos as putting more emphasis on socialization and community whereas Whites might emphasize education, providing for the family, and allowing the children to leave, which might not be the case with Latino families.

This issue of leaving the nest versus staying at home with the family fell under the theme of autonomy and interdependence and was mentioned by half of the participants. Cedric said that Latino/a clients seemed to have “a different sense of self, relational style, values, and beliefs that reflect less emphasis on autonomy and individuality. What one would characterize as a successful life would be very different for a Latino/a person than for a White person.” Chiara said that Latino parents are much more “enmeshed” with their children than White parents seem to be.

Language emerged as a significant difference, the most obvious piece of this being the prevalence of Spanish speakers among the Latino population. However, two participants went further on the issue of language. For instance, Nikko offered the following with regard to language.

I think that one thing that really sets the Latino community as a whole aside from other immigrant groups, is that they often will be speaking Spanish two, three, four generations in, whereas for most other immigrant groups, by the second generation the language is gone.

On the other hand there was mention of those Latinos who do not speak Spanish and how this might affect their cultural identity. Charlotte, a social worker, offered an example of a Mexican client for whom this brought on an even stronger desire for a connection to his culture because not speaking the language made him feel ostracized from other Mexicans. She said that among her Mexican clients “awareness of origins and culture remains strong, even several generations after immigration.”

Spirituality and religion were significant themes in talking about differences though there was variation within this discussion. Cedric expressed the sense that his Latino/a clients “consider things as happening as part of god’s plan or destiny for them and therefore they may have less focus on free will.” Three social workers who work largely with the Puerto Rican community discussed religion in terms of *Santeria* and *espiritismo*. In the following quote, a social worker named Ethan discusses his response to working with practitioners of *Santeria*.

The heavy influence of Christianity and Catholicism within Puerto Rican culture especially is very different for me. *Santeria* and the different saint rituals as well as white and black magic is very foreign to me. I think I tried at first to be sensitive to it. I would be lying to say that it wasn’t unsettling at times, particularly because for some of my clients, their experience of it, particularly the black magic, they were very disturbed and sometimes even hurt by it. And I think for me culturally that difference was very apparent. I found myself getting very upset because I saw it hurting my clients and it pisses me off when my clients are hurt.

Sirus, who identified as Catholic was surprised that many of his Latino/a clients might say they were married even though they had not been “married before god. And yet they were as committed to their partners and children as any other population.”

Two participants mentioned the pervasiveness of violence within the Latino community on the street and in gangs as well as in the home in the form of domestic violence and child abuse. Three mentioned a higher incidence of drug use and dealing among Latinos. Of these responses only Sirius drew a correlation between these trends and class background.

I think that the Latino folks versus White populations, percentage wise, they tend to have a less terrible view of violence to some extent. We have many people here who are members of gangs, and drug addicts and stuff like that. Some are more prone to violence. However, the White lower class population is prone to it too.

Chiara said that many of the men in the Latino families she was treating were in prison which led to a great deal of struggle, loss, and grief for the mothers and children. She went on to talk in detail about gender dynamics within Latino families. This was the only participant to explicitly point out gender when discussing differences although two other responses referenced gender when expressing concerns around domestic violence and early childbirth rates among Latina women.

Men in Latino families are often there as back-up to get the children in line and they seem to be more authoritarian. This is really hard for the mothers when the fathers are not around anymore because they are in prison....Boys are treated like kings and there is more projection of fathers onto the sons. Girls are shot down more and sexualized very young. And then these single moms are working two or three jobs trying to support their kids, or on disability because of some traumatic experience, whereas in White families there is usually a husband who is working.

Additionally, in terms of mental health, Charlotte reported that according to the other clinicians at her agency there was a noticeable pattern in diagnoses that seemed to be related to ethnicity.

This is not something I believe to be true, but I heard again and again from both Mexican and Caucasian clinicians at my clinic, that Caucasian clients more frequently present with personality disorders whereas Latino clients present with depression and anxiety and more sociological factors.

Two participants felt that there was considerably more emotional expressiveness among their Latino/a clients. For instance, Izzy stated:

When I say Latina, most of my clients are women, and my Latina clients are on the whole much more able to express themselves emotionally and cry. They're not shy about expressing sadness or anxiety, they are not as guarded.

Other differences that were mentioned were that there were less secrets in Latino families, more deference and a sense of hierarchy within the family, a more engrained sense of stereotyped roles.

Charlotte discussed the differences more in terms of her own comfort level rather than the behavior patterns of her Latino/a clients.

A lot of the Latino clients I work with in Spanish and it's different for me working with a Spanish-speaking Latino client versus an English-speaking Latino client versus English-speaking Caucasian client. With Latino Spanish-speaking clients I am more uncomfortable because I am always monitoring myself. Am I completely understanding you and how are you perceiving me because of my "intermediate advanced" Spanish? What is it like for you to be working with me? So I am a lot more self-conscious. With English-speaking Latino clients I feel like I am very aware of the cultural differences and how they may be perceiving me. Whereas with Caucasian clients I am not as aware of that, I don't think of that as often even though there may be huge cultural differences between us.

Clients' Perceptions of White Therapists

When asked how they imagined their clients were perceiving or being affected by the fact that they were White, the responses seemed to fall into three categories. The first was that it wasn't something that affected the therapeutic relationship at all and did not come up. The second was that it definitely had an affect on the therapy and needed to be

addressed, and the third was that it was something they had not thought about before and were unable to speculate about.

Overall, participants were more reserved in their reactions to this question. Some of the reflections on race and whiteness included comments on power. In general, however, responses to this question stood out from others in that participants seemed to reply more with their feelings as opposed to relying on the tendency to answer the question in terms of its political or social context.

Of those who believed that it was not an issue that affected the therapeutic relationship several said that in fact they felt that their clients appreciated having a White clinician rather than a Latino/a because they felt they would not be judged by a White clinician in the way that a Latino/a clinician might judge them. This is illustrated in the following quote by Sirius.

Some of my Latino clients have told me that they seek out and prefer White therapists for various reasons. I have heard that many times. They seem to have more respect for them or something and seem to think they know what they are doing more. And there's one guy who would be very vocal about it. He's left three or four Hispanic therapists over the years and now swears he will only see White therapists. He said they were very judgmental and looking down on him from above. He didn't find it helpful.

Two of those said that it did not seem to be an issue for their Latino clients and reported that it was more of an issue with their African American clients.

A social worker named Jessie said that she often wondered if she put more emphasis on her race than her clients did.

I don't feel that the clients seem to have so much of a problem. Sometimes I felt like in my mind I was making a bigger deal of what is it like to sit with someone who is White, than they actually did, that sometimes it's just a curiosity on their part of where you are from or how you learned Spanish.

She also suggested that any sense she did have of her whiteness coming up for a client might have been more connected to her education level than to her race.

I don't know if it had more to do with the fact that I was an graduate student or that I was White. Their attitude was more like, just because you have gone to school and studied and read all those books and I haven't doesn't mean that I don't have more experience and that my experience hasn't taught me more than what you know.

Sabina, who felt that it did have an affect, saw it as a reflection of larger institutional dynamics. "I don't think it comes as a surprise for families to walk into a room for the first time with someone who is in a position of a certain kind of power within an institution and have that be a White person." Another therapist concurred stating, "They see me as knowing the system or having more connections within the system."

Participants, such as Cedric, spoke of this power as something that might both be enraging, idealizing, or cause envy.

I think it's complicated. With one client it was always there. It was something we were luckily able to discuss and the relationship went on for many years. But I had to sit with a lot of anger. I didn't feel angry myself consciously about that issue. I knew where this person was living and their stories made sense to me and here I was working for a hospital, part of the system, so why wouldn't I be associated with some of the other oppressive experiences they had experienced.

Ethan described a situation in which a client expressed feelings of insecurity around working with a White person.

She had requested someone who spoke a little bit of Spanish and at the end of intake I brought this up and she said, "I asked for that because my experience of White people has been that they are very impatient with me which makes it uncomfortable for me to talk and makes me more anxious." And I think that's totally legitimate and in many ways I feel I am not the best clinician for her.

Due to her trauma background, this clinician emphasized the importance of his client's ability to express herself, and therefore felt that the language barrier was a significant issue.

Three of those who felt it did have an affect talked about feeling their whiteness in session. Charlotte worried that her clients would feel misunderstood by her, that they would feel the need to explain things to her more than they might with a Latino/a therapist. Ethan said, "I have one client, who often says, "You know what I mean?" And I imagine that in part she's asking that because I am not from her cultural background and she thinks I don't know what she means." Chiara described her feeling of whiteness as follows.

I think that the fact that I am White and short and very nice all make it so I could be perceived as just the nice White girl, which I have had my entire life in interracial environments and so far it hasn't felt like it's been an issue and maybe it's because it's really hard to get a therapist so they take who they can get. One time I mentioned something about the mom complaining about a kid swearing all the time and I was asking her about where he could have learned it and she was very defensive about that and of course I was saying something very provoking. And in that moment I felt very white. I felt like the accuser.

