



# Adaptation Guidelines for Serving Latino Children and Families Affected by Trauma

By  
The Workgroup on  
Adapting Latino Services

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*December 1, 2008*



A PARTNER IN  
**NCTSN**

The National Child  
Traumatic Stress Network

## **Chadwick Center for Children and Families, Rady Children's Hospital, San Diego**

The Chadwick Center is a Child Advocacy Center located on the campus of Rady Children's Hospital in San Diego, CA. It is one of the largest centers of its kind and is staffed with more than 120 professionals and para-professionals in the field of medicine, social work, psychology, psychiatry, child development, nursing and education technology. We have made lasting differences in the lives of thousands of children and families since opening our doors in 1976. The staff is committed to family-centered care and a multidisciplinary approach to child abuse and family violence. Our Mission is to promote the health and well-being of abused and traumatized children and their families. We will accomplish this through excellence and leadership in evaluation, treatment, prevention, education, advocacy, and research. Our Vision is to create a world where children and families are healthy and free from abuse and neglect.

## **The National Child Traumatic Stress Network (NCTSN)**

Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) is a unique collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and attention to cultural perspectives, the NCTSN serves as a national resource for developing and disseminating evidence-based interventions, trauma-informed services, and public and professional education.

The Network comprises 70 member centers - 45 current grantees and 25 previous grantees-and is funded by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services through a congressional initiative: the Donald J. Cohen National Child Traumatic Stress Initiative.

## **Suggested Citation:**

The Workgroup on Adapting Latino Services. (2008). *Adaptation guidelines for serving Latino children and families affected by trauma* (1st ed.). San Diego, CA: Chadwick Center for Children and Families.

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## **Funding Information**

This document is supported with funding from grant award No. 5-U79-SM054289-05 from the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. This document reflects the thinking of many individuals and organizations, as well as information from valuable resource documents and documents describing federal laws and policies. It does not necessarily represent official policy or positions of the funding source.

Document Available from:  
Chadwick Center for Children and Families  
Rady Children's Hospital, San Diego  
3020 Children's Way, MC 5131  
San Diego, CA 92123

Also available on the web at [www.chadwickcenter.org](http://www.chadwickcenter.org)

# Acknowledgements

These Adaptation Guidelines represent a collaborative effort between the Chadwick Center for Children and Families at Rady Children's Hospital, San Diego, the National Child Traumatic Stress Network (NCTSN) and the numerous Steering Committee and subcommittee members who comprised the Workgroup on Adapting Latino Services (WALS). In particular, the following individuals were instrumental in the creation of these guidelines:

## WALS Chairs

Lisa Conradi, PsyD - Chadwick Center for Children and Families, Rady Children's Hospital, San Diego  
Alison Hendricks, LCSW - Chadwick Center for Children and Families, Rady Children's Hospital, San Diego  
Clorinda Merino, MEd - Chadwick Center for Children and Families, Rady Children's Hospital, San Diego

## WALS Consultant

Michael de Arellano, PhD - National Crime Victims Center, Medical University of South Carolina

## WALS Guidelines Design

Jennifer Demaree, MS - Chadwick Center for Children and Families, Rady Children's Hospital, San Diego

## WALS Steering Committee

- Assessment - Carla Danielson, PhD, National Crime Victims Center, Medical University of South Carolina
- Provision of Therapy - Michael de Arellano, PhD, National Crime Victims Center, Medical University of South Carolina
- Communication and Linguistic Competence - Luis E. Flores, MA, LPC, LCDC, RPT-S, Serving Children and Adolescents in Need, Inc. (SCAN)
- Cultural Values - Magdalena Perez, PhD, I3 Research
- Immigration/Documentation - Susana Rivera, PhD, Serving Children and Adolescents in Need, Inc. (SCAN)
- Child Welfare/Resource Families - Jorge Cabrera, MSW, ACSW, Casey Family Programs, San Diego Field Office
- Service Utilization and Case Management - Ana Bridges, PhD, University of Arkansas
- Diversity Among Latinos - Clorinda Merino, MEd, Chadwick Center for Children and Families, Rady Children's Hospital, San Diego
- Research - Kristen McCabe, PhD, University of California, San Diego, Child and Adolescent Services Research Center, Rady Children's Hospital, San Diego
- Therapist Training and Support - Carmen Ortiz Hendricks, DSW, ACSW, LMSW, Yeshiva University
- Organizational Competence - Ken Martinez, PsyD, Technical Assistance Partnership, American Institutes for Research and Ernestine Briggs-King, PhD, Duke University School of Medicine, the National Center for Child Traumatic Stress and the Center for Child and Family Health
- System Challenges and Policy - Lisa Conradi, PsyD, Chadwick Center for Children and Families, Rady Children's Hospital, San Diego

## WALS Subcommittees

### Assessment Subcommittee:

- Michael de Arellano, PhD - National Crime Victims Center, Medical University of South Carolina, Charleston, SC
- Scott D. Cicero, PhD - Rockland Children's Psychiatric Center, NY State Office of Mental Health, Orangeburg, NY
- Lisa Conradi, PsyD - Chadwick Center for Children and Families, Rady Children's Hospital, San Diego, CA
- Clorinda Merino, MEd - Chadwick Center for Children and Families, Rady Children's Hospital, San Diego, CA
- Alison Hendricks, LCSW - Chadwick Center for Children and Families, Rady Children's Hospital, San Diego, CA

### Provision of Therapy Subcommittee:

- Denise Chavira, PhD - University of California, San Diego, Child and Adolescent Services Research Center (CASRC), Rady Children's Hospital, San Diego
- Manuela Diaz, PhD - Child Trauma Research Project, University of California, San Francisco
- Lisa Gutiérrez, PhD - Child Trauma Research Project, University of California, San Francisco
- Alison Hendricks, LCSW - Chadwick Center for Children and Families, Rady Children's Hospital, San Diego
- Kristen McCabe, PhD - Child and Adolescent Services Research Center (CASRC), Rady Children's Hospital, San Diego
- Katherine Elliott, PhD, MPH - Center for Reducing Health Disparities, UC Davis Medical Center

#### Communication/Linguistic Competence Subcommittee:

- Marjorie Blair, MA - Retired
- Clorinda Merino, MEd - Chadwick Center for Children and Families, Rady Children's Hospital, San Diego
- Gabriela Perez, MA, LPC - Serving Children and Adolescents in Need, Inc. (SCAN)
- Carmen Noroña, MS Ed - Child Witness to Violence Project, Boston Medical Center
- Lucila Jimenez, MA, M Phil—Harlem Hospital Center
- Griselda Oliver-Bucio, MS—Child Trauma Research Project, University of California, San Francisco

#### Cultural Values Subcommittee:

- Gladys Valdez, PhD - University of Texas, Austin
- Veronica Bordes, MA - Doctoral student, Arizona State University, Tempe
- Nicolas Carrasco, PhD - Private Practice, Adjunct Faculty, University of Texas, Austin

#### Immigration/Documentation Subcommittee:

- Suzana G.V.H. Adams, MA - Synchrony of Visalia, Inc.
- Alison Hendricks, LCSW - Chadwick Center for Children and Families, Rady Children's Hospital, San Diego
- Blanca Nelly Hernandez, PhD - DePelchin Children's Center
- Dante Jimenez, MA, LPC, NCC - Aliviane, Inc.
- Gerardo Rosas, MA, LPC - Aliviane, Inc.

#### Child Welfare/Resource Families Subcommittee:

- Sonia Velasquez - Children's Division, American Humane Association
- Alan Dettlaff, PhD - Jane Addams College of Social Work, University of Illinois-Chicago
- Joan Rycraft, PhD - University of Texas at Arlington
- Elena Cohen, MSW - JBS International
- Zulema Garza, MSW - Casey Family Programs, San Antonio field office
- George Gonzalez, MSW - Casey Family Programs, Seattle field office
- Leo Lopez - Casey Family Programs, Yakima field office
- Peter Pecora, PhD - Casey Family Programs, Seattle Headquarters
- Raquel Flores, MA - American Humane Association

#### Service Utilization/Case Management Subcommittee:

- Elizabeth Lindley - University of Arkansas, Department of Psychology

#### Diversity Among Latinos Subcommittee:

- Silvia Barragan, LCSW - Private Practice, San Diego, CA
- Lourdes Diaz-Infante - Municipal Institute of Women, Tijuana, Mexico

#### Research Subcommittee:

- Anabel Bejarano, PhD - Private Practice and Alliant International University
- Andres Sciolla, MD - University of California, San Diego
- Alejandra Postlethwaite, MD - University of California, Los Angeles
- Elissa Brown, PhD - St. John's University
- Joaquin Borrego, PhD - Texas Tech University

#### Therapist Training and Support Subcommittee:

- Alison Hendricks, LCSW - Chadwick Center for Children and Families, Rady Children's Hospital
- Omar López, MSW - Health and Human Service Administration, Child Welfare Services, San Diego

#### Organizational Competence Subcommittee:

- Roxanne Flint, MA - Duke University

#### Policy Subcommittee:

- Ernest D. Marquéz, PhD - Former Associate Director for Special Populations (Retired), National Institute of Mental Health (NIMH)

### **Additional WALs Reviewers and Contributors**

Patricia Arredondo, PhD - University of Wisconsin, Milwaukee  
Ruth Campbell, LCSW - International Institute of New Jersey  
Luisa Canales - Chadwick Center for Children and Families, Rady Children's Hospital, San Diego  
Elena Cohen, MSW - JBS International  
Scott D. Cicero, PhD - Rockland Children's Psychiatric Center, NY State Office of Mental Health  
Sylvia Fisher, PhD - SAMHSA, Child, Adolescent, and Family Branch  
Peter Guarnaccia, PhD - Institute for Health Research, CSHP, Rutgers University  
Marisa Kaprow, LCSW - Chadwick Center for Children and Families, Rady Children's Hospital, San Diego  
David Ley, PhD - New Mexico Solutions  
Ernest D. Marqu ez, PhD - Former Associate Director for Special Populations (Retired), National Institute of Mental Health (NIMH)  
Michael Paul Melendez, MSW, PhD - Simmons College School of Social Work  
Cambria Rose, LCSW - Chadwick Center for Children and Families, Rady Children's Hospital, San Diego  
Leslie Ross, PsyD - Children's Institute, Inc.

### **WALS Focus Group Participants**

Maite Acedo, MFT - Community Mental Health, County of Marin  
Suzana G.V.H. Adams, MA - Synchrony of Visalia, Inc.  
Lorena Avitea, LCSW - Chadwick Center for Children and Families, Rady Children's Hospital, San Diego  
Monica Beltran, LCSW - Kennedy Krieger Family Center  
David Bond, LCSW - Chadwick Center for Children and Families, Rady Children's Hospital, San Diego  
Martin Boron, MFT - Southeast Community Mental Health  
Jennifer Burdeaux, MSW Intern - Chadwick Center for Children and Families, Rady Children's Hospital, San Diego  
Ruth Campbell, LCSW - International Institute of New Jersey  
Luisa Canales - Chadwick Center for Children and Families, Rady Children's Hospital, San Diego  
Gabrielle Cerda, MD - Rady Children's Hospital, San Diego, Outpatient Psychiatry  
Mauricio Cruz y celis, MFT - Chadwick Center for Children and Families, Rady Children's Hospital, San Diego  
Loretta Chavez - Parents for Behaviorally Different Children  
Manuela Diaz, PhD - UCSF Child Trauma Research Project  
Paula Dominguez - Oklahoma Child Traumatic Stress Collaborative  
Teresa Dunbar, PhD. - Division of Child Mental Health, Delaware  
Migali Fana - National Alliance of Multi-Ethnic Behavioral Health Associations  
Sylvia Fisher, PhD - SAMHSA, Child, Adolescent, and Family Branch  
Luis Flores, MA, LPC, LCDC, RPT-S - Serving Children and Adolescents in Need, Inc. (SCAN)  
David Ley, PhD - New Mexico Solutions  
Luis Morones, MFT - Private Practice, San Diego, CA  
Magdalena Perez, PhD - i3 Research  
Ken Martinez, PsyD - Technical Assistance Partnership, American Institutes for Research  
Betty Ribeiro, MFT - Southeast Community Mental Health  
Marianne Rickards, LCSW - Chadwick Center for Children and Families, Rady Children's Hospital, San Diego  
Paola Santana - Parents for Behaviorally Different Children  
Jacque Smith, MFT - Chadwick Center for Children and Families, Rady Children's Hospital, San Diego  
Elizabeth Suarez Kuneman, MS - Department of Services for Children, Youth, and their Families  
Erica Torres, PsyD - UCSF Child and Adolescent Sexual Assault Recovery Center  
Elias Villafa a, LCSW - Chadwick Center for Children and Families, Rady Children's Hospital, San Diego  
Christauria Welland, PsyD - Health Transformations

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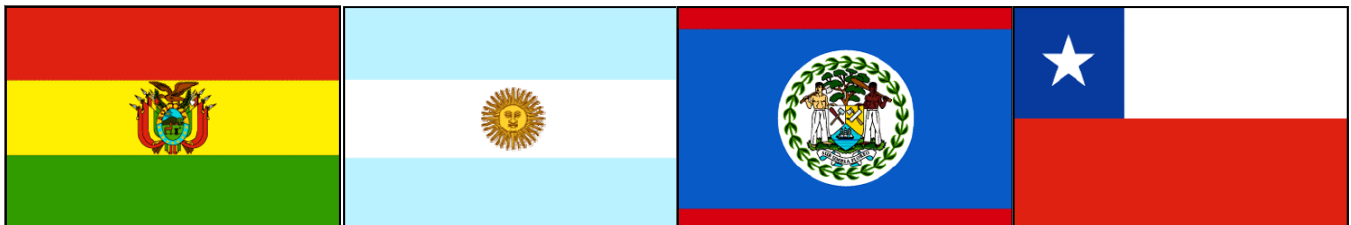
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# Overview of the Project

Latinos/Hispanics are the largest and fastest growing ethnic group in the United States. The U.S. Census Bureau (2006) reported that 14.8% of the entire U.S. population was comprised of Latinos/Hispanics and that Latinos/Hispanics accounted for one half of the nation's growth between 2000 and 2006. However, Latinos are over-represented in the child welfare system. Latinos represent 18% of children reported as maltreated in 2006 (U.S. Department of Health and Human Services, Administration for Children and Families, 2008). While Latino children and families are experiencing higher rates of child maltreatment, there is still a lack of resources for clinicians, administrators, policy makers, and organizations that serve Latino children and families (McCabe, Yeh, Garland, Lau, & Chavez, 2005). Latino/Hispanic-focused groups, such as the National Latino Behavioral Health Association and the National Alliance for Hispanic Health, are taking the lead in meeting the general mental health needs of the Latino/Hispanic community, and serve as a resource for clinicians working with these populations. However, in our review of available community resources, we found that, while many organizations serve Latino/Hispanic children and families, there were a number of domains identified that were in need of improvement. For example, of the evidence-based practices identified in the National Registry of Evidence-based Practices and Programs (NREPP; [www.nrepp.samhsa.gov](http://www.nrepp.samhsa.gov)), and on the National Child Traumatic Stress Network (NCTSN) Promising Practices website ([www.nctsn.org](http://www.nctsn.org)), very few have trials evaluating the effectiveness of these methods with Spanish-speaking populations. In addition, although many of the standardized assessment measures used with trauma populations have been translated into Spanish, and some have been back translated, very few of these have rigorous research into the psychometric properties for the Latino population (Achenbach & Rescorla, 2001; Benjet, Hernández-Guzmán, Tercero-Quintanilla, Hernández-Roque, & Cjhartt-León, 1999; Maddox, 1997; McMurtry & Torres, 2002).

In an effort to improve services for Latino/Hispanic children and families who have experienced trauma, the Chadwick Center for Children and Families in San Diego, California, has coordinated a national effort to create *Adaptation Guidelines for Serving Latino Children and Families Affected by Trauma* as part of the National Child Traumatic Stress Network (NCTSN), with funding from the Substance Abuse and Mental Health Services Administration (SAMHSA). Experts in the fields of child trauma research, clinical practice, policy, and cultural diversity participated in multiple focus groups. These focus groups were designed to identify key priority areas that should be addressed when adapting evidence-based practice, and mental health practice in general, to fit the needs of Latino/Hispanic children and families affected by trauma. The focus group participants identified the following priority areas to be addressed (See Appendix A for a full description of each priority area):

- Assessment
- Provision of Therapy
- Communication and Linguistic Competence
- Cultural Values
- Immigration/Documentation
- Child Welfare/Resource Families
- Service Utilization and Case Management
- Diversity Among Latinos
- Research
- Therapist Training and Support
- Organizational Competence
- System Challenges and Policy





**Priority Area Guideline Format**

Based on the priority areas, a Steering Committee of national experts was created to oversee the creation of Priority Area guidelines. Each Steering Committee member was asked to oversee a small subcommittee who worked together to complete a guideline for each priority area. Each guideline is very brief (4 pages) and contains the following sections which can be easily found using their corresponding icon:

 <p><b>Background:</b></p>	<p>Subcommittees were asked to provide some background information on their priority area. This information included a brief literature review providing some history of the problem, and current status of the field related to this priority area. They were asked to describe the current information we have regarding this issue as succinctly as possible and provide a review of any research that has been conducted on this topic.</p>
 <p><b>Statement of the Issue:</b></p>	<p>Based on the information provided in the Background, subcommittees were asked to provide a very brief abstract, or a “Statement of the Issue.” This extremely succinct review is designed to provide the reader with a snapshot of the issue and encourage them to read more.</p>
 <p><b>Recommendations from the Field:</b></p>	<p>Based on the information in the literature and work currently being done in each priority area, subcommittees were asked to generate 5-10 general recommendations for addressing the issue in a culturally-appropriate and effective way. This may include suggested solutions, and a description of what success “looks like.”</p>
<p><b>Recommendations on Promoting Resilience in this priority area:</b></p>	<p>In order to encourage a strengths-based approach, subcommittees were also asked to consider how to best promote resilience within their priority area. Subcommittees provided at least two recommendations related to promoting resilience.</p>
<p><b>Recommendations on Partnering with Youth/Families in this priority area:</b></p>	<p>Subcommittees were also asked to provide at least two additional recommendations that focused on the best ways to partner with youth and families when addressing their priority area.</p>
 <p><b>Community Examples/ Best Practices:</b></p>	<p>Subcommittees were asked to list up to three examples of community examples or programs that have successfully navigated the priority area. While some of the community examples represent Latino/Hispanic families, overall we found a lack of related Community Examples that were specific to Latinos/Hispanics. This highlights the need for more work in this area. Therefore, some of the examples include programs that have a strong general framework that can be adapted to fit the needs of Latino/Hispanic families. In most cases, a relevant contact person or web address is listed so that the reader can access this information. Readers are also encouraged to search for good community examples in their local area.</p>
 <p><b>Resources:</b></p>	<p>Since the subcommittees had very little room to adequately describe the issue and relevant recommendations, they were asked to list at least five additional resources that the audience can refer to for more information regarding this priority area. These include books, websites, key reports, conference proceedings, and webinars focused on the topic.</p>
 <p><b>References:</b></p>	<p>All references cited within each priority area of the Adaptation Guidelines should be listed in the priority area’s References section.</p>



## Priority Area Guideline Review Process

Once each subcommittee completed their priority area guideline, it was preliminarily reviewed by the WALs Chairs to ensure that all of the necessary information was contained within it. Following this review, it was sent out for multiple reviews by other subcommittee members, the National Child Traumatic Stress Network Culture Consortium, and other individuals in the field to ensure that all relevant information was covered. The priority areas were then combined to create the overall Adaptation Guidelines document. The final document is designed to be viewed either in its entirety or by individual priority area.

## Intended Audience

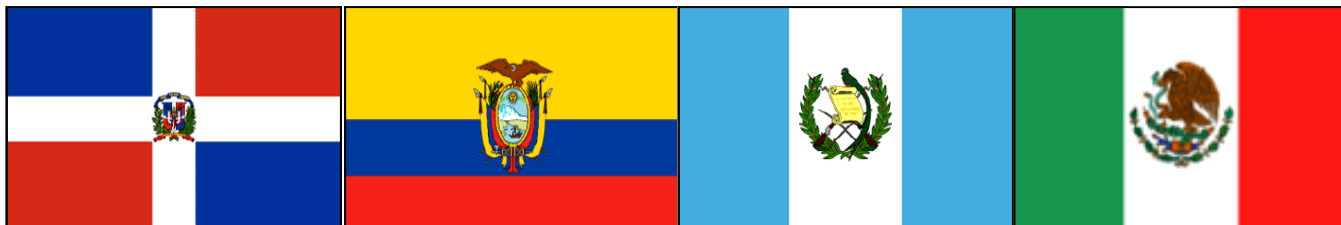
These Adaptation Guidelines have been designed for use by anyone who is interested in better serving Latino/Hispanic children and families who have been impacted by trauma. Some of the content and recommendations are more relevant for advocates and therapists, while other content and recommendations are designed for program administrators and policy makers.

Since Spanish-speaking Latinos/Hispanics are the largest and fastest growing ethnic group in the U.S., this document was designed to provide adaptation guidelines for serving Spanish-speaking Latino/Hispanic individuals who are receiving care for trauma within the United States. Unfortunately, it is beyond the scope of this document to address the needs of Latin countries that speak languages other than Spanish (i.e., Portuguese or native languages). We encourage the development of guidelines specifically designed to meet the needs of those populations.

### A Note about Terminology

Additionally, a key discussion point that must be addressed in any document focusing on the Latino/Hispanic population is the use of terminology. Specifically, across the literature, there is mixed use of the terms “Latino” and “Hispanic.” The terms “Latino” and “Hispanic” are used interchangeably by the U.S. Census Bureau and throughout this document to identify persons of Mexican, Puerto Rican, Cuban, Central and South American, Dominican, and Spanish descent; they may be of any race. In many instances, one term is used instead of another because that is how it was used in the source document or reference that is being cited. Where appropriate, we chose to use both as, “Latino/Hispanic” to encompass both groups and minimize confusion.

While there may be some confusion regarding terminology within the field, it is the recommendation of the entire Workgroup on Adapting Latino Services (WALS) that it is best practice to use the terminology that the client uses to self-identify. That is, if a client identifies as, “Latino” or “Hispanic”, the service provider should mirror that terminology in their work with the client.



# Background

The adaptation of services for Latinos/Hispanics is a necessity that has resulted from many changes in the past decade within the trauma field and the U.S. population. Eleven different areas help clarify these changes and explain the need for these adaptations:

- Childhood Trauma
- Responses to Trauma
- Latinos/Hispanics in the United States
- Culture and Trauma
- Latino/Hispanic Children and Trauma
- Risk Factors
- Cultural Competence and Culturally Appropriate Services
- Service Utilization and Policy Implications
- Evidence-Based Treatment
- Evidence-Based Practices with Latino/Hispanic Families
- Adapting Evidence-Based Practices for Latino/Hispanic Populations

In the following pages, these areas will be described with emphasis on how they influence the need for the adaptation of services for Latinos/Hispanics.

## Childhood Trauma

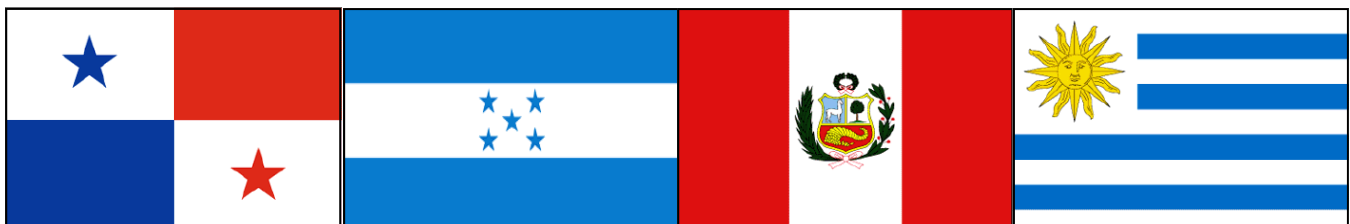
The problem of childhood trauma has become more prominent during the past 10 years, in large part due to the establishment of the National Child Traumatic Stress Network (NCTSN) in 2000, which is funded through the Donald J. Cohen National Child Traumatic Stress Initiative. This initiative aims to improve services to children affected by trauma and promote collaboration between trauma service providers through a series of federal grants. Childhood trauma is defined as “experiencing a serious injury to yourself or witnessing a serious injury to or the death of someone else...facing imminent threats of serious injury or death to yourself or others, or...experiencing a violation of personal physical integrity” ([www.nctsn.org](http://www.nctsn.org)). Traumatic events evoke feelings of terror and helplessness and may be acute (single episode) or chronic (multiple episodes).

Studies have reported high rates of trauma among children in the United States. For example, Costello, Erkanli, Fairbank, and Angold (2002) found that 25% of their sample of 9-16 year olds had recently experienced a potentially traumatic event. Table 1 displays the breakout of types of trauma experienced from a national sample of 12-17 year olds (Kilpatrick et al., 2003).

Type of Trauma	%
Sexually assaulted	8%
Physically assaulted	17%
Witnessed Violence	39%

(Kilpatrick et al., 2003)

There are many mental health treatment options for children who have experienced trauma. The Kauffman Report (Chadwick Center for Children and Families, 2004) provided information on various treatment models and rated them for efficacy. Best practices in the field of childhood trauma include many evidence-based practices (EBPs), which have shown through research to effectively reduce negative trauma effects among children.



# Responses to Trauma

Immediate responses to trauma are characterized by:

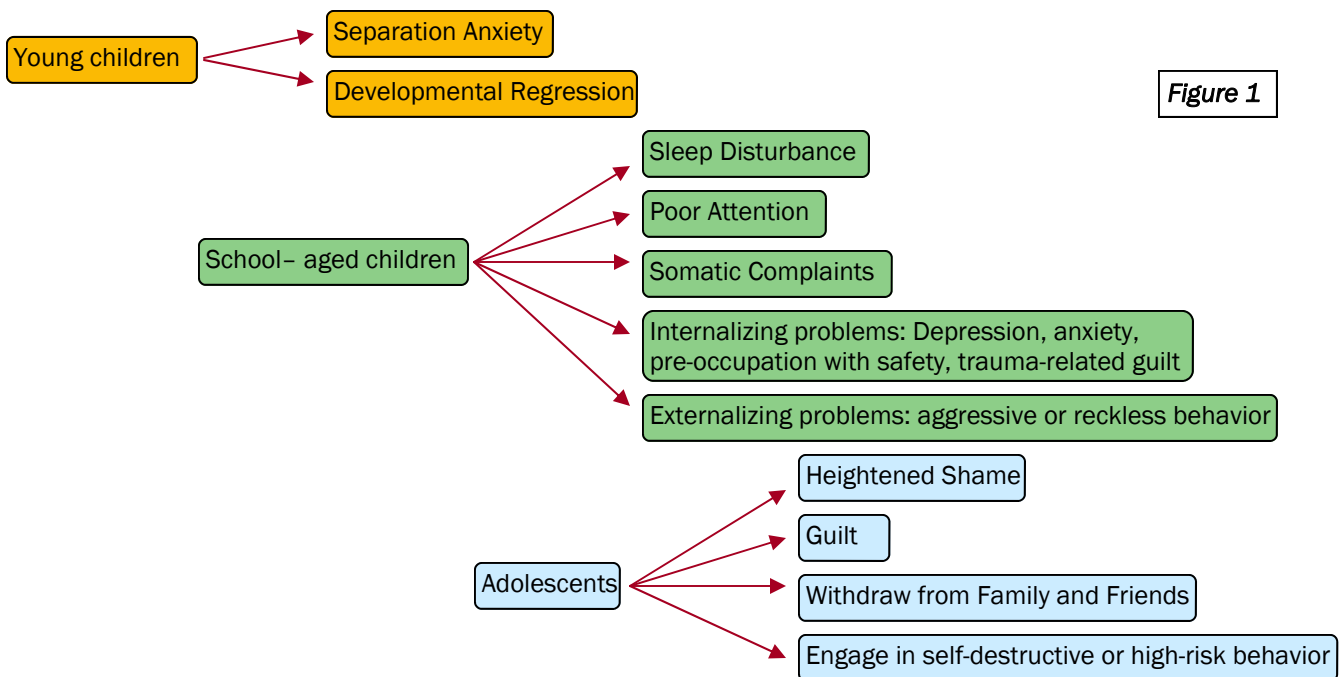
- Terror
- Shock
- Fear
- Horror
- Helplessness
- Physiological reactions.

Post-traumatic symptoms often persist, such as:

- Intrusive reactions
  - ⇒ Re-experiencing
  - ⇒ Nightmares
  - ⇒ Distressing memories
- Avoidance and withdrawal reactions
  - ⇒ Not talking about the trauma
  - ⇒ Avoiding trauma reminders
  - ⇒ Emotional numbing
- Hyperarousal reactions
  - ⇒ Exaggerated startle response
  - ⇒ Hypervigilance
  - ⇒ Irritability
  - ⇒ Poor concentration.

