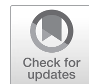

Behavioral Health Service Delivery with Latinos

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Ana J. Bridges and Aubrey R. Dueweke

Introduction

It is a near certainty that clinicians will, at some point, work closely with Latinx clients, likely some who were born outside of the USA and many who will be fluent in Spanish with limited English proficiency. In this chapter, we provide an overview to help introduce clinicians to the Latinx population in the USA and how historical, cultural, and adjustment experiences may be important to consider when providing treatment. After describing the rich, diverse cultures that comprise the Latinx population, we provide suggestions for delivering behavioral health services in an engaging and culturally informed manner. These suggestions are presented by phases of treatment, from intake to termination. Together, they provide a baseline from which clinicians can branch out to learn how to work effectively with their Latinx clients.

Latinos in the USA

Since 2003, Latinos have comprised the largest minority group in the USA, surpassing African Americans. Currently, approximately 18% of the US population is Latinx, and the percentage is expected to near 25% by 2065 (Pew Research Center, 2017). Approximately two-thirds of Latinos living in the USA are Mexican origin, 10% are Puerto Rican, 4% are Salvadoran, 4% Cuban, 3% Dominican, 2% Guatemalan, with the remaining groups each comprising <2% of the Hispanic population in the USA (Pew Research Center, 2013; US Census Bureau, 2016). Approximately one-third are born outside of the USA. Among US-born Latinos, 69% speak English fluently, while among foreign-born Latinos, less than 35% are fluent in English.

Although Latinos share a common geography (spanning from North to Central and South America, including the Caribbean) and language (primarily Spanish, but also some speak Portuguese or native languages, such as Quechua), there are important differences among the major subgroups of Latinos in the USA, and important generational differences (see Table 12.1). Different decades have seen different waves of migration to the USA from Latinx countries. The history of Latinos in the USA is part of the history of the USA. Spaniards were the first to land in the Americas from Europe (Schwab, 2018), and parts of what is now the USA were originally settled by the Spanish. For instance, current day New Mexico, Texas, and California were originally Spanish territories. In fact, Texas was part of Mexico until 1845, when the USA officially annexed Texas. The Homestead Act of 1862 allowed US residents to settle and

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Table 12.1 Demographic differences by Hispanic subgroups in the USA (Pew Research Center, 2013)

Country of origin	% US-born	% English fluent	Median age	% Married	% College educated (age 25+)	Median annual personal income (age 16+)	% In poverty	% No health insurance	% Home owners
Argentina	38	74	35	56	40	$30,000	11	22	53
Colombia	36	60	34	47	31	$24,000	13	27	49
Cuba	42	60	40	45	25	$24,400	19	25	56
Dominican Republic	44	56	28	35	16	$20,000	28	21	25
Ecuador	38	53	32	46	19	$22,000	18	32	40
El Salvador	40	48	29	42	7	$20,000	23	39	41
Guatemala	36	43	27	40	7	$17,000	29	46	30
Honduras	36	47	28	36	8	$17,500	33	46	29
Mexico	65	66	25	45	10	$20,000	28	33	49
Nicaragua	40	62	32	44	20	$22,000	18	31	44
Peru	32	60	35	47	31	$24,000	13	28	50
Puerto Rico	99	82	28	35	16	$25,000	28	15	37
Venezuela	31	68	32	49	51	$25,000	15	26	48
All Hispanics	64	66	27	43	13	$20,000	26	30	46
General US population	87	–	37	48	29	$29,000	16	15	65

claim lands in the West, lands that had until then belonged to Mexicans. In 1917, Puerto Ricans were officially granted US citizenship. Just a few years later, the US Congress began to limit the number of immigrants allowed to enter the USA (until that time, there was no "legal" or "illegal" entry system) and subsequently created a border patrol. In 1932, the USA began deporting Mexican immigrants for the first time. It was not until 1954 that the US Supreme Court formally recognized the discrimination and inequality Latinos in the USA experience (in Hernandez v. The State of Texas), followed later by the Civil Rights Act of 1964 that prohibited discrimination on the basis of gender, race, or ethnicity. In the mid-1970s, the Equal Educational Opportunity Act paved the way for public schools in the USA to offer bilingual programming to students. In short, while Latinos have been part of the US geographical landscape since the country's origins 200+ years ago, it has only been in the past 50 or so years that efforts to address disparities and inequalities have been formalized by the legislative and judicial branches of the government.

Immigration to the USA from Latin American countries has accelerated in the past few decades. Economic and political factors in Latinx countries were largely responsible for many waves of migration to the USA in the mid- to late twentieth century (Tienda & Sanchez, 2013). Fidel Castro rose to power in Cuba (late 1950s), aligning Cuba with communism and the Soviet Union, leading to massive exile of upper- and middle-class, highly educated Cubans to Miami. In the 1950s and 1960s, many Latinos from diverse countries such as Argentina, Mexico, and Colombia came to the USA because of limited economic opportunities in their countries of origin. In the 1970s, military dictatorships in Argentina and Chile and civil war in El Salvador lead many people to immigrate to the USA, fleeing violence and repression. More recently, concerns about lack of economic opportunities, gang violence, natural disasters, drug cartels, and continued political unrest have resulted in additional immigrants from Mexico, El Salvador, Honduras, Guatemala, and Colombia (Holmes, 2018).

Stressors and Mental Health

Compared to non-Latinx Whites, Latinos residing in the USA tend to experience similar or better overall mental health. For example, a national epidemiological study found comparable rates of lifetime anxiety disorders, depressive disorders, impulse control disorders, and substance use disorders in Hispanic and non-Hispanic White adults overall (Breslau et al., 2006). However, when examining group differences for specific disorders, the only significant differences found favored Hispanics. For example, Hispanics had rates of generalized anxiety that were nearly half that of non-Hispanic Whites (4.8% vs. 8.6%). Similarly, lower rates of social phobia (8.8% vs. 12.6%), dysthymia (2.2% vs. 4.3%), and major depression (13.5% vs. 17.9%) were observed. However, this global picture masks important subgroup differences within the Latinx population. For instance, compared to Puerto Ricans, Mexican-origin Latinos experience lower rates of lifetime depressive disorders, while Cubans experience lower rates of substance use disorders (Alegría et al., 2007). Furthermore, compared to US-born Latinos of any country of origin or Latinos who speak English well, immigrants and Latinos with low English fluency experience lower rates of lifetime substance use and psychiatric disorders. This is consistent with prior work suggesting a possible negative impact of acculturation on the mental health of Latinos (Ortega, Rosenheck, Alegría, & Desai, 2000).