Similarly, Julia reported wondering if her clients were just acquiescing and "making do" having been assigned a White therapist.

Charlotte went into detail about her experience with a particular client, with whom she felt culture and race were getting in the way of her ability to build a therapeutic alliance.

I just felt like there was a barrier there throughout our therapy together, like there was something I wasn't hitting on, there was a combination between that and just

trying to understand how she was feeling (about having a baby) and I felt like a lot of it was cultural and I just wasn't getting it and I think although she never said it I think she was feeling the same way. I asked her what it was like to talk to me, a White woman, about these things and she just said, "it's fine, it's fine." But I never really believed it was fine.

Of those who felt that their clients responded positively to their whiteness Nikko said that his Latino clients were simply grateful to have a therapist who spoke Spanish in a mostly English-speaking profession, "who was invested in their culture," and who was willing to help them. This was echoed by several participants. For instance, Natalie, a therapist with a PHD in family systems therapy, said, "the Latino community is just thrilled when I speak Spanish. They are beyond! They introduce me saying "this is my therapist and doesn't she speak great Spanish..." and there's an empowerment in having that connection."

Izzy said, "These are not cultural or racial things. They are human things. I can't remember when anyone's ever questioned my ability or perspective based on my being Anglo vs. Latin. It was more on other non cultural non racial things."

In a similar vein, Natalie responded by saying, "Differences are there because I'm a different education, culture, ethnicity, religion, etc. but the boundaries get blurred as you live and work and deal with so many differences. Really, people are people."

Addressing Race and Culture with Latino/a Clients

When asked how they addressed issues of race and culture in therapy with their Latino/a clients there was a vast array of responses. The question had two parts. The first was an open-ended inquiry into how issues of racial and cultural difference were

addressed in therapy. The second part questioned whether or not treatment modality was adjusted for these differences.

Six participants stated that their treatment modality stayed the same regardless of racial or cultural difference. Genevieve said that her motto was to “assume nothing and resist thinking in stereotypes.” Similarly, Sabina spoke about her approach in terms of her way of thinking rather than in terms of her way of conducting therapy which virtually did not change from client to client regardless of race or culture. The third said that she wouldn’t address these differences at all unless they came up on their own, in which case she would ask direct questions about culture. Ethan believed that the use of empathy and a belief in the “innate potential of all people” was sufficient for addressing differences, but said these values laid the foundation for his work with all of his clients. Izzy said of a client that “depression is depression and PTSD is PTSD and more what I was concerned about with her in terms of differences was her age and the fact that she was 8 1/2 months pregnant rather than the fact that she was Puerto Rican.”

The remaining participants reported that they would adjust their approaches for these differences. For instance, Cedric discussed the importance of understanding a person’s or family’s culture so as to avoid offending them. “I may be more personable with many Latino clients. I have done home visits and if I had refused an offer of food or a cup of coffee it would have been terribly insulting.”

Cedric also addressed the significance of getting to know the family even when treating an individual.

After all, I might be working with the client, but I will also be working with their family. Especially with clients who do tend to be strongly identified and who

embrace a more family community perspective on self, I would need to have familiarity with the family to understand and work with them.

Around the issue of race he said:

In the end we are talking about power differentials, or status, opportunities, money, all of these things. I wouldn't want to bring it up in a way that might cause the other person to feel disempowered or pressured...I think one has to weigh that vs. doing the same thing by not bringing it up. I would prefer to bring it up in a forthright way and one has to be willing to sit with anger or rage, disappointment, all kinds of different feelings and to know that that's okay, to be comfortable with that.

Charlotte reported that she still wasn't comfortable addressing cultural and racial differences and had made many errors trying.

I try to include questions in the beginning about culture, race and ethnicity, but I want to get better at asking how these issues affect their lives and what it is like to be talking and confiding in a White clinician.

Similarly, Ethan, who stated that his treatment modality did not change, simultaneously mentioned that he might acknowledge his whiteness with a non-White client or specifically ask, "What has it been like for you to talk about these things with someone who doesn't come from your culture or background?"

On the other hand Jessie said that while she was tempted to ask what it was like talking to a White person, she followed the advice of her supervisor who recommended that she take a more psychodynamic approach and "see where they go with who they think you are and what it means to them" rather than assuming that they were seeing her as White, or as a *gringa*.

Several participants reported using language and immigration as an inroad to talking about differences. And many relied on the use of empathy, listening, using client-centered skills, or “putting themselves in their client’s shoes.”

Jessie also talked about the importance of learning about cultures she did not know about. Natalie agreed with this sentiment, feeling that if she could learn about the other culture and let her clients know that she knew something about it; it would free them to talk about it.

Chiara had a unique position in saying that because she found her Latino/a clients to be more withholding than her White clients, she tended to

...sit back and let them come out of themselves. They will either act it out in play therapy or in our relationship. I take a more active role with my White kids because the Latino kids can be resistant or very defensive...resistant because in their stories there is a lot of trauma and they act out this trauma by not trusting me, so I try to create a trusting relationship where I am not all in their face.

Explicit Discussion of Race and Culture in Therapy

Participants were asked to think about whether or not they had ever explicitly discussed culture or race in therapy. It is important to note that in answering this question many of the participants combined race and culture without distinguishing between the two, which likely indicated a problem in how the question was presented. That being said, seven out of twelve participants reported that they had explicitly addressed these issues with their clients and five reported that they did not. Sabina expressed the desire to discuss culture more with her clients, but found it most easily facilitated in group settings.

I think that’s where I have had the best conversations about difference in race and ethnicity, differences in power, critiques of the institution. I feel like there is a

way in which when people are together and not an isolated voice or position, they can really articulate those positions.

She also stated that there were ways that institutions were initiating discussion about culture by asking cultural questions, for example, on applications for services and biopsychosocial assessments. In one instance, she treated a client in a hospital whose family believed was possessed by the spirit of his uncle. Though the hospital talked about the possibility of psychosis, the treatment team ultimately agreed to arrange an exorcism. Perhaps because of the hospital's show of good faith and respect for their cultural position, in the end the family was willing to adhere to some of the psychiatrist's medical recommendations as well.

Julia said that culture came up often while talking about family dynamics, immigration history, or the experiences of the client in their country of origin. "In these cases I will ask culturally specific questions about their growing up."

The same clinician encountered a situation which she said rendered a discussion of culture unavoidable, when her patient brought his wife into therapy to translate for him because there were no Spanish-speaking therapists available. A discussion of the situation raised a host of issues about whether or not the therapist was the right person to work with the patient given their cultural and racial differences and ultimately resulted in early termination of treatment and transfer to a Latino clinician.

This sense of misunderstanding does not only come in the form of language barriers. Cedric discussed race with a client who directly stated that the therapist could not possibly understand what he was going through because he was White.

For Nikko, who reported that culture came up all the time, he said he frequently heard the phrase “you don’t understand, in our culture...” and gave an example of a Peruvian couple attempting to explain what the meaning of a marital separation was for their relationships with each other’s families of origin.

Sirus cited a conversation he had had with a client about cultural similarities between Italian Americans and Latinos. However, other than this, he said he rarely had “troubles” that merited a discussion of culture or race, since his clients liked him and saw him as “helper.”

Charlotte reported discussing familism a great deal with her Latino/a clients. She also reported trying more to discuss culture with her clients saying, “I have realized that many times when the therapist brings it up it gives people permission to talk about it.”

Natalie gave the following example of how she might discuss culture explicitly.

I might say, “you know if it were me, I might do (this or that), but I’m not you and I don’t come from the culture that you come from and I know that in the culture you come from it might be more traditional to do this and less traditional might be to do that. I don’t know what you would do. What would you do at this point? What would you have done? If you were still in Puerto Rico what would be different. But you are in the U.S. now so what’s the difference here?”

Of the five who did not discuss race or culture, two said that it wasn’t comfortable or that it did not come up. Chiara said that she did not remember ever having discussions about culture or race, but that she wasn’t intentional about it. Genevieve said that in her practice of sociometry there was a phenomenon called “tele” which means “projection into space; that there are attractions and repulsions that people have and therapists tend to attract the clients that they can help.” She believed that as long as she could avoid making

assumptions about her clients it wasn't necessary to explicitly discuss culture, because the client had come to her for a reason.

Jessie was taught in her graduate training that "If I did not discuss culture and race with my clients it would contribute to racism and ally me with the oppressor." However, she rarely felt it was comfortable or made sense to bring it up. She said that she would in the beginning of her career, just to acknowledge that it was there, but that clients would very quickly say that it was okay and brush it off.

I think part of it is that sometimes I don't know if they understand the internalized racism part of it, where a lot of this anger comes from and sometimes I find that they are trying to please me, like "whatever you want." It's hard for them to claim this as their time and say "this is what I want."

