

Spring 2014

# Cracking invisible barriers: A focus on mental health service use among immigrant Latinos in the United States

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Cracking Invisible Barriers: A Focus on Mental Health Service Use among Immigrant  
Latinos in the United States

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A research project submitted to the Graduate Faculty of

JAMES MADISON UNIVERSITY

In

Partial Fulfillment of the Requirements

for the degree of

Educational Specialist

Clinical Mental Health Counseling

May 2014

## Dedication

Me gustaría dedicar este proyecto de investigación para todas las personas que me ha permitido crecer culturalmente. Quiero agradecer el apoyo de mis padres, familia, amigos, y de mi mejor amigo/pareja J.S.

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## Abstract

Rapidly changing demographics often result in disparities in services offered for the population. Increasing Latino presence in many parts of the United States has yet to be recognized when developing adequate mental health care. This is specifically true with those who are less proficient in English. The purpose of this study is to explore the barriers many Latinos face when seeking mental health services. These barriers include sociological, cultural, and organizational factors that have been found to influence the underutilization rates of services by Latinos. By exploring these barriers, potential growth areas in the service provided for Spanish speaking clients will be identified. With this information, practical interventions will be offered to help mental health service providers in delivering services to Spanish speaking individuals in a more effective and therapeutic manner. Based on the findings of this study, other service providers who serve a diverse community may benefit from the practical interventions explored.

*Keywords:* mental health, Latino, immigrant, service disparities, less English proficiency

# Cracking Invisible Barriers: A Focus on Mental Health Service Use among Immigrant Latinos in the United States

## **Introduction**

Throughout the world, health care services are as varied as the types of individuals who seek them. The process of accessing health care can be vastly different depending on where an individual is located and the health policies in place within those locations. Even with the presence of an established health care system, there can be limited accessibility and/or availability of services. For many individuals and families in the United States (US), the process of obtaining health care services can be extremely difficult, expensive, and time consuming. The lack of free public services, lack of information within the community, and the limitations of what insurance plans can cover force many individuals to receive stabilization services instead of preventative care. This is especially true with groups that are already marginalized throughout the US. Of those groups, immigrant Latinos often face many unique barriers when seeking many types of mental health resources. A combination of environmental and cultural factors fuel increasing disparities between the mental health services provided for native and immigrant Latinos and those provided for members of majority cultures. By taking those considerations into account, service providers can lessen disparities while delivering adequate treatment to the Latino population. Service providers can also take certain steps to promote organizational change to influence future mental health utilization trends of immigrant Latino populations in the US.

## **Population Trends**

Latinos currently make up the largest ethnic/racial minority group in the US; there are approximately 50 million Latinos nationwide (Garcia, 2012) with foreign-born Latinos estimated to be nearly half of the population (Shantell, Hamilton, Starr, Jenkins, & Hinderliter, 2008). Latinos are expected to comprise nearly 25% of the US population by the year 2050. Latinos are also considered a young population, with over 30% under the age of 18 and nearly half under the age of 25 (Shantell et al., 2008). An increasing number of Latinos have been populating states unaccustomed to their presence over the last decade (Garcia, 2012). Out of the 50 states and 2 US territories, Latinos were found to be the largest ethnic minority group.

The Latino population has a large amount of within group differences. Jorge I. Ramirez (2012) defined Latinos as an ethnocultural group with individuals that share a common Latin language (e.g. Spanish and sometimes Portuguese) in the continent of America. Latinos originate from various countries found in Central and South America as well as many countries located in the Caribbean, such as Cuba and the Dominican Republic (Garcia, 2012). Along with a common language, many Latino countries also share a history of development and origin. Many Latino countries were first conquered by European nations such as Spain, France, and the United Kingdom before later gaining independence (Garcia, 2012). Latino populations commonly include native individuals as well as those of European descent, mestizo descent (a mixture of both native and European descent), and African descent in some groups in the Caribbean. Due to the diversity within the population, Latinos include white, black, and medium dark skin phenotypic expressions (Garcia, 2012).

Specifically looking at the US, one quarter (25%) of Latinos have incomes that qualify them as living in “poverty” and nearly 1/3 (32.4%) lack health insurance. Commonwealth Fund’s Health Care Quality Survey found that Latinos were significantly less satisfied with their health care services than European Americans (Polo, Alegria, & Sirkin, 2012). Furthermore, Latinos born in the US have been found more likely to experience depressive disorders, anxiety disorders, and substance use disorders than those born in their native countries (Shattell et al., 2008). Third generation Latinos have been found to have higher rates of these psychiatric disorders than first and second generation Latinos.