Latinos in the USA may face unique stressors that can impact their well-being. These primarily include discrimination, acculturative stress (difficulties adjusting as an immigrant because of financial or language barriers, loss of social networks and status, family conflict, etc.; Caplan, 2007), and vulnerability due to immigration policies and laws (Schwab, 2013, 2018). A recent national poll found approximately one-third of Latinos living in the USA experience discrimination, oftentimes in the context of work (e.g., applying for jobs, equal pay, and opportunities for promotion) (National Public Radio (NPR), Robert Wood Johnson Foundation, & Harvard T. H. Chan School of Public Health, 2017). A similar proportion encountered discrimination when attempting to rent or purchase a home. Over 25% reported experiencing discrimination in the context of law enforcement. Central to the topic of this chapter, 20% of Latinos polled reported experiencing discrimination in the health care setting and a nearly identical number reported they would rather avoid seeking care than to face such poor treatment.

The types of discrimination the majority of Latinx people reported experiencing were verbal insults or offensive/insensitive comments; however, a large portion had also been threatened, experienced violence, or been sexually harassed (NPR et al., 2017). Experiences of discrimination may differ, however, in different subgroups of Latinos, in part because of associated sociodemographic differences such as acculturation, age, and socioeconomic status (Anderson & Finch, 2017; Arellano-Morales et al., 2015). In addition, Latinos residing in cities with large Hispanic populations (e.g., Miami, San Diego) tend to report lower discrimination than those living in cities where Hispanics comprise a smaller proportion of the population (e.g., Chicago; Arellano-Morales et al., 2015). The NPR poll (NPR et al., 2017) found an association between education, birth region, and discrimination in ways that are perhaps surprising: well-educated Latinos and those born in the USA actually reported *greater* instances of experiencing discrimination, perhaps because they interact more with other groups or because they are more aware of subtler forms of discrimination (called microaggressions; Anderson & Finch, 2017).

Ethnic Identity

Ethnic identity can be loosely defined as the sense of belonging or commitment to an ethnic group (Smith & Silva, 2011). It is thought to develop in a dynamic manner throughout the lifespan, particularly in adolescence and early adulthood (e.g., French, Seidman, Allen, & Aber,

2006; Phinney, 1993) and includes cognitive, behavioral, and emotional components. Processes such as acculturation and enculturation are key to the development of one's ethnic identity.

While the broader US culture may group together everyone from Latin America or Spanish-speaking countries into what is called a "panethnic" group (e.g., *Hispanic* or *Latinx*), a significant minority of Latinos do not identify with such broad panethnic labels and instead identify with their country of origin (e.g., *Salvadoren, Argentinian*) (Pew Research Center, 2012). Most Latinos say they do not share a common culture with people of other countries of origin, even if there is a shared language (Pew Research Center, 2012).

Complicating even further the issue of ethnic identity is the notion of intersecting identities. Increased attention has focused on the myriad ways people are diverse—despite sharing some characteristics (e.g., being of the same country of origin), people differ in gender, sexual orientation, generation status, physical ability, gender expression, socioeconomic status, educational attainment, and so on. The term "intersectionality" refers to the many social systems of privilege and oppression a single person can encompass, and how this configuration is woven into the way a person experiences the world (Crenshaw, 1989). For instance, while being White and male are each, individually, characteristics associated with social privilege, a gay White man or a Black heterosexual man may experience the world through the lens of both his privilege and his marginalized statuses. Similarly, a Mexican woman with a doctoral degree may experience the world complexly through her marginalized *and* privileged statuses in ways that will differ from those experienced by a Mexican male from a working class background. In short, ethnicity is but one component, and perhaps not even an important component, of any given person's identity. Other aspects of identity (skin color, gender, education, sexual orientation, geographic origin) may proffer privilege or serve as a source of marginalization in ways that shape an individual's identity.

General Approach to Treatment

Altogether, the diversity of the Latinx population in the USA, the recognition of ethnic identity as a developmental, dynamic process, the limitations of panethnic labels, and the recognition of the intersecting components of social characteristics we all have (some of which are valued and some of which are devalued by the contexts in which we find ourselves) make sweeping generalized statements about the treatment of any group of people limited in their utility. Therefore, we caution the reader to note that what follows is a set of recommendations we make based on scholars who have devoted their careers to understanding the mental health needs of Latinos in the USA, but typically those recommendations arise from largely Mexican, largely recent immigrant, and largely working class groups. It is imperative for clinicians to assess each client, to consider the ways the client identifies—including the strength of a Latinx identity but also other identities—and then weave those components that are most central to the self into the approach the clinician takes in therapy. Stated differently, and at the risk of stating the obvious, just because a particular client identifies as Latinx (or Hispanic, or Venezuelan, or Puerto Rican) does not mean all or even any of the recommendations that follow will be important for therapy.

Prior to Intake

Many scholars who have written about cultural competence agree on the importance of self-awareness when working with a diverse client base (Rust et al., 2006; Sue, Zane, Nagayama Hall, & Berger, 2009; Trimble, Scharrón-del-Río, & Hill, 2012). The first step towards building self-awareness involves actively exploring one's own biases, beliefs, cultural norms, values, and worldview. Some questions therapists may want to ask themselves during this process include, "How central is my ethnic and/or cultural identity to my sense of self?" "What are my values?" "What are my personal 'hot button issues' that could lead me to misjudge or miscommunicate

with others?" and "How does my cultural background, including my educational experience, influence my way of thinking about mental health and treatment?" For instance, a young therapist born and raised in the USA may value strongly egalitarian gender roles and may struggle if working with a Latina client who subordinates her personal needs to those of her husband and children.

After answering questions like these and identifying personal biases and beliefs, one must continually examine how these may be influencing perceptions of and interactions with Latinx clients. Building self-awareness and cultural competence are ongoing processes, not an achievable end state (Caldwell et al., 2008). Providers who wish to keep themselves accountable to the lifelong nature of these processes can work with clinical supervisors and colleagues to bring discussions about personal biases and beliefs to the forefront, with the goal of non-defensively considering and challenging them throughout one's career.

Providers should also be mindful of the hubris that often permeates academic and clinical training, and work to counteract it. Humility is essential when working with clients who differ from one's own cultural background or experience. Indeed, therapists who have not had much experience working with Latinx clients must be willing to acknowledge the gaps in their knowledge and commit to learning from each individual they serve. It will also be important to refrain from making sweeping generalizations based on ethnic group membership. Instead, clinicians should treat each client as the expert on his or her own experience and, when unsure of whether a particular thought or behavior reflects that client's culture, ask.

In addition to taking time to reflect on personal beliefs about culture and values and a commitment to being open, humble, and eager to learn from one's clients, therapists should consider how the structure of their practices may convey a sense of comfort and approachability for Latinx clients (see, for instance, Siegel, Haugland, & Chambers, 2003). Does the practice have a mission statement that includes aspects of culture? Is the website available in multiple languages? Is there a policy or strategy to include language interpretation services? Are forms (consent forms, intake paperwork) available in Spanish or other Latinx languages? Do members of the practice (staff, therapists, others) reflect diversity? Has the therapist established connections with other local providers and organizations who serve Latinos? Are practice hours, locations, and physical spaces (artwork, building access, and so forth) welcoming to diverse clients?