Ethan, the fifth participant to report that he did not explicitly discuss cultural differences in therapy, attributed it to the fact that he believed himself to share the culture of his (mostly) Puerto Rican clients.

My challenges in answering this question are somewhat reflective of the majority of my clients being Puerto Rican and Puerto Rican culture being a shared Latino and American culture. I think between myself and my Puerto Rican clients there are less cultural differences, societal national differences. They are a part of America. They are American citizens. Many of them speak fluent English, many of them have grown up with a similar education, the same tv shows, the same music. And vice versa. I am someone who lives in this area of the country where there are so many Puerto Ricans and I also share their culture. I see cars with bumper stickers, I hear the music from cars or on the radio, I see Spanish publications. I see Spanish on the tv. To say that that's not then my culture, it's not my culture, but it's part of my experience as an American, I think is incorrect.

Conflict of Values

Clinicians were asked if they could think of a time when a Latino/a clients' values were in direct conflict with their own in a way that affected the therapeutic relationship.

Three of the twelve participants reported that they did not experience a conflict in values with their Latino/a clients that they felt affected the therapeutic relationship. Seven of the twelve were able to provide concrete examples of these kinds of conflicts and one participant reported and cited specific examples of value conflicts, but said that she experienced this with all of her clients and could not be sure if these values were culturally-driven or not.

Chiara said that she experienced value conflicts with all of her clients irregardless of culture or race.

For me it's the presence of television and video games, often it'll be the kind of food they are feeding their children or the use of television as babysitter, hitting and yelling. A couple of different things have come up and I often will challenge the parents, but I am not sure if they are cultural or not. It doesn't seem like they are. It's about medication, or attachment, or family secrets, or how you punish a child, but I have that with all of my clients, not just Latinos.

Sabina responded that her values were often more in conflict with the institution than with any Latino/a client.

My deepest value is that people have knowledge and skills about how to deal with the problems in their life. I am not the expert and where I am in conflict is not in relation to my Latino clients, it's in relation to the institution, through insurance or hospital protocol or other things that would in some manner devalue that way of practicing or understanding.

Six participants mentioned the presence of violence or abuse in the home when asked this question. Julia discussed this in terms of corporal punishment of children.

I have witnessed Latino parents hitting their children. That's hard. But I also remember getting hit as a kid, so I don't look at it as though it's abuse. It's like when I was a kid. It's what their culture is, it's the norm. I get conflicted about that. My first reaction is that it's not cool. But then it's hard for me to pass judgment.

Izzy said that it was difficult for her when her Latina clients stayed with men who were abusing them. Nikko stated that corporal punishment was just as common among his Anglo clients as it was among his Latino/a clients. This person was in the minority of participants who reported that they did not experience value conflicts with his clients, Latino/a or other.

It's not my place to impose my own personal value around anything, education, religion, anything. I think it's a core therapeutic value to have neutrality around these kinds of things. I don't view it as a conflict if someone has different values, because most people do.

Chiara talked about yelling as another expression of abuse and attempted to dissect why her Latino clients would be driven to yelling.

It does seem that there's generations of Latino families who come here and are not heard in this culture. They are the underdog and if you don't get heard you become a yeller, this seems to be the case, that if you don't get heard you yell to be heard and there are generations of families that are yelling at their children, to be heard, or because they are so frustrated with their jobs or the kind of oppression that they have experienced that they come home and let out all of their stress on their families. I don't know what to do when this happens because I think that to argue or try to change that pattern or say to a parent who has been oppressed their whole lives that yelling might not be the way to get your child to hear you, is like talking to a wall.

Charlotte expressed her own internal value conflict around when to call the Department of Social Services and report violence if she was questioning whether or not the violence was truly harmful to her client or not.

This comes up every day in my work because I am working with a lot of kids and moms where hitting your kids is really common and I have a really tough time with this and yet I know it's normal. That creates conflict for me and I am still trying to figure out how to resolve it, especially when it comes to reporting to DSS and at what point do you report to DSS. That's a little bit of a value conflict. I feel like I have done a good job in understanding that this is a cultural difference

and figuring out when it is dangerous and when it is cultural, but I am still working on that.

Jessie was the final participant to mention abuse emphasized the potential for emotional maltreatment rather than physical.

Certainly disciplining children comes up with Latino parents and it's hard when they are so strict and rigid in working with that. I don't see a lot of praising of children or positive reinforcement. One Latina client I am working with is so negative; everything about her daughter is bad, bad, bad. And just working with her to say that if everything is bad and negative then that's the attention that her daughter is seeking because that's all she's getting. And it's not that she's a bad mother, it's just that this method is not working. So I try to figure out what we can do to try to change that pattern.

Two participants mentioned having differing perspectives on education as a value conflict with their Latino/a clients. Cedric discussed his differences in thought around education through this story.

I was treating a young Latino man who was very close to graduation and was, from my perspective, sabotaging his progress in pretty serious ways and I was approaching him from the perspective of why wouldn't he want to graduate, why wouldn't he want to go to college, move away, get out of the terrible situation he's in, facing trauma and violence every day, living in a poor, inflicted neighborhood. And my values were why wouldn't he want to get out of there and become "successful" so yeah I think that got into the treatment and created some obstacles for us.

Similarly, Sirius connected his values on education to economic and social class, feeling that an education was the best way to get ahead.

I would guess the biggest factor is that their parents never push this stuff too much, whereas my immigrant parents pushed me like heck. And I don't see much of that at all. Often I don't even see Latino parents knowing how their kids are doing in school, let alone caring. Many times they tell me they are not sure. They just sign the reports without really looking at them.

Ethan discussed his being conflicted about the practice of Santeria by his Puerto Rican clients stating that it “flies in the face of what I believe is shared humanity, and of my Jewish values, my Buddhist values, and my common sense decency.”

I have had clients report that they feel people have put hexes on them, that they have had curses put on them. Typically women are victims of their ex-boyfriends, who are often violent. I am upset now even talking about it. I see these men, and of course I believe in the innate potential of all people, but I see these people as way out of touch with that and that they are accessing the evil inside of them and they are acting upon it and infringing upon the rights and welfare of other people.

Izzy mentioned that it was difficult for her to witness the role of Latina mothers with their adult children feeling that they were too involved in their children’s lives. “I feel a lot of my work with mothers of adult children, is to help them decide what their boundaries are.”

Charlotte talked about *Marianisma* among Mexican mothers. She described this as “the concept of being like Mary and carrying everything on your back.”

A lot of my Mexican female clients felt like it was their responsibility to do everything around the house and to take care of the kids, have a job, bring in the money, to do everything, and that it was okay for the man to not do these things and that was tough for me because I saw how much it hurt them and wore them down. But this was a value that a lot of Mexican women had and they were so strong that it was tough.

She also called attention to a tendency she observed in the Dominican culture of men to have two families simultaneously. She said that it was hard to witness women getting upset about this, but having to accept it as a normal part of their culture.

Natalie talked about her value conflicts in terms of how her Latina clients relate to their male relationships and adhere to their stereotyped roles.

It really really really bothers me when they are married to a guy, he has a kid out of wedlock, and then wants the woman to take care of his other kid. And I am going why don't we deal with the issue here of how I see it? And also, that a Latina woman is not socially acceptable without a husband.

Clinicians Biases about Latino/a Clients

Clinicians were asked about any biases they thought they might have had about Latinos. Going into the interview it was assumed that the definition of "bias" would be universally understood as a prejudice of preformed judgment and would imply an unfavorable opinion. However, participants aptly pointed out that the term "bias" could be both favorable as well as unfavorable. It was therefore left to the interviewee's discretion to respond to the question as they understood it. In retrospect I feel it would have been preferable to substitute the word "prejudice" for "bias." Nonetheless, the results are as follows. Eight of the twelve participants acknowledged having biases about Latinos. Two of the eight described positive biases. Three said that they did not have biases.

Of the three who reported not having biases, Genevieve explained this lack of bias by a feeling that she was Latina even though she did not look it or come from a Latin American country. She felt that to have biases against them would mean that she had biases against herself. She told a story of having been told that based on what he had heard about her practice, one client had assumed she was African American. She said this made her feel honored and was an indication that she did not hold biases or racist beliefs.

Chiara, who said she did not have biases, added that she could not think of any in the moment of the interview. She said that she spent a lot of time trying not to see her clients as Latino, “trying to erase their race.”

Often what I feel is just the oppression, the oppression of children, or single moms. Maybe I get angry that they have to work so hard, or have so many jobs. Maybe I just don't have that many biases about them. Maybe I get scared sometimes. Feel like I am not powerful enough.

Sirus the third participant to deny biases said, “I don't think I have tremendous biases. I don't think one could really survive at this agency and in this city with biases. I don't know anyone who has them and I don't think it would go over too well.”