### **Youth**

Latinos are considered a young population. Studies have found that Latino youth in the US report higher rates of mental health issues such as anxiety, depression, and suicidal ideation and suicide attempts compared to non-Latino white and black youth (Garcia, Gilchrist, Vazquez, Leite, & Raymond, 2011). Latino youth also experience more behavioral problems such as delinquency and substance abuse compared as to their non-Latino counterparts (Bridges, Andrews, & Deen, 2012). Specifically with females, higher rates of suicide attempts have been found when compared to that of Latino male youth (Garcia et al., 2011). Latinos in the US have the highest rates of high school dropouts of any ethnic group, and some argue that without preventative mental health services, Latino youth are likely to exhibit risky behaviors that could lead to teen pregnancy and gang involvement (Shattell et al., 2008). Immigrant Latino youth face unique stressors that are likely to contribute towards the development of mental health issues as well as exacerbating already existing mental health concerns. These unique



stressors include acculturation pressure, familial separation, nativity status, lack of proper documentation (e.g. citizenship papers), and fears of deportation (Garcia et al., 2011).

With this impending demographic growth, the US will face difficulty dealing with untreated mental health problems among those who will soon make up a large proportion of the workforce and of parents (Garcia et al., 2011).

### **Elderly**

Elderly Latinos (over the age of 65) make up about 35 million people in the US and are expected to rise to nearly 70 million by 2030 (Weisman et al., 2005). Of those elderly Latinos, about 11% are considered to be foreign born. Comparing these two elderly populations in the US, foreign born elderly Latinos are more likely to live under poverty line and have more difficulty in accessing health care services (Weisman et al., 2005). Due to physical and cognitive deficits related to age, elderly Latino people are likely to face greater difficulties securing the means to flourish in the US such as acquiring a job and seeking outside community resources (Weisman et al., 2005). Immigrant elderly Latinos face unique stressors by immigrating to the US. By immigrating, Elderly immigrants frequently must alter or change their previous social roles they had in their native land (e.g. viewed as honored, valued or wise) (Weisman et al., 2005). Comparative to younger individuals, older Latinos are more likely to face struggles mastering language of their adoptive country. This acculturative stress for elderly immigrants can frequently be seen in multigenerational households. Generational differences often clash when younger Latino generations embrace US culture while elderly Latino insist on upholding previous cultural values and practices (Weisman et al., 2005). When the focus is on mental health research has found that elderly Latinos

significantly had more visits, longer length of mental health distress, and greater mental health care expenditures compared to non-Latino whites (Jimenez, Cook, Bartels, & Alegria, 2013). Some universal risks factors for mental health issues in older adults include severe physical illness, loss of spouse, low educational attainment, impaired functioning (both social and cognitive), and substance abuse (Chavez-Korell et al., 2012).

### **Immigrants**

Immigrants are among the most traumatized and vulnerable groups of people in the world because of the struggles associated with migrating to a new country. These include trauma associated with migration, individual or family disintegration and loss, marriage dissolution, and racial prejudice and discrimination (Weisman et al., 2005). Latino immigrants typically migrate to the US from countries such as Mexico and those located in the Caribbean and Central America. Typically, the immigration process is a response towards aspirations for a better life. Immigrants hope to establish themselves in the US in order to improve the quality of life for self and immediate and extended family back in their native country (Weisman et al., 2005). Some also seek refuge from political hardship in their country of origins.

Immigrants who decide to migrate have been found to be at a considerable risk for mental health issues. Traumatic events experienced in their home country (e.g. interpersonal violence, government instability, after effects of war) may have enduring psychological consequences on immigrants. Personal histories and experiences including while crossing the border, domestic violence/sexual abuse, and nostalgia for the homeland are common stressors for immigrants (Shattell et al., 2008). Latino immigrants can be considered a very heterogeneous group due to the large differences in racial

makeup, socioeconomic background, and level of education, English language proficiency (ELP), and country of origin (Weisman et al., 2005). Research has found that Latino immigrants who come from impoverished, rural backgrounds with little education face the most difficulty migrating and establishing themselves in the US. However, it's important to note that affluent Latino immigrants are not immune to pervasive mental health issues associated with the immigration process.

Many immigrants who are successful in migrating to the US often end up residing in either rural farm areas or large inner city neighborhoods (Jimenez et al., 2013). After going through the stress of coming into the US legally or illegally, Latino immigrants commonly face poverty, unemployment, and exposure to violence within their communities (Bridges, Andrews, & Deen, 2012). All of these stressors are shown to negatively affect mental health. In addition, Latino immigrants are typically disempowered in any host nation, especially those who enter the country illegally. Jorge Garcia (2012) argued that it may take generations for immigrants to become successful at climbing the ladder of economic-political power. Latino immigrants often identify themselves as people who are constantly being watched, discriminated against, marginalized, detained, prosecuted, and deported. This self-identity limits the amount of interaction Latinos are willing to have with others, the places they go, and the resources they believe they can access (Shattell et al., 2008). Despite rapid demographic shifts, public services (including mental health care) in these areas have not yet been able to catch up in meeting the needs of the growing Latino population found in the US.