At Intake

Intake interviews are typically the first points of face-to-face contact clinicians have with their clients, and thus provide a vital opportunity to set the tone for the remainder of the working relationship. Too often, clinicians will adopt a "color-blind" stance, taking each client as an individual stripped of their unique social identities or assuming the experiences of clients across ethnic groups are similar. Both approaches minimize the unique experiences of ethnic minority clients (Neville, Spanierman, & Doan, 2006). This should be avoided. At best, a color-blind stance leads clinicians to miss potentially vital pieces of information to case conceptualization, and at worst it can make minority clients feel silenced, minimized, and oppressed (Sue, 2004). Instead, providers should strive to take a multicultural approach to assessment and intervention, wherein cultural differences are actively examined and incorporated into treatment. Below, we review a few steps therapists can take at the outset of treatment to foster a multicultural approach when working with Latinx clients.

Be Mindful of the Power Differential Regardless of client or therapist cultural background, there is an inherent power differential in every therapeutic relationship. These relationships are largely one-sided, as clients are expected to divulge their thoughts, emotions, reactions, and behaviors openly to a relative stranger, with much less self-disclosure on the part of the therapist. In cases where the therapist is a member of the

majority ethnic group (i.e., White) and the client is a member of a minority ethnic group (e.g., Latinx), this power differential is likely to feel even more substantial. The client may feel pressured to follow the therapist's lead when it comes to discussions of race and privilege, which could be quite damaging if the therapist insists on minimizing and ignoring the role of culture in the room and in the client's life. Therapists who acknowledge the power differential and actively attempt to understand their clients' worldviews will be able to build a stronger working relationship with their minority clients (Ibrahim, Roysircar-Sodowsky, & Ohnishi, 2001). With this in mind, therapists working with Latinx clients should be ready and willing to take the lead on initiating conversations about the role of culture and ethnicity both in the therapeutic relationship and as they relate to the client's presenting concerns (Muñoz & Mendelson, 2005). In addition to fostering a strong working alliance, assessing for and affirming cultural differences will also allow therapists greater opportunity to tailor and optimize their care plan for their clients.

Inquire About Stressors That May Be Unique to Latinx Clients The presenting problems of Latinx clients are often embedded in a different historical, political, social, cultural, and economic reality than those of non-Latinx White clients. To make space for these differences, therapists should consider modifying their standard intake interview to inquire about the specific sociopolitical factors that may be contributing to or maintaining their Latinx clients' current difficulties. As mentioned earlier, Latinos may be experiencing unique stressors related to discrimination (Pérez, Fortuna, & Alegría, 2008), acculturation (Da Silva, Dillon, Rose Verdejo, Sanchez, & De La Rosa, 2017; White, Roosa, Weaver, & Nair, 2009), stereotype threat (Appel, Weber, & Kronberger, 2015; Gonzales, Blanton, & Williams, 2002), legal status (Cavazos-Rehg, Zayas, & Spitznagel, 2007), and refugee status or family separation (Perreira, Chapman, & Stein, 2006; Suárez-Orozco, Todorova, & Louie, 2002).

By asking directly about these sociopolitical stressors, the therapist models an open and honest stance, and conveys that she is willing to wrestle with potentially uncomfortable topics like privilege, oppression, discrimination, and racism as they relate to mental health. Starting a dialogue about these stressors early on in therapy can serve to establish trust with Latinx clients, making them feel seen and respected (Muñoz & Mendelson, 2005). It also signals to Latinx clients that the clinic represents a safe space. Undocumented Latinos often report fear of deportation as a deterrent from seeking mental health care (Bridges, Andrews, & Deen, 2012; Rastogi, Massey-Hastings, & Wieling, 2012; Wells, Lagomasino, Palinkas, Green, & Gonzalez, 2013). Thus, depending on clinic policy, it could be worth explicitly mentioning the clinic will not maintain any information about or request proof of legal status, as a further safeguard to the client's privacy and well-being (if this is indeed a policy both the therapist and the clinic are comfortable with).

Assess for the Centrality of Latinx Culture and Cultural Values to the Individual As noted above, there is immense heterogeneity among Latinos (Furman et al., 2009; Zsembik & Fennell, 2005), and the individual sitting in front of a clinician may see being Latinx as core to their identity, or they may not. Hence, clinicians striving for cultural humility should assess the centrality of a Latinx (or national) cultural identity to their Latinx clients, taking care not to make assumptions about the client's values based on ethnic group membership. For example, a therapist with knowledge about *familismo*, a cultural value found in many Latinx countries that emphasizes strong family bonds and loyalty to the family group (Antshel, 2002), may be tempted to show off his knowledge by saying something like, "I know family must be important to you." While this knowledge may be helpful, it would be much better to simply prompt, "Tell me about your family" and allow the client to explain whether or not family ties are important to them personally. The humble therapist should ask their clients what they value and what would make

them feel respected, take an open stance, and be ready to simply listen and affirm their client's experience (Rust et al., 2006).

On the other hand, having knowledge about traditional Latinx cultural values can be helpful to guide therapists as they consider therapeutic processes, interpret clients' behaviors, enact interventions, and assign homework to their clients. For instance, knowing *familismo* is important for many Latinx people, when considering a plan to change behaviors (such as engaging in greater self-care activities for depression or reducing television viewing before bed for insomnia), a therapist might consider asking how others in the client's family might respond to these potential behavior changes. As another example, many Latinx clients value *personalismo*, which is a personal (more informal) relationship with people, especially those with whom they do business. A Latinx client may ask their clinician personal questions or expect some degree of personal self-disclosure from their clinician. Therapists who are less aware of this value may consider such questions "out of bounds" or seek to uncover the reasons why clients are curious about their personal lives (e.g., may interpret the behavior to mean the client is not respecting boundaries, or is avoiding a difficult topic). Knowing the extent to which such personal engagement is simply part of how a Latinx client relates to others can help therapists avoid pathologizing such behavior. On the other hand, *assuming* behavior is due to cultural beliefs and values, and not attempts to avoid a difficult topic, is just as problematic. Therefore, therapists should be knowledgeable about common cultural values but assess the degree to which these are applicable for their individual clients.