There was a larger array of responses among those who did acknowledge biases. Some themes included lack of individualism and being overly tied to family, an over reliance on the “system” such as social security, welfare, and disability, biases about religion, an idealization of Latinos and views of them as social, partying people, a belief that they are heavy substance abusers, a resentment of Latinos who did not make effort to learn English, or conversely, the assumption that all Latinos speak Spanish. Charlotte mentioned having developed a lack of trust for Mexican men after leading a group of Mexican women who had lived in situations of domestic violence. Ethan quoted George Bush in describing his biases calling it “the soft bigotry of low expectations.”

He explained this with an example of some of the thoughts that go through his head when he is working with a Latino client.

So you tell a Latino person “You are Latino. You have a shitty education, your chances for a job are shitty, you might as well collect welfare or go back to your country or come and get our social services and we'll take care of you. My bias is that I don't think that's a healthy message. I think that it's a prevailing message. I

think my biases toward Latinos would be that I kind of feel like they bought into their oppression. That they bought into the hood, the gangster lifestyle and it annoys me. Sometimes I get really annoyed at the way they talk. You know with improper English, using derogatory terms, particularly “nigger” it drives me crazy. And I judge them. And I get frustrated. Like, you are telling me it’s your culture to drop out of school, to have sex with all these different people, to deal drugs, to be in gangs, that’s your culture?! Don’t get me wrong, I don’t see that separate from the context that it’s in. That’s internalized racism. That’s internalized oppression. I know that. It still pisses me off.

Two participants talked about feeling that Latinos were more likely to abuse substances.

Julia presented the following anecdote.

I was called to jury duty and I didn’t get accepted because I was a substance abuse counselor. I was asked if I believed that a person of color was more likely to be a drug user. My answer was immediately no. I walked away and knew I didn’t answer it completely correctly. I live in an area where there are huge numbers of Latino drug users. But I think it’s about poverty and lack of opportunity, but I couldn’t say that to the judge. But I wanted to say yes, because of poverty they don’t have the opportunities we have and this is what they learn as a way to live and survive.

Nikko echoed and expanded upon this sentiment.

When I was working with the Puerto Rican community it was overwhelming at times, the level of violence and intense drug involvement, but I barely saw a Puerto Rican client in any setting whether on the inpatient unit or crisis, who didn’t present with a history of serious violence personally or in their family, or someone in their immediate family with HIV or AIDS, child sexual abuse. I mean it was person after person after person after person.

Three participants discussed the tendency of Latinos to rely too much on the system, wondering if those receiving disability really couldn’t work, or if those receiving welfare were not willing to work their way out of the system.

Both Natalie and Nikko understood biases to be favorable as well as unfavorable and spoke of their biases in what they described as positive feelings about Latinos, stating that they see them as “livelier,” “more emotive,” and “have better parties.” Nikko said:

I love working with Latino people and I love hanging out with Latino people too. I find it refreshing and I like the emotional presence of Latinos and the expressiveness feels very comfortable to me.

Natalie talked briefly about how she works around her biases.

I know I have my biases and stereotypes. But it's more like you bump into them and go, "oh there goes one." I do get annoyed. A lot of times it will be about not showing up or not calling and not ever saying no, always saying yes, whether they are going to do it or not. So in most cases I try to acknowledge that that is going to be part of the culture. I would ask about coming to the home at a certain time and they would say fine and not tell me if it wasn't fine. So I have changed the way I interact with the culture unless it's an issue I want to address because of the psychology of it.

Training

Therapists were asked to report on how they received training in cultural competence. They were specifically asked to consider life experience as well as formal schooling. Of the twelve participants, one reported that that they received their training exclusively from formal institutions such as school or conferences. Four felt that they learned about issues of race and culture from life experience alone. Eight said that they received their training from both life experience and formal training.

Of those who claimed to receive their training from both, three cited their own immigration histories as contributing to their learning. Interestingly, although this was not a question that was asked of participants, the three who related their own immigration histories were of Italian descent. Julia disclosed her own experience with racial discrimination.

I had to write a paper for school about what it was like being an Italian immigrant in a white neighborhood. And I got called *wop* and *ginny* constantly by this one neighbor. And I hated being Italian. I hated it. And my extended family is very racist and I remember hating it when I was a little kid. I grew up really noticing difference in color. I notice difference.

Four participants discussed their upbringing and the diversity or lack of diversity in their hometowns and high schools. Ethan and Nikko offered the following narratives.

I grew up in a White Christian middle class town outside of Boston that was very White Anglo Saxon protestant. Being one of the few Jewish families when I was young there, I experienced a lot of discrimination and prejudice toward both myself and my family and my community.

The high school I went to was about 20% African American and it was unbelievably segregated. I would hang out a lot with the Black kids. I would move back and forth. A lot of the White kids didn't do that. So I don't know I had that comfort with different cultures early on.

Four said that their experiences living and traveling in other countries were significant factors in their learning. This enabled people to think about what it was like to be in the minority sometimes for the first time in their lives and said that this helped increase their empathy for their clients, who were often in the minority. Charlotte discussed this in terms of her experiences as a minority in other countries.

The biggest training I had in cultural sensitivity was definitely living and traveling abroad. Because you are interacting with so many people and people are interacting with you and you get to see what it feels like to be the one or the only, or a member of the minority in another country which I think is really important. Going to a country where you look different from everyone. I feel like that really does contribute even if the power dynamic is different.

Of those who discussed their formal or school training, feedback regarding the quality and methodology of the training varied depending on when the participant went to school and where. Those who completed their study within the last ten years reported that

issues of racial, cultural and ethnic identity, regardless of discipline (i.e. psychology, social work, family therapy, etc.), were amply addressed in their program of study.

Cedric had this to say about the quality of current training opportunities.

In general it's hard to find good training around sensitivity. It's generally superficial. In some ways it may need to be because you are dealing with some of the most difficult feelings that we have of racism, parts of ourselves we don't like or might split off onto other folks. We're pushing against our defenses here. One of my thoughts is we are always looking for what to do. We want to invent the latest way to be pc or to cure suffering and the truth is living is suffering and conflict and being in relationships. And I think what we need to do is be in our relationships and think about them from a deep perspective that includes both sides of the dyad or multiple sides of the group and all of these things and the facets of the individual are complicated and I think that the way to do that is to be open to reflection and dialogue. I don't think there's a simple way to do it by saying well we could just train people and make them watch a movie. People have to be taking risks, they have to be in supervision.

Those who studied in the 60s and 70s reported significantly less commitment to these issues within their programs. For instance, the following quote was spoken by Natalie who completed her graduate studies in the 70s and ended up teaching cultural sensitivity classes at the university level.

When I started working in the field there wasn't any of this cultural hoopla. I had been a Spanish major in college and no one around me spoke Spanish, so I never used it. So it's been pretty much experience, my own teaching of the class, living with Latino communities and families while studying Spanish that has informed my own learning about cultural sensitivity. It would get absorbed doing my doctoral dissertation which was heavily involved working in a Latino clinic over years and years and years.

Overall, there was less emphasis on knowledge (i.e. about culturally sensitive practice and other cultures), than on importance of attitude, such as being empathetic and open, and feelings, such as being comfortable dealing with cultural issues. Throughout

the course of the interviews there were no references to authors, theorists, or researchers that indicated a strong sense of continued interest in the formal study of multicultural therapy, though the majority of participants said that they would attend trainings if they were offered.

Changes in Thought and Hopes

Finally, participants were asked whether or not their approach to or thinking about their work with Latinos had changed throughout the course of their career and to reflect on their hopes for growth as they continued to work cross-culturally. Ten of the twelve participants reported that their ideas or approach to addressing and perceiving issues of racial and cultural difference had changed over time. Of the remaining two, Julia said, “Once I get to know someone they are a just people. I don’t feel the difference; I just feel the sameness of human and the natural differences of just being human.” Genevieve said simply that her approach had not changed at all.

Those who felt they had changed reflected on a variety of ways in which this change had taken place and why. Many agreed that change is fluid and inevitable. Seven participants reported that their level of comfort had changed; comfort with difference, with talking about culture and race or asking questions about things they are not familiar with or do not understand, clarifying confusion, or with just being with whatever is in the room.

Sirus said that his political ideology had changed over time, once believing that Latinos should assimilate and ultimately feeling that “people should have a right to remain as they always were.”

All, but one of the twelve participants expressed having hopes for growth. Five clinicians said that they wanted to learn or develop their Spanish speaking skills in order to improve communication with their Spanish-speaking clients.

Two expressed a desire to pursue more diversity training. Ethan specifically acknowledged a need to keep better track of his biases, in order to be more present, to listen, to understand, and to assist people better.

The following are some more general quotes reflecting hopes for growth offered by Sabina and Cedric.

My hope would be that as I continue to work I continue to understand all that I don't know.

We start this work when we are still evolving, finding out who we are, and settling into that. As we settle in, hopefully we are open to doing work on ourselves, are aware of who we are, know that's going to get into the relationship, and are able to talk about it more. I think we hopefully defend less against that and bring it into the negotiation, not in a way that's transgressing boundaries inappropriately, but in a way that's facilitating a mutual growth process, a real relationship.