(Cook, Blaustein, Spinazzola, and van der Kolk, 2003)

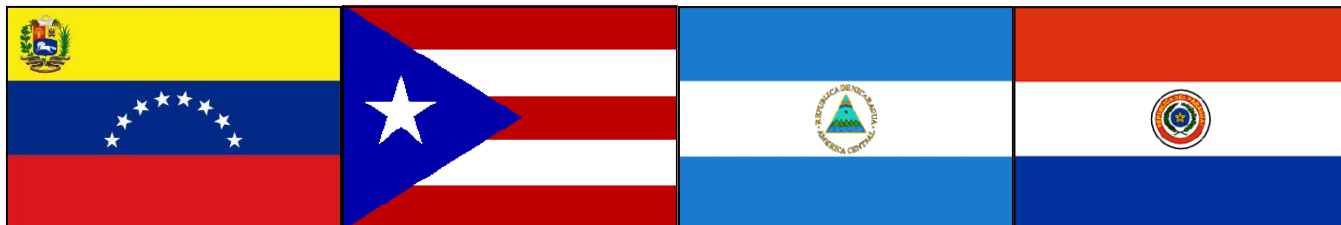
The NCTSN ([www.nctsn.org](http://www.nctsn.org)) describes typical trauma reactions among children of different ages. Figure 1 below shows these reactions for the three major age groups.



Traumatic experiences during childhood have been linked to numerous long-term health and social problems, such as:

- Alcohol and drug abuse
  - Domestic violence
  - Depression
  - Sexually transmitted diseases
  - Heart disease
  - Suicide attempts.
- (Felitti et al., 1998)

These costly effects highlight the importance of making appropriate and timely treatment available to all children who suffer from post-traumatic reactions.



## Latinos/Hispanics in the United States

There has also been increased attention over the past decade to issues of cultural diversity and cultural sensitivity in mental health services, including a focus on Latinos/Hispanics, which are the largest and fastest growing ethnic group in the U.S. The U.S. Census Bureau (2006) reported that 14.8% of the entire U.S. population was comprised of Latinos/Hispanics and that this ethnic group accounted for one half of the nation's growth between 2000 and 2006. There are diverse Latino/Hispanic populations residing in this country, each with their own rich cultures and identities, see the Table 2.

<b>Table 2. Latino Populations in U.S.</b>	<b>%</b>
Mexican Americans	64.0%
Puerto Ricans	9.0%
Cubans	3.4%
Dominicans	2.8%
Central Americans	7.6%
South Americans	5.5%
Other Hispanic/Latin American countries	7.7%
(U.S. Census Bureau, 2006)	

There are common values among Latino/Hispanic groups, such as:

- *Familismo*
- *Simpatia*
- *Respeto*
- *Personalismo*
- Religion/Spirituality. (Dingfelder, 2005)

There are also significant differences, such as:

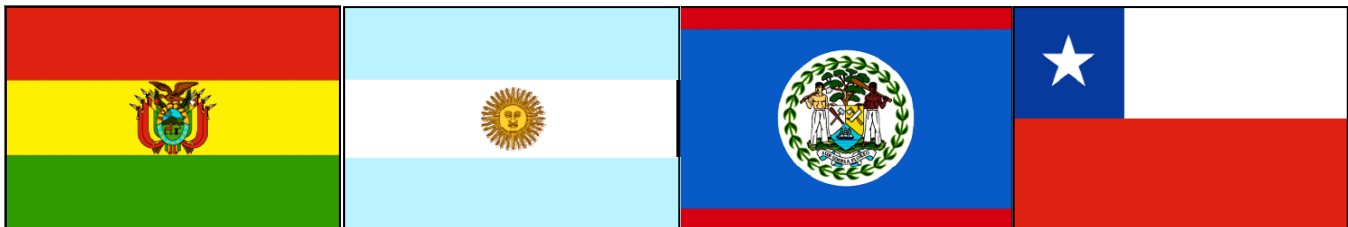
- Practices
- Cultural experiences. (Dingfelder, 2005)

Even among people from the same country, there are important differences related to:

- Region of origin
- Socio-economic factors
  - ⇒ social position in home country
  - ⇒ level of education
- Race
- Acculturation.

There may also be subtle differences in patterns of language across Latinos/Hispanics. This ethnic group varies widely in the length of time they have lived in the United States, from very recent immigrants to individuals whose families have resided in the United States for many generations. Therefore, some Latinos/Hispanics are much more acculturated to mainstream American culture than are others. Forty percent of Latinos/Hispanics in the United States are foreign-born (U.S. Census Bureau, 2006). There is also diversity among Latinos/Hispanics regarding their experience of immigration and the level of support offered to them by the U.S. Government. For example, many Cubans who fled their country after the communist revolution were granted refugee or entrant status by the U.S. and were able to obtain work permits and eventual citizenship (Gil & Vega, 1996). Despite the civil wars and oppressive regimes that have traumatized so many Central American immigrants, very few are granted refugee status by the U.S. Government (U.S. Department of Health and Human Services, 1999). Immigrants who enter the U.S. without proper documentation have more difficulty obtaining jobs and often live in fear of deportation. Additionally, these immigrants may experience traumatic experiences during their journey to the United States, including parental separation, physical and sexual assault, and exploitation (Perez-Foster, 2005).

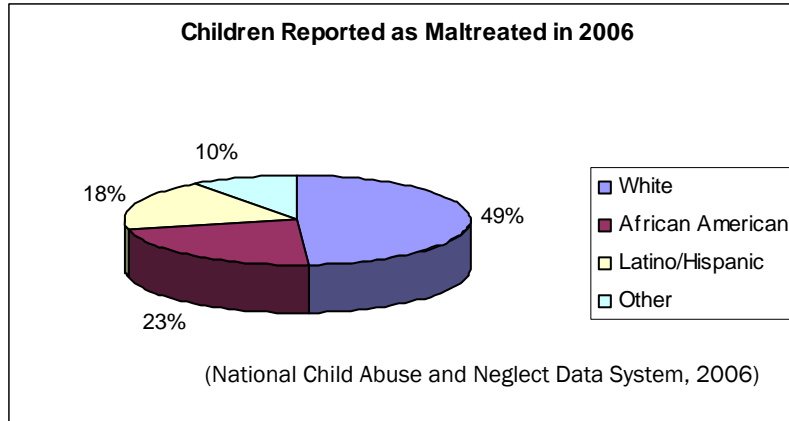
The southwestern region of the U.S. (especially California and Texas) has the highest concentration of Latinos/Hispanics. Most southwestern Latinos/Hispanics tend to be recent immigrants from Mexico or Central America. Florida has a high concentration of Cuban Americans. However, according to the U.S. Census Bureau (2006), the Latino/Hispanic population is rapidly growing in states such as Arkansas, Georgia, the Carolinas, and Tennessee.



## Culture and Trauma

The literature and research on maltreatment among ethnic groups have been sparse and contradictory. For example, Charlow (2001-2002) found no ethnic differences in child abuse reporting rates. However, Latinos are over-represented in the child welfare system (U.S. Department of Health and Human Services, Administration for Children and Families, 2008). Figure 2 below shows that 18% of the children reported as maltreated in 2006 were Latino, this is in comparison to Latinos/Hispanics making up 14.8% of the U.S. population (U.S. Census Bureau, 2006).

Figure 2



Ethnic children are more vulnerable in the face of trauma due to a combination of factors:

- Experience of prior traumas
- Stressors related to poverty
- Less access to resources. (NCTSN, 2005)

Fontes (2005) notes that gender roles, religious beliefs, views of sex and purity, disciplinary practices, and a host of other cultural norms together shape a person's experience of maltreatment.



## Latino/Hispanic Children and Trauma

In a national sample of children who experienced traumatic events (Core Data Set), the NCTSN (2005) found significant differences between ethnic groups on types of trauma experienced. Table 3 displays the separate percentages for Latinos/Hispanics and Caucasians for the types of traumas they experienced. Latinos/Hispanics in this study experienced lower incidence of sexual abuse and neglect, but higher incidence of domestic violence, impaired caregiver, and community violence when compared to Caucasian children. Almost three times as many Latinos/Hispanics as Caucasians experienced community violence.

Despite the increased focus on both childhood trauma and Latino/Hispanic cultures, there is a gap in the field of knowledge and research related to the intersection of these two fields. These guidelines aim to provide information, recommendations, and resources to begin filling this gap. This is an important step toward ensuring that Latino/Hispanic children affected by trauma in the United States not only have better access to mental health treatment, but access to the best treatment possible.

Table 3. Types of Trauma	Latinos/Hispanics	Caucasians
Physically Abused	33%	33%
Sexually Abused	29%	38%
Emotionally Abused	42%	42%
Neglected	27%	33%
Exposed to Domestic Violence	53%	49%
Experienced Traumatic Loss	42%	43%
Impaired Caregiver	47%	43%
Exposed to Community Violence	22%	8%
Experienced Complex Trauma (more than two distinct types of traumatic events)	72%	69%
(NCTSN Core Data Set, 2005)		

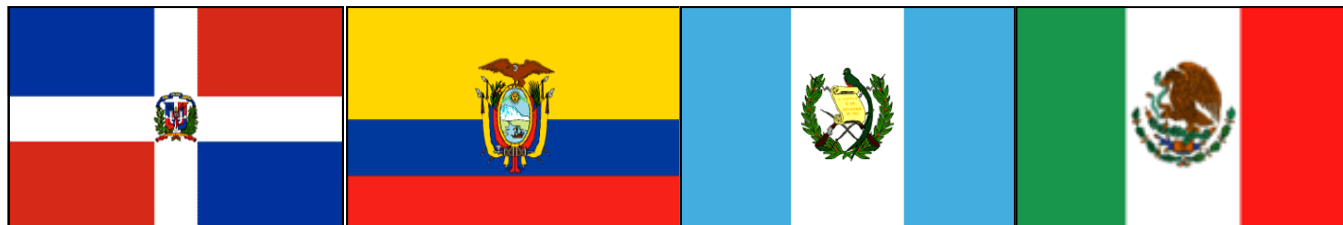
Research on trauma reactions in Latino/Hispanic children has shown varied results. Mennen (1995) found that ethnicity had no independent effect on symptom level in sexually abused girls, but that Latinas whose abuse included penetration did exhibit higher levels of depression and anxiety and lower self-worth. Mennen (1995) concluded that, "The experience of sexual abuse may have universalities that transcend culture. The distress a victim suffers is more likely related to the particular experience of sexual abuse than to racial/ethnic factors" (p. 122).

However, in their smaller sample of sexually abused girls, Sanders-Phillips, Moisan, Wadlington, Morgan, and English (1995) found that ethnicity alone did predict depression scores, which were higher among the Latina subjects. Ethnic differences were also found in abuse and family factors, Latina subjects were:

- Abused at a younger age
- More likely to be abused by their fathers or other relatives
- More likely to have siblings who were also abused
- Reported higher levels of family conflict
- Reported less maternal support.

Another study found that recent adult immigrants from Central American countries, many of whom were exposed to war and other traumas, exhibited more somatic symptoms and lower rates of PTSD (Escobar, 1998). However, Arroyo and Eth (1984) found high rates (33%) of PTSD in Central American refugee children.

There is scant research exploring Latinos'/Hispanics' experiences of trauma based on level of acculturation. A handful of studies have found higher rates of depression among Mexican-American youth when compared to Caucasian youth and Mexican youth still residing in Mexico (Roberts & Chen, 1995; Roberts & Sobhan, 1992; Roberts Roberts, & Chen, 1997; Swanson, Linskey, Qunitero-Salinas, Pumariega, & Holzer, 1992). These findings suggest that acculturative stress may contribute to depression in Latin-American/Hispanic-American youth.



## Risk Factors

Certain risk factors that have been linked to trauma exposure are more prevalent among Latino children in the United States.

### ■ Environmental Factors:

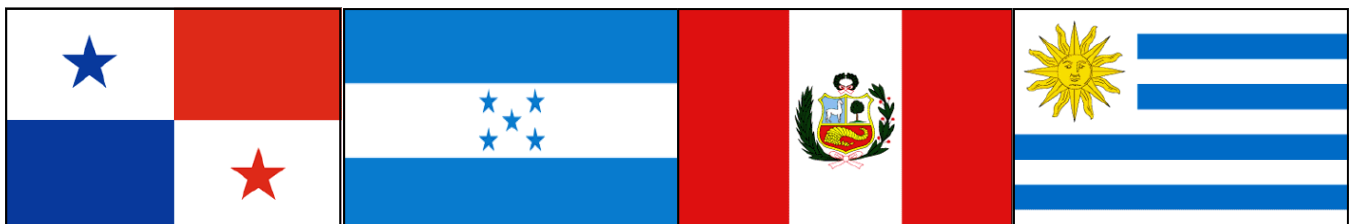
- ⇒ Poverty (For example, 29% of Latino children live in poverty compared to 10% of Caucasian children (Cauthen & Fass, 2008).)
- ⇒ Inadequate housing
- ⇒ Single-parent families
- ⇒ Substance abuse problems
- ⇒ Stress related to acculturation and discrimination
- ⇒ Lower levels of education
- ⇒ Cultural history of oppression. (Bernal & Saez-Santiago 2006)

- **Immigration Experience:** According to de Arellano and his colleagues (de Arellano et al., 2005) report that “Children who have recently immigrated have also reported military- and guerilla-warfare-related events (e.g., encountering the corpse of an individual who had been executed) and other traumatic events that occurred while crossing the Mexico-United States border” (p. 134).
- **Anti-immigrant Discrimination:** Fontes (2005) points out that, “Immigrants are often subjected to discrimination by the very organizations that are charged with protecting and caring for them, such as school, police, legal, and social service personnel” (p. 34).
- **History of Civil War or Oppressive Dictatorship:** Families that fled from civil war or oppressive dictatorship will also carry intergenerational and historical trauma related to that home country experience (Cardona, Busby, & Wampler, 2004).
- **Culture-related Intergenerational Conflicts:** The stress of immigration and culture-related intergenerational conflicts may also place children of immigrant families at higher risk for maltreatment (Dutton, Orloff, & Hass, 2000).

## Cultural Competence and Culturally Appropriate Services

The terminology related to “cultural competence,” “cultural sensitivity,” “cultural knowledge,” and “cultural awareness” has often been debated in the fields of social work, counseling, and psychology. While it is outside the scope of this document to provide a thorough discussion of these debates, we have settled on the following definitions for the purposes of the current Guidelines:

- **Cultural Knowledge:** Familiarization with selected cultural characteristics, history, values, belief systems, and behaviors of the members of another ethnic group (Adams, 1995).
- **Cultural Awareness:** Developing sensitivity and understanding of another ethnic group. This usually involves internal changes in terms of attitudes and values. Awareness and sensitivity also refer to the qualities of openness and flexibility that people develop in relation to others. Cultural awareness must be supplemented with cultural knowledge (Adams, 1995).
- **Cultural Sensitivity:** Knowing that cultural differences as well as similarities exist, without assigning values (i.e., better or worse, right or wrong) to those cultural differences (National Maternal and Child Health Center on Cultural Competency, 1997).
- **Cultural Competence:** In 2001, the National Association of Social Workers developed guidelines on cultural competence in social work practice. Cultural competence was defined as:
  - ⇒ *The process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each* (National Association of Social Workers, 2001, p. 11).





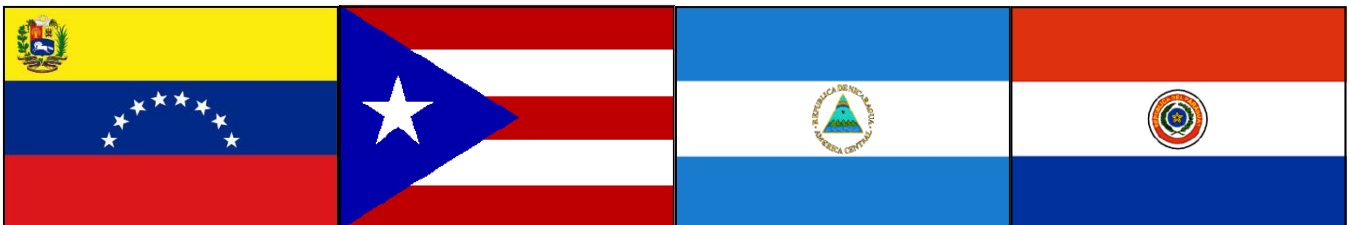
## Cultural Competence and Culturally Appropriate Services (Continued)

There is discussion within the field on whether cultural competence is on a continuum where the provider can reach proficiency, or whether it's an ongoing process that can never be fully mastered, but should always be the goal. Because culture is a dynamic, ever-changing construct, practitioners must remain flexible and adapt to new cultural influences and practices. Therefore, many professionals prefer to use the term “culturally sensitive” or “culturally appropriate” instead of “culturally competent.” In the current document, the WALC committee chose to use the term “cultural competence” and views it as an ongoing process that is defined as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations (Cross, Bazron, Dennis, & Isaacs, 1989).

It is the ethical responsibility of mental health service providers and systems to be culturally competent (NASW, 2001). This means that all ethnic groups must have equal access to an array of effective, culturally appropriate treatment options. Cultural competence incorporates knowing the strengths and limitations of treatment modalities/models/theories with diverse populations. Therefore, the efficacy of trauma treatment models with Latinos/Hispanics needs to be evaluated and any necessary adaptations need to be made, in order to ensure equity in the delivery of quality services to diverse populations.

An important aspect of cultural competence is language. According to Pew Hispanic Center (2004), 72% of first-generation Latino immigrants are primarily Spanish-speaking. This number shifts for second-generation Latinos. 46% of second-generation Latinos report English dominant as their primary language. When working with Latino/Hispanic families, it is important to be able to communicate with them in the language in which they feel most comfortable and can best express themselves. A common mistake among mental health professionals is to assume that a bilingual therapist or professional interpreter is not needed as long as the child speaks English. Many Latino/Hispanic parents, especially recent immigrants, may not be proficient in English. As *familismo* is a core Latino/Hispanic value, it is essential to engage the family in the child's treatment. In order to do this, service providers must be able to communicate clearly and congruently with the family. Asking the child client to translate is clinically inappropriate and may upset the family authority structure and put the child in a position where he or she is transmitting information about him/herself that is not developmentally or therapeutically appropriate (Hopkins, Huici, & Bermudez, 2005). Also, as Fontes (2005) points out, even children who speak English fluently may prefer using Spanish to describe emotions or trauma issues. A bilingual therapist who is attuned to the meaning and affective nuances of language and can follow the child's and the family's lead regarding the language/languages used in treatment, is ideal.

Cultural competence, however, extends far beyond language issues. Therapists treating Latino/Hispanic children need to be familiar with cultural values and how to engage these values in trauma treatment. Goode (2001) states that culturally appropriate organizations and their employees “(1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to diversity and the cultural contexts of individuals and communities served” (p. 1). Fontes (2005) emphasizes that all agencies need to formally assess their level of cultural sensitivity at least every 10 years, using appropriate assessment instruments.



## Service Utilization and Policy Implications

The U.S. Department of Health and Human Services (2001) reported that 88% of Latino children do not receive the mental health care they need. Among children in foster care in San Diego, mental health service utilization rates were much lower (47%) for Latino children when compared to 65% for Caucasian children, and Latino children engaged in fewer visits (Garland et al., 2000). According to the Denavas-Walt, Proctor, and Mills (2004), 21% of Latino children lacked health insurance compared to 7.4% of white, non-Latino children.

Several structural and attitudinal barriers exist for Latino children in need of trauma treatment, which result in lower service utility by Latinos and higher drop-out rates (Dingfelder, 2005). Structural barriers include:

- Lack of health insurance
- Transportation issues
- Lack of bilingual service providers
- Lack of culturally appropriate information about services (lack of written materials in Spanish and effective outreach/marketing to Latino populations).

The lack of bilingual service providers often leads to longer waitlists for monolingual Spanish clients, which may reduce motivation to follow through with treatment. The lack of bicultural clinicians can also be a barrier to treatment, Fontes (2005) notes that language and cultural barriers, especially, pose problems for immigrant families to access services.

Attitudinal barriers to mental health treatment also exist among Latinos/Hispanics:

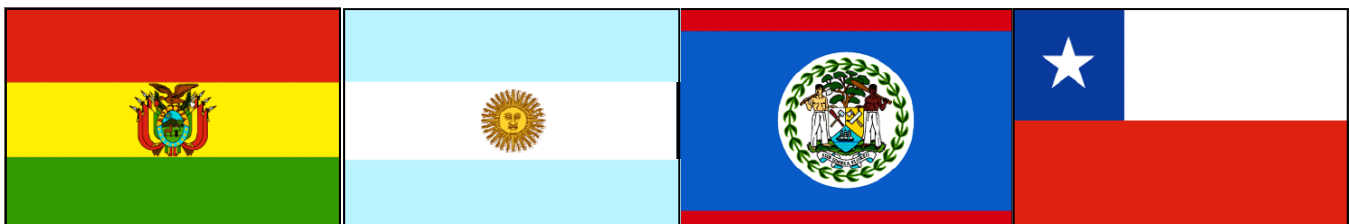
- Unfamiliarity with mental health treatment, which may lead to misconceptions that serve to maintain stigma (Dittmann, 2005)
- Self-consciousness and a feeling that they don't want to "bother" people with their personal problems. They may wonder what the provider will think of them
- Lack of sophistication related to treatment that can lead to embarrassment, which can be a strong deterrent to entering into treatment
- Perception that culturally sensitive services are not available
- Distrust the system due to immigration issues
- Distrust the system due to past experiences of discrimination
- Maltreatment by authorities here or in their home countries (U.S. Department of Health and Human Services, 2001)
- Shame and stigma related to mental health problems and seeking help outside the family also serve as barriers to treatment.

Service providers should understand that rapport building may help counter some of the barriers that exist and continues on an ongoing basis. Latinos/Hispanics may be more likely to seek help outside the family if they perceive that service providers will be able to relate to them on a cultural level, which includes race and ethnicity. However, only 7% of social workers, 4% of psychologists, 4.6% of physicians are of Latino origin (Institute of Medicine, 2004).

In order to improve service utilization for Latinos/Hispanics, organizations and programs need to convey cultural competence, as well. They can do this in a number of ways, including hiring bilingual and bicultural staff, writing cultural competence activities into their budgets, and showing a commitment to cultural competence in their strategic plans.

From a national perspective, federal laws, regulations, and enforcement practices also play a critical role in influencing the trauma-specific services provided and received by Latino/Hispanic families. Changes in health public policy are integral in improving the mental health status of Latinos/Hispanics, particularly in the context of trauma treatment services.

All of the above barriers will need to be addressed in order for Latino/Hispanic children and their families to engage in services and stay in treatment long enough to experience beneficial outcomes.



## Evidence-Based Treatment

The Institute of Medicine (IOM) defines "evidence-based practice" as a combination of the following three factors:

- (1) Best research evidence
- (2) Best clinical experience
- (3) Consistent with patient values (IOM, 2001).

Lieberman, Van Horn, and Ippen (2005) lists some of the common benefits of various evidence-based treatments (EBTs) for use with children affected by trauma, such as:

- Providing a safe interpersonal relationship
- Following a structure/predictable course
- Encouraging parental involvement
- Setting age-appropriate goals.

Examples of EBTs that have been used to treat children affected by trauma include:

- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT: Cohen, Mannarino, & Deblinger; 2006)
- Abuse-Focused Cognitive Behavioral Therapy (AF-CBT: Kolko & Swenson, 2002)
- Child-Parent Psychotherapy for Family Violence (CPP-FV: Lieberman & Van Horn, 2004)
- Parent-Child Interaction Therapy (PCIT: Eyberg, 1988)
- Cognitive-Behavioral Intervention for Trauma in Schools (CBITS: Jaycox et al., 2002).

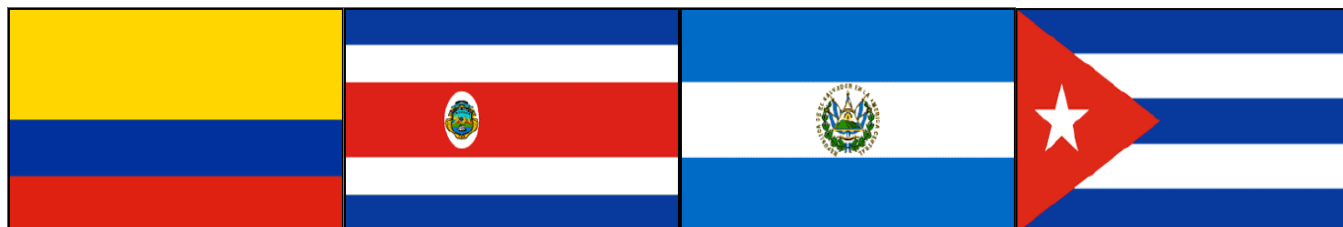
## Evidence-Based Practices with Latino Families

Currently, available research on the efficacy of evidence-based treatment (EBT) for Latino children affected by trauma is scarce (de Arellano et al., 2005). Studies evaluating the efficacy of certain parent management training (PMT) programs with diverse cultural groups have shown promising results. For example, PCIT was as effective at reducing abusive parenting behaviors among Caucasians, Latinos, and African-Americans (Chaffin et al., 2004). The Incredible Years program has demonstrated efficacy in reducing child behavior problems among Caucasians, Latinos, African-Americans, and Asian-Americans (Reid, Webster-Stratton, & Beauchaine, 2001).

EBTs are typically highly structured and short-term interventions. While these characteristics may appeal to Latin-Americans (Sue & Sue, 1990), the time frames need to be flexible in order to suit the needs of individual families. Fontes (2005) asserts that additional time may need to be spent on rapport building with immigrant clients, especially at the beginning of treatment. Assessing the following at the outset of treatment can help toward engaging a family and keeping them in treatment, possibly preventing problem by addressing these barriers from the start:

- Cultural identity
- Trans-generational immigration experiences
- Values
- Beliefs about the cause of the presenting problem
- Attitudes and expectations related to therapy
- Attitudinal barriers
- Family support
- Discrimination experiences.

Further research is needed on how well various trauma-treatment models, including EBTs, work with Latino/Hispanics populations, specifically evaluating race/ethnicity effects on treatment response. Bernal and Saez-Santiago (2006) argue that "In the absence of reliable information on the efficacy and effectiveness of mental health treatments for ethnic minorities, there is a need for research that can contribute to the knowledge base of what works and how it works" (p. 125). Of the few studies that have studied ethnicity and EBTs, the results have been varied. For example, Cohen and Mannarino (2000) found that race did not significantly predict treatment response to TF-CBT in their sample of sexually abused adolescents. However, in their study of maltreated preschoolers, Cohen and Mannarino (1996, 1998) found that race did predict improvement on certain post-treatment variables, with ethnic children showing less gains compared to their white counterparts.



## Adapting Evidence-Based Treatments for Latino Populations

Stronger empirical evidence will likely be needed to warrant large-scale adaptations of EBTs for diverse cultures. Larger studies in community settings, which tend to show less beneficial outcomes than in controlled research settings, and the usage of culturally appropriate instruments and measures are needed. Race and/or ethnicity should be included as an integral part of the data analyses, and more Latinos need to be recruited and retained in research studies (Cohen, Deblinger, Mannarino, & de Arellano, 2001). In the field of childhood trauma, further research is also needed on issues such as the impact of culture on:

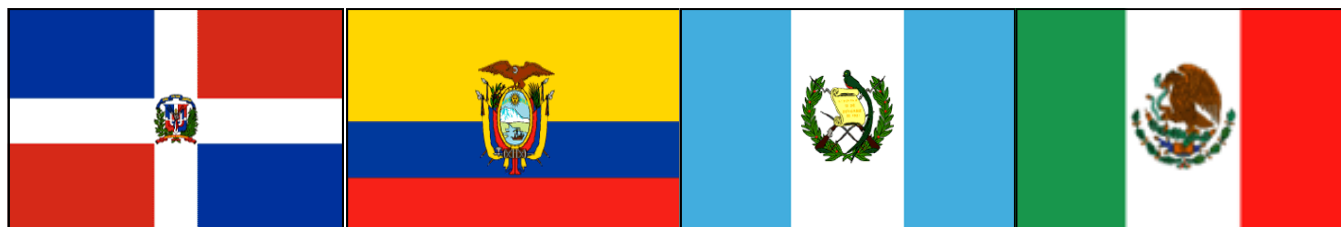
- Symptom presentation and severity
- Type of treatment preferred by families
- Access to a wide variety of treatment modalities (including EBTs)
- Engagement and retention in therapy
- The efficacy of various treatment models
- Resilience and protective factors.

The question often arises as to whether EBTs need to be adapted for different cultures, or if flexible application of EBTs by culturally aware and sensitive therapists is sufficient for positive outcomes (de Arellano et al., 2005). It is important to consider if the particular EBT has demonstrated external validity and generalizability across diverse populations. Until more research is available, the best available treatment options should be offered to Latinos and other ethnic groups with cultural competence (U.S. Department of Health and Human Services, 2001). De Arellano et al. (2005) reported a positive treatment response to TF-CBT in their community-based project for rural, ethnic (African-American and Latino) families. The authors point out that TF-CBT has shown success across ethnic groups, but they warn that, “in the absence of validation studies, special care must be taken when applying these interventions to individuals from various backgrounds to be certain to address their special needs...” (p. 151). McCabe et al. (2005) also found that *Guiando a Niños Activos* (GANA), an adaptation of PCIT outperformed treatment as usual and non-adapted PCIT in symptom reduction across multiple measures. Therefore, when an adaptation to an EBT is conducted in a culturally appropriate and sensitive manner, there is promise that it will better serve Latino/Hispanic children and families who have been affected by trauma.