Ask About the Client's Understanding of Their Problems and Hopes for Treatment We also recommend that clinicians working with Latinx clients take some time during the intake interview to ask about the client's understanding of the nature of their problems and beliefs about how to best approach treatment. This conversation could involve eliciting the client's thoughts about the cause of their problems, expectations of how long their problems will last, perceived consequences experienced as a result of their problems, and beliefs about controllability (i.e., whether the problem is under personal control and able to be addressed in treatment). It should also involve a discussion about what "healthy" would look like to the client. Although these types of questions are beneficial regardless of client ethnic background, they may be of particular importance when working with Latinx clients.

First, asking these types of questions at intake allows therapists to assess for the client's mental health literacy and attitudes toward mental illness and treatment. Limited mental health literacy may be a barrier to treatment-seeking among Latinos (Cabassa, Lester, & Zayas, 2007, López et al., 2009). Studies have shown that Latinos experiencing psychological distress are more likely than non-Latinx Whites to conceptualize their problems as somatic, not just psychological (Varela et al., 2004), which may orient them towards seeking medical solutions. Having an idea of the client's mental health literacy and illness perceptions at intake can allow therapists to enhance psychoeducation and potentially protect against premature treatment termination. Second, having an understanding of what clients tell themselves about their problems will provide therapists with important information that can be readily incorporated into interventions to increase treatment engagement. It is important that, while having this discussion, therapists attend to and express respect for the client's explanatory model or beliefs about the nature and causes of their difficulties (Benish, Quintana, & Wampold, 2011). Research has shown that clients have higher expectations of change, are more satisfied with progress, remain in treatment longer, and have greater symptom improvement when they perceive their therapist's views about their illness to be congruent with their own (e.g., Claiborn, Ward, & Strong, 1981; Long, 2001). Even if a client's explanation about their difficulties seems unhelpful, preliminary validation of the client's perceptions at the outset of treatment will likely foster a positive relationship that will allow

therapists greater leeway for proposing alternative explanations later in treatment (Benish et al., 2011; Kleinman, Eisenberg, & Good, 2006).

Orient the Client to Therapeutic Services in a Non-stigmatizing Manner Traditional models of therapy are grounded in Western cultural ideals and epistemology (Trimble et al., 2012), and parts of the therapeutic process may feel foreign or counterintuitive to Latinx clients, especially if they are less acculturated (Kouyoumdjian, Zamboanga, & Hansen, 2003). Thus, providers working with Latinx clients should conclude the intake interview by providing some brief education about the rationale for treatment, and having a collaborative discussion about expectations for therapy visits. When discussing treatment rationale, clinicians should be wary of potentially stigmatizing terms, taking care to replace them with more culturally responsive language. For example, in cognitive-behavioral approaches it is not uncommon for therapists to describe a person's behaviors as "maladaptive," or label one's beliefs as "magical thinking." Because of the potentially condemning tone of these phrases, providers may consider using words such as "unhelpful" instead, serving to reduce the amount of implied blame placed on the client. Taking time to orient Latinx clients to the therapeutic services in a non-stigmatizing way will likely increase treatment engagement and reduce premature drop-out (Hays, 2009; Swift, Greenberg, Whipple, & Kominiak, 2012).

During Treatment

Recent meta-analytic findings support the notion that making cultural adaptations to empirically supported treatments results in superior treatment outcomes for minority ethnic group members, compared to traditional, non-adapted treatments (Benish et al., 2011; Smith, Domenech Rodríguez, & Bernal, 2011). In the context of behavioral health service delivery, cultural adaptation refers to the modification of a treatment protocol to make it "compatible with the client's cultural patterns, meanings, and values" (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009, p. 362). Modifications can include changes to both the psychotherapeutic *process* (e.g., treatment delivery, the therapeutic relationship; Sue et al., 2009; Whaley & Davis, 2007) and to the *content* of treatment.

Adaptations to Process There are several adaptations to the psychotherapeutic process that practitioners should consider when working with Latinx clients. One obvious adaptation that will be of particular importance for clients who are not fluent English speakers is ensuring one's clinic has the ability to provide services in Spanish (either through bilingual providers or trained interpreters). In a recent qualitative investigation of the effects of language concordance and interpreter use on therapeutic alliance in a primary care behavioral health setting, Spanish-speaking patients expressed a strong preference for bilingual providers, citing benefits such as greater privacy, an increased sense of trust, and more accurate communication of ideas (Villalobos et al., 2016). In the absence of bilingual providers, patients found the use of trained interpreters to be incredibly helpful, given their role in increasing access to care and facilitating communication with English-speaking providers (Villalobos et al., 2016).

Because of *personalismo*, a Latinx cultural value that ascribes importance to friendly, personal relationships (even in professional domains; Añez, Silva, Paris Jr., & Bedregal, 2008), providers should also try to foster a warm and personable relationship with their Latinx clients. This may take the form of increased self-disclosure or involvement of the self in therapy, greater willingness to engage in informal small talk before and after sessions, asking clients about family members, and making good eye contact to demonstrate active listening (Uebelacker et al., 2012). When interactions between clients and therapists or clinic staff are perceived as warm and friendly, this will likely serve to increase treatment engagement among Latinx clients. Conversely, therapists who adhere tightly to a businesslike style of interaction, deflect personal questions,

and minimize attempts at forming a bidirectional relationship may be seen as cold or unwelcoming to Latinx patients, thereby decreasing treatment engagement (Antshel, 2002).

Therapists may also want to consider engaging family members in treatment, given the Latinx cultural value of *familismo,* which emphasizes the importance of strong family bonds and loyalty (Antshel, 2002). There are several ways clinicians can incorporate family members into treatment, if *familismo* seems to be important to the client. One option would be to bring family members into sessions occasionally. If the client is amenable to this approach, family members could be brought in to give their perspective on the client's functioning and current difficulties (i.e., an assessment-focused session), or to collaborate on a particular treatment plan (i.e., an intervention-focused session). For example, a client in the midst of planning outside-of-session exposure exercises may wish to bring a supportive family member into their appointment to assist with planning and troubleshooting these homework assignments, along with holding the client accountable to completing them. Family members could also be brought in for some of the initial sessions focused on psychoeducation and goal-setting. Even when family members cannot be physically present, therapists can still demonstrate a focus on the importance of family by asking clients about family members' thoughts on and responses to their current difficulties, and encouraging clients to involve family members in outside-of-session practice and conversations about treatment. Including family members in the treatment of Latinx clients can increase treatment engagement through increasing mental health literacy and decreasing stigma among family members (López et al., 2009), who often play a role in facilitating mental health care for their relatives with mental illness (Urdaneta, Saldaña, & Winkler, 1995).