Final Comments and Reflections

There was a variety of attitudes about the topics posed to participants. It is difficult to categorize this range, because people were not necessarily congruent with their own responses as they moved through the questions. In addition, I am not using a standardized measure for gauging cultural sensitivity. However, with these limitations in mind, based on total comments, about one third of the responses indicated a severe degree of cultural and racial biases and lack of cultural sensitivity. Those who fell on this end of the spectrum expressed the following sentiments which diverged from current thinking about cultural sensitivity methodology. Some of these included, not thinking

about the affect of whiteness or believing that it is a significant issue, denying differences between people of diverse cultures and races, believing that with White clients culture is not an issue, feeling precluded from having bias because of an affinity for Latino culture or failing to acknowledge bias and believing that race can be erased.

About one half engaged in the interview process in an exploratory fashion expressing a willingness to be in the confusion of the process. At times these participants acknowledged that they had not previously thought about the issues raised or were able to recognize the biases that did come up for them as they responded to the questions.

The remaining two participants clearly indicated a sufficient degree of knowledge, training, and comprehension of culturally sensitive practice. For example, they put forth the ideas that one is always in the process of attaining cultural sensitivity and working toward gaining knowledge, experience, and an ability to communicate, know one's limits and be aware of one's biases towards oneself and others. While these kinds of statements are not necessarily definitive signifiers of one's clinical practice, they offer as much as can be gleaned from this type and depth of research.

Upon examining responses in conjunction with demographic data, certain trends became apparent that are worth mentioning. Although the research was not designed to focus in on these particular characteristics, it appeared that the era in which participants received their graduate training influenced their responses. For instance, clinicians who studied in the past ten or twenty years were more apt to see race, and recognize its relevance, whereas among those who studied in the 60s, 70s, and 80s it was more common for responses to reflect a colorblind belief system. Again, these observations can

not be substantiated at this time without additional research. However, they seem to merit further investigation.

In addition, though there is not sufficient information to qualify this, educational background seemed to inform responses. For instance, social workers appeared to be more likely to have discussed issues of culture and race in greater depth in their graduate studies than other professionals in the group. This could be even further narrowed down by factors such as the specific educational institution that the participant attended.

DISCUSSION

Introduction

As stated in its title, the intended purpose of this thesis was to explore how White clinicians perceive and address racial and cultural differences with their Latino clients. Ultimately, however, its function is to better understand cultural competence. What is it? Is it being taught and practiced? If not, what is impeding this process? What elements of clinical work are in need of honing in order to be more culturally competent? How may other areas of research within the social sciences such as the study of culture, race politics, and human development contribute to or enhance the clinician's understanding of cultural competence? This paper begins to address these questions, by posing them, and by putting them out there to those who are performing this work.

This is one of the few qualitative studies on the experience of White clinicians working with non White Latino/a clients. After conducting interviews with twelve clinicians in this demographic, an examination of the findings generated myriad themes around the intersections of therapy, culture, and race, as well as cultural competence methodology, and the question of the existence of Latino-specific therapy.

This section draws from previous chapters, comparing the self-reported techniques of these twelve therapists to cultural competency standards as outlined in existing literature. Narratives are scrutinized in terms of general awareness, treatment, and assessment. The discussion also examines the limits of this particular study and concludes with implications for further research and practice.

As evidenced in the following sections, the majority of respondents did not display high degrees of cultural competence or awareness of many of the issues raised in the questions posed during the interview. However, it is worth noting that participants were grateful for the opportunity to think about and discuss these issues and commented retrospectively and positively that the interview had sparked new thoughts and ideas about their work. One participant approached the researcher months later and stated that subsequent to the interview she began to see and think about her work with her Latino clients differently, and had begun to seek out reading materials and dialogue that would allow her explore cross-cultural work more fully.

Summary of Findings

The personal narratives shared in this study were complex and nuanced and can not easily be condensed. In order to present a simplified overview of participant responses, corresponding views have been clustered together and are later broken down into more detail. Generally speaking, about one third of participants displayed a significant degree of cultural and racial biases and lack of cultural sensitivity. About half, while not demonstrating the same severity of biases and lack of awareness, simultaneously did not exhibit sufficient training or implementation of culturally competent practice in accordance with current literature. These engaged openly in the interview process and often acknowledged that they had not previously thought about the issues raised while also taking the opportunity to observe and reflect upon their biases as they emerged during the interview. A minority of participants (one sixth) clearly

indicated a more sufficient degree of knowledge, training, and comprehension of culturally sensitive practice.

Findings also suggest that cross-cultural competence, among those who are currently practicing cross-cultural work, while on the periphery, is not being prioritized by professionals in the field. This study reveals an attitude towards cross-cultural and racial issues that indicates a lack of individual motivation for continued learning and exploration by clinicians, indifference on the part of institutional policy makers, and an absence of quality trainings being made available within the discipline.

Cultural Competence

General Awareness

Perhaps one of the greatest stumbling blocks of this study was the reticence of participants to generalize when asked about their views, understandings, and notions of Latino cultural characteristics. This hesitation did not preclude the existence of their generalizations and preconceptions, however, which surfaced more easily when participants were asked the question indirectly. Generalizations flowed out more freely, for instance, when participants were asked about value differences or distinctions between working with Latino and White clients.

Awareness and knowledge of the client's culture is one of the key components of cultural competence (Campinha-Bacote 1995). Yet, there seemed to be a fear on the part of the respondents that displaying knowledge about characteristics or commonalities between Latinos might be viewed as an inability to see the person before them rather than just seeing the person's culture or race. Participants seemed to have difficulty finding a

way to talk knowledgably about their Latino clients, and the meaning and impact of their ethnicity, without appearing to generalize or overemphasize the significance of these factors. What resulted in a denial of culture and race was nonetheless unsustainable even for the duration of a one-hour interview when inevitably, culturally and racially-based attitudes were expressed.

In addition, distinctions made in the literature between different Latino groups (such as Mexican and Puerto Rican) were rarely made by participants. This could in part be explained by the fact that the majority of participants were working mostly with Puerto Rican clients. Nonetheless, even in cases where distinctions were made between groups, characteristics were not distinguished between them.

The fear of being misunderstood culturally has been found to lead to underutilization of mental health services by Latinos (Falicov, 1998). Although a direct question about utilization was not asked, it was apparent through related questions that this was not a risk that was recognized or understood by participants in the study. Clinicians were often either confident in their ability to understand their client's culture, or they did not recognize it as a significant enough issue to justify an adjustment of their treatment methods. The responses of those who expressed the opinion that "people are people," or that culture did not play into their thinking about their treatment of Latino clients, further confirmed this premise.

Through continued discussion of their Latino clients, however, many of the major themes identified in the literature were touched upon by at least some of the clinicians. These included Latino tendency toward collectivism, emphasis on *familismo*, *machismo* and *marianismo*, *curanderismo*, *fatalismo*, and *espiritismo*. There was virtually no

mention of the importance of *personalismo*, *respeto*, *compadrazgo*, or *simpatia*.

Familismo was touched upon considerably, sufficient enough to support the often made claim that that *familismo* is one of the most important factors influencing the lives of Latinos (Coohey, 2001; Zayas & Halleja, 1988).

In addition to awareness and knowledge of cultural characteristics, there are many in the literature who believe in an awareness of one's own biases to be one of the building blocks toward cultural competency (Sue and Sue, 2003). It seemed that the majority of participants were not readily aware of their presumptions and assumptions about their clients. It was often difficult to discern whether or not this was the result of reluctance and shame around discussing prejudices or a lack of awareness. When asked directly about biases, at least half reported that they did not have biases or had simply never thought about it before. On the other hand, in some cases the participants' statements of biases were egregiously and unapologetically stated. Several descriptions were conveyed with what seemed to be a deep lack of awareness about the meaning of the words that were being spoken. This can be seen in the statement made by the therapist who felt that Latino/a clients could not benefit from psycho-analysis or insight-oriented therapy, but that they were rather seeking simply friendship and advocacy. While it is acknowledged in the literature that classical theories may need to be adjusted to fit people from different cultures, Hamilton-Mason also argues that it is important not to undermine the capacity of a client to think and be understood intra-psychically (2004).

Participants did acknowledge external systemic issues at play such as class and segregation. However, this was often discussed in the context of reconciling their own compliance with client requests for assistance accessing social services such as welfare or

disability insurance. In many instances, therapists saw themselves as both therapist and case manager and felt that their role as case manager was elicited more by Latino clients than White.