When adapting a specific treatment model to better fit the Latino/Hispanic population, the issue of maintaining fidelity to the model versus cultural responsiveness will invariably arise. The content of the model may need to be “contextualized” in order to be effective in a particular community, while maintaining the core components of the treatment. This often includes, but is not limited to, modifying language and terminology, adapting the practice on an interpersonal level to fit the needs of the individual, and incorporating cultural values and rituals into the treatment. One important factor in adaptation is acknowledgment and respect for the values and adaptive practices of that cultural group.

Organizational and community characteristics must also be considered when implementing trauma treatment models in ethnic communities. In order to implement services in a culturally appropriate manner, adequate infrastructure is required, as well as sufficient resources. Organizational and administrative changes are often required to maximize public relations (Derezotes & Snowden, 1990). A thorough assessment of the particular community and its needs would help determine whether the proposed treatment model is a good match with the community. It is important to engage the identified community in the design, implementation, and evaluation processes. Derezotes and Snowden (1990) state that, in order for an intervention to succeed in an ethnic community, “Members of different ethnic and cultural communities must really be involved at all levels of policy, administration, and direct service” (p. 173). When implementing services, it is vital to consider the strengths of that particular community, and how to engage those strengths as protective factors in the treatment process.

Children and their families who have been affected by trauma need to perceive therapy as a safe place where they feel understood, and therefore the cultural appropriateness of services needs to be a priority when adopting and implementing best practices in this field. Organizations and educational institutions also need to consider culture in the provision of trauma-informed services and training of professionals, given our increasingly diverse population. Cultural issues related to childhood trauma also extend to the policy level, as laws and regulations impact how children and families recover from trauma to become productive members of society. Reducing the long-term health and social consequences of childhood trauma among all sectors of the population benefits society as a whole.



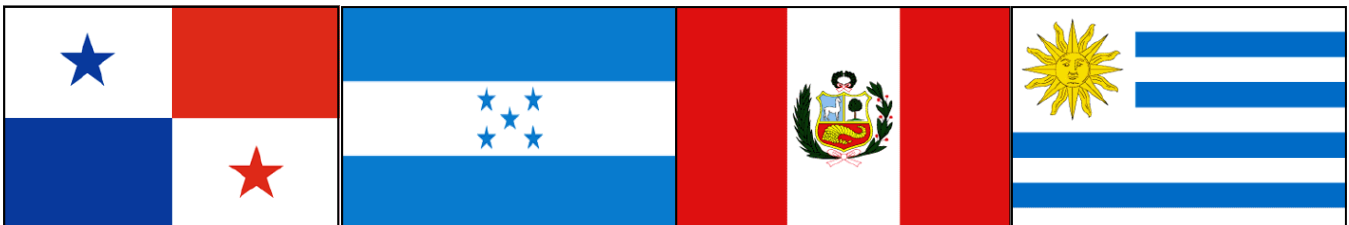
# Recommendations for Policy and Practice

Taken together, the previous discussion illustrates that efforts to improve trauma treatment services for Latinos/Hispanics will need to occur on several fronts, ranging from a micro to a macro level. To that end, a summary of the recommendations included in the templates are outlined below. These are targeted to a number of audiences - from front-line advocates and practitioners, to administrators and policy-makers. Individuals, organizations and policy makers are encouraged to review these recommendations and begin assessing their capacity to begin implementing them on both a micro and macro level. They are categorized according to the following:

- **Short-term Goals:** High-priority, high-impact, and will generate immediate results substantiated by relevant data.
- **Intermediate-term Goals:** These goals require some research to further define how the problem can be approached, and what the possible interventions would be.
- **Long-term Goals:** Reaching these goals require much more effort, funding, and time, but are worthwhile to consider.

## Short-Term Goals

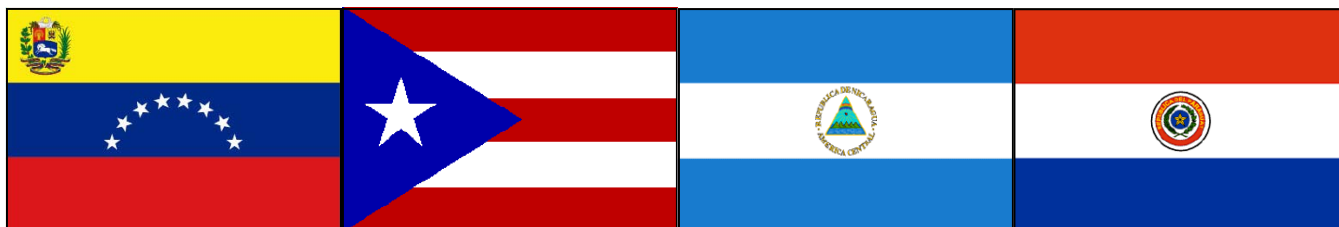
- Make the physical environment of your center more culturally sensitive. This includes the following:
  - ⇒ Display pictures, posters, artwork, and other decor that reflect the Latino/Hispanic culture.
  - ⇒ Ensure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the diverse Latino/Hispanic cultures that are in your community.
  - ⇒ Provide literature in English and Spanish that addresses stigma, normalizes help-seeking behavior, and explains the therapeutic process.
  - ⇒ Take into consideration possible client concerns about privacy when designing waiting areas and other public spaces.
  - ⇒ When using videos, films, or other media resources for health education, treatment, or other interventions, ensure that they reflect the Latino/Hispanic culture.
- Focus on establishing trust and rapport with the client and his/her family, from the very first contact:
  - ⇒ Demonstrate knowledge of the client's culture, including cultural values, rituals, and practices.
  - ⇒ Dedicate some time to learn about the diversity of the Latino/Hispanic families that you serve and to learn about Latino/Hispanic specific values, such as *familismo*, *marianismo*, *machismo*, *personalismo* and *respeto*.
- Conduct a thorough assessment that includes assessment of:
  - ⇒ Cultural values
  - ⇒ Immigration and documentation status
  - ⇒ Language needs
  - ⇒ Immigration experiences including trauma during the immigration process
  - ⇒ Discrimination
  - ⇒ Trauma experienced in their country of origin
  - ⇒ Acculturative stress



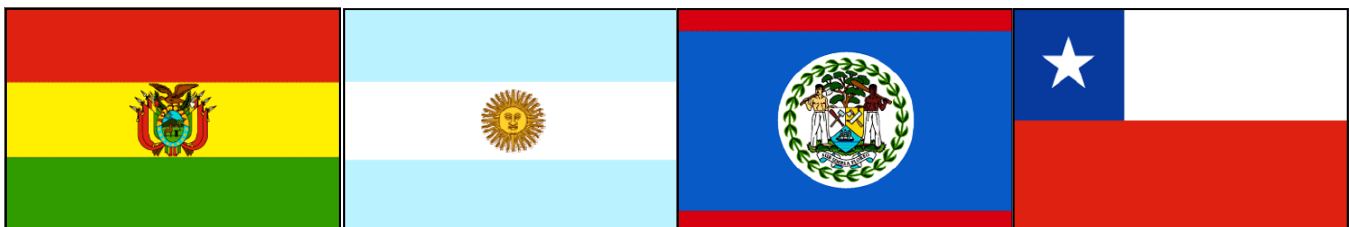
- ⇒ Specific life experiences for Latino/Hispanic children and families who are involved in child welfare, such as the trauma associated with out-of-home placement and the experiences of multiple placement changes that many Latino/Hispanic children experience while in foster care.
- Involve family and youth as full partners in the assessment process and in the development and implementation of case/treatment planning. Also consider gathering information from extended family members and other collaterals, when appropriate.
- Incorporate protective factors (i.e., cultural values, extended family and community relationships, family/youth experiences in overcoming hardships, etc.) into assessment instruments that account for a balanced picture of Latino/Hispanic children and families and thus informing decision-making and intervention plans that include familial strengths and resources that can be mobilized for maximum goal attainment.
- Provide psycho-education to Latino/Hispanic youth and caregivers (foster parents, birth parents, kin caregivers), so that they can better understand the impact of trauma and the therapeutic process.
- Stress integration of the extended family in treatment by encouraging their participation in sessions and seeking feedback from family members about their treatment experience and ways to improve services.
- Consider the role of the mental health practitioner as expanding to include ensuring the child's and family's basic needs are being met. At times, an appropriate mental health intervention may mean assisting parents of Latino/Hispanic children to reduce debts and work with creditors so that the child can stay in the home; provide assistance with immigration-related paperwork; or liaison with the school. Such help may provide the security and stability for children and families to then turn their attention to improving trauma-related symptoms. Instrumental assistance of this kind may also increase trust and improve the therapeutic relationship, allowing for more effective traditional therapeutic interventions later.
- Familiarize yourself with immigration laws, policies, and resources (i.e., Violence Against Women Act, U-Visa).
- Researchers should:
  - ⇒ Design studies to include adequate representation of a variety of racial ethnic groups. Often, partnering with researchers in other geographic locations can improve the ability to recruit and retain a diverse sample.
  - ⇒ Examine the extent to which responses to trauma differ across racial/ethnic groups. Risk factors for a negative response to trauma may differ across cultures, and therefore clinicians may need to intervene in the response process differently. To the extent that these differences are understood, clinicians will be better able to focus their attentions to areas likely to respond to intervention.
  - ⇒ Determine in which cases new and unique interventions must be developed to address a particular trauma-related issue among Latino/Hispanic families.

### Intermediate-Term Goals

- Partner with family, youth and community members on both a micro and macro level when working with Latino/Hispanic youth and families. Successful partnership may include the following:
  - ⇒ Researchers should include community members from diverse racial and ethnic groups in all stages of the research process, including selection of research questions, study design, recruitment and data collection, interpretation and dissemination of findings.
  - ⇒ Include representation of Latinos/Hispanics on Steering and planning groups as well as organizational governance and management teams which have decision-making authority in the agency.
- Increase recruitment efforts for bilingual and bicultural families as foster parents in the child welfare system. This may include considering kinship care. Provide educational and skill-building opportunities for resource families including kinship caregivers to better address and manage the mental health needs of youth in their care, including the impact of trauma.



- Integrate cultural competency training into budgetary allocations. This may include the following:
  - ⇒ Designate dedicated budget line-items for cultural and linguistic competence development activities.
  - ⇒ Allocate funds in the budget to provide for certified Spanish interpreters.
  - ⇒ Designate a specific allocation/line item in the budget to support the participation of culturally diverse families and youth on governance boards and committees. This includes stipends, food, travel, child care costs, interpretation, and translation costs.
  - ⇒ Provide salaries/compensation commensurate with experience and specialized skills, such as the ability to provide culturally appropriate services in Spanish and translation services.
- Researchers should undertake research projects that examine the extent to which responses to trauma differ across racial and ethnic groups.
- Colleges and universities should integrate culture-specific curricula into their Social Work, Counseling, and Psychology graduate/post-graduate level programs. This may include the following:
  - ⇒ Offer coursework in Latino/Hispanic psychology, theories of multicultural counseling, cultural values, acculturation, diversity among Latinos/Hispanics, and engaging Latino/Hispanic families in services.
  - ⇒ Offer a Spanish language class for mental health providers (to develop proficiency in professional spoken and written Spanish and understand regional dialects).
  - ⇒ Translate and apply psychological theories and interventions into Spanish.
  - ⇒ Offer the opportunity to earn a certificate in bilingual mental health services, and develop standards for bilingual certification.
  - ⇒ Assess the cultural appropriateness and relevance of curricula, systems, policies and practices.
  - ⇒ Recruit and hire practitioners who have extensive experience working with Latino/Hispanic communities to teach or co-teach graduate courses.
- Increase training for providers working with Latino/Hispanic youth and families in both the mental health and child welfare systems. This includes the following:
  - ⇒ Provide practice/field work in bilingual settings with culturally competent, bilingual supervision at practicum and internship sites (Lee et al., 1999).
  - ⇒ Ensure that orientation, training, and continuing education content addresses the needs of staff and the populations served and are customized to fit staff roles (e.g., clinical, administrative, marketing, etc.).
  - ⇒ Host professional workshops and conferences that include more content related to working with Latino/Hispanic families.
  - ⇒ Ensure that clinicians and agencies are familiar with and adhere to APA and NASW Cultural Guidelines.
  - ⇒ Ensure that clinicians examine their own cultural attitudes, beliefs, and biases and understand the importance of multicultural responsiveness.
- Reduce economic barriers to service utilization. This may include the following:
  - ⇒ Provide transportation for consumers.
  - ⇒ Consider expanding service delivery; if you are a not-for-profit center, consider writing grants to fund the expansion.
  - ⇒ Assist families in completing paperwork to ensure children are covered under state and federal medical insurance laws, such as Medicaid or Social Security.
  - ⇒ Provide services where the families are already located, such as in schools and churches. This may help lower transportation time and barriers to service utilization.
  - ⇒ Extend hours of operation beyond traditional, 8 AM to 5 PM Monday through Friday clinic models. Extended services on evenings and weekends will permit more flexibility for appointments and more engagement in services.



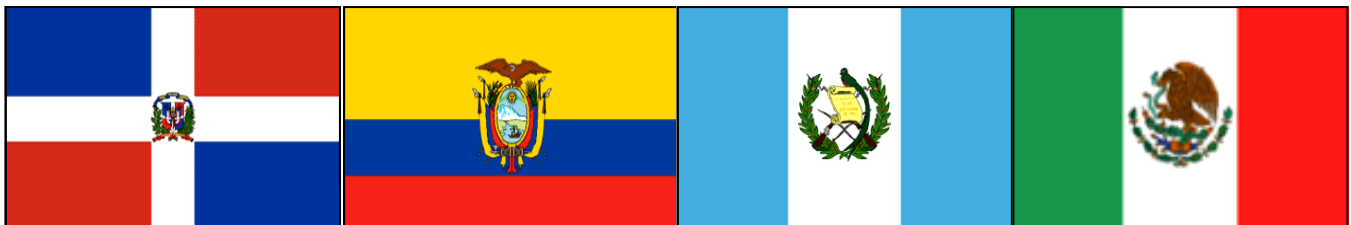
## Long-Term Goals

- Determine evidence-based and best practices for working with Latino/Hispanic youth and families.
  - ⇒ Educational and professional institutions should promote research on best practices for Latino/Hispanic children affected by trauma (i.e., incorporating cultural issues into research classes, supporting theses and dissertations related to Latino/Hispanic children, trauma, and treatment outcomes) and special challenges faced by bilingual therapists working with this population.
  - ⇒ Develop guidelines for tailoring evidence-based interventions. The majority of adapted interventions currently contain the established elements of care, along with elements specifically tailored to the cultural group. Because culture may change over time due to numerous influences (e.g., acculturation, globalization, change in SES), the ability to identify salient factors that are amenable to adaptation would provide a framework for continually assessing the intervention's sensitivity.
  - ⇒ Recognize that there are multiple types of research evidence that may potentially have value. These include clinical observation, qualitative methods, and systematic case reviews.
- The federal government could assist some of the most vulnerable children of immigrants by increasing opportunities for undocumented immigrants to gain legal status and by granting undocumented children access to public health insurance and other federal benefits.
- Increase access to trauma-informed mental health services for all Latinos/Hispanics. Latinos/Hispanics, particularly those most vulnerable, must be provided with comprehensive mental health care. This includes the following:
  - ⇒ Promote, through National and state-level advocacy efforts, open access to trauma-informed mental health treatment and services for Latinos/Hispanics which is critical to reducing barriers in the health delivery system.
  - ⇒ Provide culturally and linguistically relevant trauma-informed mental health care to facilitate early diagnosis and keep costs to a minimum.
  - ⇒ Provide funding for services for Latinos/Hispanics who lack health insurance or are unable to pay for diagnosis and treatment, especially for undocumented Latinos/Hispanics.
- Support community and ethnic-based organizations. Given that most Latino/Hispanic youth and families impacted by the child welfare system will likely receive services by community and ethnic-based organizations, consider expanding the role of these groups to build capacity and have the adequate infrastructure and resources to deliver and adapt evidence-based practices in their contexts.
- Apply leadership and organizational practices in your agency that integrate cultural and linguistic competence into daily practice. This may include one or more of the following:
  - ⇒ Implement specific policies and procedures that integrate cultural and linguistic competence into service delivery and other core functions of the agency, such as participatory management practices that create shared ownership, creating a safe environment for managing differences, capitalizing on the strengths and assets of a diverse workforce, monitoring and evaluating progress, and maintaining focus on the long-term goals of cultural and linguistic competence.
  - ⇒ Develop and implement written policies that will be used to recruit and retain staff members with a knowledge base and experience to effectively provide services to racial/ethnic, culturally, and linguistically diverse populations of focus.
  - ⇒ Ensure that your agency's governing body is proportionally representative of the Latino/Hispanic children, youth and families served.
  - ⇒ Utilize instruments to assess multicultural training competence.
- Include Latino/Hispanic representation on national, state, and local mental health advocacy group boards in order to address Latino/Hispanic issues and concerns in the development of all programs and policy recommendations.



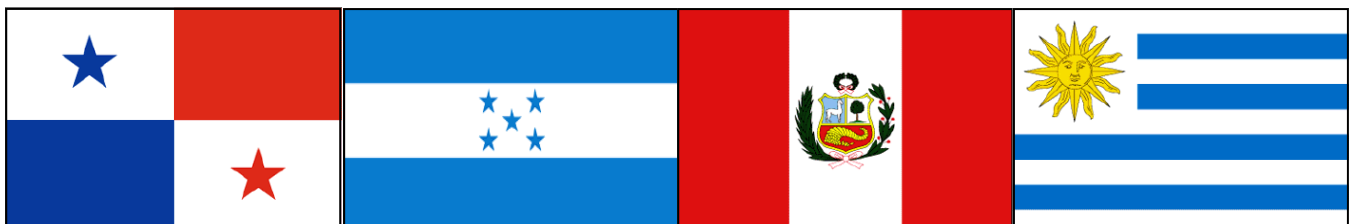


- Provide education to both the public and to government officials on Latino/Hispanic specific needs and issues. This includes the following:
  - ⇒ Mount public education campaigns to create awareness of trauma within Latino/Hispanic communities and the need for appropriate assessment and treatment of issues such as acculturative stress for recent immigrants.
  - ⇒ Provide training for national, state, local government employees and elected officials specifically on Latinos/Hispanics and trauma, and the importance of a strengths-based approach when creating policy that impacts Latino/Hispanic children and families.
  - ⇒ Educate funding sources on the importance of supporting relevant Latino/Hispanic community issues for consumer/family driven community-based research.
- Provide federal funding to train and educate Latino consumers and family members to become leaders in order to educate and inform Congress. Selected federal agencies should fund Latino/Hispanic-specific sponsors to establish and enhance community-level coalitions and to educate and train Latino/Hispanic consumers/families on public-speaking, data issues, policy development, grant writing, program development, and self-sufficiency for sustainability.

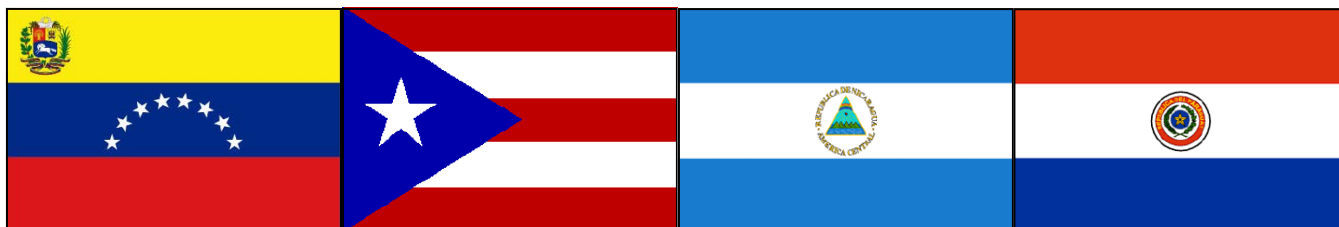


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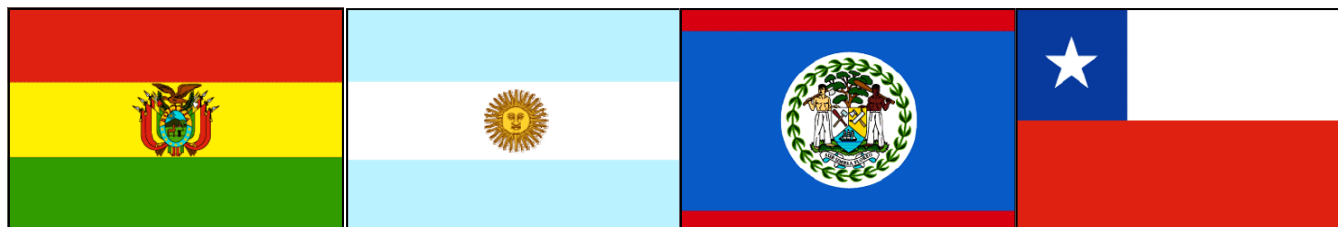
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# Assessment

## Background

Research suggests that ethnic groups may be at higher risk for experiencing traumatic events when compared to the majority population (Finkelhor, Ormrod, Turner, & Hamby, 2005; Kilpatrick et al., 2003). Ethnic groups may also suffer from more negative effects of trauma (La Greca, Silverman, & Vernberg, & Prinstein, 1996; Moisan, Sanders-Phillips, & Moisan, 1997; Sanders-Phillips, Moisan, Wadlington, Morgan, & English, 1995). An important step toward optimal trauma-focused treatment minimizing the negative impact of trauma for all populations is to conduct a comprehensive trauma-related assessment.

General guidelines have been created for culturally competent assessment and treatment of ethnic populations (American Psychological Association, 2003; Bernal, Bonilla, & Bellido, 1996; Lopez, Kopelowicz, & Canive, 2002). These guidelines highlight important issues to consider during a standard assessment, such as preferred language, cultural values, community/social support, socioeconomic status, history (country of origin, immigration), and beliefs about mental health treatment. Standard assessment protocols often omit these important issues. However, these guidelines do not specifically address trauma.

Guidelines for effective trauma-informed assessment have also been created, but these guidelines are largely based on research and treatment with the mainstream population in the US that may not include an adequate representation of racial and ethnic groups (e.g. Myers et al., 2002; Saunders, Berliner, & Hanson, 2001). Due to differences in types of trauma and manifestation of trauma symptoms among many individuals from ethnic groups, a standard trauma assessment may not suffice (Carlson, 1997). For example, traumatic events that occur during the immigration process will likely not be reported unless children are specifically asked about such events during assessment (de Arellano, Danielson, Rheingold, & Bridges, 2006).

*Más vale pájaro en mano que cien volando.\**

Conducting a culturally competent trauma-informed assessment for Latinos/Hispanics is important because varying responses to trauma have been reported among certain ethnic groups. Children of Hispanic descent may report more somatic symptoms when compared with their non-Hispanic peers (Piña & Silverman, 2004). Standard assessment protocols may fail to detect somatic complaints as well as common culture-bound reactions to trauma, such as *ataque de nervios* (Guarnaccia, Canino, Rubio-Superc, & Bravo, 1993). Assessment should also incorporate a lifetime approach. That is, when working with Latinos/Hispanics, it is impor-

tant to assess their lifetime history of traumatic events, especially with first-generation immigrants (Cohen, 2007).



The standard approach to trauma assessment includes a semi-structured interview composed of a thorough trauma history and assessment of trauma-related mental health problems. An effective assessment considers time-line and developmental issues (Saunders et al., 2003), which helps differentiate direct effects of trauma from possible co-morbid conditions. Standardized measures such as the *Trauma Symptom Checklist for Children* (Briere, 1996) are often used to target specific symptoms for treatment planning and to provide a baseline assessment (from which change can be subsequently measured in treatment). It is also important to assess the child's overall functioning and family members' trauma history, as well as the safety of the child's current living environment.

A comprehensive assessment using standardized measures is only one step in the process of guiding decisions on service planning. Other steps include working with caregivers and collateral sources, conducting the clinical interview and observing behavior. The assessment process is ongoing and occurs throughout treatment to ensure that the treatment is working or if it needs to be refined. This becomes more important in the case of Latino/Hispanic families who may not share information until a relationship of trust has been obtained.

A comprehensive culturally appropriate trauma-informed assessment is an essential component of good clinical practice and is a component of many trauma-focused evidence-based practices. Therefore, it is imperative that a culturally competent assessment is conducted when working with Latino/Hispanic children and families affected by trauma.



## Statement of the Issue

A number of guidelines have been proposed for culturally competent assessment and treatment of ethnic populations. These guidelines (e.g., American Psychological Association, 2003; Bernal, et al., 1996; Lopez et al., 2002) emphasize the importance of considering the cultural context within which the family exists and adapting the approach to treatment with these families accordingly (e.g., Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002; Vera, Vila, & Alegría, 2003). However, standard assessment models do not thoroughly consider these issues and may be inadequate to effectively assess trauma within the appropriate cultural context. The need for modifications to standard assessment practices is highlighted by the growing population of ethnic groups in the U.S., and the potentially heightened vulnerability of these groups to certain traumatic events. In a culturally appropriate trauma-informed assessment, one needs to address a family's preferred language, cultural beliefs, current community, social support system, socioeconomic status, preconceived notions about mental health treatment, and specific trauma history.



## Recommendations from the Field



- **Investigate the intended population.** Dedicate some time to learn about the intended culture through a variety of resources. In order to know what clinical questions must be asked in a trauma assessment and how to ask such questions, a working understanding of the intended population is necessary (de Arellano & Danielson, 2008).
- **Navigate new ways of delivering assessment services.** Upon investigating the intended population, modifications should be made to the way the assessment is introduced and conducted to better accommodate individuals' needs and characteristics. Often, this involves introducing the assessments in a sensitive manner, and navigating such obstacles as distrust of providers and language and logistical barriers.
- **Further assess caregiver, extended family members, and other collateral sources.** Consistent with the family-focused or group (vs. individualistic) orientation often ascribed to many ethnic cultures (e.g., Marín & Triandis, 1985), it is important to consider the potential value of collecting information from a broad range of informants (e.g., extended family, other members of the community).
- **Organize background assessment to better accommodate the intended population.** A careful assessment of relevant background information can provide a better understanding of the context in which the victimization or other traumatic event occurred. Areas for the background assessment typically include social, educational, legal, medical and mental health history. Having a solid understanding of the family's culture can help guide interview questions about potential background events (e.g., frequent moves and changing living arrangements for recent immigrant families who must migrate often for employment).
- **Recognize and broaden the range of traumatic events to be assessed.** Questions in an assessment of traumatic experiences should be behaviorally specific in order to increase the validity of the assessment (Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993). In addition to commonly assessed traumatic events, a broad range of other traumatic events that occur more frequently within a particular population can be added, depending on the family's background. Some examples include political trauma (e.g., political violence among families from Chile [Allodi, 1980]); immigration related crime (e.g., human trafficking among Mexican and Central American immigrant women [Farley, 2003]); or natural disasters (e.g., hurricanes in Puerto Rico and other Latin American countries in the Caribbean).
- **Increase efforts on translating existing measures into Spanish and researching their validity and reliability once translated.** While there are many assessment measures that exist, it is important that they are translated into Spanish using best practices translation techniques (see the "Communication/Linguistic Competence" priority area for more information). Once translated, their reliability and validity, as well as real world utility, needs to be established.
- **Incorporate the use of cultural measures into your assessment process.** These include measures of acculturation and acculturative stress. For more information on these measures, refer to the "Resource" section of this document.
- **Create comprehensive guidelines for conducting a culturally competent assessment that links the assessment results to the development of the treatment plan.** While guidelines exist for conducting a culturally competent assessment, few of these guidelines provide the link between the information gathered, the initial decision-making, and the development of the treatment plan.
- **Create the organizational and administrative supports that are necessary to build and sustain an effective assessment program.** This includes resource allocation in relation to staff time needed to engage families in the form of workload, supervision, and data systems (see the "Organizational Competence" priority area for more information).
- **When conducting assessments with a translator, it is critical to define exactly what we mean.** Specifically, for some clients, what a provider may see as a traumatic experience may be viewed by the client as a "part of life." It is important to clearly and concretely describe the events you are referring to in your assessment (see the "Communication/Linguistic Competence" priority area for more information on working with translators).

### Resilience

- Many Latino/Hispanic families hold the cultural value of *familismo* (see "Cultural Values" priority area for more information). In this context, the family can be a strong support network and plays a valuable role in the assessment process. Taking the time to engage with the family and thoroughly introduce the assessment process can help the family become involved in the treatment process itself.
- The assessment process should focus on the client's strengths as well as on the areas that will be addressed by treatment. By identifying and working with the client's strengths, the clinician will be better able to pave the way for a stronger and more effective therapeutic relationship.