### **Mental Health Utilization Trends**

US born Latinos and those who immigrate as children have been found to have rates of mental illnesses similar to those found in the general US population. According to the Surgeon General's report (2011) less than one in eleven Latinos with a mental health disorder would seek services from a mental health professional. In a survey that focused on identifying the service utilization among Latino immigrants, it was found that Latino immigrants are more likely to turn towards primary care physicians and religious leaders instead of mental health service providers (e.g. counselors and psychologists) for help with mental health concerns (Jimenez et al., 2013). Polo, Sirkin, and Alegria (2012) reported that Latinos were significantly less satisfied with their mental health care, compared to European Americans. Compared to European Americans, Latinos are typically less informed about diagnosis and prognosis, and are likely to feel dissatisfied with the lack of information provided (Polo et al., 2012). Latinos are also more likely to attend fewer sessions of treatment, discontinue medication and continue to remain symptomatic longer compared to European Americans (Polo et al., 2012). Latinos were also found to experience higher expenditures than other minority groups (Chavez-Korell et al., 2012). Overall, Latinos consistently underutilize mental health services and are less likely to receive mental health care that is consistent with current guidelines (Polo et al., 2012).

A study that assessed mental health needs and service utilization patterns in Latino immigrants found that most commonly used health service by immigrant Latinos were physician consultation (Bridges et al., 2012). Common symptoms reported by participants include symptoms such as diabetes, allergies, migraines, and other chronic illnesses (Bridges et al., 2012). Alternative healers were used by participants for concerns

such gastrointestinal or body aches and pains (Bridges et al., 2012). Mental health service providers (e.g. counselors, psychologists) were sought out by participants for issues such as depression, family problems, and domestic violence (Bridges et al., 2012). Religious leaders were also consulted for concerns similar to those presented to mental health service providers. Participants in this study indicated that they were more satisfied by the service provided by religious leaders and mental health service providers (compared to physicians and alternative healers) when alleviating mental health distress (Bridges et al., 2012).

### **Sociocultural Considerations of Mental Illness**

Mental illness can affect persons of any creed, color, or age. Just like other chronic illnesses, mental health issues can be life-long and require treatment to attenuate debilitating symptoms as well as prevent further decompensation. Cultural factors are likely to influence the conceptualization of health in general, including mental health in particular, held by Latinos. Level of acculturation should be considered before over generalizing these following trends to all individuals who identify as Latinos. Since many mental health concepts aren't well know and accepted outside of the Western world, Latinos often report mental distress through somatic presentation (Weisman et al., 2005). Somatic complaints such as difficulty sleeping, irritability, body aches, and digestive problems are more likely to be reported to service providers by Latinos compared to psychological distress symptoms such as depression, mania, or anxiety. Somatization (which is common in many ethno cultural groups) can have different meanings for different individuals – it can serve as a means of expression of disease, indication of psychopathology, a symbol of intrapsychic conflict, a culturally coded expression of

distress, or a means of expressing social disconnect (Shattell et al., 20082).

Psychotherapy in general can also be a “hard sell” to certain Latinos - short term visits may be interpreted as cold and impersonal, while longer term therapy may be viewed as excessive. Latinos often expect concrete treatments for the issues brought into therapy and the sometimes nebulous time frame of therapy can be seen as negative.

Being in therapy can also have many implications when viewed through a systems perspective. Typically, Latino culture highly values community and togetherness over individuality. The concept of familismo (family orientation and connectedness) encompasses immediate and extended family members, as well as close friends of the family. By seeking therapy, that identified client may be seen as disrespectful and cause shame and embarrassment towards their family and/or community (Shattell et al., 2008). Speaking about one’s personal issues can be viewed as taboo and unacceptable within a collectivist culture. Some Latinos can often be suspicious of practitioners and reluctant to disclose significant complaints or problems. They might feel that they’re neglecting their family’s needs by focusing on their own issues.

Culturally determined gender roles also influence the way Latinos view mental illness and use mental health services. Marianismo is a gender-specific value that encourages Latinas to be spiritually strong, morally superior, and nurturing. However, Latinas are also expected to sacrifice their own needs for their family, and be strong enough to endure all suffering on behalf of the family (Chavez-Korell et al., 2012). Most Latinas are also expected to manage all household and parenting duties. In public, women are expected to be respectful and honor their husband’s decisions. Isolation, overwhelming home and child care responsibilities, and abuse are likely to contribute to

women's mental distress, yet few women seek mental health services because they feel it requires their husband's permission (Shattell et al., 2005). Machismo is a gender-specific value that encourages men to be seen as the dominant figures in their families. Latinos are expected to be generally unforthcoming about feelings and emotions. Latinos are viewed as "breadwinners" and are primarily focused on attaining basic needs for their immediate families and extended families who may still live in their country of origin (Shattell et al., 2008). Men's reluctance to discuss their problems (compounded with stress) could lead to alcoholism, substance abuse, and violent behaviors.

Some Latinos often attribute mental illness to have some sort of supernatural component. For example, some immigrant Latinos may attribute their mental distress due to a demonic spirit attacking their body or as a malevolent act directed towards them (such a curse) (Weisman et al., 2005). As previously mentioned, this notion of a spiritual component towards mental illness leads some Latinos to seek help from religious leaders and folk healers in the community. There are also a number of culture bound syndromes within Latino culture such as "ataque de nervios" and "susto." Ataque de nervios directly translates as "nerve attack" and includes symptoms of uncontrollable screaming or shouting, crying, trembling, dissociative experiences, and verbal or physical aggression as a response to a stressful event (e.g. death in the family). Susto directly translates to "fear" and describes a response to a frightful experience. Symptoms of susto share a resemblance to mental issues such as anxiety and depression. While these syndromes are recognized by the Latino community, it's common for individuals and families dealing with these symptoms to seek out "curanderos" (shamans) to alleviate their distress. Acculturation stress can also have a big impact on mental health wellbeing. This is

especially true where there are generational differences within Latino households. Latino youth are likely to maneuver between cultures much easier than their parents/caretakers (Garcia et al., 2011). This can cause conflict within households where cultural values of the host nation clash with those of their home country. Role reversals between parent and child can also occur (e.g. child translating information for parent) depending on the family's level of acculturation (Garcia et al., 2011).