A majority of the participants were virtually unable to respond to the question about their clients' reactions to the fact that they were White, stating either that they didn't feel that it affected the therapeutic relationship or that they had not previously considered the issue. According to literature on white privilege, this is a direct reflection of one of the main privileges of being White, which is the freedom not to think about what it means to be White (McIntosh, 2001). The implications of this are that the therapist is not accepting the existence of white privilege and potentially not acknowledging the emphasis that this might add to his/her position of power in the therapeutic relationship. While participants readily acknowledged institutional power differentials, they seemed, with few exceptions not to see themselves as part of the institution or imagine that their clients might associate them with the institution. One person drew attention to the impact of colonization on her clients, but still did not see herself as being associated with the colonizer. Some participants professed to be colorblind, to see people as people rather than seeing them for their race or culture. Though this is an attempt on the part of the therapist to equalize the relationship, it might also be perceived as a negation of the person's identity, which according to authors such as Perez-Foster can be a traumatic experience for a client, especially one who has experienced discrimination or stressors connected to identity such as poverty (1998).

The rescue fantasy, said to be another consequence of white privilege (McIntosh, 2001) was not explicitly discussed by participants, but was in some ways implied. A

question was not asked about motivation to work with communities of color. However, a degree of pride in the decision to do so did emerge, either through feelings of identification with the client, the choice to respond to the question about biases with positive rather than negative biases, or the general sense that their clients were honored by and grateful for their therapists' willingness to work with them, as well as to learn their language.

According to the majority of participants, clients did not express a strong sense of ethnic affiliation, or have strong responses to the cultural and racial differences in the room. Their sense was that this was not a pivotal issue since the subject was not being raised by clients. However, clinicians were also not asking the question. It is the researcher's assumption that these issues are stronger for their clients than their White therapists have been able to glean.

In one particular study it was concluded that clinicians with higher levels of racism exhibited decreased awareness of cultural issues in counseling (Constantine, Juby and Liang, 2001). The virtual consensus of the clinicians in this study that clients are not affected by cultural and racial differences, evoked concern about the existence of high levels of racism among participants. As stated previously, the prevalence of higher levels of racism, lack of cultural awareness, and the failure to recognize biases, are all factors which have been predicted to lead to decreased therapeutic effectiveness. Though level of therapeutic effectiveness can not be gauged based on this data, the findings suggest a need for a follow-up study examining Latino/a clients perceptions of treatment with White therapists.

Assessment

Although the majority of participants felt that their treatment methods did not vacillate based on their client's cultural or racial background, this was not the case with regard to assessment. Despite the absence of references to specific evaluation tools such as ethno-cultural assessments, participants were more able to adjust the framework in which they understood their clients and incorporate factors such as cultural, racial, political, and immigration history into the assessment phase.

On the whole, however, participants stated that although they might be aware of their client's oppressed identity, they did not necessarily see this identity as central to treatment. If we are to recognize the crucial link between assessment and treatment, then there is a clear discrepancy here. This divergence conflicts with those who suggest that as assessment moves into treatment the therapist use insights about culture or race to collaboratively create a plan for treatment. For instance, within recent literature there is a great deal of mention of client-centered therapy (Weinrach and Thomas, 2001). This can manifest in several ways, such as the act of establishing goals cooperatively, or deferring to the client's description of the presenting problem. This holds some potential for leveling the playing field between a therapist from the dominant culture and a client of color. Deferring to the client's description of the presenting problem, rather than relying on what one perceives to be his/her professional interpretation of the problem or diagnosis might pose a challenge to the therapist. This is an area that requires refinement, openness, and clear communication between the dyad.

In terms of assessment, some awareness did emerge among clinicians regarding the concept that therapy has the potential to be culturally-bound. For instance, one social

worker recognized the hearing of voices as potentially cultural rather than as a justification for a diagnosis of schizophrenia. There was also mention of ways of understanding hitting within a cultural context as opposed to understanding it as abuse.

Yet, confusion may arise when determining what is culturally-bound. For instance, viewing a phenomenon such as *familismo* as pathology is not the same as recognizing one's own theory or methodology as culturally-bound (or in this case Eurocentric). Conversely, it places the burden of the pathology on the clients' culture and suggests the need for modification. In this example, Latino families might be seen by White therapists as being enmeshed or over attached. This begs the question of whether or not understanding and adjusting for cultural characteristics as a part of a person's presentation is enough. Might *familismo* be recognized and approached as a strength rather than as something to be changed? Assessment is fundamental to devising a treatment plan and therefore if biases are left unchecked and errors made in this stage, they might also be made in the therapy itself. Similarly, if a client is assessed as being incapable of insight-oriented therapy, as only seeking out assistance with social services, or as being less motivated toward upward mobility, as described by respondents, then how might this affect his/her treatment?

Treatment

There are two main paths to be pursued with regard to cross-cultural treatment. The first is typified by Falicov, who, while deeply contextualizing, states that there is no such thing as "Latino Therapy," but that one should utilize empathic listening skills and concentrate on building a strong therapeutic alliance regardless of the client's background

(Falicov, 1998). This view is not necessarily consistent with those who suggest that Latino/a clients can benefit from treatment variations such as increased emphasis on family therapy sessions, engaging in therapy with warmth and *personalismo*, taking levels of acculturation into account, or serving as an advocate or broker between the family and other agencies (Bean, Perry, and Bedell, 2001). On the whole, participants agreed that their treatment approach did not waiver based on their client's cultural or racial background—that it was in some form universal. Though there are arguments for both approaches, the question of the effectiveness of these treatment practices naturally emerges.

Though concessions were made around assessment, there was not one participant who acknowledged his/her treatment methodology as being culturally-bound. Rather, many said that their way of working made room for a conversation about culture if it should need to come up, and many relied on listening and empathy as the tool to accommodate this need. Is empathy and listening enough or should the therapist take on a more active role in bringing a discussion of culture and race into therapy? Additionally, the therapist might simply fortify his/her notion of what it means to be culturally-bound and let this deepened understanding work its way into treatment.

A specific question was not posed regarding separation-individuation, cited in the literature as an issue which illustrates the manifestation of culturally-bound theories (Choi, 2002). However, it was raised by a number of participants as a phenomenon which they found to be more salient among their Latino clients, not only in terms of children separating from their parents, but also in terms of parents separating from their children. There was no recognition of the cultural implications of these statements on the part of

the therapists, and this was not suggested by the researcher during the interviews. Participants were instead asked if they found themselves adjusting their theoretical orientation or approach in their work with Latino/a clients to which the answer was usually no. Treatment stayed the same.

Until the question is asked it is difficult to know, how it feels to a Latino/a client to receive encouragement or pressure from their therapist to separate from his/her family of origin. The therapists interviewed in this study did not offer examples of clients who challenged this kind of thinking. One might wonder if this is an example of deference to the therapist, of real resonance on the part of the client, or perhaps a combination of the two.

While the majority of participants self-identified as culturally sensitive, few provided responses regarding their notions of cultural sensitivity which were consistent with cultural competency guidelines promoted in the literature. In terms of treatment modality, most participants did not purport to take on the charge of recognizing race and political power in the therapeutic relationship, or of working to understand cultural, racial and ethnic identity development. There were several references to studying these issues in graduate school, but they were accompanied by the sense that the importance of these issues had faded away since entering into practice. Is it possible also that it is easier not to see it or think about it than to choose the complex and challenging route of addressing it?

Interestingly, the one area in which sentiment was strong in supporting treatment modification was with regard to language. Perhaps this is because it is safer to attribute breakdowns in communication to differences in language. Participants were easily able to recognize the importance of the Spanish language, issues around translation, the

importance of working with a therapist who could understand their jokes and idioms, and how these issues affect communication with their clients. Nonetheless, it was much rarer for therapists to mention other forms of treatment modification or other culturally important adjustments.

In addition, none of the participants discussed knowledge of formal or specific guidelines such as the MCCs (multicultural counseling competencies) developed by the Association of Multicultural Counseling and Development, or MECA (Multicultural Ecosystemic Comparative Approach) devised by Falicov (1998). Clinicians seemed to rely more on instincts and experience to guide their treatment methodology rather than keeping abreast of related literature.

Lastly, though it is often recommended in the literature, participants did not speak to the importance of being aware of one's own cultural identity as a component of practicing cultural competence. Nor was there mention of the use and examination of cultural countertransference or the therapist's subjective response to working with a client from another culture. Though many did cite their own cultural or racial identity, experiences, and history as their primary source of education around cross-cultural work, they did not do so with an acknowledgement or consciousness of the fact that they were White and consider the implications of their whiteness. Occasionally there was an attempt to draw from their own cultural experiences as a way of relating to their clients. However, they often failed to acknowledge and explore cultural and racial differences in the process, defeating the purpose of the original intent of this way of practicing.

Study Limitations

As with any piece of research, the limitations need to be acknowledged.

Limitations of this study play out in various forms, such as the manner in which the information relates to the greater body of literature on the subject, methodology confines, confusion caused by terminology use, and the inherent subjectivity of the social sciences.

Although there are scores of articles and books written about cross-cultural and racial therapy methodologies, there has been little empirical research conducted exposing the actual experiences of White clinicians practicing cross-culturally and racially.