Finally, providers may consider the potential need for a more flexible attendance policy when treating Latinx clients. It is not uncommon for Latinos to work longer hours (Wells et al., 2013), have lower levels of full-time employment, make less money, and have poorer benefits packages than non-Latinx Whites (Bridges & Lindly, 2008; Kouyoumdjian et al., 2003). These factors could interfere with a client's ability to initiate and maintain therapy, especially in the traditional specialty mental health clinic model, where clients are expected to attend weekly hour-long appointments over the span of several months (Snell-Johns, Mendez, & Smith, 2004). Outpatient mental health clinics typically adhere to strict attendance policies (e.g., if a client misses three sessions in a row without canceling ahead of time they are no longer eligible for receiving treatment). However, clinicians working with Latinx clients should be aware of potential external factors that could be prohibiting regular attendance, and work with their clients directly to problem-solve and perhaps establish a more flexible attendance policy.

Adaptations to Content In Benish and colleagues' meta-analysis (2011) examining the efficacy of culturally adapted treatments, they found not only that culturally adapted psychotherapies are more effective than unadapted, bona fide psychotherapies, but also that the superior treatment outcomes evidenced by culturally adapted psychotherapies are driven by just one important moderator—incorporation of the client's illness myth into treatment. A client's illness myth, also known as their "explanatory model," refers to the client's inferences about the types of symptoms they are experiencing, assumptions about the cause of their illness (e.g., psychosocial, supernatural, behavioral, physical), estimation of the course of their illness (e.g., acute, chronic), postulation about consequences resulting from their illness, and expectations about what types of treatment would be appropriate for them (Benish et al., 2011; Bhui, Rudell, & Priebe, 2006; Rudell, Bhui, & Priebe, 2009). It is not uncommon for Latinos to experience greater somatic symptoms associated with mental illness (Lewis-Fernandez, Das, Alfonso, Weissman, & Olfson, 2005; Piña & Silverman, 2004; Varela et al., 2004), see mental illness as being caused by primarily psychosocial (Caplan et al., 2011; Jimenez, Bartels, Cardenas, Dhaliwal, & Alegría, 2012) or religious/supernatural (Caplan et al.,

2011) forces, worry their mental illness will result in consequences such as social shame or rejection (Hirai, Vernon, Popan, & Clum, 2015; Interian, Martinez, Guarnaccia, Vega, & Escobar, 2007), and express concerns about the use of psychotropic medications (Cabassa et al., 2007; Cooper et al., 2003).

As stated above, it is important to elicit the client's explanatory model during intake and throughout the initial phases of treatment. Starting treatment with an expressed understanding and respect for the client's framing of their problems allows the therapist greater flexibility to build alternative explanatory model later in treatment (Benish et al., 2011). Ultimately, the therapist and client can work together to co-create a new, culturally congruent illness explanation that incorporates both clinical science and the client's initial framing of their illness (Wampold, 2007). During the process of collaboratively constructing a new framework and treatment rationale, therapists working with Latinx clients would be wise to use relevant cultural values to their advantage, rather than challenging or fighting against them (Hays, 2009). For example, if a client has expressed a strong belief in *respeto,* a cultural value emphasizing obedience to authority and maintenance of harmony (Calzada, Fernandez, & Cortes, 2010; Gonzales-Ramos, Zayas, & Cohen, 1998), encouraging assertiveness skills may not be a welcomed therapeutic activity, particularly if a therapist is asking the client to practice assertiveness skills within a family context (e.g., standing up to unfair treatment by a parent). Rather than questioning the utility or validity of *respeto* as a cultural belief, the therapist could instead frame assertive communication as a respectful avenue for solving problems, because it honors the rights and beliefs of all people involved in a situation (Bernal & Saez-Santiago, 2005).

Beyond incorporation of the client's illness myth and relevant cultural values into treatment, therapists working with Latinx clients should also consider adapting the metaphors and case examples used throughout treatment to make them more relevant. If a therapist is unsure about whether a particular metaphor, for example, makes sense to the client, they should ask. Similarly, it could be a useful exercise for therapists to first explain a particular treatment concept, then work collaboratively with the client to create a metaphor for that concept that feels relevant (Bernal, Bonilla, & Bellido, 1995). For instance, when creating a progressive muscle relaxation exercise with children, rather than asking the child to pretend to be uncooked spaghetti (tense up the body), then cooked spaghetti (loosen the body muscles), the therapist and child opted to talk about being a hard shell tortilla and a soft shell tortilla (de Arellano, 2012, personal communication).

Finally, therapists working with Latinx clients must be willing to be flexible and devote time to addressing the unique therapeutic needs that may arise from living as a Latinx in a predominantly White culture. For example, addressing immigration stressors specifically could lead to a decrease in symptoms associated with this domain in ways that would not occur with strict adherence to a manualized treatment (Barrera & Castro, 2006). We have worked with countless Latinx clients experiencing depression, anxiety, and worry as a result of increased Immigration and Customs Enforcement (ICE) raids in the area. While manualized cognitive-behavioral treatments typically include a focus on the client's thoughts and behaviors that may be maladaptive, these cases involved serious mental health symptoms that followed from an external situation that was, in actuality, extremely stressful and upsetting. In many of these cases, we devoted therapy sessions to validation of the client's concerns and active problem-solving (e.g., education about legal rights, facilitating connections with local immigration clinics, creating a plan in case of removal procedures) rather than debating the validity of the client's fears.

While Latinx clients may be faced with distinct risk factors (e.g., discrimination, low social standing, cultural intergenerational conflict, unemployment) compared to non-Latinx White clients, they may also benefit from unique protective factors (e.g., strong family support networks, religious involvement). The interplay between

cultural context and the distinct set of risk and resilience factors Latinx clients experience is crucial to consider when reflecting on how and when to pursue culturally adapted models of care (Lau, 2006).

At Termination

Therapy is a strange endeavor. Therapists and clients build strong relationships, focused on solving a particular problem or set of problems, meet regularly for a period of time, and then (ideally once problems are solved successfully), the relationship ends. Typically, endings of therapy are formal events that involve a final session or set of sessions specifically designed to review treatment gains, help prevent relapse in the future, and say goodbye. Then, the relationship disappears. Compare this to a relationship patients have with their primary care doctors or dentists—these relationships may also be problem-focused, but are ongoing and may last months, years, even decades. Some Latinx clients have an orientation towards therapy that is more consistent with a doctor or dentist model than with traditional mental health models (Antshel, 2002). Such a crisis orientation means Latinx clients may want, or even expect, that therapists will continue to be available for occasional sessions, as life events arise. Therapists may consider a more flexible approach to treating such clients (should the clinic include "open access" therapy appointments for just such occasions for prior clients?) or, at minimum, providing information about the nature of treatment and the nature of termination.

Conclusion

The growing, vibrant Latinx population has been part of the USA since its inception. Latinos in the USA are diverse with respect to sociopolitical and cultural pasts and present circumstances. Therapists who want to enhance their cultural competence related to working with Latinx clients are urged to consider how Latinx identity weaves into other identities to impact that person's lived experiences, and to let this guide their approach to therapy. While the *content* of what a therapist provides to her clients in therapy may not change much (that is, therapeutic processes remain similar although metaphors and particular interventions may be adapted), what we have emphasized here is a *process* for inviting discussions about power and privilege, culture and values, into treatment from intake to termination.