Despite these concerning alarming disparities for Latinos, certain studies have positive findings in terms of mental health prevalence. Overall, Latino Americans have been found to have lower rates of lifelong prevalence of any mental health disorder than non-Latino Whites; cultural factors such as resiliency within Latino communities and families may contribute to this finding (Lopez, Bario, Kopelowicz, & Vega, 2012).

### **Common Barriers**

There is no single barrier that prevents Latinos in the US from acquiring competent mental health care. A combination of factors is responsible for the utilization trends of mental health within the US Latino population. These barriers also impede Latinos from seeking other types of health services. Barriers such as lack of health insurance, costly expenditures associated to mental health cost, perceived inefficiency, language barriers, lack of transportation, no knowledge of services and fears of deportation are all important issues that should be addressed when focusing on service use for any minority group. The following is a focus on barriers that frequently obstruct Latinos from obtaining mental health care in the US.

One of the most obvious barriers deals with the lack of individual resources Latinos may have. This includes lack of insurance or the monetary resources needed to



get services without health insurance. As with most people who do not have adequate health care, uninsured Latinos are less likely to have an established medical source of care and are more likely to postpone seeking out care due to costs. Those costs also include supplementary sources of treatment such as follow ups, referrals, and prescriptions (Shattell et al., 2008). The cost of mental health care was also found to be a significant barrier. A combination of low skill sets and low education create limited job opportunities that may not provide enough resources to cover anything outside of what is needed for basic living (e.g. housing, food) (Shattell et al., 2008).

Latino Immigrants report experiencing discrimination when trying to acquire mental health services, which has been found to contribute to poor self-assessed mental health. Furthermore, undocumented Latino immigrants often describe feeling watched, discriminated against, marginalized and live with a constant fear of deportation (Bridges et al., 2010). Many immigrant Latinos believe that seeking any type of services would ultimately expose their immigration status and increase the likelihood of being detained, prosecuted, and deported (Bridges et al., 2010). Many areas throughout the US have in place anti-immigration policies which block immigrants to receive multiple kinds of public services available to others. The combination of being marginalized, isolated, and possibly exploited by the host nation creates mental health distress in immigrant Latinos as well as prevents them from receiving support to attenuate that distress (Shattell et al., 2008).

Another common barrier Latinos face when seeking services is the lack of knowledge of available services in the community. For example, many immigrant Latinos see a large power differentiation between themselves and service providers. This

perceived power difference leads many immigrant Latinos to take a much more complacent role in their interactions with professionals, and it is uncommon for immigrant Latinos to question their prescribed care from a doctor. Therefore, many immigrant Latinos would never receive mental health services because of the lack of inquiry into those services. Research has shown that as the level of acculturation to US values and knowledge about mental health services increases, so do utilization rates. Bridges et al. (2012) found that Latinos from Puerto Rico use mental health services at a higher rate than other Latino immigrants living in the US. This is likely due to the culture's familiarity with mainland US culture, traditions, and values.

As previously mentioned, mental health services are sometimes stigmatized in the eyes of Latinos (both native born and immigrant). Many believe that one can only seek mental health services when they are "loco" or crazy. The concept of actually paying someone to listen to one's problems may seem a bizarre concept to some Latinos and ultimately unfruitful (Shattell et al., 2008). This attitude that mental health services are available to only the severely mentally ill prevents many Latinos from seeking services for things such as depression, substance abuse, interpersonal concerns, and anxiety.

Besides lack of resources, stigma, and distrust towards the host nation, language may be the most salient barrier Latinos face when looking for mental health services. Despite the growing need and drastic population changes in the recent years, there is still a relatively small number of bilingual Spanish speaking mental health professional (MHP). While 40% of Latinos living in the US aren't proficient in the English language, only 1% of licensed psychologists speak Spanish (Bridges et al., 2012). Language

barriers can be troublesome in mental health care because, compared to other medical services, mental health diagnosis and treatment relies on direct communication rather than objective tests or medication (Platt, 2012). Compared to individuals who were English-proficient (EP), limited English-proficient (LEP) Latinos were significantly less likely to identify a need for services and experience longer duration of untreated disorders. LEP Latinos with mental health issues typically delay seeking services due to language barriers, even after recognizing a need for treatment (Bauer et al., 2010). Even if LEP Latinos do seek help for mental health issues, the quality of care and the competency of mental health providers may vary drastically. When LEP Latinos do locate a bilingual Spanish-speaking MHP, many face additional barriers such as long waiting lists, additional costs, and transportation issues (Bauer et al., 2010). A culturally competent bilingual MHP still isn't enough – documents must be translated, such as informed consent forms, depression informational material, questionnaires, and treatment worksheets. LEP individuals live with untreated disorders for significantly longer than their EP counterparts (14.6 years vs. 9.4 years). LEP individuals are less likely than EP counterparts to identify a need for treatment (Bauer et al., 2010). Although LEP is associated with age, nativity, lack of insurance and lower education, LEP remains associated with lower likelihood of lifetime treatment after adjustment for these and other variables, highlighting its importance as an independent contributor to disparities in care for mental health (Bauer et al., 2010).