Unfortunately, due to the small sample size, the results of this study can not be generalized to the broad-spectrum population and therefore do not sufficiently fill this gap. Also limiting was the need to narrow the focus of the study to culture and race at the expense and exclusion of other important factors such as class or gender. In addition, reliability and validity were affected by the inclusion and at times conflation of multiple Latino populations rather than looking at relationships between groups from differing countries of origin. Reliability and validity would also have increased had there been an opportunity to focus on particular characteristics of the sample such as geography, educational background, age, and era in which participants received their professional training.

Furthermore, limitations arose as a result of self reporting. For instance, participants were asked if and how they believed their clients to be affected by the therapist's race and culture as well as approach to practice. Based on clinicians' reports it is impossible to accurately assess client responses. This would be a more comprehensive and usable study to include in the research the other half of these dyads. Future research

will need to also examine the experiences of Latino/a clients and their perceptions and responses to issues of racial and cultural difference as they consult with White therapists for mental health treatment.

Additional limitations are brought forth by issues born from the inevitable subjectivity of qualitative research. First, both the researcher and thesis advisor are White. In addition, the researcher is currently engaged as a practitioner in the field working with Latino/a clients and while exploring multiple cross-cultural and racial therapy methodologies, possesses predispositions to certain approaches. Although all attempts were made to maintain an awareness of biases and blind spots, affects on the way in which data was gathered, interpreted, scrutinized, and presented were unavoidable.

Second, qualitative methods rely on the judgment of the researcher and trust this person to extract, emphasize, and present the true essence of each participant's response, to hear their responses in context and as they were intended to be heard, and to bring all of this information together in a way that does justice to the material. It is the position of this researcher that she had no agenda when going into the research, other than to reveal the real practices of real clinicians in order to understand how to build on and improve curriculum and research to better serve clients of color. However, as issues come to light, more specific aspirations begin to form, as well as ideas about how to bring them to bear. It is possible that the reader will begin to observe these as s(he) reads deeper into the thesis.

For numerous reasons on many levels it is an exercise in subjectivity to assess participants' levels of racism and compliance or lack thereof with cross-cultural and

racial competency standards. To begin with, these standards are not uniform, but varied, and no specific scale is being used here. Furthermore, these interviews reveal only in part how the participating clinicians address and perceive cultural and racial differences with their clients.

Conclusions within the thesis rely on a retrospective interpretation of words that were spoken in a specific context without an opportunity to follow up and clarify questionable statements. Nonetheless, I proceeded with such an assessment, because subjectivity is inevitable, and because of the ways in which I was struck with the information presented by participants. A telling example is how freely many were able to delve into their biases and often without exhibiting a recognition of them as biases. It also appeared that some had reached a point at which they no longer felt it necessary to continue seeking cultural awareness, knowledge, and skill. They presented a sense that they had “arrived,” that they no longer needed to maintain a consciousness of their assumptions and presumptions or understand and explore the meaning behind issues such as race, culture, socioeconomic status and acculturation. Given these impressions, it comes as no surprise that the Latino client community expresses dissatisfaction with the services they are receiving currently.

It should be mentioned as well that there were some discrepancies that arose as a result of the difficulty in clearly defining terms for participants. For the most part clinicians were not particularly cognizant of language use and application, often blurring definitions of terms such as culture, race, and ethnicity. The lack of universal definitions of terms is an issue that is touched upon in the literature. When asked questions related to culture without first being provided with a working definition of the term, many were

inclined to articulate their own definition and from that point on responded to each question according to this definition. A significant number of respondents independently raised the issue of the tension and confusion around speaking to “cultural” issues when they felt that class factors were also at play, stating for instance that their poor White clients shared many of the experiences of their Latino clients and identifying class as the link between these two groups and their intermittent collective experience. One psychologist specifically stated that he felt that class was more prominent than culture when asked about differences between Latino and White clients.

Implications for Clinical Social Work Research and Practice

This study’s findings hold numerous implications for the field of clinical social work. Participants offered descriptions of their work which were both concurrent and incongruous with suggestions for practice of cross-cultural and racial therapy presented in the literature. The majority of responses, however, were consistently reflective of aspects of the literature calling for continued research and training around cultural competence. For instance, the oversight of the importance of racial and cultural identity and the ways in which this can offset the balance of power both within the therapeutic relationship as well as within society, was prevalent throughout the findings.

The findings especially elicited a need for cultural sensitivity trainings and workshops geared toward exploring issues surrounding one’s own cultural identity (including race and class). This need seems to be even less recognized and emphasized in therapeutic disciplines outside of that of social work such as psychology and counseling. Questions were raised about practice such as whether or not to and how to raise cultural

and racial differences with clients in therapy, whether or not clinicians should adjust their approach to therapy to accommodate clients of differing cultures and races, and whether or not effectiveness of treatment varies as concessions are made or not made for these differences. These questions need to continually be explored through both theoretical and empirical research and ultimately fed back into practice.

Specifically, this researcher recommends that further investigations be conducted addressing the cultural aspects of the various treatment modalities, with a focus on the feedback of clients. In addition, the field could benefit from more in-depth analysis and comparisons of clinicians with varying degrees of cultural sensitivity.

In addition, for those working with particular immigrant groups there is a need for increased knowledge about culture, history, immigration and acculturation stages (Perez-Foster, 1998). Apart from education and training around immigration, special studies of stress factors and language obstacles are recommended in order to address the unique circumstances of recent immigrants.

If the responses of the participants in this study echo the opinions, perspectives, thoughts, and practices of other White clinicians who are working with Latino/a clients and struggling with these questions on a daily basis, then this study and its analysis presents an opportunity to strengthen the field. The recognition and dialoguing of these issues is important as practitioners consider how to avoid treatment impasses and early termination in an environment in which Latinos and other clients of varying cultures and races are dependent on a profession dominated by White clinicians to receive mental health care (Cervantes, 2005).

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APPENDIX A

Human Subject Review Application Smith School for Social Work

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Master's Thesis Project Title: How White Non-Latino/a Therapists Perceive and Address Racial and Cultural Differences When Working with Latino/a Clients

Project Purpose and Design

The main purpose of this research is to understand how White non-Latino/a clinicians experience and conduct cross-cultural therapy with Latino/a clients, as well as to identify important themes around cross-cultural therapy with Latino/a clients and to offer areas for further research. A qualitative, exploratory, cross-sectional research design will be utilized to investigate the questions put forth in this paper. The data for this study is being collected for use in my Master's thesis, which will be submitted in partial fulfillment of the requirements for the Master of Social Work degree at Smith College. In addition, this research study may be used for presentation and publication.

I intend to collect qualitative data through partially structured interviews with White non-Latino/a therapists, who have been working with Latino/a clients for at least one year.

The questions posed to these clinicians attempt to elucidate the ways in which White non-Latino/a clinicians perceive and address issues of cultural and racial difference when working with Latino clients.

With a sample population of approximately 12-15 respondents, this narrative data will not be generalizable to other similarly situated clinicians and therefore, threats to the external validity will not be measured. As a means of ensuring reliability, I will first carry out pilot interviews to test the research questions.

The Characteristics of the Participants

Inclusion/exclusion selection criteria for the participants are as follows. I will recruit twelve to fifteen White non-Latino/a therapists with a master's or higher level degree in clinical social work or psychology and who have a minimum of one year experience working with Latino/a clients. Restrictions as to location of practice and gender will not be considered.

The Recruitment Process

I will be recruiting participants from the agency where I am working as an intern as well as from neighboring local clinics. Within my own agency, after procuring a letter of permission from the director of the clinic, I will directly approach clinicians who I believe meet the criteria for this project. In an initial conversation I will briefly describe the project, make sure that they fit the criteria for participation and ask them if they would be interested in participating. I will also ask colleagues if they are aware of anyone outside of the agency who might fit the criteria and be interested in participating. To these candidates, I will send the attached recruitment letter. When recruiting from other clinics, I will discuss the project first with the director of the clinic to gain access and obtain a letter of permission to recruit there. I will then display a poster in the clinic with

my name and contact information for potential participants to contact me. If necessary I will request time to conduct a recruitment presentation at a staff meeting (talking points attached). This will be a sample of convenience and will rely on snowball sampling.

The Nature of Participation

After making contact with potential participants I will discuss the project with them verbally (either by phone or in person) and hand deliver or mail a consent form so that they are fully aware of what it means to participate in the study as well as the risks and benefits that it might entail. I will arrange a meeting time according to the participant's availability and at a location that is convenient for them.

The interview will consist of demographic as well as guided open-ended semi-structured questions establishing some wording and sequence prior to the interview (questions attached). I have chosen this format for purposes of increased validity while still allowing flexibility for building upon questions and open-ended discussion. Each interview will last approximately 40-60 minutes and will be audio taped and transcribed by me. I will request that participants disguise any identifying information about clients in order to protect their confidentiality.