References

Alegría, M., Mulvaney-Day, N., Torres, M., Polo, A., Cao, Z., & Canino, G. (2007). Prevalence of psychiatric disorders across Latinx subgroups in the United States. *American Journal of Public Health, 97*, 68–75. https://doi.org/10.2105/AJPH.2006.087205

Anderson, K. F., & Finch, J. K. (2017). The role of racial microaggressions, stress, and acculturation in understanding Latinx health outcomes in the USA. *Race and Social Problems, 9*, 218–233. https://doi.org/10.1007/s12552-017-9212-2

Añez, L. M., Silva, M. A., Paris, M., Jr., & Bedregal, L. E. (2008). Engaging Latinos through the integration of cultural values and motivational interviewing principles. *Professional Psychology: Research and Practice, 39*, 153–159. https://doi.org/10.1037/07357028.39.2.153

Antshel, K. M. (2002). Integrating culture as a means of improving treatment adherence in the Latinx population. *Psychology, Health & Medicine, 7*, 435–449. https://doi.org/10.1080/1354850021000015258

Appel, M., Weber, S., & Kronberger, N. (2015). The influence of stereotype threat on immigrants: Review and meta-analysis. *Frontiers in Psychology, 6*, 900. https://doi.org/10.3389/fpsyg.2015.00900

Arellano-Morales, L., Roesch, S. C., Gallo, L. C., Emory, K. T., Molina, K. M., Gonzalez, P., … Brondolo, E. (2015). Prevalence and correlates of perceived ethnic discrimination in the Hispanic Community Health Study/Study of Latinos Sociocultural Ancillary study. *Journal of Latina/o Psychology, 3*, 160–176. https://doi.org/10.1037/lat0000040

Barrera, M., Jr., & Castro, F. G. (2006). A heuristic framework for the cultural adaptation of interventions. *Clinical Psychology: Science and Practice, 13*, 311–316. https://doi.org/10.1111/j.1468-2850.2006.00043.x

Benish, S. G., Quintana, S., & Wampold, B. E. (2011). Culturally adapted psychotherapy and the legitimacy of myth: A direct-comparison meta-analysis. *Journal of Counseling Psychology, 58*, 279–289. https://doi.org/10.1037/a0023626

Bernal, G., Bonilla, J., & Bellido, C. (1995). Ecological validity and cultural sensitivity for outcome research: Issues for the cultural adaptation and development of psychosocial treatments with Hispanics. *Journal of Abnormal Child Psychology, 23*, 67–82. https://doi.org/10.1007/BF01447045

Bernal, G., Jiménez-Chafey, M. I., & Domenech Rodríguez, M. M. (2009). Cultural adaptation of treatments: A resource for considering culture in evidence-based practice. *Professional Psychology: Research and Practice, 40*, 361–368. https://doi.org/10.1037/a0016401

Bernal, G., & Saez-Santiago, E. (2005). Toward culturally centered and evidenced-based treatments for depressed adolescents. In W. Pinsoff & J. Lebow (Eds.), *Family psychology: The art of the science* (pp. 471–489). New York, NY: Oxford University Press.

Bhui, K., Rudell, K., & Priebe, S. (2006). Assessing explanatory models for common mental disorders. *Journal of Clinical Psychiatry, 67*, 964–971. https://doi.org/10.4088/jcp.v67n0614

Breslau, J., Aguilar-Gaxiola, S., Kendler, K. S., Su, M., Williams, D., & Kessler, R. C. (2006). Specifying race-ethnic differences in risk for psychiatric disorder in a US national sample. *Psychological Medicine, 36*, 57–68.

Bridges, A. J., Andrews, A. I., & Deen, T. L. (2012). Mental health needs and service utilization by Hispanic immigrants residing in midsouthern United States. *Journal of Transcultural Nursing, 23*, 359–368. https://doi.org/10.1177/1043659612451259

Bridges, A. J., & Lindly, E. (2008). Service utilization and case management. In *Workgroup on adapting Latinx services, Adaptation guidelines for serving Latinx children and families affected by trauma* (1st ed.). San Diego, CA: Chadwick Center for Children and Families.

Cabassa, L. J., Lester, R., & Zayas, L. H. (2007). It's like being in a labyrinth': Hispanic immigrants' perceptions of depression and attitudes toward treatments. *Journal of Immigrant and Minority Health, 9*, 1–16. https://doi.org/10.1007/s10903006690101

Caldwell, L. D., Tarver, D., Iwamoto, D. K., Herzberg, S., Cerda-Lizarraga, P., & Mack, T. (2008). Defining cultural competency: From a human service provider prospective. *Journal of Multicultural Counseling and Development, 36*, 88–100.

Calzada, E. J., Fernandez, Y., & Cortes, D. E. (2010). Incorporating the cultural value of respeto into a framework of Latinx parenting. *Cultural Diversity and Ethnic Minority Psychology, 16*, 77–86. https://doi.org/10.1037/a0016071

Caplan, S. (2007). Latinos, acculturation, and acculturative stress: A dimensional concept analysis. *Policy, Politics, & Nursing Practice, 8*, 93–106. https://doi.org/10.1177/1527154407301751

Caplan, S., Paris, M., Whittemore, R., Desai, M., Dixon, J., Alvidrez, J., … Scahill, L. (2011). Correlates of religious, supernatural and psychosocial causal beliefs about depression among Latinx immigrants in primary care. *Mental Health, Religion & Culture, 14*, 589–611. https://doi.org/10.1080/13674676.2010.497810

Cavazos-Rehg, P. A., Zayas, L. H., & Spitznagel, E. L. (2007). Legal status, emotional well-being and subjective health status of Latinx immigrants. *Journal of the National Medical Association, 99*, 1126–1131.

Claiborn, C. D., Ward, S. R., & Strong, S. R. (1981). Effects of congruence between counselor interpretations and client beliefs. *Journal of Counseling Psychology, 28*, 101–109. https://doi.org/10.1037/0022-0167.28.2.101

Cooper, L. A., Gonzales, J. J., Gallo, J. J., Rost, K. M., Meredith, L. S., Rubenstein, L. V., … Ford, D. E. (2003). The acceptability of treatment for depression among African-American, Hispanic, and White primary care patients, *Medical Care, 41*, 479–489. https://doi.org/10.1097/01.MLR.0000053228.58042.E4

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum, 1989*, 139–167.