### Family/Youth Engagement

- Trust is paramount to engaging youth and families in the assessment process. Trust issues often impede ethnic minorities from accessing mental health services (U.S. DHHS, 1999). Therefore, in order to engage ethnic families and obtain an accurate assessment, clinicians and agencies need to focus on building trust and rapport with the client's family and their community. Some ways to establish rapport include spending more time with clients' and their families, demonstrating knowledge of the client's culture, respect and interest in cultural values, rituals, and practices. Developing a positive reputation in the community and participating in local events also helps to establish trust.
- Provide the family with a strong rationale for the assessment and explain assessment procedures (to clarify any misunderstandings such as fear of being reported to authorities in order to better engage the family in the assessment process). It is helpful to explain why certain questions (i.e., related to sexual abuse) are being asked and to phrase questions in a descriptive, non-stigmatizing way (Resnick et al., 1993). Interviews and self-report instruments need to be available in the appropriate language and terminology as well.
- Assist the family with overcoming logistical barriers to treatment and current stressors. Providing bus tokens or linking a family to childcare resources can demonstrate concern for the family's problems and facilitate their participation in services. Flexibility in scheduling also serves this dual purpose (see the "Service Utilization and Case Management" priority area for more information).
- Elicit feedback from the family about their assessment experience. This shows the family that their opinion is valued and invites the family to take an active role in the treatment process.

## Community Examples/Best Practices



- **Chadwick Center for Children and Families – Assessment-Based Treatment for Traumatized Children: A Trauma Assessment Pathway (TAP)** - TAP is a treatment model that incorporates assessment, triage, and essential components of trauma treatment into clinical pathways. In TAP, the clinician conducts a thorough client assessment that includes the use of standardized measures, behavioral observations, and clinical interview. The assessment is designed to investigate and address the individual needs of the client, including relevant cultural factors.
  - ⇒ Website: [www.taptraining.net](http://www.taptraining.net)
  - ⇒ Address: Chadwick Center for Children and Families, Rady Children's Hospital - San Diego, 3020 Children's Way, MC 5131, San Diego, CA 92123
- **Medical University of South Carolina, Community Outreach Program – Esperanza (COPE)** – Provides community-based assessment, referral, and treatment services to children and adolescents who have been victimized by crime (e.g., sexual abuse, physical abuse, domestic violence) or have experienced other traumatic events such as natural disasters or serious accidents. Michael de Arellano, PhD, and Carla Kmett Danielson, PhD have created a culturally INFORMED approach to trauma assessment with Latino/Hispanic families (de Arellano & Danielson, 2008).
  - ⇒ Website: [www.musc.edu/outreach/programs/outreachprograms.html#cope](http://www.musc.edu/outreach/programs/outreachprograms.html#cope)
  - ⇒ Address: Medical University of South Carolina, 165 Cannon St., MSC 852, Charleston, SC 29425
- **Border Traumatic Stress Response (Border TSR), Serving Children and Adolescents in Need, Inc. (S.C.A.N.)** - Works to improve and expand the service delivery system in Webb County, Texas, for children and adolescents aged 2 to 18 who have experienced any type of traumatic event. S.C.A.N. is a community-based, nonprofit organization with more than twenty years of experience providing services to children and adolescents and their families. S.C.A.N.'s trauma-informed system includes a thorough assessment and treatment tailored to his/her individual needs. Webb County is located along the Texas–Mexico border, and most of the children served are first-generation Mexican-Americans or Mexican immigrants who are bilingual or primarily Spanish-speaking.
  - ⇒ Website: [www.scan-inc.org](http://www.scan-inc.org)
  - ⇒ Address: 2387 E. Saunders St., Laredo, TX 78041
- **Children's Institute, Inc.– Responding to Domestic Violence: the “Whole Person” Approach** - Children's Institute Inc., developed this model for group intervention with families exposed to domestic violence. 87% of the clients in this program are Latino/Hispanic. There are outpatient groups and residential treatment in a long-term DV Shelter. Treatment is provided in both English and Spanish. It includes an integrated assessment model with culturally sensitive questions.
  - ⇒ Website: [www.childrensinstitute.org](http://www.childrensinstitute.org)
  - ⇒ Address: 711 S. New Hampshire Ave., Los Angeles, CA 90005

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*\*Dichos translation: A bird in the hand is worth a hundred in the air.*

## Assessment Subcommittee

### Chair:

Carla Kmett Danielson, PhD - National Crime Victims Center, Medical University of South Carolina, Charleston, SC

### Members:

- Michael de Arellano, PhD - National Crime Victims Center, Medical University of South Carolina, Charleston, SC
- Scott D. Cicero, PhD - Rockland Children's Psychiatric Center, NY State Office of Mental Health, Orangeburg, NY
- Lisa Conradi, PsyD - Chadwick Center for Children and Families, Rady Children's Hospital, San Diego, CA
- Clorinda Merino, MEd - Chadwick Center for Children and Families, Rady Children's Hospital, San Diego, CA
- Alison Hendricks, LCSW - Chadwick Center for Children and Families, Rady Children's Hospital, San Diego, CA



# Provision of Therapy

## Background

There currently are numerous different treatment options for children who have experienced trauma. These include evidence-based treatment models, which aim to improve patient outcomes through the use of clinical practices informed by research (APA, 2006). Evidence-based practice in psychology (EBPP) is defined as “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (APA, 2006). EBPP emphasizes the importance of tailoring care to the individual patient by encouraging clinicians to consult the research evidence to identify viable options for assessment, prevention, and treatment services (Hunsley, 2007). Most of what currently constitutes evidence-based psychological practice comes from research in the area of empirically supported treatments (ESTs) (Bauer, 2007). ESTs refer to interventions or techniques that have produced therapeutic change in controlled trials (Kazdin, 2008). However, concerns about the utility of EBPPs in clinical practice have stemmed from issues related to inclusion/exclusion criteria for participants, the highly structured environment in which studies are conducted, level of supervision and training of treating clinicians, and the close monitoring of treatment fidelity.

Clinicians seeking to practice in an evidence-based manner are therefore often confronted by numerous challenges in attempting to translate the evidence into practice, especially when working with ethnically diverse patient populations. As with other realms of psychological research, ethnic groups are largely missing from the efficacy studies that make up the evidence base for treatments (Miranda et al., 2005; U.S. Department of Health and Human Services [U.S. DHHS], 2001). Because of these omissions, questions arise as to whether treatments found to be efficacious with primarily non-minority samples can be generalized to ethnic minority populations, and whether interventions need to be culturally adapted to be effective with ethnic minority patients.

While there are currently many ESTs for children affected by trauma, there has been scarce research on the efficacy of such treatments with Latino/Hispanic children. There is debate in the field as to whether evidence-based treatments can be equally effective with Latino/Hispanic children as compared to their Caucasian counterparts, if they are implemented in a culturally sensitive and competent manner, or whether cultural adaptations need

to be made. A recent meta-analysis that examined ethnic differences in response to evidence-based treatments found that ethnic minorities responded at least as well, if not better to evidence-based



“While there are currently many ESTs for children affected by trauma, there has been scarce research on the efficacy of such treatments with Latino children.”

treatments than their non-ethnic minority counterparts (Huey & Polo, 2008). However, other research has found that interventions which had been modified for cultural groups, including Latinos/Hispanics, were more effective than interventions without such modifications (Griner & Smith, 2006).

At present, disparities in mental health care exist for both Latino adults and youth; not only are Latinos less likely to receive mental health services than Caucasians, they are also less likely to receive quality care (e.g., Lagomasino et al., 2005; Alegría et al., 2004; Kataoka, Zhang, & Wells, 2002; Padgett,

Patrick, Burns, & Schlesinger, 1994). Various reasons have been postulated for the underutilization of mental health services: perceptions of mental health treatment, stigma, and reliance on alternative sources for assistance, as well as barriers to care such as availability, affordability, cultural appropriateness, and location of services (U.S. DHHS, 2001; see “Service Utilization and Case Management” priority area for more information). Cultural values and spiritual beliefs and practices, which can be an important source of support among many Latino/Hispanic families, may also affect the use of mental health services. Cultural values and spirituality can have an effect on ways in which children and families respond to trauma (de Arellano & Danielson, 2008) and treatment (see “Cultural Values” priority area for more information).



The delivery, and ultimate success, of the therapy rests on the ability to engage the child and family in services. Empirically supported strategies to improve service engagement are currently available and have been shown to increase attendance at initial appointments and ongoing sessions, as well as improving treatment response (e.g., Santiesteban, et al., 1996; McKay, Nudelman, McCadam, & Gonzales, 1996; Szapocznik et al., 1988). In general, such strategies encompass culturally informed engagement skills to address the range of barriers that can exist within families, environments, and agencies.

## Statement of the Issue

In a national sample of children affected by trauma, the NCTSN (2005) found that Latino children were at greater risk for certain types of trauma than Caucasian children, including exposure to domestic violence, impaired caregiver, and community violence. Unfortunately, Latino children tend to underutilize mental health services (Hough et al., 1987), including being at greater risk for premature termination (Sue, Fujino, Hu, Takeuchi, & Zane, 1991), and have limited access to culturally appropriate services (Acosta, 1979; Young, Klap, Sherbourne, & Wells, 2001). Research on the efficacy of evidence-based treatments with Latinos/Hispanics has been scarce, and Latinos/Hispanics may not have access to best practices in the field of trauma treatment. Guidelines that focus on increasing access and quality of trauma-informed mental health services for Latino/Hispanic children and families, as well as keeping these families engaged in treatment, are greatly needed.



## Recommendations from the Field



- **Develop guidelines for tailoring evidence-based interventions.** The majority of adapted interventions currently contain the established elements of care, along with elements specifically tailored to the cultural group. Because culture may change over time due to numerous influences (e.g., acculturation, globalization, change in SES), the ability to identify salient factors that are amenable to adaptation would provide a framework for continually assessing the intervention's sensitivity.
- **Recognize multiple types of research evidence.** While most of what constitutes evidence-based psychological practice comes from research in the area of empirically supported treatments (EST), the APA Presidential Task Force on Evidence-Based Practice (2006) endorsed the use of multiple types of research evidence. Practitioners working with diverse clientele that are under-represented in mainstream efficacy studies must therefore recognize the potential value of data collected through different research designs (i.e., clinical observation, qualitative research, systematic case-reviews, etc.) and in practice-based evidence approaches to treatment (see the "Research" priority area for more information).
- **Utilize principles of community engagement to conduct research and disseminate treatments that are relevant and beneficial to the intended groups.** By engaging communities in efforts to identify priority needs, risk and resiliency factors, and effective approaches to treatment, researchers will increase the likelihood of success achieving intended outcomes and increasing utilization of services. Some strategies may include working with community-based organizations that already have a relationship with community members, providing services within places of worship, the home and other locations where families feel more comfortable (see the "Research" priority area for more information).
- **Consider views of mental health and service utilization practices, including use of alternative approaches to healing (e.g., traditional spiritual healing) and involvement of family members in treatment.** In order to improve service access and use, care should be taken to ensure that the therapist has a clear understanding of the child and family members' conceptualization of the trauma and trauma-related problems and their views of how treatment should progress. Conversely, a conscientious effort should be made to ensure that the child and family members fully understand the purpose and course of the intervention. Use of alternative approaches to healing should be assessed and considered in treatment.
- **Therapists should be aware of their own biases and prejudiced beliefs toward the populations being served in treatment.** Efforts should be made to critically evaluate one's beliefs about a cultural group and to correct misconceptions. Clinicians also need to educate themselves about cultural values and experiences of various Latino/Hispanic groups and how these issues may impact treatment. If a therapist's belief system interferes with his/her ability to provide effective and respectful services, an appropriate referral should be made.

*Después de la lluvia sale el sol.\**

### Resilience

- Different cultures have established rituals and practices that promote feelings of safety and belonging. For Latinos/Hispanics, these activities may include praying, participating in religious and/or spiritual practices (attending church, confession, etc.), and engaging in familial activities. If these elements emerge in the course of treatment (and are relevant to the established treatment goals), the clinician may promote or incorporate these activities into the work plan, emphasizing those aspects associated with well-being.
- Strategies for improving resilience, and mental health in general, from the client's perspective should be assessed and considered in treatment. Research has found Latinos in their country of origin have fewer mental health problems than non-Latino Caucasians and Latinos residing in the United States (e.g., Vega et al., 1998). Culturally-derived healing practices should be considered.
- Latino/Hispanic cultural values such as *familismo* can be utilized in treatment as protective factors to buffer against the negative impact of trauma and enhance the efficacy of treatment (see the "Cultural Values" priority area for more information). Engaging the support of all influential family members (including extended family and godparents) is key to helping the child recover and stay safe.

- **Treatment providers should partner with case management services that facilitate access to culturally relevant services that address other challenges confronting Latino/Hispanic families** (See the "Service Utilization/Case Management" priority area for more information on this topic).

### Family/Youth Engagement

- Respect is essential in engaging Latino/Hispanic youth and families in treatment. Providing clear descriptions of the treatment model, discussing the therapeutic relationship, focusing on establishing rapport, and encouraging patients to collaborate in identifying treatment goals can help build strong alliances and communicate positive regard and respect. Through a respectful relationship, patients can come to see that they hold knowledge and expertise, often rooted in their own culture that can help them achieve a higher level of psychological functioning and well-being.
- Engagement strategies include *personalismo*, which means that the clinician should adopt a warm, friendly, and personal approach to the family. Showing personal interest and concern regarding the child and family's well-being will help engage the family into the treatment process and keep them engaged. Empirically supported engagement strategies (Santiesteban et al., 1996; McKay et al., 1996; Szapocznik et al., 1988) should be adapted for use with Latino/Hispanic families.

## Community Examples/Best Practices



- **Child-Parent Psychotherapy for Family Violence (CPP-FV)** – Developed by Dr. Alicia Lieberman and Dr. Patricia Van Horn, CPP-FV is a psychotherapy model that integrates psychodynamic, attachment, trauma, cognitive-behavioral, and social-learning theories into a dyadic treatment approach designed to restore the child-parent relationship and the child's mental health and developmental progression that have been damaged by the experience of domestic violence. Child-parent interactions are the focus of six intervention modalities aimed at restoring a sense of mastery, security, and growth and promoting congruence between bodily sensations, feelings, and thinking on the part of both child and parent and in their relationship with one another. CPP-FV was developed and evaluated with Latino/Hispanic families.  
⇒ Website: [www.nctsn.org/nctsn\\_assets/pdfs/promising\\_practices/CPPsychtherapyforFV\\_21105.pdf](http://www.nctsn.org/nctsn_assets/pdfs/promising_practices/CPPsychtherapyforFV_21105.pdf)
- **Culturally Modified Trauma Focused Treatment (CM-TFT)** – Developed by Dr. Michael de Arellano, CM-TFT was developed for use with Latino/Hispanic children and is based on Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), with the addition of modules integrating cultural concepts throughout treatment. CM-TFT was developed and tested with Latino/Hispanic families. For more information, contact Dr. Michael de Arellano at [dearelma@musc.edu](mailto:dearelma@musc.edu).  
⇒ Website: [www.nctsn.org/nctsn\\_assets/pdfs/promising\\_practices/cmtft\\_general.pdf](http://www.nctsn.org/nctsn_assets/pdfs/promising_practices/cmtft_general.pdf)
- **Chadwick Center for Children and Families – Assessment Based Treatment for Traumatized Children: A Trauma Assessment Pathway (TAP)** – TAP is a treatment model that incorporates assessment, triage, and essential components of trauma treatment into clinical pathways. In TAP, the clinician conducts a thorough client assessment that includes the use of standardized measures, behavioral observations and clinical interview. The assessment is designed to investigate and address the individual needs of the client, including relevant cultural factors.  
⇒ Website: [www.taptraining.net](http://www.taptraining.net)  
⇒ Address: Chadwick Center for Children and Families, Rady Children's Hospital, San Diego, 3020 Children's Way, MC 5131, San Diego, CA 92123

## Resources



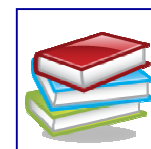
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*\*Dichos translation: After the rain, comes the sun.*

## Provision of Therapy Subcommittee

### Chair:

Michael A. de Arellano, PhD - National Crime Victims Research and Treatment Center, Medical University of South Carolina, Charleston, SC

### Members:

- Denise Chavira, PhD - University of California, San Diego, Child and Adolescent Services Research Center (CASRC), Rady Children's Hospital, San Diego, CA
- Manuela Diaz, PhD - Child Trauma Research Project, University of California, San Francisco
- Lisa Gutiérrez, PhD - Child Trauma Research Project, University of California, San Francisco
- Alison Hendricks, LCSW - Chadwick Center for Children and Families, Rady Children's Hospital, San Diego, CA
- Kristen McCabe, PhD - Child and Adolescent Services Research Center (CASRC), Rady Children's Hospital, San Diego, CA
- Katherine Elliott, PhD, MPH - Center for Reducing Health Disparities, UC Davis Medical Center, Davis, CA

# Communication and Linguistic Competence

## Background

Latinos/Hispanics are now the largest ethnic group in the nation, accounting for 13.3% of the total population in the United States.

Many Latinos/Hispanics do not speak English or have limited English proficiency and face barriers from the first moment they come in contact with organizations. There are severe shortages of bilingual and bicultural clinicians that can provide competent care and this shortage is likely to continue (Malgady & Zayas, 2001). Biases may also exist when Latinos/Hispanics are assessed and diagnosed by clinicians unfamiliar with the cultural and meaning nuances of the Spanish spoken by the family. Language barriers create difficulties both in the person's ability to express her/his thoughts, feelings, and emotions and in the clinician's ability to tune in to the meaning the person is attempting to convey. Therefore, clinicians lacking understanding of language and culture and how Latinos/Hispanics express distress and other internal states may unwillingly misdiagnose, "pathologize," or miscalculate the severity of the person's needs (Malgady & Zayas, 2001).

Serious problems also exist when attempting to select and use materials in English or Spanish or when translating verbally or graphically the materials, surveys, measures and other products into Spanish. Inappropriate translations and use of materials may lead to inadequate or awkwardly conveyed information and collection of inaccurate data that can lead to: misdiagnosis; misidentification of needs; poor resource utilization; poor engagement and retention; negative repercussions on the families' physical and emotional well-being; inaccurate survey conclusions about Latinos/Hispanics and their needs; and biased or discriminatory results (Berkanovic, 1980; Marín & Marín, 1991; Taylor & Lurie, 2004; Araújo & Borrell, 2006; Mazor, Hampers, Chande, & Krug, 2002; Fernandez, Boccaccini & Noland, 2007).

One of the many challenges in achieving communicative competence with Latino/Hispanic families is that Latino/Hispanic groups in the United States are very diverse in regards to country of origin, level of acculturation, language abilities, geographic location in the US, and

socioeconomic status. Communities have unique cultures based on the dynamics created by the interaction of multiple characteristics and factors exclusive to their area, including their unique degrees and forms of multiculturalism. Service systems must strive to develop the competency to provide services that are congruent with the communication needs of Latino/Hispanic groups. Two interrelated general areas are identified when discussing linguistic competence: 1) Understanding the holistic meaning of communication among various Latino/Hispanic groups, including similarities and differences among subgroups; and 2) Developing a workforce that uses available resources appropriately to convey understanding and to provide the most competent care possible.



"Latino families experiencing traumatic stress require services through which they can effectively communicate their needs."

Latino/Hispanic families experiencing traumatic stress require services through which they can effectively communicate their needs, particularly after a traumatic event when the need to experience understanding, safety, and empowerment becomes extremely important. Latino/Hispanic families experiencing trauma may be grieving the loss of their country of origin and their *lengua materna* (mother tongue) and may face challenges in conveying their *dolor and duelo* (pain and grief). Traumatic events are fragmenting and disorganizing. They require interventions that can allow children and families to integrate their experience and incorporate the traumatic event in their lives so that it can cease being the lens through which they view and interpret the world. Trauma treatment services for Latino/Hispanic families should strive towards helping the family find its *voz* (voice), which is the most congruent expression of their experience that can effectively and safely allow them to heal (Lieberman & Van Horn, 2005).



*El lenguaje es el rostro del alma.\**

## Statement of the Issue

Communication and cultural barriers affect Latino/Hispanic families experiencing trauma in various ways. Many Latinos/Hispanics have limited or no English proficiency. These barriers sometimes lead to poor service utilization, lack of treatment compliance, dropping out of treatment, misdiagnosis, misassessment, and experiences of discrimination that can lead to negative emotional and physical outcomes. For example, lack of communication competence, such as inadequate use of translators or incorrectly translated instruments, can lead to misdiagnosis. Additionally, families with limited English proficiency may not know how to navigate the service systems and access trauma services. This may lead to higher dropout rates among families receiving trauma services, because they do not feel comfortable with clinicians with limited language proficiency and perceive them as lacking warmth or as cold or uncaring. Therefore, it is important that individual therapists and organizations serving Latino/Hispanic children and families affected by trauma develop linguistic competence in their service provision.



## Recommendations from the Field



- Providers should **develop deep knowledge of their intended population and their communication needs**. They should identify local resources and use them according to the best practices available to meet those identified needs. Examples of resources include translators, personnel, language training opportunities, translating available materials, consultation, etc.
- Providers should **translate all written materials using best practices available**. Providers should translate materials using a qualified translator, and translations should be reviewed by a committee that includes bilingual speakers who are members of the same Latino/Hispanic group as the intended population or who have experience working with the intended population. Translations should always be reviewed by members of the intended population seeking feedback for content, meaning, readability and overall quality. Translations should be done by a qualified person who is also familiar somewhat with the terminology and content area.
- Organizations should **develop strategies for hiring, recruiting, and developing Latino/Hispanic clinicians who are bilingual and bicultural**.
- Organizations should **have an interpreter available if bilingual clinicians are not available**. Some guidelines for use of an interpreter include the following (adapted from Minas, Stankovska, & Ziguras, 2001):
  - ⇒ Use a qualified interpreter with an understanding of the mental health profession. Do NOT use an available family member.
  - ⇒ Meet with the interpreter prior to the scheduled time for the assessment to discuss the purpose of the session and ask that the interpreter translate sentences word for word.
  - ⇒ Try to have the same interpreter present when meeting with the same client.
- Organizations should **develop strategies for improving their personnel's Spanish skills as well as other forms of communication**.
- Organizations should **utilize translated measures of the highest quality**. Organizations should ensure that translated instruments have achieved validity and reliability in Spanish and are sensitive to the language needs of the Latino/Hispanic groups they target. Non-translated instruments should be translated using the forward and back translation process, as well as the review-by-committee and consumer feedback process followed by pretesting, and alpha and beta testing (see Fernandez et al., 2007).
- Clinicians should **assess language needs individually and provide services that are linguistically attuned to those specific needs, matching the family's language**. Clinicians should be familiar with the variations in Spanish among different Latino/Hispanic groups, including local usage. Examples of variations in language among Latinos/Hispanics are: car could be translated as *carro*, *coche*, *auto*, *automóvil*, or *máquina*; eyeglasses could be *lentes* or *gafas*; groceries could be *el mandado* or *la compra*, etc.
- Clinicians should **strive to become a puente de comunicación (communication bridge) for affective states experienced by family members with different communication needs that are the result of intergenerational differences, level of acculturation, or country of origin**. Bicultural clinicians familiar with the client's culture of origin and with the process of acculturation and accommodation to the U.S. can tune in to the affective nuances in the communication differences among family members, differences that are inherent to the family's individual acculturation process.
- Universities and organizations should **create Spanish training and clinical supervision methods and programs for the development of bilingual and bicultural clinicians**. Clinical supervision programs in Spanish that are mentored by experienced bilingual and bicultural clinicians can allow bilingual therapists to develop the language skills to work across several Latino/Hispanic groups (see "Therapist Training and Support" priority area for more information).

### Resilience

- The cultural value of *personalismo* is closely tied to resilience (see the "Cultural Values" priority area for more information on *personalismo* and other cultural values). In order to promote *personalismo*, organizations should develop communication skills that pay close attention to language nuances that honor *personalismo* and lead to improved chances of retention. Communication skills address not only language but also personal space, non-verbal communication, appropriate use of transitions, use of "small talk," and other forms of communication that can enhance establishment of a strong therapeutic connection.
- Another way to promote *personalismo* is for providers to understand that language proficiency varies among family members. Personnel should develop the skills to meet the diverse communication needs among family members, according to their language preference and level of acculturation.

### Family/Youth Engagement

- Organizations should have quality materials in Spanish that are readily available in the organization and in visible places. These include books and magazines in the waiting room as well as handouts and forms used in the treatment process.
- Families should be greeted in a warm manner and in their preferred language from the first contact. Providers should understand that Latinos/Hispanics may feel intimidated making contact with the organization and may lack sophistication in accessing services.
- Families' need for warmth and strong connection with personnel should be maintained throughout the treatment experience. Staff members should be aware that family members can interpret being too direct or too "business like" as cold or uncaring.

## Community Examples/Best Practices



- **Serving Children and Adolescents in Need (S.C.A.N.)** - Works to improve and expand the service delivery system in Webb County, Texas, for children and adolescents aged 2 to 18 who have experienced any type of traumatic event. S.C.A.N. is a community-based, nonprofit organization with more than more than twenty years of experience providing services to children and adolescents and their families. S.C.A.N.'s trauma-informed system allows children and adolescents to have immediate access to a wide array of trauma-informed services and treatment, tailored to their individual needs. Webb County is located along the Texas-Mexico border, and most of the children served are first-generation Mexican Americans or Mexican immigrants who are bilingual or primarily Spanish-speaking. All staff members are bilingual and bicultural.  
⇒ Website: [www.scan-inc.org](http://www.scan-inc.org)  
⇒ Address: 2387 E. Saunders St., Laredo, TX 78041
- **DePelchin Children's Center** - Delivers screening, assessment, case management, and mental health services to children affected by trauma who reside in four southeast counties in Texas. DePelchin focuses on children who are the victims of complex trauma or who suffer from trauma related to traumatic loss, abuse (physical, psychological, or sexual), maltreatment, or neglect. DePelchin works with the community to provide information and training on best practices in child trauma treatment, and to increase the availability of and improve access to mental health services in the Greater Houston metropolitan area. Many of the clients are primarily Spanish-speaking and their materials have been translated according to best practice methods.  
⇒ Website: [www.depelchin.org](http://www.depelchin.org)  
⇒ Address: 4950 Memorial Drive, Houston, TX 77007
- **Latin American Health Institute** - Provides treatment and intervention services for Latino children and their families living in the Greater Boston area who have been impacted by traumatic events. The program is also focused on working with mental health providers that serve Latinos in Greater Boston and in other areas of Massachusetts to increase their knowledge of evidence-based interventions. The intended population has experienced losses, domestic and community violence, disasters, severe and chronic neglect, physical and sexual abuse, and chronic trauma. Many of the staff members are bilingual and bicultural.  
⇒ Website: [www.lhi.org](http://www.lhi.org)  
⇒ Address: 95 Berkeley St Ste 600, Boston, MA 02116-6246

## Resources



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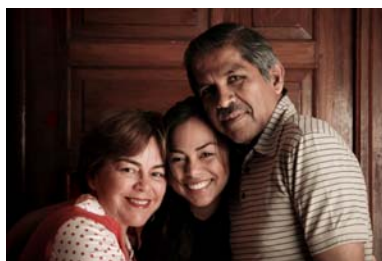
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*\*Dichos translation: Language is the face of the soul.*

### *Communication and Linguistic Competence Subcommittee*

**Chair:**

Luis E. Flores, MA, LPC, LCDC, RPT-S - Serving Children and Adolescents in Need, Inc. (SCAN), Laredo, TX

**Members:**

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- Gabriela Perez, MA, LPC - Serving Children and Adolescents in Need (SCAN), Inc., Laredo, TX
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- Lucila Jimenez, MA, M Phil - Harlem Hospital Center, New York, NY
- Griselda Oliver-Bucio, MS - Child Trauma Research Project, University of California, San Francisco



# Cultural Values

## Background

Latino cultural values play a significant role in the treatment of children affected by trauma and their families. Prior research has indicated that failure to incorporate values into treatment results in higher attrition rates (Sonkin, 1995) and possibly less efficacious treatment (Miranda, Siddique, Der-Martirosian, & Belin, 2005). Service providers working with Latino/Hispanic families must become familiar with the subtle nuances of Latino/Hispanic cultural values and explore how these values may or may not be influencing the course of treatment with the child over time. When possible, practitioners should incorporate them into their treatment plans in order to provide the most efficacious and culturally sensitive treatment to these families.