Risks of Participation

Some of the risks of participation include disclosure of sensitive information and thoughts about personal experiences working cross-culturally. It may be difficult for clinicians to discuss biases and thoughts about cultural and racial identity. In addition,

participants may experience some discomfort when asked to evaluate aspects of their work. Although all information disclosed by participants will be kept confidential, it might be difficult to conceal the fact that they are participating in the study since I will be interviewing multiple clinicians from the same agency. If they should feel uncomfortable at any point during the interview, participants may bring this to my attention immediately and, if they choose, refuse to answer a particular question or withdraw from the interview altogether.

Along with this consent form I will provide a list of resources, regardless of whether or not they are requested, which participants may choose to use at any point during their participation in the research. Resources will include reading materials around cross-cultural therapy and therapy with the Latino community. If available it will also include a listing of geographically convenient trainings, conferences, lectures, etc. around these topics.

Benefits of Participation

There are several possible benefits to clinicians who choose to partake in this project. The first is that it can offer participants an opportunity to contribute to research intended to illuminate areas for growth around cross-cultural therapy. In a similar vein, it may provide them with a chance to supply important information that might later be used by professionals working specifically with Latino/a clients. Lastly, it will grant therapists an occasion to confidentially share, mourn, and celebrate experiences of working cross-culturally as well as beliefs and intentions around the work that they do.

Informed Consent Procedures

Participants will be asked to sign a written informed consent form in person before the interview takes place. At that time I will explain the consent form and the participant will have the opportunity to ask clarifying questions. I will inform all participants of the right to withdraw from this study before during or after the interview. I will also inform them that they may choose not to answer any questions at their discretion. I will notify all participants of the final day for withdrawal as April 1, 2006 when the report will be written.

Precautions Taken to Safeguard Confidentiality and Identifiable Information

Privacy will be protected by assigning a numeric code to each participant's tape and by removing identifying information from the transcripts. When discussing case material I will ask participants to refrain from using the names of clients or other identifying data in order to protect the confidentiality of clients. The interview will be tape recorded, transcribed and analyzed and all materials (such as tapes and written transcriptions) will be destroyed within three years after the interview is transcribed and coded. The coding system will serve to keep data anonymous and the data will be stored in a safe location (locked box) and seen only by myself and my research advisor.

Lisa Amato _____ Date: _____

Advisor's Signature _____ Date: _____

APPENDIX B

Dear Participant,

My name is Lisa Amato. I am a student at Smith College School for Social Work and am conducting a study to explore how White non-Latino/a clinicians perceive and address issues of racial and cultural difference when working with Latino/a clients. The data for this study is being collected for use in my Master's thesis, which will be submitted in partial fulfillment of the requirements for the Master of Social Work degree at Smith College. In addition, this research study may be used for presentation and publication.

I have asked you to participate in this study because you have self-identified as a White non-Latino/a clinical therapist with at least one year's experience working with Latino populations. Participation in this study will require a 40-60 minute in-person interview. I will ask questions about your experience with, approach to, and thoughts about working with Latino/a clients. You will also be asked to complete a background questionnaire (including some demographic data). Ultimately, this study is being undertaken to understand how White non-Latino/a clinicians conduct cross-cultural therapy with Latino/a clients. If a question should be asked that you do not feel comfortable answering for any reason, you may decline to answer that question.

Participation in this study is voluntary and without monetary compensation. Some of the risks of participation include disclosing sensitive information and thoughts about your personal experiences working cross-culturally. It may be difficult for you to discuss your

own biases and thoughts about cultural and racial identity development. In addition, since I will be interviewing multiple clinicians in the same agency, it might be difficult to conceal the fact that you are participating in the study. If you should feel uncomfortable at any point during the interview, you may bring this to my attention immediately. Along with this consent form I will provide a list of resources, which you may choose to use at any point during your participation in the research.

There are several possible benefits to those who choose to partake in this project. The first is that it can offer you an opportunity to contribute to research intended to illuminate areas for growth around cross-cultural therapy. In a similar vein, it may provide you with a chance to supply important information that might later be used by professionals working specifically with Latino/a clients. Lastly, it will grant you an occasion to confidentially share stories, discuss challenges, and celebrate experiences of working cross-culturally as well as beliefs and intentions around the work that you do.

I will be tape recording, transcribing and analyzing the interview. As required by federal guidelines, all of these materials (tapes and written transcriptions) will be destroyed within three years after the interview is transcribed and coded. The coding system will serve to keep your data anonymous and the data will be stored in a safe location and seen only by myself and my research advisor. I will be pleased to answer any questions related to the methods of this study.

The main purpose of this study is to identify important themes around cross-cultural therapy with Latino/a clients and to offer areas for further research. You may choose to withdraw your involvement in this study at any point prior to April 1, 2007. Please sign and date this copy of the consent form. I will also provide you with a copy for your records.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Signature of participant

Date

If you have any questions or wish to withdraw your consent, please contact:

Lisa Amato
6 Pomeroy Terrace
Northampton, MA 01060
lamato@smith.edu

APPENDIX C

Demographic Questions

1. How old are you?
2. How long have you worked in the field?
3. How long have you worked with the Latino/a population?
4. What countries are the Latinos that you work with from?
5. Do you have any experience with Latino communities outside of Mental Health work? If so, please describe briefly.
6. What degree did you receive?
7. How do you identify yourself in terms of race and ethnicity?
8. What is the racial/ethnic/cultural composition of your client caseload?
9. Do you speak Spanish? If so with what level of fluency? If so, how often do you use Spanish with your Latino/a clients?
10. Did you receive diversity or cultural competence training in your graduate program? Workshops? From your agency?
11. Do you continue to seek out such trainings?

Guiding Interview Questions

1. Would you describe yourself as “culturally sensitive?” If so, can you describe what it means to you to be culturally sensitive? Has your definition of cultural sensitivity been influenced by the work you've done?
2. What are some of the differences that you have experienced between working with Latino/a clients and White non-Latino/a clients?
3. How do you address cultural and racial differences in your relationships with Latino/a clients? For example: Are you aware of differences in treatment/using different treatment modalities? Do cultural and/or racial differences play a role in how you understand the presenting problem? Do you do more or less family work with your clients?
4. What do you imagine your clients feel about the fact that you are White and non-Latino/a? Can you think of an example of a time when your being White and non-Latino/a has affected the therapeutic relationship?
5. Can you think of an example of a time when cultural or racial differences were discussed explicitly in therapy?
6. Can you think of a time when a Latino/a clients' values were in direct conflict with your own in a way that affected the therapeutic relationship (i.e. position on abortion)? If so, was this an isolated instance or does this happen frequently?
7. What are some of the biases that you think you might have about Latinos. If so, how do these biases affect your work with Latino clients (i.e. Latinos are less educated or enmeshed)? Do you do anything to limit the effect that these biases have on your work with your clients?

8. Do you feel issues of cultural competence/multicultural assessment were addressed adequately in your clinical training? How or how not? If you feel your learning emerged more from life experience than from formal trainings or higher education, please describe how you gained the knowledge or how were you prepared to work cross-culturally with clients? Do you feel there are sufficient opportunities to receive training on these issues?
9. Has your approach to your work with Latinos changed throughout the course of your career and if so, how? What are your hopes for your own growth as you continue to work cross-culturally?

APPENDIX D

Dear Colleague,

I am conducting an independent investigation into how White non-Latino/a therapists perceive and address issues of cultural and racial difference when working with Latino/a clients. This study is being submitted in partial fulfillment of the requirements for the degree of Master of Social Work at Smith College School of Social Work.

I am seeking participants who are White non-Latino/a therapists with a master's or higher level degree in clinical social work or psychology and who have a minimum of one year experience working with Latino/a clients. I request your willingness to reflect on your experiences working with Latino/a clients.

There will be no financial benefits for participating in this study. However, the potential benefits of your participation are as follows. 1) The opportunity to contribute to research intended to illuminate areas for growth around cross-cultural therapy. 2) The prospect of providing important information that might later be used by professionals working with Latino/a clients. 3) An occasion to confidentially share experiences of working cross-culturally as well as beliefs and intentions around the work that you do.

If you choose to participate, I will ask that you sign a consent form at the start of our interview indicating that you have read and understand all of the necessary information,

including risks and benefits to your participation. I will follow up with you within the week to see if you are interested, and if so will arrange a 40-60 minute, face-to-face interview at the location and time of your convenience.

Thank you for your consideration,

Lisa Amato
Smith College School for Social Work

APPENDIX E

October 25, 2006

Lisa Amato
6 Pomeroy Terrace
Northampton, MA 01060

Dear Lisa,

The Human Subjects Review Committee has reviewed your amended materials. You have done a fine job and we are glad to now approve the project. You did forget to add to the Application Purpose the sentence about publishing and presenting, which you did add in the Consent. We will not hold up approval for that addition, but please send a copy of your Application with that addition to Laurie Wyman for your permanent file.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain signed consent documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

We wish you success with this very interesting study. It promises to provide some very useful information.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

Cc: Nel Wijnhoven, Research Advisor