The most effective means of building relationship with clients is to have the same culture and speak the same language. However, this is an almost unrealistic and impossible goal in many situations (especially in a nation that hosts various different

cultural backgrounds). When language is an apparent issue in delivering treatment, interpretive services are frequently used. Many LEP Latinos seek language services; a staggering 90% of Latinos who do seek mental health services use interpreters to receive care (Bridges et al., 2012). While this may alleviate some immediate stress by providing services to LEP Latinos, the use of an interpreter can have negative consequences. Some mental health service providers make the mistake of focusing their attention towards the interpreter rather than the identified client. This kind of interaction leads clients to form relationships with their interpreters rather than their service providers. Furthermore, some service providers may rely on culturally insensitive interventions when working with LEP Latinos (Santiago-Irizarry, 2001).

Seemingly practical strategies such as direct translation of materials often leave LEP Latinos confused and dissatisfied with the service provided to them. Even if languages share similarities, there are cultural differences in context and word choice that direct translation frequently does not take into account (Platt, 2012). While Spanish is a common language for mostly all Latinos, the language itself has its own nuances. Literal translation from English to Spanish can easily affect the way mental health service provided to Latino's with limited ELP. For example, the word "discutir" can mean "to talk about" as well as "to debate" (Polo et al., 2012). Literal translation of "discuta con tu proveedor" could be interpreted as "argue with your provider." Small details such as that can drastically alter the way LEP Latinos experience the service provided to them and ultimately influence utilization rates of future services use.

### **Clinical Experiences Working with Latino Immigrants**

While the transition of moving to the Shenandoah Valley from Miami, FL for graduate school seemed simple it took me a while to get accustomed to the perceived lack of diversity Harrisonburg had. Before moving here, speaking Spanish was something I did naturally throughout my day. I used it to communicate with friends, family, and people in the community. In Harrisonburg, I'd be lucky to find at least one person to speak Spanish every few months. The most I spoke Spanish here was when I would communicate with my family back home. I often worried that I would "lose my Spanish" which troubled me because I associate that ability very close to my personal identity as a 1<sup>st</sup> generation Latino. I often joke about other 1<sup>st</sup> generation Latinos that only know a few sentences in Spanish such as "Hola abuelita" or "Hi grandma." I feel close to my Nicaraguan heritage and I feel the need to not completely acculturate to the US value system. Speaking Spanish has been my way of both sharing my culture to the outside world and staying connected to my heritage.

What was particularly strange for me to realize is that Harrisonburg is actually a pretty diverse town. Thirty-five percent of Harrisonburg High School students are English language learners. The top foreign languages spoken by students are Spanish, Russian, and Kurdish. Many peers tell me that there are over 30 additional languages spoken at that school as well. When I hear this staggering fact, I think to myself "Where are all these diverse people!?" I want to see these minority groups have a presence in this town (similar to what my own hometown looks like). Even during my practicum and internship experiences, the majority of my clientele would identify as white. However, I have been fortunate enough to work with specifically immigrant Latinos throughout my graduate career.

I was first approached by my supervisor regarding a referral for a LEP Latino immigrant seeking services. Knowing that I knew Spanish, I was asked whether or not I would pick up the case. I immediately said yes; I felt it was my duty as a counseling intern to not refuse service due client characteristics. I also felt that it was my duty as a bilingual counseling intern to help someone who probably has had a difficult time finding services in the Shenandoah Valley. My understanding was that there was only one other Spanish speaking clinician in the area who was contacted regarding the same client. I was also looking forward to actually speaking Spanish with someone who wasn't my parents! This surge of excitement quickly subsided once I really started to think about what counseling someone in Spanish entails.

My first thought focused on the intake process. My internship site only had documents written in English. I would have to translate verbatim things such as informed consent, issues regarding confidentiality, releases for health information, sliding scale processes, and what the services I provide as a counselor all in Spanish. I also thought about future supervision regarding this client. I would joke around with fellow interns about how I practically could make up what my client reports in session due to my supervisor not being able to speak Spanish. I felt I had a certain level of power taking on this client as well as feeling alone with regards towards possible consultation with other clinicians due to the language barrier. I received the client's contact information and called to set up an initial appointment for the following week. Once I actually got the client sitting in front of me a whole new set of issues quickly arose.

I experienced some of the common barriers previously mentioned while providing services to this client. Transportation and payment options were the most pressing issues.