There is a substantial amount of literature published on Latino cultural values (Lopez-Baez, 1999; Marin & Triandis, 1985; Morales, 1996; Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002). It is beyond the scope of these guidelines to address and define all of these values. However, these guidelines will focus on the following Latino/Hispanic values which often impact the trauma treatment of children and their families:

- **Familismo** is the preference for maintaining a close connection to the family. Latinos/Hispanics, in general, are socialized to value close relationships, cohesiveness, and cooperativeness with other family members. These close relationships are typically developed across immediate and extended family members, as well as close friends of the family (Marin & Triandis, 1985).
- **Value of Children** reflects the value that Latino/Hispanic families place on children. Parents are often very affectionate with their children. However, in some homes, children are expected to be seen and not heard (Pajewski & Enriquez, 1996).
- **Marianismo** is a gender-specific value that applies to Latinas. *Marianismo* encourages Latinas to use the Virgin Mary as a role model of the ideal woman. Thus, Latinas are encouraged to be spiritually strong, morally superior, nurturing, and self-sacrificing (Lopez-Baez, 1999). Also, Latina youth must remain virgins until they marry.
- **Machismo** is a gender-specific value that applies to Latinos. *Machismo* refers to a man's responsibility to provide for, protect, and defend his family (Morales, 1996). The service providers should be aware that there is currently some debate surrounding the negative connotations of *machismo*, including sexual aggressiveness, male domination, and arrogance.
- **Personalismo** is the valuing and building of interpersonal relationships. *Personalismo* encourages the development of warm and friendly relationships, as opposed to impersonal or overly formal relationships (Santiago-Rivera et al., 2002).

"Service providers working with Latino families must become familiar with Latino values and incorporate them into their treatment plans in order to provide the most efficacious and culturally sensitive treatment to these families."

- **Respeto** implies deference to authority or a more hierarchical relationship orientation. *Respeto* emphasizes the importance of setting clear boundaries and knowing one's place of respect in hierarchical relationship (Santiago-Rivera et al., 2002). This may be displayed through the family's relationship with the provider and in their openness to discussing family relationships. This dynamic may create a situation where the relationship is not seen as a partnership. Rather, the family may defer to the professional and not express disagreement.

- **Simpatía** ("kindness") emphasizes the importance of being polite and pleasant, even in the face of stress and adversity. Avoidance of hostile confrontation is an important component of *simpatía*. Because of *simpatía*, some Latinos/Hispanics may not feel comfortable openly expressing disagreement with a service provider or treatment plan. This can lead to decreased satisfaction with care, non-adherence to therapy, and poor follow-up.

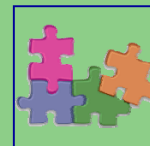
- **Religion and Spirituality** refers to the critical role that faith plays in the everyday life of most Latinos/Hispanics. Most Latinos/Hispanics are Christian, with the majority belonging to the Roman Catholic Church. However, different groups may have different faith affiliation. As it does for many people, religion offers Latinos/Hispanics a sense of direction in their lives and guidance in the education and raising of their children. Depending on where they are from, they may also seek medical or mental health care from alternative healthcare providers, such as *curanderos*, *sobadores*, and *espiritistas* (Pajewski & Enriquez, 1996).

The degree to which Latinos/Hispanics endorse these values is highly influenced by their acculturation level and generational status. For example, Latinos/Hispanics who are more acculturated into the United States' mainstream culture may not identify as strongly with these Latino/Hispanic values as compared to their less acculturated counterparts. Similarly, older generations of Latinos/Hispanics (first- or second-generation) may identify with these Latino/Hispanic values more strongly than younger generations. Given the dynamic process of acculturation and family members belonging to different generations, it is not uncommon for Latino/Hispanic families to have intrafamilial value differences: family members differing in their endorsement of Latino values (Smokowski, Rose, & Bacallao, 2008; Szapocznik, Kurtines, & Fernandez, 1980; Szapocznik, Kurtines, Foote, Pérez-Vidal, & Hervis, 1986). Research has shown that intrafamilial value differences often lead to more familial conflict and poorer mental health in the child (Félix-Ortiz, Fernandez, & Newcomb, 1998; Ying & Han, 2007). Thus, when working with Latino/Hispanic children affected by trauma, it is important to understand these value differences among family members given that they may exacerbate the trauma symptoms of the child.



## Statement of the Issue

Similar to other ethnic groups, Latinos/Hispanics have a unique set of cultural values that shape their behaviors, thoughts, feelings, and overall worldview. Not surprisingly, when trauma occurs in a Latino/Hispanic family, these values shape their reaction to the trauma, psychological consequences, coping responses, and meaning attributed to the trauma (Mennen, 1994). Thus, it is pivotal for service providers working with Latino/Hispanic children affected by trauma and their families to become familiar with these values. By developing familiarity with these values and incorporating these values into treatment, service providers can ultimately help these families process the traumatic event from their unique worldviews.



## Recommendations from the Field



- **Become familiar with Latino/Hispanic specific values and the moderating factors that may lead to value differences among family members.** Evaluate how the Latino/Hispanic specific values fall within your worldview (see APA, 2002 for more information).
- **Conduct a Latino-value focused assessment and feedback session on these values.** Please refer to the Resource section below for three assessment scales used to assess Latino/Hispanic values (Cuéllar, Arnold, & Maldonado, 1995; Marín, Sabogal, Marín, Otero-Sabogal, & Pérez-Stable, 1987; Ramirez & Carrasco, 1996). Practitioners should understand that cultural values emerge in subtle ways over time and the assessment is ongoing throughout treatment (see “Assessment” priority area for more information).
- **Assist families in understanding how their Latino/Hispanic values shape their perceptions about the trauma, their psychological response and approach to treatment.**
  - ⇒ *Familismo*: In cases of intrafamilial abuse, how has the child’s immediate and extended family reacted to the child’s disclosure of the abuse? How has the betrayal of a family member affected how the child perceives his/her family? Did the child’s allegiance to the value of *familismo* prolong the child’s disclosure of the abuse?
  - ⇒ *Marianismo*: Are the females of the family reluctant to engage in treatment because they feel that this is the suffering they must endure (“*Esto es una cruz que debo de llevar*”—“This is the cross that I have to bear”) (Garcia-Preto, 1990)? In child sexual abuse cases, how is virginity being perceived? Does the family feel that the child’s virginity has been taken away? Is there a concern that the child will not marry well because she has “lost” her virginity?
  - ⇒ *Machismo*: In male cases, is the child suppressing/underreporting his traumatic symptoms in order uphold the value of appearing as a strong male? Is the father reluctant to participate in treatment because he does not want to be perceived as being vulnerable? Is the non-offending father feeling overly responsible for failing to protect his family?
- **Assist families in reframing their perceptions of Latino/Hispanic values that may be hindering the child from processing and integrating his/her traumatic experience.** Service providers working with Latinos/Hispanics should never attempt to change their patients’ values. When appropriate, service providers can help the family reframe their perceptions regarding their values if these perceptions are impeding the child’s healing process. Examples of reframing Latino/Hispanic value perceptions include:
  - ⇒ *Familismo*: In cases of intrafamilial abuse, helping the child understand how his/her disclosure was a heroic act and not a betrayal to his/her family. The child’s disclosure essentially protected other family members from undergoing his/her trauma.
  - ⇒ *Marianismo*: In child sexual abuse cases, helping the family members understand that virginity is a virtue that is consensually given and cannot be taken away. Given the strong religious and spiritual orientation among Latinos/Hispanics, often involving spiritual/indigenous leaders from the community (i.e., priests, pastors, *espiritistas*, *curanderos*, etc.) to discuss the topic of virginity can be helpful.
  - ⇒ *Machismo*: Educating the child on normal emotional responses to a traumatic event. Educating the non-offending father on the secrecy and manipulation surrounding most abuse cases which may have prevented him from recognizing the abuse that was taking place.

*Padres sanos, hijos honrados.\**

## Resilience

- Latino/Hispanic children can be positively affected by the reaction and support they receive from their immediate family members, extended family members, and friends. Latino/Hispanic non-offending parents, especially mothers and other extended non-offending family members, such as grandparents and aunts/uncles, are typically readily available to engage in the therapeutic process with the child to help him/her overcome his/her trauma.
- Because religion/spirituality is a central factor in the lives of most Latinos/Hispanics, it often serves as a protective factor. The child and his/her family will often use their religious/spiritual beliefs to find a meaning/purpose in the traumatic experience. In addition, it is often their religious/spiritual beliefs that give them faith and strength to continue with life’s difficult challenges and find meaning and purpose in their lives.



## Family/Youth Engagement

- Telephone the family before they attend their first session. The telephone conversation should focus on answering any questions that they may have about the upcoming session. This telephone conversation helps develop *confianza* (trust) between the service provider and parents. Additionally, it begins to develop an alliance with the parents which is very important when working with children.
- Exemplifying traits of *personalismo* is important when establishing rapport with the child and the family. Appropriate self-disclosures made by the service provider may help the family perceive the therapist as more personable and approachable.
- Exemplifying traits of *respeto* is also important when establishing rapport with the child and the family. Service providers working with Latinos/Hispanics should acknowledge the hierarchical relationships that may exist within the family and the respect that is given to those with more authority. At initial sessions, address adults with formal titles, such as, *Doña*, *Don*, *Señor*, or *Señora* which symbolize a sign of respect for them regardless of the service provider position/title. Also, follow a hierarchical approach to greetings, starting with adults first and then children. Professionals may need to openly invite and encourage collaboration and highlight the parents’ roles as experts on their children.

## Community Examples/Best Practices



- **Culturally Modified Trauma Focused Treatment (CM-TFT)** – Developed by Dr. Michael de Arellano, CM-TFT was developed for use with Latino/Hispanic children and is based on Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), with the addition of modules integrating cultural concepts and values throughout treatment. For more information, contact Dr. Michael de Arellano at [dearelma@musc.edu](mailto:dearelma@musc.edu).
  - ⇒ Website: [www.nctsn.org/nctsn\\_assets/pdfs/promising\\_practices/cmtft\\_general.pdf](http://www.nctsn.org/nctsn_assets/pdfs/promising_practices/cmtft_general.pdf)
  - ⇒ Address: Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina, 165 Cannon Street, MSC 852, Charleston, SC 29425
- **The Chicago Child Trauma Center at La Rabida Children's Hospital (LRCH)** - serves inner-city African Americans and other Chicago-area children exposed to traumatic events including medical trauma, sexual abuse, witnessing violence, and complex trauma. For decades, LRCH has been a leader in the development and provision of abuse- and trauma-related psychological services for children. Their work integrate cultural values throughout treatment
  - ⇒ Website: [www.larabida.org](http://www.larabida.org)
  - ⇒ Address: 8949 S. Stony Island, Chicago, IL 60649
- **Under the Rainbow at Mt. Sinai Hospital** - Under the Rainbow (UTR) provides treatment for most childhood disorders and specializes in the evaluation and treatment of child abuse and neglect. Under the Rainbow offers evaluation of abuse and neglect, Zero-to-Five developmental evaluation, and parent training for behavior management problems. Spanish-speaking therapists offer individual and family therapy for monolingual Spanish-speaking clients living in the Pilsen-Little Village area and integrate cultural values into treatment.
  - ⇒ Website: <http://sinai.org/services/psychiatry/childBehavioralHealth.asp>
  - ⇒ Address: California Avenue at 15th St., 5th Floor Nurses Residence, Chicago, IL 60608

## Resources

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*\*Dichos translation: Healthy parents raise honorable children.*

### Cultural Values Subcommittee

**Chair:**

Magdalena Perez, PhD - i3 Research, Chicago, IL

**Members:**

- Gladys Valdez, PhD - Manhattan Psychiatric Center, New York, NY
- Veronica Bordes, MA - Doctoral Student, Arizona State University, Tempe, AZ
- Nicolas Carrasco, PhD - Private Practice and University of Texas, Austin, TX

# Immigration/Documentation

## Background

Hispanics represent the largest ethnic group in the U.S. and the number of Latino/Hispanic immigrants is steadily increasing (Passel, 2006). Immigration and documentation issues may increase stress among Latino/Hispanic families as they struggle to meet their basic needs and can put children at greater risk of maltreatment. As of March 2005, the Pew Hispanic Center estimated that of the 11 million undocumented immigrants living in the U.S., six million came from Mexico (Passel, 2006).

Immigration is a process that includes the initial decision to migrate, the process of migration, and acclimatization to the new country (Pérez-Foster, 2005). Families may experience perimigration trauma (Pérez-Foster, 2005), which is psychological distress occurring at four points of the migration process: events before migration (e.g., extreme poverty, war exposure, torture); events during migration (e.g., parental separation, physical and sexual assault, theft of the money they saved to immigrate with, exploitation at the hands of a human smuggler, hunger, and death of traveling companions); continued rejection and suffering while seeking asylum (e.g., chronic deprivation of basic needs); and survival as an immigrant (e.g., substandard living conditions, lack of sufficient income, racism).

The immigration process often occurs in increments, leading to separation of the family. Many times one parent immigrates first with plans to work and send money home so that the rest of the family can later immigrate. In other cases, both parents may immigrate and leave children with relatives while they work and save money. These separations can last for months or even years, causing strain on the relationship between parents and children. After arriving in the U.S., many immigrants isolate themselves for fear of being discovered and deported. This lack of a support system is very difficult. In addition, many immigrants are treated poorly due to racism (Pérez-Foster, 2005).

Recent immigration raids have also had an effect on families who are undocumented and living in fear that they will be discovered. A child may be separated from one or both of his/her parents as a result of immigration enforcement. While their parents may be undocumented, as many as two-thirds of these children may be U.S. citizens, suggesting that the future costs to our

country and the long-term impact of this separation on the children are significant (Capps, Castañeda, Chaudry & Santos, 2007).



“Immigration is a process that includes the initial decision to migrate, the process of migration, and acclimatization to the new country.”

There is also a growing problem of human trafficking, in which Latino/Hispanic women and children are brought into the United States and forced into prostitution (U.S. Department of State, 2008). After they arrive in the United States, many immigrants are exploited by being forced to work for below minimum wage under abusive conditions. Immigrants live with these conditions for fear of being deported if they complain.

In addition, learning a new language and way of life can also be stressful. Immigrants are struggling to

acculturate while still maintaining their cultural heritage. The acculturative process within the same family may also be diverse, with younger children acculturating more quickly than their parents. Although trauma services may be available in the community, immigrant families are likely unaware of the services available and if they are aware, may be reluctant to access services for fear of deportation.



Service providers need to understand that immigrant families face unique challenges that may affect their ability and willingness to seek trauma treatment services. They may not qualify for certain services if they are undocumented. Also, they may also be unable to access services due to language barriers and poverty. They may not understand the process of mental health treatment, which may also prevent immigrant families from seeking trauma treatment services. Many immigrants live in rural, impoverished areas where transportation is a problem. Instability in the lives of immigrant families may also prevent them from seeking or following through with services. For those families, facing homelessness, hunger and violence takes priority over receiving mental health services, despite the effects of trauma. A greater understanding of the unique challenges that many immigrant families experience plays a crucial role in improving service provision for these families.

## Statement of the Issue

Immigration and documentation issues are a problem for families in need of trauma treatment for several reasons. First, the immigration process itself often entails traumatic experiences and separation of families. Recent immigrants may be unaware of available resources or how to access resources to help them cope with trauma and separation. Agencies may not provide services to undocumented families, or families may be reluctant to seek services if they are undocumented for fear of deportation. Not speaking or understanding English may prevent families from seeking services. For families wishing to access services, a lack of transportation may also pose a barrier. Finally, stigma associated with mental health treatment may prevent recent immigrants or those less acculturated from seeking services for lack of understanding what counseling is or a fear of being labeled.



## Recommendations from the Field



- **Provide assurance that undocumented families need not fear being reported to immigration authorities (i.e., ICE) by staff or deported if they receive mental health services at our agencies.** This can be achieved through community outreach and public service campaigns.
- **Conduct a thorough intake, including asking questions about immigration and documentation status,** as these issues may prevent families from accessing or continuing with services. If a family is undocumented, the providers are in a unique position of being able to help them connect with other available services.
- During the assessment, **ask specific questions about their immigration experiences,** including trauma experienced during the immigration process, trauma related to discrimination, and trauma experienced in their country of origin. Often, families choose to migrate to the United States because of potentially traumatic events that occurred in their country of origin. It is important to assess for their experiences prior to migration, as well as throughout the migration process (see the “Assessment” priority area for more information).
- **Assess for acculturation differences within the same family.** Children may acculturate to the new culture faster than their parents, which could lead to further problems and distress. Scales such as the Acculturation Rating Scale for Mexican-Americans, second edition (ARSMA-II; Cuéllar, Arnold, & Maldonado, 1995) can aid in this assessment (see the “Assessment” priority area for more information).
- **Assess for acculturative stress** and any crisis issues related to basic needs, family functioning, and trauma symptoms. Acculturative stress refers to the psychological, somatic, and social difficulties that may accompany acculturation processes (Chavez, Moran, Reid, & Lopez, 1997). This acculturative stress may lead to anxiety, depression, and substance abuse (Dettlaff & Rycraft, 2006). Children and families undergoing the process of acculturation may or may not be experiencing acculturative stress. Therefore, it is important to assess for this specific construct during the interview and through objective measures (i.e., SAFE Scale; Chavez et al., 1997; see the “Assessment priority area for more information).

*Poco a poco  
se anda  
lejos.\**

- **Hire bilingual staff and if possible, bicultural staff** (Santiago-Rivera, Arredondo & Gallardo-Cooper, 2002; see the “Therapist Training and Support” and “Communication/Linguistic Competence” priority areas for more information).
- **Familiarize yourself with immigration laws, policies, and resources** (i.e., Violence Against Women Act, U-Visas). Children and families may be eligible to receive various services if they have been the victim of a crime, whether or not they are undocumented (see the “Policy” priority area for more information).

### Resilience

- Help children and families identify strengths and resources within themselves and their environment. For example, spirituality may be a strength for many immigrant families, and religious institutions may provide support and a sense of community to reduce isolation.
- Make sure to engage the family (immediate as well as extended) throughout the therapeutic process, being respectful of the importance of *familismo* (please refer to the “Cultural Values” priority area for more information on this and other cultural values). The family can be a strong support system for the client.



### Family/Youth Engagement

- Stress integration of the immediate and extended family in treatment by encouraging their participation in sessions and seeking feedback from family members about their treatment experience and ways to improve services.
- If transportation is a problem, conduct sessions in the home or at locations more accessible within the community (i.e., churches). This will also allow for extended family members who also live in the home or community to participate in the therapeutic process (see the “Service Utilization/Case Management” priority area for more information).
- Learn as much as possible about the family’s culture, including cultural values and traditions, and be respectful of their cultural beliefs. It is also important to realize that not all members of a culture have similar beliefs. Be careful to be individually sensitive and not stereotype the family.
- When working with families that may have immigrated illegally, reassure them that they will not be reported to immigration authorities (i.e., ICE) by your agency. This will ease their apprehension about seeking services.
- Explain the therapeutic process and the relationship between the clinician and the family. Giving the family a clear sense of what they can expect as well as what is expected of them and help them to understand the importance of mental health services. This is a step in challenging the stigma associated with mental health services in the Latino/Hispanic culture.

## Community Examples/Best Practices



- **Border Traumatic Stress Response (Border TSR), Serving Children and Adolescents in Need (S.C.A.N.)** - Works to improve and expand the service delivery system in Webb County, Texas, for children and adolescents aged 2 to 18 who have experienced any type of traumatic event. S.C.A.N. is a community-based, nonprofit organization with more than twenty years of experience providing services to children and adolescents and their families. S.C.A.N.'s trauma-informed system allows children and adolescents to have immediate access to a wide array of trauma-informed services and treatment, tailored to their individual needs. Webb County is located along the Texas-Mexico border, and most of the children served are first-generation Mexican Americans or Mexican immigrants who are bilingual or primarily Spanish-speaking.
  - ⇒ Website: [www.scan-inc.org](http://www.scan-inc.org)
  - ⇒ Address: 2387 E. Saunders St., Laredo, TX 78041
- **The Chadwick Center's Family Violence Program (FVP)** - Located at the San Diego Family Justice Center in downtown San Diego, the Family Violence Program pairs each family with an advocate and a therapist. Advocates assist with: Developing safety plans; Accessing restraining orders; Accompanying clients to court and mediation; Accessing emergency and long-term housing; Accessing financial and medical resources; Planning for long-term goals; and Coordinating with other providers (CPS, schools, attorneys, etc.). Therapists specialized in trauma counseling facilitate individual, group, and family therapy, and, advocates are on-site to help families navigate the legal system related to documentation issues. The goal of treatment is to heal from the abuse and to transition to a safe future.
  - ⇒ Website: [www.chadwickcenter.org/FV.htm](http://www.chadwickcenter.org/FV.htm)
  - ⇒ Address: San Diego Family Justice Center, 707 Broadway, 2nd Floor, San Diego, CA 92101
- **Latin American Health Institute** - Provides treatment and intervention services for Latino/Hispanic children and their families living in the Greater Boston area who have been impacted by traumatic events. The program is also focused on working with mental health providers that serve Latinos/Hispanics in Greater Boston and in other areas of Massachusetts to increase their knowledge of evidence-based interventions. The intended population has experienced losses, domestic and community violence, disasters, severe and chronic neglect, physical and sexual abuse, and chronic trauma.
  - ⇒ Website: [www.lhi.org](http://www.lhi.org)
  - ⇒ Address: 95 Berkeley St Ste 600, Boston, MA 02116-6246

## Resources



About.com: Immigration Issues - Information regarding immigration laws and citizenship as well as links to additional resources. Retrieved November 8, 2008, from <http://immigration.about.com>

Academy for Educational Development: [humantrafficking.org](http://humantrafficking.org) - A web resource for combating human trafficking. Retrieved November 8, 2008, from [www.humantrafficking.org](http://www.humantrafficking.org)

ACTION Network - A comprehensive community response to ending the prostitution of children in San Diego. Retrieved November 8, 2008, from [www.humantrafficking.org/organizations/395](http://www.humantrafficking.org/organizations/395)

Immigration Legal Resource Center - A resource dedicated to promoting, educating, and empowering immigrants and their advocates. Retrieved November 17, 2008 from [www.ilrc.org](http://www.ilrc.org)

LegalAid.com - Assistance with findings attorneys that address immigration issues. Retrieved November 8, 2008, from [www.legalaid.com](http://www.legalaid.com)

Martínez, O. J. (1994). *Border people: Life and society in the U.S. - Mexico borderlands*. Tucson: The University of Arizona Press.

National Conference of State Legislatures - Provides updated information on immigration policies, including an overview on immigrant policies. [www.ncsl.org/programs/immig/](http://www.ncsl.org/programs/immig/)

Paniagua, F. A. (2005). *Assessing and treating culturally diverse clients: A practical guide* (3rd ed.). Thousand Oaks, CA: Sage.

Pew Hispanic Center: Chronicling Latinos' diverse experiences in a changing America - [www.pewhispanic.org](http://www.pewhispanic.org)

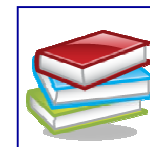
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Pérez-Foster, R. M. (2005). The new faces of childhood perimigration trauma in the United States. *Journal of Infant, Child, and Adolescent Psychotherapy*, 4(1), 21-41.

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*\*Dichos translation: Little by little you will go far/ If you persevere, you will go far.*

### *Immigration/Documentation Subcommittee*

#### **Chair:**

Susana Rivera, PhD - SCAN, Inc. Border Traumatic Stress Response Center, Laredo, TX

#### **Members:**

- Suzana G.V.H. Adams, MA - Synchrony of Visalia, Inc., Visalia, CA
- Alison Hendricks, LCSW - Chadwick Center for Children and Families, Rady Children's Hospital, San Diego, CA
- Blanca Nelly Hernandez, PhD - DePelchin Children's Center, Houston, TX
- Dante Jimenez, MA, LPC, NCC - Aliviane, Inc., El Paso, TX
- Gerardo Rosas, MA, LPC - Aliviane, Inc., El Paso, TX



# Child Welfare/ Resource Families

## Background

The number of Latino children in the child welfare system has been increasing at a dramatic rate. Between 1990 and September 2002, the number of Latino children almost doubled from 8% of the general foster care population to 15%. Furthermore, 62% of Latino children served by child welfare services are placed in out-of home care compared to 25% in 1977. In certain states, such as California and Texas, the number of Latino children has grown significantly. In California, out of approximately 83,000 youth in foster care, 40% are Latino (Ortega, 2001).

Most children who enter the child welfare system have experienced significant trauma and have a high prevalence of mental health needs; however only about one-fourth of those with diagnosed mental health needs receive specialty care (McCarthy, Van Buren, & Irvine, 2007).

It is well documented that Latino children involved in foster care experience disproportionately negative outcomes of well-being when compared to their White counterparts (Church, Gross, & Baldwin, 2005). One dimension of this outcome disparity is manifested in the uneven access to services that are delivered with consideration to socio-cultural, ethnic, linguistic and other contextual variables such as levels of acculturation and immigration considerations. One recent study (Vericker, Kuehn, & Capps, 2007) suggests that many children of immigrants coming to the attention of child welfare, are less likely to have a goal of permanency.

*Amor con amor  
se paga.\**

Children involved in the foster care system who are placed in homes of their own culture tend to have more positive self-identity and self-esteem. However, Latino foster children are more likely to be placed in settings that are not culturally or linguistically consistent with their family of origin (Hollingsworth, 1998). This lack of understanding of the cultural and linguistic needs, or more dramatically the presence of racial bias in placement contexts, can have detrimental consequences for the psychosocial adjustment of Latino/Hispanic children and thus place them at higher risk for mental health concerns.

Foster youth often receive individual-based services that may not include caregivers, and/or resource families in the treatment and

intervention plans (Friedman, 2003). However, it is well-known that individual interventions without caregiver involvement is of limited value (Landsverk, Burns, Stambaugh, & Rolls-Reutz, 2006).



Along with the life experiences consistent with abuse/neglect and involvement with child welfare and out-of home care, there are other life experiences of a traumatic nature for Latino/Hispanic children and families. These include cultural traumas such as societal stances that attempt to eradicate or invalidate parts of the culture. Therefore, it is vitally important that Latino/Hispanic children in the child welfare system receive interventions that are trauma-informed. However, there is concern that child welfare systems are lacking the ability to respond to the specific needs of children that present complex trauma issues (Igelman, Conradi, & Ryan, 2007).

“Most children who enter the child welfare system have experienced significant trauma and have a high prevalence of mental health needs.”

There is growing recognition of the importance of creating trauma-informed child welfare systems that would be more responsive to the needs of youth and families and incorporate the use of evidence-based practices into case planning.



While there is an increased focus on the importance of providing high-quality, evidence-based practices in response to trauma, these practices are usually developed and evaluated in highly controlled environments with access to training, supervision and monitoring for program fidelity. These conditions are less likely to be replicated in the contexts and agencies where most Latino/Hispanic families and youth impacted by foster care will receive services.

The primary goal of child welfare is to achieve a permanent, safe and stable family connection that enhances well-being. The mitigation of traumatic stress and other mental health concerns is best addressed and interventions are more likely to be effective in the context of permanency planning and with family members and/or other significant adults whom the youth see as meaningful in their lives. Given the unique experiences of Latino/Hispanic children in the child welfare system, it is important to address the specific needs of this population.



## Statement of the Issue

Latino/Hispanic children, youth and families impacted by the child welfare system lack consistent access to adequate mental health services that are culturally and linguistically relevant and are grounded in the context of important socio-cultural and economic variables. These include foster care and immigration experiences and other traumatic events inherent in the life experiences of these children and families. More efforts need to be directed to ensure that mental health services that address traumatic stress are taking place as part of the concurrent planning towards achievement of permanency, safety and well-being for Latino/Hispanic youth in out-of home care.



## Recommendations from the Field



- **Expand the definition of trauma for Latino/Hispanic families and children involved in child welfare.** It is important to consider specific life experiences for Latino/Hispanic children and families involved in child welfare and consider those when assessing for traumatic stress with this population and account for the cultural implications of these experiences (Cohen, 2007). These experiences include the trauma associated with out-of home placement, and the experiences of multiple placement changes that many Latino/Hispanic children experience while in foster care.
- **Focus on early intervention and prevention of entry into foster care.** Given that entry into foster care can be a traumatizing experience for children and families, prevention of entry into care through effective, culturally competent differential response assessment is critical. When children need to be placed in foster care, every effort needs to be made to secure stable placements and timely permanency planning and avoid the multiple placement changes that often times can be re-traumatizing.
- **Increase training of child welfare staff.** Train child welfare staff on trauma-informed child welfare interventions as well as on the specific issues and needs of Latino/Hispanic children and families involved in child welfare with consideration of socio-cultural, ethnic, linguistic and other contextual variables (e.g., immigration) that may compound the presence of trauma (Igelman et al., 2007).
- **Build capacity within Latino/Hispanic mental health providers.** Develop training opportunities for Latino/Hispanic clinicians to become trained in evidence-based interventions and the contextual dynamics of child welfare and foster care.
- **Expand the range of interventions that mitigate traumatic stress through achievement of Permanency, Safety, and Well-being.** Consider the value of typical child welfare intervention models such as the Annie E. Casey's *Family to Family* initiative (The Annie E. Casey Foundation, 1999), *Family Group Conferencing* (Merkel-Holguin, Tinworth, Horner & Wilmot, 2008) and other innovative cross-system approaches such as those advanced by the *Systems of Care* model (Pumariega, & Noboa-Ríos, 2005), and evaluate their value in mitigating trauma and its many manifestations through the promotion of stable, safe and permanent family connections with Latino/Hispanic populations.
- **Support community and ethnic-based organizations.** Given that most Latino/Hispanic youth and families impacted by the child welfare system will likely receive services by community and ethnic-based organizations, consider expanding the role of these groups to build capacity and have the adequate infrastructure and resources to deliver and adapt evidence-based practices in their contexts. This may include providing trainings to these agencies on Latino/Hispanic children in child welfare and the impact of trauma.
- **Increase social marketing efforts to recruit bilingual and bicultural families.** A critical component of effective child welfare practice is the need to ensure that there is enough capacity of resource families that can provide cultural and linguistic continuity and support Latino/Hispanic foster youth's ethnic identity.
- **Provide educational and skill building opportunities for Resource families.** These would include kinship caregivers to better address and manage the mental health needs of youth in their care, including the impact of trauma. An example is the *Parent Engagement and Self-Advocacy* curricula available at [www.TheReachInstitute.org](http://www.TheReachInstitute.org).