Da Silva, N., Dillon, F. R., Rose Verdejo, T., Sanchez, M., & De La Rosa, M. (2017). Acculturative stress, psychological distress, and religious coping among Latina young adult immigrants. *The Counseling Psychologist, 45*, 213–236. https://doi.org/10.1177/0011000017692111

French, S. E., Seidman, E., Allen, L., & Aber, J. L. (2006). The development of ethnic identity during adolescence. *Developmental Psychology, 42*, 1–10. https://doi.org/10.1037/0012-1649.42.1.1

Furman, R., Negi, N. J., Iwamoto, D. K., Rowan, D., Shukraft, A., & Gragg, J. (2009). Social work practice with Latinos: Key issues for social workers. *Social Work, 54*, 167–174. https://doi.org/10.1093/sw/54.2.167

Gonzales, P. M., Blanton, H., & Williams, K. J. (2002). The effects of stereotype threat and double-minority status on the test performance of Latinx women. *Personality and Social Psychology Bulletin, 28*, 659–670. https://doi.org/10.1177/0146167202288010

Gonzales-Ramos, G., Zayas, L. H., & Cohen, E. V. (1998). Child-rearing values of low-income, urban Puerto Rican mothers of preschool children. *Professional Psychology: Research & Practice, 29*, 377–382. https://doi.org/10.1037/0735-7028.29.4.377

Hays, P. A. (2009). Integrating evidence-based practice, cognitive-behavior therapy, and multicultural therapy: Ten steps for culturally competent practice. *Professional Psychology: Research and Practice, 40*, 354–360. https://doi.org/10.1037/a0016250

Hirai, M., Vernon, L. L., Popan, J. R., & Clum, G. A. (2015). Acculturation and enculturation, stigma toward psychological disorders, and treatment preferences in a Mexican American sample: The role of education in reducing stigma. *Journal of Latina/o Psychology, 3*, 88–102. https://doi.org/10.1037/lat0000035

Holmes, C. (2018, June 21). Five facts on migrants coming to the U.S. *US News and World Report*. Retrieved

from www.usnews.com/news/best-countries/articles/2018-06-21/why-are-central-americans-coming-to-the-united-states

Ibrahim, F. A., Roysircar-Sodowsky, G. R., & Ohnishi, H. (2001). Worldview: Recent developments and needed direction. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (2nd ed., pp. 425–456). Thousand Oaks, CA: Sage.

Interian, A., Martinez, I. E., Guarnaccia, P. J., Vega, W. A., & Escobar, J. I. (2007). A qualitative analysis of the perception of stigma among Latinos receiving antidepressants. *Psychiatric Services, 58*, 1591–1594. https://doi.org/10.1176/appi.ps.58.12.1591

Jimenez, D. E., Bartels, S. J., Cardenas, V., Dhaliwal, S. S., & Alegría, M. (2012). Cultural beliefs and mental health treatment preferences of ethnically diverse older adult consumers in primary care. *American Journal of Geriatric Psychiatry, 20*, 533–542. https://doi.org/10.1097/JGP.0b013e318227f876

Kleinman, A., Eisenberg, L., & Good, B. (2006). Culture, illness, and care: Clinical lessons from anthropologic and cross-cultural research. *Focus, 4*, 140–149. https://doi.org/10.1176/foc.4.1.140

Kouyoumdjian, H., Zamboanga, B. L., & Hansen, D. J. (2003). Barriers to community mental health services for Latinos: Treatment considerations. *Clinical Psychology: Science and Practice, 10*, 394–422. https://doi.org/10.1093/clipsy/bpg041

Lau, A. S. (2006). Making the case for selective and directed cultural adaptations of evidence-based treatments: Examples from parent training. *Clinical Psychology: Science and Practice, 13*, 295–310. https://doi.org/10.1111/j.1468-2850.2006.00042.x

Lewis-Fernandez, R., Das, A. K., Alfonso, C., Weissman, M. M., & Olfson, M. (2005). Depression in US Hispanics: Diagnostic and management considerations in family practice. *Journal of the American Board of Family Medicine, 18*, 282–296. https://doi.org/10.3122/jabfm.18.4.282

Long, J. R. (2001). Goal agreement and early therapeutic change. *Psychotherapy: Theory, Research, Practice, Training, 38*, 219–232. https://doi.org/10.1037/0033-3204.38.2.219

López, S. R., Lara, M. C., Kopelowicz, A., Solano, S., Foncerrada, H., & Aguilera, A. (2009). La CLAve to increase psychosis literacy of Spanishspeaking community residents and family caregivers. *Journal of Consulting and Clinical Psychology, 77*, 763–774. https://doi.org/10.1037/a0016031

Muñoz, R. F., & Mendelson, T. (2005). Toward evidence-based interventions for diverse populations: The San Francisco General Hospital prevention and treatment manuals. *Journal of Consulting and Clinical Psychology, 73*, 790–799. https://doi.org/10.1037/0022-006X.73.5.790

National Public Radio (NPR), Robert Wood Johnson Foundation, & Harvard T. H. Chan School of Public Health. (2017). *Discrimination in America: Experiences and view of Latinos.* Retrieved from https://www.hsph.harvard.edu/news/press-release/poll-Latinos-discrimination/

Neville, H. A., Spanierman, L. B., & Doan, B. (2006). Exploring the association between color-blind racial ideology and multicultural counseling competencies. *Cultural Diversity and Ethnic Minority Psychology, 12*, 275–290. https://doi.org/10.1037/1099-9809.12.2.275

Ortega, A. N., Rosenheck, R., Alegría, M., & Desai, R. A. (2000). Acculturation and the lifetime risk of psychiatric and substance use disorders among Hispanics. *Journal of Nervous and Mental Disease, 188*, 728–735.

Pérez, D. J., Fortuna, L., & Alegría, M. (2008). Prevalence and correlates of everyday discrimination among U.S. Latinos. *Journal of Community Psychology, 36*, 421–433. https://doi.org/10.1002/jcop.20221

Perreira, K. M., Chapman, M. V., & Stein, G. L. (2006). Becoming an American parent: Overcoming challenges and finding strength in a new immigrant Latinx community. *Journal of Family Issues, 27*, 1383–1414. https://doi.org/10.1177/0192513X06290041

Pew Research Center. (2012). *Identity, pan-ethnicity and race.* Retrieved from https://www.pewhispanic.org/2012/04/04/ii-identity-pan-ethnicity-and-race/

Pew Research Center. (2013). *Diverse origins: The nation's 14 largest Hispanic-origin groups.* Retrieved from www.pewhispanic.org/2013/06/19/diverse-origins-the-nations-14-largest-hispanic-origin-groups/

Pew Research Center. (2017). *Facts on US Latinos, 2015: Statistical portrait of Hispanics in the United States.* Retrieved from www.pewhispanic.org/2017/09/18/facts-on-u-s-Latinos/#hispanic-rising-share

Phinney, J. S. (1993). A three-stage model of ethnic identity development in adolescence. In M. E. Bernal & G. P. Knight (Eds.), *Ethnic identity: Formation and transmission among Hispanics and other minorities* (pp. 61–79). New York, NY: State University of New York Press.