My client had no stable income. At that time, my client recently immigrated to the US, didn't have the proper documentation for work and was staying at a homeless shelter. Fortunately, I was able to communicate my client's situation to my internship site and was able to see this client for free. I realize that this type of exception would not have been possible if I was interning at a site that identified less as training facility for future clinicians. Transportation was a consistent barrier for my client; my client would frequently reschedule or cancel appointments throughout our time together due to lack of transportation. I'd consider the first two sessions with this client to be my most difficult clinical experience during my internship. I would frequently catch myself trying to translate all my common counseling phrases when responding to my client. I was quickly becoming self-conscious of my both my Spanish speaking and counseling abilities. I somehow felt the same way as when I first entered my graduate counseling program. I questioned whether or not I'd be able to actually provide therapeutic services in Spanish. After our second session I realized that while I'm not completely fluent in "psychological Spanish" I could still provide good-enough counseling to help this client achieve important personal goals.

Looking back at my work with this client, I'd say that rapport building seemed very natural yet different from my English speaking clients. My client and I each shared our personal cultural background; exploring things such as where we grew up (e.g. country of origin), favorite foods, and family history of immigration seemed to be an effective way of gaining trust with my client whose acculturation level to US values/culture was still low. Once trust was established, I was able to enter my client's world and explore current stressors and previous trauma that resulted from

immigrating illegally into the US. The majority of our work dealt with understanding and normalizing symptoms of anxiety and depression as a result of adjusting to a new environment as well as facing uncertainty surrounding future opportunities in the US. I also advocated for my client in regards to connecting with different community resources that could aid my client in acquiring proper documents for future housing and employment.

Even though I'm a fluent Spanish speaker, some cultural differences did come when working with this client. For example, during one session my client spoke about the children left behind in their native country. The client kept referring to the kids as "sipotes." Growing up, I would frequently hear my parents scream this word (sometimes with an expletive adjective attached to it) when I was being mischievous or bothersome. I always associated the word "sipote" with something negative. I was confused when I'd see my client speak about the "sipotes" left behind with tears in their eyes. Instead of just brushing off my own confusion, I brought it up at a later appropriate time. "Sipote" is a slang word commonly used in Central America referring to small children. While that one example didn't alter the growing therapeutic relationship, it did help me understand the importance of confusion in therapy. I encouraged my client to voice any confusion regarding my own Spanish as well as any questions regarding symptoms, diagnosis, prognosis, treatment methods, and even anything outside of the therapy session.

Throughout our work together, my client was able to move out of the homeless shelter with the help of community resources and extended family. We also began the process of obtaining the necessary requirements for a work visa and eventually towards citizenship. Near the end of our relationship, my client wanted to give me feedback and



appreciation for my counseling. My client stated to me “me has dado el chance para desahogarme” which basically means “you have given me the chance to vent my worries.” As I previously mentioned, literal translation of the Spanish language can sometimes cause more confusion. However, I like to remember the literal meaning of my client’s verbal memento. I feel that the Spanish language is extremely descriptive and naturally poetic. The word “desahogarme” literally translates to “undrown one’s self.” I feel that word perfectly summed up what I was able to offer my client. I was much more than a therapist to my client; I believe I was a person that was capable of bridging information from the outside world into my client’s isolated world. I never recognized how much power I had until I examined my clinical experience with this client.

### **Interventions and Recommendations**

The following are interventions and recommendations that have been found to be successful when working with Latino immigrants. However, one can infer that these strategies can also be helpful when working with Latinos who may not identify themselves as immigrants (e.g. 1<sup>st</sup> generation Latinos).

Many MHP and health agencies are challenged by task of maximizing the possible benefits for immigrant Latino clients (or any sort of specific clientele group) while still containing costs (Jimenez et al., 2013). Mental healthcare treatment choices are often chosen by “an objective weighing of risks and benefits of different treatments and outcomes” (Jimenez et al., 2013). However, a client’s personal preference and previous history of mental health services/treatments must also be taken into consideration. For immigrant Latino clients (and other racial or ethnic minorities), this includes personal beliefs regarding mental health care services and past discrimination.

Basic counseling skills such as building trust, credibility, and rapport are essential when working with clients regardless of their cultural or racial backgrounds. Building a therapeutic relationship acts as a support structure for future work with clients. With Latino immigrants, a simple strategies to help build this relationship revolves around including the family in the client's care as well as using culturally sensitive information gathering procedures(Weisman et al., 2005). Another strategy focuses on increasing mental health literacy in immigrant Latinos. Especially at the onset of mental distress, providing materials and information about mental health issues can help immigrant clients feel more secure about making important health care decisions (Lopez et al., 2012). Before treatment can start, clinicians must also be aware of the cultural implications regarding the treatment modalities decided to treat Latino immigrants. Since the majority of techniques or theories were founded on western values and beliefs, clinicians should be able to make cultural adaptations of empirically supported treatments (EST) and/or cross-cultural interventions.