### Resilience

- Recognize the value of identifying the youth and families experiences with overcoming problems, finding their own solutions. These are often grounded in their cultural, ethnic and other contextual backgrounds (e.g., immigration stories) that point to meaningful themes and core cultural beliefs that assist in better informing interventions and coping with trauma.
- Incorporate protective factors, (e.g., cultural values, extended family and community relationships, family/youth experiences in overcoming hardships, etc.) into risk assessment instruments that account for a balanced picture of Latino/Hispanic children and families. This will help inform decision-making and intervention plans that include familial strengths and resources that can be mobilized for maximum goal attainment.

### Family/Youth Engagement

- Involve family and youth as full partners in the development and implementation of case/treatment planning while intentionally including information and themes consistent with the families' cultural and socio-economic contexts in order to seek ownership of the plan and maximize the likelihood of success.
- Promote enhanced educational and skill building opportunities for Latino/Hispanic caregivers (foster parents, birth parents, kin caregivers) to better understand the mental health issues, including the impact of trauma on their children, as well as their role as advocates in seeking the best possible care for their youth and families (e.g., *Parent Engagement and Self-Advocacy curricula*, Casey Family Programs-REACH Institute collaboration available at [www.TheReachInstitute.org](http://www.TheReachInstitute.org)).
- Promote enhanced educational and skill building opportunities for Latino/Hispanic youth in care to better understand the mental health issues they are facing and their role as advocates in seeking care on their own behalf (e.g., *Taking Control* curriculum, Casey Family Programs-REACH Institute collaboration available at [www.TheReachInstitute.org](http://www.TheReachInstitute.org)).

## Community Examples/Best Practices



- **Centro de Bienestar Mental** – Provides counseling services to adolescents, adults and elders. Group and family therapy services provided to children and individuals, including foster children. Medi-Cal accepted.  
⇒ Website: [www.sanjose.com/centro-de-bienestar-mental-health-b2599251](http://www.sanjose.com/centro-de-bienestar-mental-health-b2599251)  
⇒ Address: 160 E. Virginia St., Ste. 280, San Jose, CA 95112
- **Roberto Clemente Center - An Outpatient Mental Health Clinic, The Roberto Clemente Family Guidance Program** - Provides counseling and psychotherapy services with an emphasis in family counseling and family therapy. Other services provided are: individual therapy, group therapy, marital therapy, play therapy, and pharmacotherapy. Mental health professionals (Psychiatrists, Psychologists, Social Workers, and Counselors), all bilingual and bicultural, provide services for an active caseload of over 300 clients, many of whom are involved in the child welfare system.  
⇒ Website: [www.clementecenter.org](http://www.clementecenter.org)  
⇒ Address: 540 E. 13th St., New York, NY 10009
- **Yakima Valley Farm Workers Clinic's Behavioral Health Services, Children's Village** – A licensed mental health agency serving children, adolescents and adults living throughout Yakima County. They provide individual, group, and family counseling and work closely with children in the child welfare system.  
⇒ Website: [www.yfwc.com/yakima\\_bhs.html](http://www.yfwc.com/yakima_bhs.html)  
⇒ Address: 3801 Kern Rd., Yakima, WA 98902
- **Cognitive Behavioral Intervention for Trauma in Schools (CBITS)** – Developed by Dr. Lisa Jaycox and colleagues, this program is an intervention for children in schools with violence-related mental health symptoms such as depression, anxiety, and posttraumatic stress disorder. CBITS was developed from empirical data on the effects of trauma on Latino/Hispanic and immigrant youth. The RAND Institute in Los Angeles is currently implementing a group version of CBITS in LA Unified School District with foster youth.  
⇒ Website: [www.hsrcenter.ucla.edu/people/jaycox.shtml](http://www.hsrcenter.ucla.edu/people/jaycox.shtml)  
⇒ Book: <http://store.cambiumlearning.com/ProductPage.aspx?parentId=019004232&functionID=009000008&site=sw>

## Resources



Casey Family Programs. (2005). *Knowing who you are: A journey to help youth in care develop their racial and ethnic identity*. Retrieved from November 8, 2008, from [www.casey.org/Resources/Projects/REI/](http://www.casey.org/Resources/Projects/REI/). This curriculum helps child welfare professionals explore racial and ethnic identity, preparing them to support the healthy development of their constituent's racial and ethnic identity.

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Kinship Center, [www.kinshipcenter.org](http://www.kinshipcenter.org). Mission: Kinship Center is dedicated to the creation, preservation and support of foster, adoptive and relative families for children who need them.

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Safe Start Center, [www.safestartcenter.org](http://www.safestartcenter.org). The Safe Start Center is a national resource center designed to support the Safe Start Initiative. The Center works with national partners and a multidisciplinary group of experts to provide training and technical assistance to the 15 Promising Approaches Pilot Sites.

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*\*Dichos translation: Love with love is repaid.*

### *Child Welfare/Resource Families Subcommittee*

**Chair:**

Jorge Cabrera, MSW, ACSW - Casey Family Programs, San Diego Field Office

**Members:**

- Sonia Velasquez - Children's Division, American Humane Association
- Alan Dettlaff, PhD - Jane Addams College of Social Work, University of Illinois-Chicago, IL
- Joan Rycraft, PhD - University of Texas at Arlington
- Elena Cohen, MSW - JBS International
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- Leo Lopez - Casey Family Programs, Yakima field office, WA
- Peter Pecora, PhD - Casey Family Programs, Seattle headquarters, WA
- Raquel Flores, MA - American Humane Association

# Service Utilization and Case Management

## Background

Latinos/Hispanics are the largest ethnic group in the United States (Takeuchi, Alegria, Jackson, & Williams, 2007) and constitute the largest portion of new immigrants (U.S. Census Bureau, 2003). Stressors that Latino/Hispanic children and families often face, such as few social supports, higher rates of poverty, substandard housing and consequent exposure to community violence, are known to adversely affect mental health (Atdjian & Vega, 2005). Although there is a notable lack of scientific research in the area of child trauma and service utilization, studies of Hispanic adults have consistently found that Hispanics use mental health services less often than European Americans (Hough et al., 1987), remain in treatment for less time (Sue, Fujino, Hu, Takeuchi, & Zane, 1991), and receive appropriate treatment less often (Acosta, 1979; Young, Klap, Sherbourne, & Wells, 2001).

Here are suggested reasons for the underutilization of services.

**Conceptualization of Symptoms:** Researchers have suggested that Hispanics may be more likely to conceptualize mental health symptoms as somatic compared to Caucasian Americans (e.g., Peifer, Hu & Vega, 2000; Varela et al., 2004). In general, recent Hispanic immigrants are more likely to consult with primary care physicians and general health clinics prior to being referred for psychiatric services (Vega, Kolody, Aguilar-Gaxiola, & Catalano, 1999).

**Acculturation Level:** One possible impediment to service utilization is low acculturation rates, particularly for recent immigrants. Research has demonstrated that, as Latinos/Hispanics become acculturated to the United States, and for those Hispanics who have resided in the United States and its territories (e.g., Puerto Ricans), rates of service utilization match those of the majority ethnic group (U.S. Department of Health and Human Services, 2001). The level of acculturation is particularly important given that many Latinos/Hispanics value family loyalty and, consequently, view mental health problems as matters that are private and ought not to be shared with others outside of the family (Leaf, Bruce, Tischler, & Holzer, 1987).

**Lack of Knowledge About or Awareness of Services:** Related to acculturation rates, a lack of familiarity with available services may impede help-seeking. Indeed, studies have demonstrated that Hispanic women were more likely to seek treatment when they

personally knew someone who had also received services (Alvidrez, 1999).

**Social and Legal Consequences of Seeking Services:** Lower utilization rates in Latinos/Hispanics with mental illness may be partially attributable to the social consequences of service seeking.

For example, a survey of mental health service providers in communities with high percentages of Latino/Hispanic residents suggested that some people were reluctant to seek help because of fears of deportation, distrust of service providers, and fear of law enforcement officials (Lewis, West, Bautista, Greenberg, & Done-Perez, 2005). Social consequences within the family unit and tight-knit community may also inhibit service seeking. Studies have suggested that Hispanics fear bringing shame to the family for even seeking mental health treatment, regardless of etiology (Leaf et al., 1987).

**Economic Consequences of Seeking Services:** The economic burden of seeking services may further inhibit utilization. Latinos/Hispanics are more frequently unemployed or underemployed compared to other ethnic groups in the United States, and so may not have adequate health insurance (U.S. Department of Health and Human Services, 2001). Areas with poor public transportation services may make it difficult for families without cars to keep appointments. Few social supports, such as neighbors who can baby sit other children, may further exacerbate the problem. Families who have recently immigrated may face additional economic barriers, particularly if the breadwinner of the family faces deportation, job lay-offs, employment insecurity or other situations that put the family's economic stability in jeopardy (Cavazos-Rehg, Zayas, & Spitznagel, 2007).

**Lack of Culturally Sensitive and Appropriate Services:** An important consideration for low rates of service utilization may be that service delivery models, while beneficial to ethnic majority families and children, are perceived as culturally insensitive or unhelpful to Hispanic families (Añez, Paris, Bedregal, Davidson, & Grilo, 2005; Gelso & Fretz, 2001; see the "Provision of Therapy" priority area for more information). Even more basic, many service programs do not employ full- or part-time Spanish speaking staff members, leaving Latinos/Hispanics without service delivery options (Preciado & Henry, 1997).



"Research studies have consistently found that Hispanics use mental health services less often than European Americans."



## Statement of the Issue

Although Latino/Hispanic children and adolescents may experience potentially traumatic events at significantly higher rates than ethnic majority children residing in the United States (Kilpatrick et al., 2000), research studies have consistently found that Hispanics use mental health services less often than European Americans (Hough et al., 1987), remain in treatment for less time (Sue et al., 1991), and receive appropriate treatment less often (Acosta, 1979; Young et al., 2001). Some possible reasons for this may include: (1) conceptualizing mental health symptoms as somatic, so seeking medical rather than psychological services; (2) lower rates of acculturation, and consequent (3) lack of knowledge about available services; (4) fear of social consequences of seeking help; (5) economic barriers to service utilization; and (6) lack of culturally appropriate service delivery models and service providers who speak Spanish.



## Recommendations from the Field



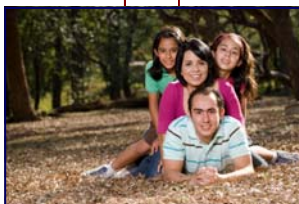
- **Increase employment of Spanish-speaking therapists and service providers.** Latino/Hispanic families may feel more comfortable seeking treatment if the providers speak their language (see the “Therapist Training and Support” priority area for more information).
- **Reduce economic barriers to service utilization.** For example, provide transportation for consumers; and advocate for universal health care to provide health insurance for all children and families. Assist families in completing paperwork to ensure children are covered under state and federal medical insurance laws, such as Medicaid or Social Security.
- **Increase public psycho-education regarding mental illness through social marketing efforts, such as media campaigns, organizing and promoting health fairs, community workshops or seminars, print materials, and informational pamphlets.** Such psycho-educational efforts can help to reduce stigma, increase understanding, reduce likelihood of misinterpreting psychological distress as somatic illness, and provide information about how therapy can help.
- **Increase accessibility of services.** This may include providing services in schools and churches which may help lower transportation and time barriers to service utilization. Agencies may also extend their hours of operation beyond traditional, 8 AM to 5 PM Monday through Friday clinic models. Extended services on evenings and weekends will permit more flexibility for appointments and more engagement in services.

*Al que no ha  
usado huaraches,  
las correas le  
sacan sangre.\**

- **Use “satellite clinics” or small locations throughout the service area.** Numerous small, regional clinics may be more likely to reduce transportation costs, be more visible to members of the community, broaden the service area to more rural and isolated sites, and develop more close and intimate relationships with the communities they serve.
- **Work to reduce the social consequences of help-seeking.** Psycho-educational efforts, pairing up with organizations that serve and have developed a trusting relationship with the local Latino/Hispanic community, and education about law enforcement and confidentiality can help increase service utilization.
- **Expand the role of the mental health practitioner to include ensuring that the child and family’s basic needs are being met.** At times, an appropriate mental health intervention may mean assisting parents of Latino/Hispanic children to reduce debts and work with creditors so that the child can stay in the home; or providing assistance with immigration-related paperwork; or liaising with the school. Such help may provide the security and stability for children and families to then turn their attention to improving trauma-related symptoms.
- **Conduct studies of Latino/Hispanic children and their families to better reduce disparities in health care access.** There is a notable lack of information regarding rates and barriers to service utilization in Latino/Hispanic children. This is a significant limitation, as children are not responsible for their own health care utilization: parents provide such access. Research on this topic is highly recommended (see the “Research” priority area for more information).

### Resilience

- Fostering and maintaining strong interpersonal relationships are important values in Latino/Hispanic cultures. Many Latino/Hispanic families rely on neighbors, good friends, and extended family members in times of need. Such people may serve as role models for children, providing numerous sources of interpersonal support. It is important for trauma treatment providers to value these relationships and incorporate these values into the treatment. This will increase the probability of service-seeking and better engage families in treatment once they get there.
- Access to needed help can be a powerful environmental factor influencing resiliency (Bonanno & Mancini, 2008). Latino/Hispanic families that are well-connected to their community and feel that they have numerous options for aid will be more likely to respond in a resilient fashion to trauma and stressful life events. Therefore, increasing access to services is a critical part of promoting resiliency in Hispanic families.



### Family/Youth Engagement

- **Develop a trusting relationship with the family.** Time spent talking with the family, including “small talk” about their day, will help develop a personal and trusting relationship that will increase family engagement in therapy services (Antshel, 2002).
- **Employ bilingual service providers.** Centers that can provide services in Spanish are more likely to attract, engage and retain Latino/Hispanic families than those who rely on on-call translators or require clients to bring their own translators (Jacobs et al., 2001). Even having forms and signs available in Spanish will provide a welcoming atmosphere that may result in higher consumer engagement (See “Communication/Linguistic Competence priority area for more information).

## Community Examples/Best Practices



- **La Clinica Hispana** – The Yale University School of Medicine’s Hispanic Clinic. The mission of the Hispanic Clinic is to provide culturally appropriate mental health services to the Hispanic community. All staff are bilingual/bicultural. Treatment programs address diverse difficulties and incorporate Hispanic cultural values and traditions. At this time, the Hispanic Clinic services only adult monolingual Hispanic clients. However, it can serve as an excellent model for clinics seeking to improve service provision for Hispanic children and families.
  - ⇒ Website: [www.med.yale.edu/psych/clinical\\_care/clinica-hispana.html](http://www.med.yale.edu/psych/clinical_care/clinica-hispana.html)
  - ⇒ Address: One Long Wharf Drive, New Haven, CT 06511
- **Community Outreach Program – Esperanza (COPE)** – The Medical University of South Carolina’s Department of Psychiatry and National Crime Victims Research and Treatment Center has a special outreach clinic, COPE, headed by Dr. Michael A. de Arellano. This clinic provides community-based treatment, advocacy, and case management to Latino/Hispanic and other underserved child victims of trauma. The clinic is unique and effective at reducing numerous barriers to service utilization, including (a) employment of bilingual/bicultural therapists; (b) provision of services in schools, homes, churches, or other community-based locations to help circumvent transportation difficulties and time constraints; (c) incorporation of cultural constructs and values into treatment services with children and their families; and (d) focusing on intensive case management services, including serving as a child advocate for interactions between the family and other government and service agencies.
  - ⇒ Website: [http://colleges.musc.edu/ncvc/about\\_us/faculty/dearellano\\_bio%2006.htm](http://colleges.musc.edu/ncvc/about_us/faculty/dearellano_bio%2006.htm) or [www.nctsn.org/nctsn\\_assets/pdfs/promising\\_practices/COPE\\_fact\\_sheet\\_3-21-07.pdf](http://www.nctsn.org/nctsn_assets/pdfs/promising_practices/COPE_fact_sheet_3-21-07.pdf)
  - ⇒ Address: Community Outreach Program- Esperanza (COPE), National Crime Victims Research and Treatment Center, Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina, 165 Cannon Street, MSC 852, Charleston, SC 29425
- **Cognitive Behavioral Intervention for Trauma in Schools (CBITS)** – Developed by Dr. Lisa Jaycox and colleagues, this program is an intervention for children with violence-related mental health symptoms such as depression, anxiety, and posttraumatic stress disorder. The CBITS was developed from empirical data on the effects of trauma on Latino/Hispanic and immigrant youth and is designed to be implemented in schools. Such a program permits the reduction of transportation and time barriers to service utilization in Latino/Hispanic children who have been victims of trauma. Furthermore, CBITS combines individual sessions (1-3) with group sessions (10), important to increasing social support and decreasing isolation.
  - ⇒ Website: [www.hsrcenter.ucla.edu/people/jaycox.shtml](http://www.hsrcenter.ucla.edu/people/jaycox.shtml) or [www.tsaforschools.org/index.php?option=com\\_content&task=view&id=49&Itemid=0](http://www.tsaforschools.org/index.php?option=com_content&task=view&id=49&Itemid=0)
  - ⇒ Book: <http://store.cambiumlearning.com/ProductPage.aspx?parentId=019004232&functionID=009000008&site=sw>

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*\*Dichos translation: Those who are not used to wearing sandals will get blisters.*

### Service Utilization and Case Management Subcommittee

**Chair:**

Ana J. Bridges, PhD - University of Arkansas, Department of Psychology, Fayetteville, AR

**Members:**

- Elizabeth Lindley - University of Arkansas, Department of Psychology, Fayetteville, AR



# Diversity Among Latinos

## Background

High immigration rates and relatively high birth rates have boosted the growth rate of the Hispanic population above that of any other major U.S. racial or ethnic group except Asians. According to the Pew Hispanic Center ([www.pewhispanic.org](http://www.pewhispanic.org)), the Hispanic or Latino population, already the nation's largest ethnic group, will triple in size and will account for most of the nation's population growth from 2005 through 2050. Hispanics will make up 29% of the U.S. population in 2050, compared with 14% in 2005. Hispanics immigrants currently comprise 54% of all Hispanic adults in the United States (Lopez & Minushkin, 2008).

The history of Americans of Spanish heritage predates the founding of the United States (Kandel & Cromartie, 2004). Nevertheless, this population of newcomers is heir to a long, and at times turbulent, history of relations between the ethnic majority — non-Hispanic whites — and the peoples of Mexico and other Spanish-speaking countries of Latin America (Kandel & Cromartie, 2004; Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002).

Latino/Hispanic groups differ in national origin and history; in the particular social formations within each country that shape age, gender and class relationships; in the pressures within each country that have led to migration and the differing waves of migration; and the differing relationships with the United States through time that have affected how those migrants were received. These features have not only created marked differences among the Latino/Hispanic groups, but considerable intra-cultural variation within groups as well. At the same time, changes within United States society and cultures have affected where migrants have gone, how they have been received, the opportunities they have had to develop themselves as individuals and groups, and the cultures of the United States with which the migrants have interacted (Guarnaccia, Martinez, & Acosta, 2005).

Latinos/Hispanics are an ethnic group, not a racial group, according to U.S. government guidelines, but this distinction escapes most Americans. Latinos/Hispanics can be of any race. Most identify as white, a smaller percentage identify as black, many identify with indigenous ancestry/race, and an increasing share identify as "other," which underscores the ambiguity of

race and ethnic-group definitions in the United States (del Pinal & Singer, 1997). Additionally, there is a racism within Latino/Hispanic groups that reflects an ongoing "pigmentocracy" that is documented throughout Latin America.



"Given the extraordinary diversity of Latinos that currently live in the United States...it is imperative that service systems increase their capacity and understanding of this diverse population."

According to Pew Hispanic Center (2006), the Hispanic population in the United States is very diverse and includes individuals from Central America and Latin America. For example, according to these statistics, 64.1% of the Hispanic resident population in the United States is Mexican, 9% are Puerto Rican, 3.4% are Cuban, and 3.1% are Guatemalan (see <http://pewhispanic.org/files/factsheets/hispanics2006/Table-5.pdf> for a complete breakdown of this demographic information). Clearly, Latinos/Hispanics in the United States are a heterogeneous population and the diversity within various Latino/Hispanic groups is as pronounced as differences between Latinos/

Hispanics and other ethnic groups. These differences include language nuances, cultural values and beliefs, educational attainment, and attitudes towards mental health treatment (Guarnaccia et al., 2007). Additionally, there may be significant differences between individuals from different regions within the same country. For example, while Spanish is the primarily language spoken in Mexico, there are some regions of Mexico where individuals speak indigenous languages (Schmal, n.d.).



Therefore, given the tremendous amount of diversity that exists among Latino/Hispanic individuals, it is important to understand the impact that this diversity has on the Latino/Hispanic family seeking trauma treatment. Each Central American and Latin American country has its own unique history which may impact the trauma experiences of individuals from that country. Additionally, the emotional and behavioral effects of trauma may be as variable as the individuals themselves and should be addressed within an individual and culturally appropriate framework.

## Statement of the Issue

The rapid growth of the Latino/Hispanic population in this country qualifies as one of the most dramatic demographic phenomena of the last century. This segment of our society is growing almost four times as fast as other groups. It is predicted that one out of every four Americans will be of Latino/Hispanic heritage by the year 2050. Given the extraordinary diversity of Latinos/Hispanics that currently live in the United States and are expected to migrate into the United States in the next 30-40 years, it is imperative that service systems increase their capacity and understanding of this diverse population. In particular, the terms "Latino" and "Hispanic" represent a wide range of individuals with unique cultural, language and value systems. Recognizing the diversity of this group and unique needs of each individual client is crucial to providing adequate and appropriate mental health and trauma treatment services to Latinos/Hispanics.



## Recommendations from the Field



- **Treatment providers should conduct a thorough assessment of the client.** This includes gathering information on the client's country of origin (if they are first-generation) or his/her family's country of origin (if they are second-generation or more). Treatment providers should seek to understand the cultural values, beliefs, and language nuances within a client's country of origin and how each client has made sense of these values and beliefs (see the "Assessment" and "Cultural Values" priority areas for more information).
- **Treatment providers and organizations should incorporate a "life course approach" when working with Latino/Hispanic families** (Blank & Torrecilha, 1998). This will enable professionals to understand the cumulative effects of racism, discrimination, resource disparities and other hardships on the families with whom they work.
- **Treatment organizations should gather information on the Latino/Hispanic clientele they serve** (U.S. Department of Health and Human Services, 2001). In particular, it is important for organizations to understand the demographic information on the Latino/Hispanic clients they serve, including their country of origin (if first-generation) or their family's country of origin (if second-generation or more), historical and political trauma that may have occurred in their country of origin, social factors that may impact the family's response to current trauma (i.e., discrimination, oppression) and provide trainings for their staff on these particular countries and regions.
- **There is a critical need for an increased number of culturally-and linguistically-relevant Spanish speaking mental health providers at all levels of mental health care** (González & Ramos-González, 2005). Service providers should receive training on the different nuances of language that exist within the Latin American and Central American countries (see the "Therapist Training and Support" and "Linguistic/Communication Competence" priority areas for more information).
- **Providers must be trained to understand the perception of mental health problems and service seeking among Latinos** (Guarnaccia et al., 2005). In particular, it is important for treatment providers to understand that seeking mental health treatment may be perceived negatively by some families, but seen as the "norm" for others.

*Cada cabeza es un mundo.\**

- **Providers should be cautioned against making assumptions about a client based on his/her Latino heritage** (Guarnaccia et al., 2007). As stated previously, Latinos/Hispanics represent a diverse group of individuals with unique beliefs and values. Treatment providers should seek to understand their clients as individuals, rather than making assumptions about a client based on his/her ethnicity.
- **Expand outreach efforts to better include the community. This may include social marketing efforts, such as health fairs and community workshops.** Such efforts should occur within the diverse communities and can help to reduce stigma, increase understanding, reduce likelihood of misinterpreting psychological distress as somatic illness, and provide information about how therapy can help.

### Resilience

- Service providers need to understand the important role that resilience plays in public health promotion for Latino communities (Delgado, 1995). In particular, service providers should understand the innate strengths present in individuals, families, communities and systems and work with those strengths in creating programs designed to address Latino/Hispanic families who have been affected by trauma.
- Organizations should be encouraged to create and disseminate informational materials, from a strengths-based perspective, that describe the impact of trauma and important family strengths that can help counter trauma's negative effects for Latino/Hispanic children and families (Galan, 1998).
- Service providers should seek to understand the unique demographic characteristics of the populations that they serve and the strengths present in the families who they serve based on their country of origin, including their cultural values and spirituality (see the "Cultural Values" priority area for more information) and incorporate them throughout the treatment and intervention process.



### Family/Youth Engagement

- Treatment providers should utilize the type of outreach that *promotores* (community members who promote health in their own communities) use to educate Latinos/Hispanics regarding mental health and trauma issues. This way effective community outreach can be conducted immediately and treatment referrals can be followed up with greater initiative (Delgado, 1995).
- Once treatment providers have gathered information on the client's country of origin (if first-generation) or his/her family's country of origin (if second-generation or above), it is important to investigate the most appropriate ways to incorporate the family in the treatment process based on the unique cultural values and beliefs of the client's heritage.

## Community Examples/Best Practices



- **La Clínica del Pueblo** - La Clínica del Pueblo was founded in 1983 in response to the growing medical and mental health care needs of Salvadoran and Guatemala refugees escaping their war-torn countries during the 1980s. For the past 25 years, La Clínica del Pueblo has provided culturally appropriate health services in the Latino/Hispanic community. 86% of La Clínica's clients are recent Latino/Hispanic immigrants from Central and South America; 55% are originally from El Salvador, representing a diverse clientele of Latino/Hispanic children and families.  
⇒ Website: [www.lcdp.org](http://www.lcdp.org)  
⇒ Address: La Clinica del Pueblo, 2831 15th St. NW, Washington, DC 20009-4607
- **DePelchin Children's Center** - Delivers screening, assessment, case management, and mental health services to children affected by trauma residing in four southeast counties in Texas. DePelchin focuses on children who are the victims of complex trauma or who suffer from trauma related to traumatic loss, abuse (physical, psychological, or sexual), maltreatment, or neglect. DePelchin works with the community to provide information and training on best practices in child trauma treatment, and to increase the availability of and improve access to mental health services in the Greater Houston metropolitan area. DePelchin's clientele are ethnically diverse and representative of the larger Houston community.  
⇒ Website: [www.depelchin.org](http://www.depelchin.org)  
⇒ Address: 4950 Memorial Dr., Houston, TX 77007
- **Latin American Health Institute** - Provides treatment and intervention services for Latino/Hispanic children and their families living in the Greater Boston area who have been impacted by traumatic events. The program is also focused on working with mental health providers that serve a diverse group of Latinos/Hispanics in Greater Boston and in other areas of Massachusetts to increase their knowledge of evidence-based interventions. The intended population has experienced losses, domestic and community violence, disasters, severe and chronic neglect, physical and sexual abuse, and chronic trauma.  
⇒ Website: [www.lhi.org](http://www.lhi.org)  
⇒ Address: 95 Berkeley St, Ste. 600, Boston, MA 02116-6246
- **Puerto Rican Family Institute** - The Puerto Rican Family Institute, founded in 1960, is a nonprofit, multi-program family oriented health and human service agency whose primary mission is to prevent family disintegration and enhance the self-sufficiency of the Latino/Hispanic community. The Puerto Rican Family Institute offers a comprehensive array of social and health care services that are culturally and linguistically relevant. Their services include mental health treatment, crisis intervention, placement prevention, residential care, and education. Their programs operate in the continental United States and in Puerto Rico. We serve a large immigrant population and have a solid record of success.  
⇒ Website: [www.prfi.org](http://www.prfi.org)  
⇒ Address: 145 W. 15th St., New York, NY 10011
- **Roberto Clemente Center** - An Outpatient Mental Health Clinic, The Roberto Clemente Family Guidance Program provides counseling and psychotherapy services with an emphasis in family counseling and family therapy. Other services provided are: individual therapy, group therapy, marital therapy, play therapy, and pharmacotherapy. Mental health professionals (Psychiatrists, Psychologists, Social Workers, and Counselors), all bilingual and bicultural, provide services for an active caseload of over 300 clients who represent the diversity of the Latino/Hispanic population.  
⇒ Website: [www.clementecenter.org](http://www.clementecenter.org)  
⇒ Address: 540 E. 13th St., New York, NY 10009

## Resources

National Center for Mental Health Promotion and Youth Violence Prevention; website: [www.promoteprevent.org](http://www.promoteprevent.org)

National Council of La Raza; website: [www.nclr.org](http://www.nclr.org)

Population Reference Bureau; website: [www.prb.org](http://www.prb.org)

National Association of State Mental Health Program Directors, Office of Technical Assistance; website: [www.nasmhpd.org/ntac.cfm](http://www.nasmhpd.org/ntac.cfm)

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Pew Hispanic Center; website: [www.pewhispanic.org](http://www.pewhispanic.org)



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*\*Dichos translation: Each head is a world of its own.*

### *Diversity Among Latinos Subcommittee*

**Chair:**

Clorinda Merino, MEd - Chadwick Center for Children and Families, Rady Children's Hospital, San Diego, CA

**Members:**

- Silvia Barragan, LCSW - Private Practice, San Diego, CA
- Lourdes Diaz-Infante - Municipal Institute of Women, Tijuana, Mexico

# Research

## Background

While Latinos/Hispanics in the U.S. are now the largest ethnic group and their growth rate is among the fastest (U.S. Census, 2006), there are important gaps in knowledge regarding psychological trauma in various age groups in this population. Research with human and animal models has shown that psychological trauma is only one among the numerous stressors that can affect an individual's health, with early life stress having distinctively harmful effects (Heim & Nemeroff, 2002). Early life stress is associated with increased risk of revictimization in the adult, and outcomes are worst among individuals victimized both in childhood and adulthood (Weisbart et al., 2008). In addition, research has shown that socially-embedded stress and traumatic experiences that are frequent among ethnic minorities, such as racial discrimination and living in a dangerous neighborhood, have measurable physiologic consequences (Ryan, Gee, & Laflamme, 2006; DeSantis et al., 2007).