Piña, A. A., & Silverman, W. K. (2004). Clinical phenomenology, somatic symptoms, and distress in Hispanic/Latinx and European American youths with anxiety disorders. *Journal of Clinical Child and Adolescent Psychology, 33*, 227–236. https://doi.org/10.1207/s15374424jccp3302_3

Rastogi, M., Massey-Hastings, N., & Wieling, E. (2012). Barriers to seeking mental health services in the Latinx/a community: A qualitative analysis. *Journal of Systemic Therapies, 31*, 1–17. https://doi.org/10.1521/jsyt.2012.31.4.1

Rudell, K., Bhui, K., & Priebe, S. (2009). Concept, development and application of a new mixed method assessment of cultural variations in illness perceptions: Barts Explanatory Model Inventory. *Journal of Health Psychology, 14*, 336–347. https://doi.org/10.1177/1359105308100218

Rust, G., Kondwani, K., Martinez, R., Dansie, R., Wong, W., Fry-Johnson, Y., & Strothers, H. (2006). A CRASH-course in cultural competence. *Ethnicity & Disease, 16*(2, Suppl. 3), S3-29–S3-36.

Schwab, W. A. (2013). *Right to dream: Immigration reform and America's future*. Fayetteville, AR: University of Arkansas Press.
Schwab, W. A. (2018). *Dreams derailed: Undocumented youths in the Trump era*. Fayetteville, AR: University of Arkansas Press.
Siegel, C., Haugland, G., & Chambers, E. D. (2003). Performance measures and their benchmarks for assessing organizational cultural competency in behavioral health care service delivery. *Administration and Policy in Mental Health, 31*, 141–170. https://doi.org/10.1023/B:APIH.0000003019.97009.15
Smith, T. B., & Silva, L. (2011). Ethnic identity and personal well-being of people of color: A meta-analysis. *Journal of Counseling Psychology, 58*, 42–60. https://doi.org/10.1037/a0021528
Smith, T. B., Domenech Rodríguez, M., & Bernal, G. (2011). Culture. *Journal of Clinical Psychology, 67*, 166–175. https://doi.org/10.1002/jclp.20757
Snell-Johns, J., Mendez, J. L., & Smith, B. H. (2004). Evidence based solutions for overcoming access barriers, decreasing attrition, and promoting change with underserved families. *Journal of Family Psychology, 18*, 19–35. https://doi.org/10.1037/08933200.18.1.19
Suárez-Orozco, C., Todorova, I., & Louie, J. (2002). Making up for lost time: The experience of separation and reunification among immigrant families. *Family Process, 41*, 625–643. https://doi.org/10.1111/j.1545-5300.2002.00625.x
Sue, D. W. (2004). Whiteness and ethnocentric monoculturalism: Making the invisible visible. *American Psychologist, 59*, 761–769. https://doi.org/10.1037/0003-066X.59.8.761
Sue, S., Zane, N., Nagayama Hall, G. C., & Berger, L. K. (2009). The case for cultural competency in psychotherapeutic interventions. *Annual Review of Psychology, 60*, 525–548. https://doi.org/10.1146/annurev.psych.60.110707.163651
Swift, J. K., Greenberg, R. P., Whipple, J. L., & Kominiak, N. (2012). Practice recommendations for reducing premature termination in therapy. *Professional Psychology: Research and Practice, 43*, 379–387. https://doi.org/10.1037/a0028291
Tienda, M., & Sanchez, S. (2013). Latin American immigration to the United States. *Daedalus, 142*, 48–64. https://doi.org/10.1162/DAED_a_00218
Trimble, J. E., Scharrón-del-Río, M. R., & Hill, J. S. (2012). Ethical considerations in the application of cultural adaptation models with ethnocultural populations. In G. Bernal & M. Domenech Rodríguez (Eds.), *Cultural adaptations: Tools for evidence-based practice with diverse populations* (pp. 45–67). Washington, DC: American Psychological Association. https://doi.org/10.1037/13752-003
Uebelacker, L. A., Marootian, B. A., Pirraglia, P. A., Primack, J., Tigue, P. M., Haggarty, R., & Miller, I. W. (2012). Barriers and facilitators of treatment for depression in a Latinx community: A focus group study. *Community Mental Health Journal, 48*, 114–126. https://doi.org/10.1007/s1059701193887
Urdaneta, M. L., Saldaña, D. H., & Winkler, A. (1995). Mexican-American perceptions of severe mental illness. *Human Organization, 54*, 70–77. https://doi.org/10.17730/humo.54.1.e216p6442857477q
US Census Bureau. (2016). *American Community Survey: Demographic and housing estimates.* Retrieved from https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF
Varela, R., Vernberg, E. M., Sanchez-Sosa, J., Riveros, A., Mitchell, M., & Mashunkashey, J. (2004). Anxiety reporting and culturally associated interpretation biases and cognitive schemas: A comparison of Mexican, Mexican American, and European American families. *Journal of Clinical Child and Adolescent Psychology, 33*, 237–247. https://doi.org/10.1207/s15374424jccp3302_4
Villalobos, B. T., Bridges, A. J., Anastasia, E. A., Ojeda, C. A., Hernandez Rodriguez, J., & Gomez, D. (2016). Effects of language concordance and interpreter use on therapeutic alliance in Spanishspeaking integrated behavioral health care patients. *Psychological Services, 13*, 49–59. https://doi.org/10.1037/ser0000051
Wampold, B. E. (2007). Psychotherapy: The humanistic (and effective) treatment. *American Psychologist, 62*, 857–873. https://doi.org/10.1037/0003-066X.62.8.857
Wells, A., Lagomasino, I. T., Palinkas, L. A., Green, J. M., & Gonzalez, D. (2013). Barriers to depression treatment among lowincome, Latinx emergency department patients. *Community Mental Health Journal, 49*, 412–418. https://doi.org/10.1007/s1059701295475
Whaley, A. L., & Davis, K. E. (2007). Cultural competence and evidence-based practice in mental health services: A complementary perspective. *American Psychologist, 62*, 563–574. https://doi.org/10.1037/0003-066X.62.6.563
White, R. M. B., Roosa, M. W., Weaver, S. R., & Nair, R. L. (2009). Cultural and contextual influences on parenting in Mexican American families. *Journal of Marriage and the Family, 71*, 61–79.
Zsembik, B. A., & Fennell, D. (2005). Ethnic variation in health and the determinants of health among Latinos. *Social Science and Medicine, 61*, 53–63. https://doi.org/10.1016/j.socscimed.2004.11.040