Cultural adaptations are defined as “any modification to an evidence-based treatment that involves changes in the approach to service delivery, in the nature of the therapeutic relationship, or in components of the treatment itself to accommodate the cultural beliefs, attitudes, and behaviors of the target population” (Chavez-Korell et al., 2012, p.217). The National Institute of Mental Health stated that clinicians using culturally sensitive/cross-cultural interventions must follow specific guidelines when working with minorities groups. These guidelines include being knowledgeable cultural beliefs influence clients perspective about the nature of mental illness and its treatment; awareness how individuals from different cultures express mental health distress

differently; and have skills to diagnose mental disorders while avoiding culturally biased evaluations of behaviors and the pathologizing of culture (Chavez-Korell et al., 2012).

Clinicians should also explicitly state their roles as a therapist and inform their clients the reasons why they are in need of mental health services (Weisman et al., 2005).

Psychoeducation surrounding the impact of stressful life events (e.g. migration and acculturation) can be a simple and concrete way of explaining these clients. By following these guidelines, clinicians can set up safeguards for themselves as well as help better conceptualize the presenting concerns brought by Latino clients.

School based outreach and intervention programs have been found to be effective at targeting mental health issues for youth and their families (Garcia et al., 2011).

Strategies such as promoting knowledge of warning signs not only alleviate acute distress but also strengthen overall mental health literacy (Garcia, 2012). Teachers often act as mental health triage centers and assess behavior problems in classroom settings (outside community health agencies often sponsor in-school programs surrounding this issues) (Garcia et al., 2011). Latinos in the US have the highest high school dropout rates of any ethnic groups; up to 40% of Latino youth fail to graduate. To combat this alarming statistics, a combination of interventions will most likely require collaborative efforts that address system level policies community level services, and family/individual beliefs (Garcia et al., 2011). Creating incentives for Latino youth in school can also help increase the awareness of mental health for current and future youth. For example, advocacy groups can use scholarships (provided by companies, health care facilities, or other establishments of mental health authority) as an incentive for Latino youth to obtain degrees in human services professions and ultimately provide portion of their services

back to their community(Garcia, 2012).

When working with adult and elderly immigrant Latinos, understanding the possible traumatic events that conspired during the immigration process is vital (Weisman et al., 2005). This can be done by assessing possible acculturation stressors through and developing a “migration narrative.”Both can provide clinicians access into the client’s relevant cultural and migratory history (Weisman et al., 2005). This can also help clinicians identify the most significant issues that are likely to continue to stress immigrants Latino living in the US. Development of a migratory timeline, identification of stressors and current coping skills should be a standard procedure when working with this specific population.

Speaking about losses can also help both clinicians and clients. Clinicians can help clients feel understood and validated regarding their current situation in a new place. Many immigrant Latino clients suffer tremendous loss when migrating to the US These losses include tangible resources (e.g. jobs) and/or social statuses that can be associated with age or previous work (Weisman et al., 2005). Since many Latinos somatize their distress, clinicians are recommended to collaborate with other medical professionals to rule out any possible medical issues. Teaching these clients techniques that address to physical responses of mental issues may be helpful for Latino immigrant clients (Weisman et al., 2005). While there hasn’t been enough research to test the efficacy of many common treatment modalities in Latino immigrants, concepts of systematic desensitization, in vivo exposure, and mindfulness meditation appear consistent with the “here and now” and practical orientation to care often sought by many Latino clients (Weisman et al., 2005).

Specifically when working with older elderly Latino clients, clinicians may need to address the issue of dementia. While dementia has been found to be present in all cultures, research has found that Latinos may have higher rates of dementia than for other ethnic groups (Weisman et al., 2005). Since dementia tends to affect more recent memories first, clinicians are recommended that to treat elderly Latino clients in their first language and to emphasize culturally sanctioned practices of patient's early life experience (Weisman et al., 2005). However, this can be an unlikely approach due to common language barriers.

Assessing an immigrant Latino's level of English fluency is also vital before any therapeutic work can begin. A well-validated and reliable measure of the ability to understand, speak and read English among non-speaking is the Hazuda Acculturation and Assimilation Scale (Weisman et al., 2005). This 31-item scale can also be used to measure Latino health beliefs influenced by religion on occurrence of illness and chronic disease. Other strategies include simple direct questions regarding comfort in speaking English as well as assessing language abilities within the first few sessions of therapy (Weisman et al., 2005). If language seems to be a barrier in providing treatment, transferring clients to MHP proficient enough in Spanish or incorporating an interpreter or professional mental health translator may be needed (Weisman et al., 2005).

MHP that are able to work with Spanish-speaking clients have many opportunities to learn from their clients about their values and culture through language exchange. Mutual learning can occur when either client or MHP use unfamiliar phrases or experience cultural confusion within a therapy session (Polo et al., 2012). Research suggests that during the first few interactions with a client finding a commonality with

the client such as talking about children, food, or asking about the individual's interests. MHP shouldn't be surprised if clients ask questions not relating to mental health. MHP can use this opportunity to enhance the engaging process towards a therapeutic relationship. Providing answers to these off-topic questions allows for trust to be built and enables clients to feel more ultimately feel comfortable (Shattell et al., 2008). MHP must also recognize their own limitations regarding their language competency when working with Spanish-speaking clients. By doing so MHP can ensure that their own deficits in Spanish fluency does not interfere with the client's progress in therapy (Polo et al., 2012).