Because 40% of the Latinos/Hispanics in the U.S. are foreign-born (U.S. Census, 2004), acculturative stress is likely to interact with other adverse experiences in immigrant and migrant subgroups (Romero, Martinez, & Carvajal, 2007). The synergy of adverse and traumatic experiences is compounded by revictimization (Classen, Palesh, & Aggarwal, 2005) and the intergenerational cycle of maltreatment (Newcomb & Locke, 2001). The latter includes hormonal abnormalities in offspring of mothers diagnosed with PTSD (Yehuda et al., 2007). Together, these various lines of research suggest that:

- The typical Latino/Hispanic has a larger lifetime trauma burden than his/her Caucasian counterpart;
- Posttraumatic stress disorder (PTSD) is but one of several stress-related conditions that affect an individual's health;
- Intergenerational cycle of trauma includes physiological abnormalities, in addition to behavioral and psychological effects;



"There are significant deficits in the available evidence-based practices for Latino children and adolescents."

*La experiencia es la madre de la ciencia. \**

- Psychosocial interventions for Latino/Hispanic children and adolescents exposed to trauma are critical in reducing the severity of or preventing negative outcomes in the adult and his/her offspring.



Thus, research on early intervention with children and adolescents who are victims of maltreatment has shown a sustained reduction in negative physical and mental health outcomes at follow-up (Cicchetti, Rogosch, & Toth, 2006; Kessler et al., 2008), as well as in neurobiological normalization of the stress response (Fisher, Stoolmiller, Gunnar, & Burraston, 2007). Other types of longitudinal research implies that interventions designed to improve the social and family-related factors that contribute to the incidence of childhood abuse may

also have the benefit of increasing educational achievement for children in at-risk families (Boden, Horwood, & Fergusson, 2007). Currently, Latinos are dropping out the education system at a rate that is twice as high as the dropout rate for comparable non-Hispanic whites (Fry, 2003).



While most of the observational and correlational research cited above has been conducted without significant representation of Latinos/Hispanics, a similar situation can be observed in intervention research. Thus, a recent review of evidence-based psychosocial treatments for children and adolescents exposed to traumatic events revealed that, with the exception of studies by Kataoka and colleagues (2003) and Lieberman et al (2005), none of the remaining 19 studies focused on or recruited adequate samples of Latino youth (Silverman et al., 2008). In addition, the review showed that no psychosocial treatments that have been developed and tested specifically for Latino youth with histories of sexual or physical abuse.

## Statement of the Issue

The neurobiological, behavioral, and psychological effects of childhood trauma can be ameliorated with appropriate interventions with children and adolescents. There are significant deficits in the available evidence-based practices for Latino/Hispanic children and adolescents. Currently there are no published randomized control trials of trauma-based interventions for Latino/Hispanic youth that consider cultural issues, such as shame (Fontes, 2007). In addition, there is a pressing need to expand traditional research focusing on individuals and psychological distress, to include ecological and contextual determinants as well as biomarkers and physical health in trauma- and stress-related conditions. Future basic and translational research on traumatic stress among Latinos/Hispanics of both genders and all age groups should take into account the effects of cumulative stress stemming from socioeconomic disadvantage. Likewise, the focus on pathology and dysfunction should be expanded to include socio-cultural and individual resilience factors and issues related to immigration.



## Recommendations from the Field



- Researchers should **design studies to include adequate representation of a variety of Latino/Hispanic racial and ethnic groups**. Often partnering with researchers in other geographic locations and with other local partners can improve the ability to recruit and retain a diverse sample.
- Researchers should **include community members from diverse Latino/Hispanic racial and ethnic groups in all stages of the research process**, including selection of research questions, study design, recruitment and data collection, and interpretation and dissemination of findings.
- Researchers should **focus efforts on understanding the ways in which trauma experiences differ across Latino/Hispanic racial and ethnic groups**. To the extent that the common types of trauma differ across racial and ethnic groups, resources may need to be deployed differently, assessment techniques modified, and intervention programs developed.
- Researchers should **examine the extent to which responses to trauma differ across Latino/Hispanic racial and ethnic groups**. Risk factors for a negative response to trauma may differ across cultures, and therefore clinicians may need to intervene in the response process differently. To the extent that these differences are understood, clinicians will be better able to focus their attentions to areas likely to respond to intervention.
- Researchers should **examine the extent to which existing evidence-based treatments for trauma are effective with ethnic youth**.
- Researchers should **examine the extent to which existing evidence-based programs are able to attract, engage, and retain ethnic youth**.
- Researchers should **determine in which cases new and unique interventions must be developed to address a particular trauma-related issue among Latino/Hispanic families**, in which cases existing treatments should be adapted to be more culturally sensitive, and in which cases existing treatments can be used without modifications.
- Researchers should **investigate the process of treatment adaptation with the aim of developing an “adaptation science” that can guide efforts to modify multiple existing treatments for multiple racial and ethnic groups**.

### Resilience

- Researchers should investigate if lower levels of acculturation account for higher degrees of social support which can in turn improve resilience and serve as a protective factor for Latino/Hispanic youth affected by trauma.
- Researchers should investigate if *familismo* (see “Cultural Values” priority area for more information) correlates with resilience and serves as a protective factor against mental illness in Latino/Hispanic youth affected by trauma.
- Researchers should examine the relationship between the level of acculturation, *familismo* and resilience when it comes to trauma in Latino /Hispanic youth.
- Researchers should examine the relationship between lower levels of acculturation, disclosure and families’ reactions to disclosure of traumatic experiences in Latino/Hispanic youth.
- Researchers should investigate if there is a relationship between higher levels of *familismo* and delays in disclosure of childhood traumatic experiences and reactions to that disclosure.

### Family/Youth Engagement

- Researchers should investigate if there is a relationship between the researcher’s ethnic background and the engagement and participation of Latino/Hispanic research subjects and families.
- Researchers should examine if there is a need to involve Latino/Hispanic families when the research focus is individual Latino/Hispanic youths.
- Researchers should investigate if trauma-focused interventions and trauma focused research would be more successful if applied to Latino/Hispanic families as a whole rather than individual Latino/Hispanic youth.
- Research with Latino/Hispanic youth and their families should be conducted in a culturally sensitive manner. Consent for participation might be better obtained if the researcher speaks the language and has a clear understanding of the taboos surrounding mental illness and childhood trauma, especially childhood sexual abuse, in the Latino/Hispanic population.
- Latinos/Hispanics value their families’ privacy and the privacy of their children. They protect their children and families from the judgments that could be placed upon them by their community if the news of a traumatic experiences were to spread (Fontes, 2007). Researchers should take this into account when consenting parents and their children by providing a quiet and private area for the research and consent process to take place.

## Community Examples/Best Practices



- **Cognitive Behavioral Intervention for Trauma in Schools (CBITS)** – Developed by Dr. Lisa Jaycox and colleagues, this program is an intervention for children with violence-related mental health symptoms such as depression, anxiety, and post-traumatic stress disorder. CBITS was developed from empirical data on the effects of trauma on Latino/Hispanic and immigrant youth and is designed to be implemented in schools.
  - ⇒ Website: [www.hscenter.ucla.edu/people/jaycox.shtml](http://www.hscenter.ucla.edu/people/jaycox.shtml)
  - ⇒ Book: <http://store.cambiumlearning.com/ProductPage.aspx?parentId=019004232&functionID=009000008&site=sw>
- **Culturally Modified Trauma Focused Treatment (CM-TFT)** – Developed by Dr. Michael de Arellano, CM-TFT was developed for use with Latino/Hispanic children and is based on Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), with the addition of modules integrating cultural concepts throughout treatment. For more information, contact Dr. Michael de Arellano at [dearelma@musc.edu](mailto:dearelma@musc.edu).
  - ⇒ Website: [www.nctsn.org/nctsn\\_assets/pdfs/promising\\_practices/cmtft\\_general.pdf](http://www.nctsn.org/nctsn_assets/pdfs/promising_practices/cmtft_general.pdf)
- **Guiando a Niños Activos (Guiding Active Children, or GANA)** – Created by Dr. Kristen McCabe, the GANA program is a version of Parent-Child Interaction Therapy (PCIT) that has been culturally adapted for Mexican-American families. The adaptation process involved combining information from 1) clinical literature on Mexican-American families, 2) empirical literature on barriers to treatment access and effectiveness, and 3) qualitative data drawn from focus groups and interviews with Mexican-American mothers, fathers, and therapists on how PCIT could be modified to be more culturally effective. Information from these sources was used to generate a list of potential modifications to PCIT, which were then reviewed by a panel of expert therapists and clinical and mental health researchers. For more information, contact Kristen McCabe at [kmccabe@casrc.org](mailto:kmccabe@casrc.org).

## Resources



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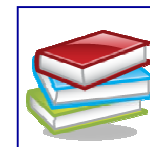
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*\*Dichos translation: After the rain, comes the sun.*

## Research Subcommittee

### Chair:

Kristen McCabe, PhD - University of San Diego and Child and Adolescent Services Research Center, Rady Children's Hospital, San Diego, CA

### Members:

- Anabel Bejarano, PhD - Private Practice and Alliant International University, San Diego, CA
- Andres Sciolla, MD - University of California, San Diego
- Alejandra Postlethwaite, MD - Department of Psychiatry, University of California, Los Angeles
- Elissa Brown, PhD - St. John's University, Queens, NY
- Joaquin Borrego, PhD - Department of Psychology, Texas Tech University, Lubbock, TX



# Therapist Training and Support

## Background

Despite research showing that significant numbers of Latino/Hispanic children experience trauma and that Latinos/Hispanics are over-represented in public welfare, child welfare, and the criminal justice systems, Latinos/Hispanics continue to be under-represented in health and mental health services (Ortiz Hendricks, Mason, & Valoy, 2008). One of the main barriers to service utilization by Latinos/Hispanics is the lack of available and accessible services that are culturally appropriate for Latinos/Hispanics (Carrillo, Trevino, Betancourt, & Coustasse, 2001). Although Latinos/Hispanics account for over 13 percent of the total U.S. population, they comprise only 4.6 percent of physicians, 4 percent of psychologists, and 7 percent of social workers (Institute of Medicine, 2004). "The majority of psychologists and social workers in the nation, who are the primary care providers in both the mental health and substance abuse fields, in 1998, were non-Latino/Hispanic whites, 84 percent and 65 percent respectively" (National Hispanic-Latino American Agenda Summit [NHAAS], 2004, p. 7). In addition to low rates of Latino/Hispanic service providers, there are also low rates of Spanish-speaking therapists who are knowledgeable and experienced in working with Latino/Hispanic families (Ortiz Hendricks et al., 2008).

*Lo que bien se aprende, nunca se olvida.\**

Many graduate and post-graduate training programs have begun to incorporate issues of diversity and culture into their curricula over the past 20 years. However, there are very few programs that provide an in-depth focus on Latino/Hispanic issues to prepare therapists to work with this growing and diverse population (i.e. how to provide culturally competent services,

how to effectively engage Latinos/Hispanics to use services, how to work with Latino/Hispanic cultural values and belief systems at varying levels during the acculturation process). Many faculty in schools of social work and psychology may have doctoral degrees but may not have extensive field experience working with Latino/Hispanic communities.

There is a great need for educational and training programs that teach about cultural values and culturally appropriate practices for Latinos/Hispanics, including training on providing therapeutic services in Spanish. Bilingual clinicians in almost all programs in the United States are trained to provide services in English only and

often find it difficult to translate concepts and terminology of the therapeutic process into Spanish while working with clients (Castaño, Biever, González, & Anderson, 2007). Conversational fluency in social or family settings may not adequately prepare clinicians to provide professional services in Spanish, especially when clinicians are not supervised by a bilingual professional (Castaño et al., 2007).



"There is a great need for educational and training programs that teach about cultural values and culturally appropriate practices for Latinos."

Continuing and professional education for current providers who work with Latino/Hispanic children affected by trauma is also needed, with a focus on culturally sensitive approaches to providing mental health services to Latinos/Hispanics (including awareness of and training on cultural adaptations to existing treatment models).

There is currently a lack of research on what methods of treatment work best with Latinos/Hispanics, and how to incorporate new modalities of treatment like evidence-based practices with Latinos (González & Ramos-González, 2005). Therefore, Latino/Hispanic children affected by trauma may not be benefiting as fully from the array of best practices that exist in the field.



Because of the low rates of bilingual and bi-cultural therapists compared to the needs of Latino/Hispanic populations, these providers are often over-utilized (i.e. higher caseloads, being asked to translate for other clinicians or to translate written materials), under-supported, and under-compensated. The additional time and energy required to provide treatment in two languages, access appropriate resources for undocumented families, and orient families to unfamiliar systems is not usually taken into account when determining caseloads (Engstrom & Min, 2004). Spanish-speaking clinicians are often isolated and do not receive supervision around issues of linguistic or cultural competence or opportunities to practice new skills or consult with colleagues or supervisors in Spanish. The challenges faced by bilingual clinicians and how they work with their Latino/Hispanic clients have not been adequately studied (Engstrom & Min, 2004).

## Statement of the Issue

It is a national crisis for the Hispanic community when there are 29 Hispanic mental health professionals for every 100,000 Hispanics (Arias, 2003). Access and barriers to health/mental health care for Latinos/Hispanics include linguistic and cultural barriers to care (Carrillo et al., 2001). Most mental health providers do not speak Spanish and do not receive in-depth training in culturally appropriate services for Latino/Hispanic families. There is a need for greater focus among graduate and post-graduate training programs, as well as professional organizations and agencies, to better prepare clinicians to serve this growing population effectively. There is also a need for schools and institutions to promote research on best practices for Latino/Hispanic children affected by trauma. Clinicians who have developed specialized skills to work effectively with Latinos/Hispanics need more support in the field and need to be adequately compensated for their specialized skills, experience, and any additional workload or duties.



## Recommendations from the Field



- **Increase recruitment of Latinos/Hispanics into graduate and post-graduate mental health programs.** Recruitment efforts can be aimed at undergraduate psychology, social work, and related programs as well as focusing on Latino/Hispanic student organizations. This includes advising and mentoring Latino/Hispanic students in higher education and developing scholarships, internships, and work-study opportunities for Latino/Hispanic students.
- **Graduate/post-graduate programs should incorporate culture-specific curricula.** Latino/Hispanic psychology, theories of multicultural counseling, Spanish language class for mental health providers (to develop proficiency in professional spoken and written Spanish and understand regional dialects), translating and applying psychological theories and interventions into Spanish, cultural values, acculturation, diversity among Latinos/Hispanics, and engaging Latino/Hispanic families in services. More schools should also offer the opportunity to earn a certificate in bilingual mental health services, and develop standards for bilingual certification.
- **Educational and training institutions should assess the cultural appropriateness and relevance of curricula, systems, policies, and practices.**
- **Schools of Social Work, Counseling, and Psychology should recruit and hire practitioners who have extensive experience working with Latino/Hispanic communities to teach or co-teach graduate courses.**
- **Practitioners should receive training in bilingual setting with culturally competent supervision.** Practitioners should have opportunities to practice providing services in Spanish and receiving bilingual supervision incorporating cultural issues at practicum sites (Lee et al., 1999).
- **Cultural and professional exchange programs should aid developing practitioners by providing opportunities for training and experience in a Latin American country** (i.e., a summer institute for bilingual clinicians.)
- **Schools, professional organizations, and agencies should provide more opportunities for training, continuing education, and consultation in cultural values and trauma-informed treatment for Latino/Hispanic children, including cultural adaptations of evidence-based practices.** Professional workshops and conferences should include more content related to working with Latino/Hispanic families.
- **Educational and professional institutions should promote research on best practices for Latino/Hispanic children affected by trauma** (i.e., incorporating cultural issues into research classes, supporting theses and dissertations related to Latinos/Hispanics, children, trauma, and treatment outcomes) **and special challenges faced by bilingual therapists working with this population.**
- **Clinicians and agencies should become familiar with and adhere to APA and NASW Cultural Guidelines.** Clinicians need to examine their own cultural attitudes, beliefs, and biases and understand the importance of multicultural responsiveness; educators/programs need to incorporate diversity into graduate programs and internships and ensure safe learning environment that promotes open discussion of cultural issues.
- **Clinicians and agencies should incorporate multicultural counseling competencies into practice.** These competencies include awareness and knowledge of the therapist's and client's cultural values and beliefs, experiences of discrimination, cultural history, and cultural identity, and how these factors impact treatment (Arredondo, et al., 1996). Competencies also include developing skills to work with diverse populations effectively.
- **Training and professional institutions and agencies should utilize instruments to assess multicultural training competence** (see Ponterotto, Rieger, Barrett, & Sparks, 1994, for review of several available measures).
- **Agencies should provide more linguistic resources for bilingual providers and adjust workloads to reflect additional duties performed by bilingual clinicians and complexities of their cases** (Engstrom & Min, 2004).
- **Increase opportunities for bilingual providers to participate in supervision/consultation in Spanish to increase support networks for bilingual providers and enhance professional proficiency across Latino/Hispanic sub-groups.**

### Resilience

- Mental health training programs should highlight Latino/Hispanic cultural values (i.e., *familismo*) that serve as strengths and help buffer the impact of acculturative stress, discrimination, and trauma (see "Cultural Values" priority area for more information).
- Educational and research institutions should promote research on resilience among Latino/Hispanic children and families who are thriving despite trauma and/or child welfare involvement.
- Increase recruitment of more Latinos/Hispanics into graduate programs in mental health as students and faculty. This promotes opportunities for professional advancement and mentoring.

- **Salaries/compensation to be commensurate with experience and specialized skills, such as the ability to provide culturally appropriate services in Spanish and translation services.**

### Family/Youth Engagement

- Engage Latino/Hispanic families/consumers in the process of identifying what additional cultural training is needed in graduate programs as well as continuing education for professionals.
- Hold focus groups with consumers to inform institutions on how to improve training on cultural issues in the field of mental health and trauma treatment.

## Community Examples/Best Practices



- **Our Lady of the Lake University, Department of Psychology: Psychological Services for Spanish Speaking Populations** - Provides a certification program that incorporates bilingual and culturally relevant coursework, a cultural and language immersion program taught in Mexico, and bilingual practice opportunities in the U.S. and Spanish-speaking countries. Specific information on the program can be found at [www.ollusa.edu/s/346/images/editor\\_documents/Psych/PSSSP%20program.pdf](http://www.ollusa.edu/s/346/images/editor_documents/Psych/PSSSP%20program.pdf).  
⇒ Website: <http://www.ollusa.edu>  
⇒ Address: 411 SW 24th St., San Antonio, TX 78207
- **University of Connecticut, Puerto Rican and Latino Studies Project in the School of Social Work** - Helps prepare social workers to competently serve the Latino community and to advocate and promote changes that safeguard and enhance the quality of life of Latino individuals, families, and communities locally, regionally, and nationally.  
⇒ Website: <http://web.uconn.edu/prlsp>
- **Learning Collaborative Approach** - This approach focuses on spreading, adopting, and adapting best practices across multiple settings and creating changes in organizations that promote the delivery of effective interventions and services, including effectively adapting interventions to fit the needs of Latino/Hispanic clients. The Learning Collaborative Toolkit can be downloaded from [www.nctsn.org/nctsn\\_assets/pdfs/lc/module\\_all.pdf](http://www.nctsn.org/nctsn_assets/pdfs/lc/module_all.pdf).
- **National Latina/o Psychological Association** - Provides opportunities for consultation and networking among Latino psychologists with diverse backgrounds, professional development workshops and conferences, and resources.  
⇒ Website: <http://nlpa.ws>

## Resources



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*\*Dichos translation: A lesson well learned is never forgotten.*

### *Therapist Support and Training Subcommittee*

**Chair:**

Carmen Ortiz Hendricks, DSW, ACSW, LMSW - Yeshiva University Wurzweiler School of Social Work, New York, NY

**Members:**

- Alison Hendricks, LCSW - Chadwick Center for Children and Families, Rady Children's Hospital - San Diego, CA
- Omar López, MSW - Health and Human Service Administration, Child Welfare Services, San Diego, CA

# Organizational Competence

## Background

A growing body of research has documented that racial and ethnic disparities exist with regard to access to mental health services for Latino/Hispanic families, notably, low utilization rates for mental health services and significant problems with treatment recidivism. Aguilar-Gaxiola (2005) reported that 70% of Latinos who access mental health services do not return after their first visit. Other barriers to mental health service utilization include lack of knowledge of where to seek treatment, limited proximity to treatment centers, transportation problems, and a lack of Spanish speakers who are culturally and linguistically competent (Aguilar-Gaxiola, Zelezny, Garcia, Alejo-García, & Vega, 2002; Rios-Ellis, 2005; see the "Service Utilization and Case Management priority area for more information). Gaps in services are further complicated by issues such as poverty, level of acculturation, and trauma exposure (Bernal & Saez-Santiago, 2006). These startling demographic and logistical realities demonstrate the need for organizations to provide culturally and linguistically competent mental health services to Latino/Hispanic children and families who have experienced trauma.

In an effort to provide optimal trauma-informed mental health treatment to the more than 45 million Latinos/Hispanics residing in the US, special care must be taken to promote cultural and linguistic competence across service systems to ensure ethical and culturally effective care for clients. In order to eliminate the racial, ethnic, and other disparities in the quality of and access to services for Latino/Hispanic families, organizations must gather information on health-related beliefs, attitudes, practices, and communication patterns of clients and their families and use this knowledge to improve services, strengthen programs, and increase community participation. Organizations that promote culturally and linguistically competent practices through formal and informal policies may help increase the likelihood that Latino/Hispanic children and families affected by trauma will not only seek treatment but benefit from those services. Both individuals and organizations must be attuned to cultural differences and how they affect mental health and the mental health service experience, including engagement of Latino/Hispanic families. This document focuses on critical components (i.e., leadership, training and workforce development, financial and budgetary allocations, physical environment, governance and organizational infrastructure) that will assist organizations as they embark on the journey toward cultural and linguistic competence with Latino/Hispanic children and families who have experienced trauma.

**Leadership.** The goal of leadership within the context of culturally and

linguistically competent organizations is to cultivate, and sustain practices that infuse competence in all services. Thus, systemic integration of culturally competent concepts into key elements of leadership, such as mission and vision, is vital in reducing disparities and enhancing competence.



"Organizations that promote culturally and linguistically competent practices through formal and informal policies may help increase the Latino children and families affected by trauma will not only seek treatment but benefit from those services."

**Training and Workforce Development.** Training and development activities that focus on cultural skills, knowledge, and attitudes will foster a shared understanding and acceptance of culturally and linguistically competent services and interventions. Moreover, an organization's efforts to recruit, train, and retain a culturally and linguistically representative workforce and to ensure that staff and other service providers have the requisite tools for delivering culturally competent services, including an understanding of the subtleties of the culture and language, is a critical part of this ongoing process towards competence.

**Financial and Budgetary Allocations.** The dedicated allocation of fiscal resources is critical to ensuring culturally and linguistically competent services. Other budgetary allocations could include: staff incentives for recruitment/retention, specialized training, outreach and engagement activities, translated materials, inter-

pretation services, stipends for family/youth trainers, sponsoring cultural events, food for gatherings, and strategic planning. Financial partnerships with other organizations may also help strengthen income and resources. These investments will help underscore the organization's commitment to the process.

**Physical Environment.** The physical facilities, resources, and materials associated with mental health settings should be inviting to diverse cultures with a décor that reflects, and is respectful of, different populations. The overarching goal is to maintain a physical environment that helps families to feel comfortable and welcomed, and which acknowledges their cultural backgrounds.

**Governance and Organizational Infrastructure.** Effective policy-making, leadership and oversight mechanisms are crucial to the delivery of culturally competent care. Particular care should be taken in regard to: 1) board composition, board selection, development, and accountability; 2) governance responsibilities, including policy-making, evaluation, stakeholder communication, community relations and communications, and strategic planning; 3) development and implementation of logic models and strategic, cultural and linguistic competency plans; and 4) leadership and management.

## Statement of the Issue

Latinos/Hispanics are one of the fastest growing segments of the US population. Underutilization of mental health services—paired with a myriad of barriers to access and quality of services—is contributing to growing disparities for Latinos/Hispanics, who are among the fastest growing segment of the U.S. population. Thus, organizations that promote culturally and linguistically competent practices through formal and informal policies may help increase the likelihood that Latino/Hispanic children affected by trauma and their families will not only seek treatment, but benefit from those services. According to the National Center for Cultural Competence (Goode & Jackson, 2003), culturally competent organizations must have the capacity to: (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to diversity and the cultural contexts of the communities they serve. To meet these goals, it is critical that organizations examine their values, principles, activities, and policies to ensure that culturally and linguistically appropriate standards are integrated throughout an organization and undertaken in partnership with the communities they serve. To this end, this document focuses on several key areas that should be addressed when creating a culturally and linguistically competent organization for serving Latino/Hispanic children and families, including leadership, training and workforce development, financial and budgetary allocations, physical environment, governance and organizational structure.



## Recommendations from the Field



Although the following recommendations have been adapted to meet the needs of organizations serving Latino/Hispanic children and families, they can be adapted as necessary to serve various populations. For additional recommendations, see Martinez and Van Buren (2008) and the materials developed by the National Center for Cultural Competence (see <http://www11.georgetown.edu/research/gucchd/nccc/> for more information).

### Leadership

- Implement policies and procedures that integrate cultural and linguistic competence into service delivery and other core functions of the agency. These may include participatory management practices that create shared ownership, creating a safe environment for managing differences, capitalizing on the strengths and assets of a diverse workforce, monitoring and evaluating progress, and maintaining focus on the long-term goals of cultural and linguistic competence.
- Develop and implement written policies to recruit and retain staff members who have the knowledge base and experience to effectively provide services to racially, ethnically, culturally, and linguistically diverse populations.
- Identify, use, and/or adapt evidence-based and promising practices, practice-based evidence, and community-defined evidence practices that are culturally and linguistically competent for Latinos/Hispanics.

### Training and Workforce Development

- Provide professional development, incentives, and financial support for the improvement of cultural and linguistic competence at the board, program, and faculty and/or staff levels.
- Develop performance standards for training in cultural and linguistic competence.
- Ensure that orientation, training, and continuing education content addresses the needs of staff and the populations served and are customized to fit staff roles (e.g., clinical, administrative, marketing, etc.).
- Disseminate information on staff training policies and opportunities in cultural competence within and outside the agency.

### Financial and Budgetary Allocations

- Designate dedicated budget line-items for cultural and linguistic competence development activities.
- Include a specific allocation/line item to provide for certified Spanish mental health interpreters.
- Include a specific allocation/line item to support the participation of culturally diverse families and youth on governance boards and committees. This includes stipends, food, travel, child care costs, interpretation, and translation costs.
- Identify and implement training curricula; community outreach and engagement; performance evaluation activities; incentives for staff recruitment and retention efforts; guidelines for staff certification/licensure; family involvement; and distance learning and other opportunities.

*Una abeja no hace una colmena.\**

### Physical Environment

- Display pictures, posters, artwork and other decor that reflect the Latino/Hispanic culture.
- Ensure that magazines, brochures, and other printed materials in reception areas are of interest to—and a reflection of—the diverse Latino/Hispanic cultures in the communities served.
- Provide literature that addresses stigma, normalizes help-seeking behavior, and explains the therapeutic process.
- Consider possible client concerns about privacy when designing waiting areas and other public spaces.
- Ensure that videos, films or other media resources that are used for health education, treatment, or other interventions, reflect the Latino/Hispanic culture.
- Ensure that staff at all levels value the diversity of the clients being served and create a respectful environment.

