1 Evidence-Based Practices for Conducting Therapy with Spanish-Speaking Clients

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Latinos in the USA

Approximately 17% of the US population is Latino making this group the largest minority group in the USA (US Census Bureau, 2015). According to the US Census Bureau (2017), Latinos and Hispanics are individuals of "Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race." The Pew Research Center (2012) reported that persons of Mexican origin make up nearly two-thirds (65%) of the US Latino population, with the remaining third distributed primarily among persons of Puerto Rican, Cuban, and Central American origin. Of the Latinos residing in the USA, 35% are immigrants with the remaining 27 million being US born (Zong & Batalova, 2017).

The extant literature cites Latino cultural characteristics such as the emphasis on respect and the family as being grist for the cultural consideration mill. However, Latinos face several contemporary issues including issues with regard to immigration status, acculturation, self-identification, language, poverty, and discrimination. Benuto (in press) also discussed how there is substantial heterogeneity among Latinos with regard to immigrant status, acculturation level, and English-language fluency among others. While Latinos face many challenges, this chapter (and book) emphasizes the substantial rates of mental illness and the associated barriers that Latinos encounter when attempting to access behavioral health services. Indeed, a considerable number of Latinos residing in the USA are affected by mental illness and have behavioral health concerns. The prevalence of mood and anxiety disorders is high among Latinos (Kim et al., 2011) with 28–30% of Latinos experiencing some form of mental illnesses in their lifetime (Alegria et al., 2008; Kim et al., 2011). Despite these high prevalence rates, the extant literature indicates that Latinos have low utilization rates for behavioral health services due to a combination of internal and external barriers.

Barriers to Services

Despite the substantial prevalence rate of mental health disorders among Latinos, Latinos have been noted to have low-treatment-seeking rates. This has been attributed to both external and

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internal barriers, and as compared to 40% of non-Hispanic whites (Agency for Healthcare Research and Quality [AHRQ], 2015), only 27% of Latinos who have a probable need for behavioral health services seek out behavioral healthcare (Bridges & Anastasia, 2016). With regard to internal barriers, stigma and low mental health literacy (Griffiths, Batterham, Barney, & Parson, 2011; Guarnaccia et al., 2009; Gulliver et al., 2012; Hirari, Vernon, Popan, & Clum, 2015; Interian et al., 2010; Jimenez, Bartels, Cardenas, & Alegria, 2012) should be taken into account as these can impact a person's decision to seek behavioral health services (Borrayo, Rosales, & Gonzalez, 2016; Jibaja-Weiss et al., 2011). External or environmental barriers are generally related to economic status and have been amply cited in the literature as an explanation for why Latinos do not seek out needed behavioral healthcare. These include lack of transportation and/or childcare, an inability to pay for services, and an inability to take time off from work (Bridges, Andrews, & Deen, 2012; Bridges et al., 2014; Gonzalez & Follette, 2015). An additional external barrier to services for Latinos is the availability of Spanish-speaking clinicians.

Language as a Barrier to Services: Enter the Spanish-Speaking Clinician

Given the large number of Latinos who are immigrants, it is not surprising that a large proportion of Latinos who reside in the USA are Spanish speaking. Indeed an astounding 35.8 million Latinos speak Spanish at home, and only 34% of Latino immigrants who reside in the USA speak English proficiently (Krogstad, Stepler, & Lopez, 2015). Thus, language has the potential to act as both internal and external barrier. The latter can be considered daunting because there are simply not enough Spanish-speaking clinicians available to meet the needs of Spanish-speaking clients. In fact, the challenge of meeting the behavioral health needs of Spanish-speaking clients has been noted by professional bodies such as the American Psychological Association. In a featured article, entitled *Wanted: Spanish-Speaking Psychologists*, Stringer (2015) discussed the substantial need for Spanish-speaking providers and the negative impact of having too few bilingual mental health professionals. Stringer noted that when clients are assessed in their second language(s), they are more likely to be incorrectly diagnosed. Likely as a result of those issues, Stinger also highlighted several training programs where therapists can learn to provide services in Spanish, many of which provide cultural immersion experiences in Latin American countries.

While cultural immersion can be an excellent second-language training experience and experts have noted that it may be easiest to train therapists to be conversant in Spanish (Dingfelder, 2005), native Spanish-speaking clinicians can also help to meet the behavioral health needs of Spanish-speaking clients. Heritage speakers are those individuals who have a proficiency in or a cultural connection to a language. An additional relevant term is a heritage language learner—this is an individual who has a proficiency in Spanish or a connection to the Spanish language and who is studying Spanish (Kelleher, 2010). These represent an additional mechanism of addressing the behavioral health needs of Spanish-speaking clients.

Regardless of the mechanism of language acquisition (and the literature appears to be equivocal on which, if any is superior), it has been noted that it is optimal to work with a client in his/her native language (Benuto & Bennett, 2015; Costa, 2010) and that the use of English as the standard in therapy puts those who cannot communicate in English at a clear disadvantage (Sue & Sue, 1999). Bilingualism has been noted to act as part of the therapeutic alliance between the client and therapist (Nguyen, 2014). Santiago-Rivera (2009) and colleagues examined how and when therapists switched from one language during therapy as well as how their clients switched language. They found that therapists use language switching as a way to establish trust, to bond with their clients, and to promote disclosure through the use of specific phrases or words. Clients were noted to switch from English to Spanish when recounting experiences that involved certain emotions and to improve communication and connect with the therapist. These find-

ings highlight how Spanish-speaking clinicians can reduce internal barriers to service by establishing a strong therapeutic alliance with their clients.