Research also suggests that service providers can help create a much more collaborative yet structured interaction with Latino clients by inviting them to ask questions, voice concerns and help them be more assertive (Shantell et al., 2008). Through empowerment, Latino clients can influence how providers respond to their concerns and ultimately improve the quality of care they receive from their providers. Latino clients can influence providers by providing a health narrative, asking questions, expressing concerns, and by being assertive (Polo et al., 2012). Questions should focus on the importance of clarifying and routinely reviewing critical aspects of persons mental health status, treatment options/prognosis, and systemic factors that shape the type/frequency/ and quality of care they receive (Polo et al., 2012). Developed by The Right Questions Project-Mental Health (RQP-MH) Latino clients can be coached through community- based services to ask specific questions when meeting with any health care service provider. These questions should focus around illness/prognosis/symptoms ("what is the definition of schizophrenia?"), treatment ("How do you decide on the

dosage for my medication?”) and health care system issues (“What are the differences between a psychologist and a psychiatrist?”). However, taking this role with a service provider may be challenging to some Latinos due to cultural norms and perceived power difference between client and service provider (Polo et al., 2012). Perceived power inequities should also be addressed with immigrant Latino clients.

### **Service improvement strategies**

Strategies have been also found to improve future services for Latino immigrants. Starting at a community level, MHP can collaborate with community leaders in many ways. Places such as schools, churches, public libraries, community centers, and other institutions that Latinos use to congregate and socialize without the fear of persecution/deportation are all areas where collaboration can occur (Shattell et al., 2008). These community centers are an invaluable source for the Latino population as they provide information and resources for immigrants, including how to get a driver’s license, housing information, job opportunities, educational resource, and both physical and mental health information (Garcia, 2012). By working closely with community leaders, MHP can ensure adequate training in recognizing and properly assessing mental health problems and establish a way to funnel referrals to needed services (Bridges et al., 2012).

From an organizational level, both MPH and agencies can advocate for more systemic changes to improve future mental health services for immigrant Latinos. However, MHP should be aware that anti-immigration attitudes may impede all these types of organization changes (Shattell et al., 2008). Implementation of things such as sliding scale programs, expansion of government programs such as Medicaid could improve the overall quality of care for Latino immigrants (Shattell et al., 2008). Other

advocacy opportunities can include local councils, health and mental health boards, or other similar policy making bodies. Adoption of the National Standards for culturally and linguistically appropriate services for health care would also improve also the quality of care. These standards include mandates for organizations must be able provide linguistically appropriate services (such as interpreters and culturally linguistically appropriate educational materials) in order to increase access, satisfaction, and maintenance of needed care for minority groups (Shattell et al., 2008). Federal public health resources should be allocated to provide mental health care for Latinos including grants to conduct research and disseminate services (Garcia, 2012). Until recently, the US didn't have a nationwide public health care system. This led public mental health services to rely on funding from programs such as Medicaid, Medicare, state/local funds, service grants and donations (Shattell et al., 2008). Attention should be placed on the recent changes to the US health care system and how it may or may not change the way immigrant populations may receive care.

Jose Garcia (2012) suggests that policy creation, intervention, and research for mental health care for immigrants could also be done through a social justice/public health lens. Social Justice is described as “the provision of basic human needs to all individuals regardless of background, ensuring the vulnerable populations such as (immigrants) are treated with fairness”(Garcia, 2012, p.314). In terms of the mental health field, immigrants should be provided mental health services despite their perceived contributions to the US Common social justice/public health approaches that can influence the future service provided to Latino immigrants include conducting epidemiological studies, needs assessments within immigrant communities, promoting



wellness through prevention and early detection, and research towards development of culturally sensitive empirically supported treatments (Garcia, 2012). The World Health Organization recommends that service providers work from more of an integrated health approach. By combining mental health care with primary care, agencies can improve the detection of mental health issues at early stages before those issues escalate and become even more costly. Criminal justice agencies can also use this approach with outside service providers (Garcia, 2012).

Another way MHP can advocate and ultimately influence future services provided to immigrant Latinos is through Health equity. Health equity is the concept that a whole society benefits from promoting overall population health (Garcia, 2012). Proponents of this approach argue that healthier immigrants more productive than unhealthier ones and by providing mental health services to immigrants would influence and improve how a society provides services to the whole population (Garcia, 2012). Health Equity also emphasizes that individuals not only attain the highest levels of wellbeing but are also able to have opportunities access to education and other resources to functional and fulfilling life (Garcia, 2012).

Lastly, recruitment can also be an effective way of influencing future service provided to immigrant populations within the US. There is an obvious deficit in the mental health field revolving around bilingual service providers. The need for competent Spanish speaker service providers is clearly apparent due to the drastic demographics changes throughout the US Greater efforts should be made to recruit bilingual students into medical and mental health professions and, once recruited, efforts to retain and support these students should be critical. Other strategies include creating incentives to bilingual

MHP to work in specific high immigrant population communities. Incentives can include higher pay, lucrative benefit plans, and public school loan forgiveness.

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