Researchers have found that satisfaction with a therapist hinges on how the Latino clients feel the therapist understood Latino culture and not on the therapist's ethnicity (Fraga, Atkinson, & Wampold, 2004). The above highlights the importance of service delivery in Spanish. One of the inherent challenges in the delivery of services to Spanish-speaking clients (in addition to the limited number of providers who speak Spanish) is the paucity of tools and/or resources available to Spanish-speaking clinicians. This presents a serious limitation as most evidence-based interventions often include handouts and homework sheets as part of the treatment protocol. In spite of evidence that suggests that Latinos benefit from evidence-based therapies regardless of whether or not the therapy has been adapted (Benuto & O'Donohue, 2015; Huey, Tilley, Jones, & Smith, 2014), there exists a fundamental challenge for clinicians working with Spanish-speaking clients who may be forced to translate handouts and homework sheets (an arduous process) and/or abandon evidence-based treatment protocols that include these components all together, which could be detrimental to Spanish-speaking clients. Further, should the clinician decide to adapt or translate a resource, it inevitably means that this scarce resource (a Spanish-speaking clinician) is pulled away from direct clinical care in order to adapt the resource.

To Adapt or Not Adapt: That Is the Question

While there are many processes that can be used to modify a treatment on account of culture (i.e., adapting, tailoring), ultimately the goal of these procedures is to modify the intervention based on cultural values and practices so that the treatment is more compatible with the client's culture (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009). Additionally, cultural modifications can be aimed at improving reach and engagement (Falicov, 2005) and increasing the appeal and effectiveness of the intervention with the group of interest (Barrera, Castro, Strycker, & Toobert, 2013). Despite the above criticisms, the literature suggests that cultural modifications to ESTs do not result in improved outcomes for minority clients (Benuto & O'Donohue, 2015; Huey et al., 2014).

Benuto, O'Donohue, and Bennett (Unpublished Manuscript) summarized how psychological treatments have been classified as efficacious or possibly efficacious based on their evaluation by randomized controlled trials (RCTs) and/or single-subject experimental designs (Chambless & Hollon, 1998). The Society of Clinical Psychology (2016) has classified the empirically supported treatment (EST) status of cognitive behavioral therapy (CBT) for depression and anxiety as having strong research support. Benuto and colleagues (Unpublished Manuscript) summarized the literature on CBT and noted that meta-analyses have established that CBT is an efficacious treatment for generalized anxiety disorder, social anxiety disorder, panic disorder (Cuijpers, Cristea, Weitz, Gentili, & Berking, 2016), hypochondriasis/health anxiety (Olatunji et al., 2014), post-traumatic stress disorder (Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010), and depression (Cuijpers et al., 2016; Okumura & Ichikura, 2014) not only among adults but also among children (Reinecke, Ryan, & DuBois, 1998) and adolescents (Lenz & Hollenbaugh, 2015; Reinecke et al., 1998).

In response to criticisms regarding the extent to which findings from randomized controlled trials (RCTs) on empirically supported treatments (ESTs) generalize to ethnic minorities (because the cultural values and assumptions in these therapies may not be representative of the values and assumptions held by ethnic minorities and because ethnic minorities have been underrepresented in clinical trials), Benuto et al., (Unpublished Manuscript) investigated the degree to which Latina/Latino victims of crime experience treatment success when they are treated with culturally untailored/unadapted ESTs in a real world compared to non-Hispanic whites via an uncontrolled effectiveness study. Results from a logistic regression revealed that ethnicity was not a predictor of treatment success

in this sample. Indeed treatment outcomes for untailored ESTs were comparable for Latinos and non-Hispanic whites (with 77% of Latinos successfully completing treatment compared to 69% of non-Hispanic whites). These results suggest that formal adaptions to ESTs may not be necessary and that results from RCTs on ESTs can be generalized to Latinos. These findings support findings from RCTs that conventional, unmodified CBT works effectively with Latinos for anxiety disorders (Barrios, 2010) and from two reviews of the literature on cultural adaptations (Benuto & O'Donohue, 2015; Huey et al., 2014). Thus, if the tools and resources that are used in standard, non-adapted evidence-based interventions are available for clinicians to use in Spanish, the research supports that Latino clients will benefit from evidence-based interventions.

Summary and Conclusion

As illustrated throughout this chapter, Latinos are a large segment of the greater US population, and there are a substantial number of Latinos who need behavioral services in Spanish. Because the shortage of Spanish-speaking mental health providers is beyond the scope of this book chapter, the editor and selected authors have set out to address the dearth of resources available in Spanish for those providers who do exist as well as (and primarily) for their Spanish-speaking clients. Thus, each chapter in this book provides an overview of the disorder and associated cultural factors (including prevalence of the disorder among Hispanics/Latinos); a discussion of a culturally variant presentation (if applicable) including a description of how the disorder might present with a Hispanic/Latino client, relevant cultural idioms of stress that are specific to the disorder, etc.; an overview of the "gold standard" treatment for the disorder (rooted in evidence-based principles) and a summary of the literature on this treatment with Hispanics/Latinos (if any); a treatment plan; and a series of handouts, tools, worksheets, informational sheets, etc. that can be used in sessions as part of the treatment plan. It is important to note that because there is limited research on actual treatment protocols with purely Latino participants, the majority of tools in this book are based in evidence-based principles but in and of themselves would not meet empirically supported treatment status.

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