### Governance and Organizational Infrastructure

- Ensure that the agency's governing body is proportionally representative of the Latino/Hispanic children, youth and families served.
- Provide ongoing training, consultation, and support to enhance the knowledge and skills of members of the governing body in cultural and linguistic competence.
- Develop policies and procedures, in partnership with the community served, to ensure cultural and linguistic competence in the following areas: 1) general administrative policies; 2) personnel and benefits; 3) fiscal policies; 4) safety and security; 5) language access/communication; and 6) family/youth/community involvement.
- Ensure that a cultural and linguistic competence (CLC) plan is developed, implemented, reviewed and revised on a regular basis. The governing board and management staff should be responsible and accountable for implementing, monitoring, and revising the CLC Plan. The CLC Plan should be developed and reviewed jointly with youth, families and the community.



## Recommendations from the Field (continued)



### Resilience

- Enhance resilience within the organization and the Latino/Hispanic communities being served by providing a transparent management structure.
- Conduct business in open forums using policies and procedures that the public has had a voice in developing.
- Be willing to adapt policies and procedures and be flexible based upon the community's input and evolving needs.
- Institute an open grievance process that ensures accountability and a willingness to operate under a continuous quality improvement process.
- Promote the involvement of youth, family, and consumers in the management and operations of the organization.
- Focus on the strengths and celebrate the successes of youth, family, consumers, and the community.

### Family/Youth Engagement

- Ensure representation of Latinos/Hispanics on steering and planning groups as well as organizational governance and management teams which have decision-making authority in the agency (purely advisory boards are insufficient to infuse the voice and experience of youth, family, and consumers).
- Involve Latino/Hispanic youth, family, and consumers when conducting community needs assessments. Ensure that all decisions on best practices incorporate and address the community's consensus regarding their unique needs.

## Community Examples/Best Practices



### Governing Body Representation

- **Butte County Connecting Circles of Care (CCOC)** - Has diverse representation on the governing board. Contact: Michael Clarke, Project Director. Web-based information about Butte County available through presentation done by Yang, Z., Vang, C., Vang, J., & Morris, A. (n.d.) *Connecting circles of care: Building a systems of care*, Retrieved November 8, 2008, from [www.tapartnership.org/resources/Winter07/Day3/ReachingOut\\_EthnicCommunity.pdf](http://www.tapartnership.org/resources/Winter07/Day3/ReachingOut_EthnicCommunity.pdf)

### Cultural Organizational Self Assessment

- **The Family Voices Network of Erie County** - Has developed and implemented a program of *Cultural and Linguistic Competence (CLC)* self-assessment to inform policies and structures related to CLC. Contact: Doris Carbonell-Medina, Director Cultural Competency & Diversity Initiatives.  
⇒ Website: [www.familyvoicesnetwork.org/en/](http://www.familyvoicesnetwork.org/en/)  
⇒ 478 Main Street, Room 511, Hens & Kelly Building, Buffalo, NY 14202
- **McHenry County Mental Health Board's Family CARE program** - Uses *Cultural and Linguistic Competence (CLC)* self-assessment. Contact: Juan Escutia, Cultural and Linguistic Competency Coordinator.  
⇒ Website: [www.mc708.org/FamilyCARE/FamilyCare.aspx](http://www.mc708.org/FamilyCARE/FamilyCare.aspx)  
⇒ 333 Commerce Dr., Crystal Lake, IL 60014

### Cultural and Linguistic Competence (CLC) Policies and Procedures

- *Broward County's system transformation: The development of a cultural competence infrastructure*. Presented at the Portland Research & Training Center's 2007 Building On Family Strengths Conference, May 31-June 2, 2007, Portland, OR. Retrieved November 8, 2008 from [www.rtc.pdx.edu/conference/Presentations/pdf13McShan.pdf](http://www.rtc.pdx.edu/conference/Presentations/pdf13McShan.pdf)

### Cultural and Linguistic Competence (CLC) Plan Implementation

- Clancy, J. (2006, January). *Cultural and linguistic competence work plan: Recommendations for mental health services oversight and accountability commission*. Retrieved November 8, 2008, from [www.dmh.cahwnet.gov/MHSOAC/docs/Cult\\_LingCompWorkPln\\_draft.pdf](http://www.dmh.cahwnet.gov/MHSOAC/docs/Cult_LingCompWorkPln_draft.pdf)
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## Resources



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*\*Dichos translation: One bee doesn't make a hive.*

## Organizational Competence Subcommittee

### Co-Chairs:

Ernestine Briggs-King, PhD - Duke University School of Medicine, The National Center for Child Traumatic Stress and The Center for Child and Family Health, Durham, NC

Ken Martinez, PsyD - Technical Assistance Partnership, American Institutes for Research, Washington, DC

### Members:

- Roxanne Flint, MA - Duke University, Durham, NC



# System Challenges and Policy

## Background

Federal laws, regulations, and enforcement practices play a critical role in the mental health, particularly trauma treatment services sought and received by Latino/Hispanic children and families (Dinan, 2005). Federal laws influence overall immigration levels, establish and define immigration categories, and influence the type of care received by Latino/Hispanic families (Dinan, 2005). Approximately 36 million foreign-born people live in the United States. Close to 30 percent or 10 million are undocumented and roughly ¾ of those are Latinos. Among children living in immigrant families, about 4.7 million have undocumented immigrant parents (Passel, 2005).

The federal government also determines the impact of immigrants' status on their eligibility for federal benefits. A key piece of legislation was the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 (Dinan, 2005). PRWORA sought to limit access to cash assistance and to move welfare recipients into the workforce. In addition, many of PRWORA's provisions specifically targeted immigrants, creating new stratifications within legal immigration categories and imposing new restrictions on certain immigrants' access to government services. Today, most noncitizens are barred from key federal income and employment supports- food stamps, public health insurance, Supplemental Security Income (SSI) and Temporary Assistance for Needy Families (TANF). One result of the changes enacted in 1996 is that significant responsibility for determining legal immigrants' eligibility for government assistance has been shifted onto states. As a result, there is now substantial variation across the states in noncitizens' eligibility for governmental supports (Dinan, 2005).

The impact of 1996 legislation on immigrant families' access to government assistance has extended beyond direct eligibility restrictions. The changes adopted that year also reduced benefit participation even among immigrants who remained eligible for assistance due to confusion over the new eligibility rules (Dinan, 2005). Another important factor is fear of interacting with government officials. Changes adopted under PRWORA and other key initiatives included heightened immigration penalties and an increased role for state and local officials in immigration enforcement. Together, such policies have exacerbated immigrants' reluctance to seek any type of assistance, compounding the impact of linguistic and cultural differences and racial and ethnic discrimina-

tion. Many immigrants fear that any contact with government officials or even with county agencies for trauma treatment, could jeopardize their immigration status and/or lead to the discovery and deportation of undocumented family members (Staudt & Capps, 2004).



“Federal laws influence overall immigration levels, establish and define immigration categories, and influence the type of care received by Latino families.”

The long-standing awareness that the playing field is uneven for ethnic and racial minorities seeking mental health services has led to several federal initiatives to place the disparity issue on the national agenda. The Healthy People 2010 report (U.S. Department of Health and Human Services, 2000) focused attention on the nation's health disparities. One of the report's stated goals was to eliminate health disparities including those related to gender, race, ethnicity, education, income, disability, living in rural localities and sexual orientation.

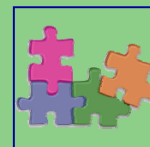
There are some current initiatives that focus on improving services for immigrant families who have experienced trauma. For example, the Violence Against Women Act (VAWA) was established in 1994 and, among other things, created special routes to immigration

status for certain battered non-citizens who are married to U.S. citizens or legal residents. If the victim has never been married to her abuser, or if her abuser is not a U.S. citizen or lawful permanent resident, then she does not qualify for residency under VAWA. However, she may qualify for a U-Visa. The U-Visa is designed for noncitizen crime victims. This includes women and children who have suffered “substantial physical or mental abuse” as the result of various forms of criminal activity, including rape, torture, trafficking, incest, domestic violence, sexual assault, etc. (for more information on VAWA and U-Visa, see [www.womenslaw.org](http://www.womenslaw.org)).

Other national initiatives have focused on improving the health and mental health care for Latinos/Hispanics and other ethnic populations: (1) National Agenda for Hispanic Mental Health developed at the SAMHSA-sponsored National Congress for Hispanic Mental Health in March 2000; (2) U.S. Surgeon General's 1999 report on mental health; (3) 2001 supplement to the Surgeon General's report on mental health, focusing on culture, race and ethnicity; and (4) NIMH Research Strategic Plan, which emphasizes investigation into mental health disparities among ethnic populations (see Resource section for links to these documents).

## Statement of the Issue

Local, state and Federal laws, regulations, and enforcement practices play a critical role in influencing the services provided for and received by Latino/Hispanic families. These systems can play a crucial role in either positively or negatively impacting the services provided to Latino/Hispanic families and their perception of these services. In particular, key pieces of Federal legislation may exacerbate immigrants' reluctance to seek any type of assistance, compounding the impact of linguistic and cultural differences and racial and ethnic discrimination. Many immigrants fear that any contact with government officials or even with county agencies for trauma treatment, could jeopardize their immigration status and/or lead to the discovery and deportation of undocumented family members. Changes in health public policy are integral in improving the mental health status of Latinos/Hispanics.



## Recommendations from the Field



- The federal government could **assist some of the most vulnerable children of immigrants by increasing opportunities for undocumented immigrants to gain legal status and by granting undocumented children access to public health insurance and other federal benefits** (National Council of La Raza, 2005).
- **Designate mental health, and the impact of trauma on mental health, as a formal health disparity category.** Mental health must be designated as a health disparity category to validate the understanding that mental health is a part of overall health and, therefore, warrants increased national attention (Chapa, 2004).
- **Increase access to mental health services for all Latinos/Hispanics.** Latinos/Hispanics, particularly those most vulnerable, must be provided with comprehensive mental health care. This includes National and state-level advocacy efforts to promote open access to mental health treatment and services for Latinos/Hispanics are critical to reducing barriers in the health delivery system; culturally and linguistically relevant mental health care is essential to facilitate early diagnosis and keep costs to a minimum; and funding for services for Latinos/Hispanics who lack health insurance or are unable to pay for diagnosis and treatment, especially for undocumented Latinos/Hispanics.
- **Educate government and elected officials on the short- and long-term effects of trauma on physical and mental health.** The short- and long-term effects of trauma are well-documented (Felitti et al., 1998). Policy makers need to take this linkage into account when considering mental health legislation.
- **Mount public education campaigns to create awareness of trauma within Latino/Hispanic communities and the need for appropriate assessment and treatment of issues such as acculturative stress for recent immigrants** (Viccora, 2001).
- **Ensure funding for Latino/Hispanic-specific mental health education and training programs is proportional to the growing demographics and need** (Viccora, 2001).
- **Educate government and elected officials on Latino/Hispanic specific needs and issues.** This includes Latino/Hispanic culturally appropriate and sensitive training for national, State, local government and elected officials and the federal fund of training of elected officials specifically on culturally appropriate and sensitive Latino/Hispanic mental health by a Latino/Hispanic organization (National Congress for Hispanic Mental Health, 2000).
- The Department of Health and Human Services (DHHS) Agencies should **mandate Latino/Hispanic representation on all mental health national boards and at all levels of professional organizations** (National Congress for Hispanic Mental Health, 2000).

*Donde hay gana,  
hay maña.\**



## Resilience

- Educate government and elected officials on Hispanic cultural values and norms that are connected to promoting resilience, including values such as *familismo* and spirituality (National Congress for Hispanic Mental Health, 2000).
- Educate government and elected officials on the importance of a strengths-based approach when creating policy that impacts Latino/Hispanic children and families (National Congress for Hispanic Mental Health, 2000).

## Family/Youth Engagement

- Include Latino/Hispanic representation on national, State, and local mental health advocacy group boards in order to address Latino/Hispanic issues and concerns in the development of all programs and policy recommendations. Ensure that public funds are not dispersed to any organizations that lack Latino/Hispanic representation and that private mental health funding sources only finance culturally competent programs (California Institute for Mental Health, 2002).
- Create and finance a national Latino/Hispanic Mental Health Consumer and Family network. This will help promote consumers and families as equal partners with decision makers in policy development, funding allocation, program design, and service delivery models. Funded programs must demonstrate the inclusion and incorporation of consumers and families in all design and implementation processes for initial receipt and continuation of funding (California Institute for Mental Health, 2002).
- Provide federal funding to train and educate Latino/Hispanic consumers and family members to become leaders in order to educate and inform Congress. Selected Federal agencies should fund Latino/Hispanic-specific sponsors to establish and enhance community-level coalitions. Selected Federal agencies should fund Latino/Hispanic-specific initiatives to educate and train Latino/Hispanic consumers/families on public-speaking, data issues, policy development, grant writing, program development, and self-sufficiency for sustainability (California Institute for Mental Health, 2002).
- Educate funding sources on the importance of supporting relevant Latino/Hispanic community issues for consumer/family driven community-based research (California Institute for Mental Health, 2002).

## Community Examples/Best Practices



- **Child Welfare League of America, Policy information** - Provides information on current legislation and initiatives that impact children and the child welfare system.  
⇒ Website: [www.cwla.org/advocacy/default.htm](http://www.cwla.org/advocacy/default.htm)
- **National Institute for Latino Policy (NILP)** - One of the leading think tanks in the Latino community organizing an action research model. NILP is involved in a wide range of policy issues affecting the Latino community.  
⇒ Website: [www.latinopolicy.org](http://www.latinopolicy.org)
- **The Tomás Rivera Policy Institute (TRPI)** - TRPI advances informed policy on key issues affecting Latino/Hispanic communities through objective and timely research contributing to the betterment of the nation.  
⇒ Website: [www.trpi.org](http://www.trpi.org)
- **The Urban Institute: Nonpartisan Economic and Social Policy Research** - The Urban Institute gathers data, conducts research, evaluates programs, offers technical assistance overseas, and educates Americans on social and economic issues.  
⇒ Website: [www.urban.org](http://www.urban.org)

## Resources



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*\*Dichos translation: Where there is a will there is a way.*

### System Challenges and Policy Subcommittee

**Chair:**

Lisa Conradi, PsyD - Chadwick Center for Children and Families, Rady Children's Hospital, San Diego, CA

**Members:**

- Ernest D. Marquéz, PhD - Former Associate Director for Special Populations (Retired), National Institute of Mental Health (NIMH), Washington, DC

# Appendix A: Priority Area Descriptions

## Descriptions Given to WALS Steering Committee for Basis of Guidelines

These priority areas were defined by multiple focus groups that took place between September 2006 and May 2007 and were led by staff at the Chadwick Center for Children and Families, Rady Children's Hospital, San Diego. The audience consisted of practitioners, administrators and policy makers from around the United States. Each subcommittee focused on one priority area. The final version of the Guidelines addressed and expanded on the majority of the topics listed under each priority area.

### *Priority #1: Assessment*

- Using assessment measures that are appropriate for use with Latino youth and their families
- Conducting and administering assessments in Spanish
- Assessing all types of trauma (including migration trauma and racism/oppression)
- Using measures to assess for acculturation and cultural values and beliefs as well as spirituality
- Recognizing the need to develop specific measures for this population

### *Priority #2: Provision of Therapy*

This priority area has a number of sub-areas:

- **Psycho-education** - This sub-area covers educating **parents about what is legally considered child abuse and about the process of therapy and mental health in general. It also discusses the role psycho-education plays in family engagement and the need for community outreach on issues of trauma and abuse.**
- **Engagement** - This sub-area focuses on the need to take time at the beginning of therapy devoted to relationship building, with less formality and a more personable and supportive approach. It covers issues such as institutional racism and mistrust as barriers to engagement.
- **Perception of Treatment** - The sub-area focuses on cultural perceptions of mental health services and those seeking mental health services and expectations regarding treatment.
- **Use of Evidence-Based Practices** - This sub-area discusses methods for adapting EBPs, including the need to integrate cultural values into the work and the need for flexibility. It also includes some of the challenges of implementing EBPs with minority populations, including questions regarding applicability of the research and treatment methods to Latino populations. It also addresses the need for consumer participation in the adaptation process.
- **Miscellaneous** - This sub-area includes topics such as how therapist gender and cultural background impact treatment, variation in treatment length, practice-based evidence approaches, and the need to understand culture and educational level when providing treatment.

### *Priority #3: Communication and Linguistic Competence*

- Determining which languages are used in therapy and when
- Generational differences between parents and children in language preference
- Providing appropriate, high-quality translation of all therapy materials into Spanish (intake forms resources, therapy worksheets, handouts, outlines, and guides)
- Appropriate use of translators when needed to provide trauma treatment

#### ***Priority #4: Cultural Values***

This priority area focuses on knowledge of and incorporating one or more of the following cultural values into treatment, as warranted:

- **Familismo** is the preference for maintaining a close connection to the family. Latinos, in general, value close relationships, cohesiveness, and cooperativeness with other family members. These close relationships are typically developed across immediate and extended family members, as well as close friends of the family.
- **Value of Children** refers to the value that many Latino/Hispanic families place on children. Parents are often very affectionate with their children. However, in some homes, children are expected to be seen and not heard.
- **Marianismo** is a gender specific value that applies to Latinas. Marianismo encourages Latinas to use the Virgin Mary as a role model of the ideal woman. Thus, Latinas are encouraged to be spiritually strong, morally superior, nurturing, and self-sacrificing (Lopez-Baez, 1999). Also, Latina children must remain virgins until they marry.
- **Machismo** refers to a man's responsibility to provide for, protect, and defend his family. This value has adopted some negative connotations related to arrogance and sexual aggression.
- **Personalismo** is the need for therapists to be warm and personable in their approach to Latino clients, and how the development of a warm relationship with the client is a necessary step in facilitating trust and ensuring that the client continues in therapy.
- **Respeto** is the concept of respect in two ways. First, the therapist is often viewed as an authority figure and needs to work with that in process of therapy. Second, it is important for the therapist to understand the hierarchy of the family and that respect of the parents is crucial for treatment compliance.
- **Spirituality, religious beliefs and faith** are very important to a majority of Latinos. The predominant religion among Latinos is Roman Catholicism; However, different groups may have different faith affiliation. Depending on where they are from, they may also seek medical or mental health care from alternative healthcare providers, such as *curandéros*, *sobadores*, and *espiritistas*.

#### ***Priority #5: Immigration/Documentation***

- Immigration as a process from the initial decision to migrate (civil wars, systems, etc), throughout the process of immigration, and acclimatization to the new country. This area also includes a discussion of the individual and family process of migration, including the implications of a child's separation from his/her family during migration and any migration trauma.
- It also focuses on the client family's possible fear of deportation post migration, and the need to incorporate issues of documentation and fears of deportation into therapy; and working with families where the child is documented but the parent is not. This area also includes issues of racism, oppression, and marginalization.
- Discusses acculturation and acculturative stress among Latino children and families and how that may impact treatment.

#### ***Priority #6: Child Welfare/Resource Families***

- Best practices for working with Latino children, youth, and families who are impacted by the child welfare system.
- It also includes recommendations for accessing adequate mental health services that are culturally and linguistically relevant and are grounded in the context of important social-cultural and economic variables, such as the foster care & immigration experiences and other traumatic events inherent in the life experiences of these children and families.
- It also focuses on the need to ensure that mental health services that address traumatic stress are taking place as part of the concurrent planning towards achievement of permanence, safety, and well-being for youth in out-of home care.

#### ***Priority #7: Service Utilization and Case Management***

- Generational use of services
- Challenges in getting to therapy including transportation and payment issues
- The role of case management and advocacy to help clients meet basic needs such as housing, etc., as an integral role to providing therapy

### ***Priority #8: Diversity among Latinos***

- Heterogeneity among Latinos
- Socioeconomic Status (including how that may change post migration)
- Country of origin
- Region of origin

### ***Priority #9: Research***

- The need to conduct research on treatment and assessment needs and best practices for this population
- The need for research on adapted versions of evidence-based trauma treatment practices designed to serve Latino children and families

### ***Priority #10: Therapist Training and Support***

- The need for increased training at the graduate and post-graduate levels on providing culturally appropriate services to Latino families.
- It also focuses on the need to recruit more Latino/a therapists and to promote Spanish language training for non-Latino therapists.
- It also discusses ways to increase support for Latino therapists and opportunities to receive supervision and training in Spanish.

### ***Priority #11: Organizational Competence***

- Matching staffing to needs of community (i.e., need for more Spanish-speaking therapists).
- Making agencies more culturally competent.
- Agencies to provide ongoing training on cultural issues.

### ***Priority #12: System Challenges and Policy***

System challenges and the ways that policy both helps and hurts our ability to provide adequate services for traumatized Latino children and their families such as:

- Fear of service systems due to documentation status
- Lack of insurance as a barrier to treatment
- Difficulty in navigation of human services systems
- Implications of existing immigration and other policies that may promote discrimination

# Appendix B: Glossary Terms

**Acculturation:** A process in which members of one cultural group adopt the beliefs and behaviors of another group. Although acculturation is usually in the direction of the newly immigrated group adopting habits and language patterns of the mainstream group, acculturation can be reciprocal - that is, the mainstream group also adopts patterns typical of the newly immigrated group. Families who have recently immigrated to the U.S. are often in crisis, separated from family and familiar supports and surroundings, experiencing culture shock, and struggling to adjust and meet their family's basic needs in a strange new world.

**Acculturative Stress:** Acculturative stress refers to the psychological, somatic, and social difficulties that may accompany acculturation processes.

**Asylum Seeker:** Until a request for refuge has been accepted, the person is referred to as an **asylum seeker**. Only after the recognition of the asylum seeker's protection needs, he or she is officially referred to as a **refugee** and enjoys refugee status, which carries certain rights and obligations according to the legislation of the receiving country. An individual may seek asylum in a new country as a result of a fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion.

**Bicultural:** Membership or affiliation in two cultures.

**Childhood Trauma:** Experiencing a serious injury to yourself or witnessing a serious injury to or the death of someone else during childhood. Also includes facing imminent threats of serious injury or death to yourself or others, or experiencing a violation of personal physical integrity.

**Community-Defined Evidence:** A set of practices that communities have used and determined to yield positive results as determined by community consensus over time, and which may or may not have been measured empirically, but have reached a level of acceptance by the community. It includes world view, contextual aspects and transactional processes that is usually made up of a set of practices that are culturally rooted.

**Comorbid:** The presence of one or more disorders (or diseases) in addition to a primary disease or disorder.

**Complex Trauma:** Refers to the experience of individuals who are exposed to trauma from several sources. For example, children in foster care have often experienced many different types of traumatic events, including physical abuse, sexual abuse, poverty, community violence, and separation from caregivers. The initial traumatic experiences predispose the individual to other types of trauma. They may experience **trauma reactions**.

**Cultural Awareness:** Developing sensitivity and understanding of another ethnic group. This usually involves internal changes in terms of attitudes and values. Awareness and sensitivity also refer to the qualities of openness and flexibility that people develop in relation to others. Cultural awareness must be supplemented with cultural knowledge

**Cultural Competence:** The process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each.

**Cultural Identity:** Refers to both the level of acculturation with host culture and how the person incorporates aspects of the new culture into the old culture to create a whole new cultural identity.

**Cultural Knowledge:** Familiarization with selected cultural characteristics, history, values, belief systems, and behaviors of the members of another ethnic group.

**Cultural Responsiveness:** Being aware of, and capable of functioning in, the context of cultural difference.

**Cultural Sensitivity:** Knowing that cultural differences as well as similarities exist, without assigning values (i.e., better or worse, right or wrong) to those cultural differences.

**Cultural Values:** Commonly held standards of what is acceptable or unacceptable, important or unimportant, right or wrong, workable or unworkable, etc., in a community or society. Latino cultural values are connected with expected social roles. The degree to which Latinos endorse these values is highly influenced by their acculturation level and generational status. For example, Latinos who are more acculturated into the United States' mainstream culture may not identify as strongly with these Latino values as compared to their less acculturated counterparts.

**Culture:** An integrated pattern of human behavior that includes thoughts, communications, languages, practices, beliefs, values, customs, courtesies, rituals, manners of interacting, roles, relationships, and expected behaviors of a racial, ethnic, religious, social or political group; the ability to transmit the above to succeeding generations; is dynamic in nature. It includes traditions, spirituality and world view.



**Curandero:** A *curandero* (or *curandera* for a female) is a traditional folk healer Hispanic America, who is dedicated to curing physical and/or spiritual illnesses.

**Documentation Status:** This refers to an immigrant's legal status in the new country. There are two types of documentation status: (1) Documented, which refers to individuals who are in the country legally (i.e., have a green card or residency); and (2) Undocumented, which refers to individuals who are in the country illegally and do not have documentation papers.

**Empirically Supported Treatments (ESTs):** These are interventions or techniques that have produced therapeutic change in controlled trials.

**Espiritista:** A practitioner of *Espiritismo*. *Espiritismo* is the Latin American and Caribbean belief that good and evil spirits can affect health, luck and other elements of human life. Many *Espiritistas* communicate with spirits in a gathering of like-minded believers.

**Ethnicity:** Refers to an individual's membership in an ethnic group. An ethnic group is a group of human beings whose members identify with each other, usually on the basis of a presumed or real common ancestry. Ethnic identity is further marked by the recognition from others of a group's distinctiveness and the recognition of common cultural, linguistic, religious, behavioral or biological traits, real or presumed, as indicators of contrast to other groups.

**Evidence-Based Practices (EBPs):** The Institute of Medicine (IOM) defines "evidence-based practice" as a combination of the following three factors: (1) Best research evidence; (2) Best clinical experience, and (3) Consistent with patient values.

**Evidence-Based Practice in Psychology (EBPP):** This is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences.

**Familismo:** A Latino cultural value that focuses on the preference for maintaining a close connection to the family.

**Family/Youth Engagement:** Refers to the process of engaging with and partnering with youth and families in the planning, assessment, and provision of care in treatment services.

**First-Generation Immigrants:** Refers to individuals who have immigrated to a new country. They are the first generation of individuals to live in the new country.

**Hispanic:** The term is now used to convey the culture and peoples of countries formerly ruled by Spain and usually but not always, speaking the Spanish language. These include: Central and South America, the Southwestern United States, Florida, the African nations of Equatorial Guinea, Western Sahara, and the Northern coastal region of Morocco, as well as the Asia-Pacific nations of the Philippines, Guam and the Northern Mariana Islands. Although Hispanic is not a homogeneous culture, it encompasses a distinct group of peoples with similar traditions, customs, beliefs and the Spanish language, whether it is the official language in the region (Spain, Central & South America, Equatorial Guinea) or spoken by a significant part of the population (Southwestern US and Florida) or has important traces in local languages (Guam and the Philippines).

**Historical Trauma:** The impact on a group of people of ordeals such as enslavement, genocide, colonization or massive disruption of traditional ways of life. The trauma may last many generations. Some individuals suffer more, perhaps because they are more aware of loss or because of other factors such as family influences, isolation or greater exposure to discrimination. Cultural trauma does not imply that all or most would display symptoms associated with, for example, PTSD.

**Human Trafficking:** This is the recruitment, transportation, harboring, or receipt of people for the purposes of slavery, forced labor (including bonded labor or debt bondage) and servitude.

**Immigration:** Refers to the movement of people among countries.

**Impaired Caregiver:** A type of child maltreatment that includes the following: (1) Functional impairment in at least one of child's primary caregivers that results in deficient performance of the caretaking role (i.e., inability to meet the child's needs); (2) Impairment means that caregiver(s) were neither able to provide children with adequate nurturance, guidance, and support nor attend to their basic developmental needs due to their own mental illness, substance abuse, criminal activity, or chronic overexposure to severe life stressors (e.g., extreme poverty, community violence); and (3) Impairment may be due to various causes (e.g., medical illness, mental illness, substance use/abuse, exposure to severe life stressors (e.g., extreme poverty, community violence)).

**Latino:** The term "Latino" was officially adopted in 1997 by the United States Government in the ethnonym "Hispanic or Latino", which replaced the single term "Hispanic". The Census Bureau attempted to identify all Hispanics by use of the following criteria in sampled sets: (1) Spanish speakers and persons belonging to a household where Spanish was spoken; (2) Persons with Spanish heritage by birth location; and (3) Persons who self-identify with Spanish ancestry or descent. Neither "Hispanic" nor "Latino" refers to a race, as a person of Latino or Hispanic ethnicity can be of any race.

**Machismo:** This is a gender-specific value that applies to Latinos. *Machismo* refers to a man's responsibility to provide for, protect, and defend his family.

**Marianismo:** Gender-specific value that applies to Latinas. *Marianismo* encourages Latinas to use the Virgin Mary as a role model of the ideal woman. Thus, Latinas are encouraged to be spiritually strong, morally superior, nurturing, and self-sacrificing.

**Peri-migration trauma:** Psychological distress occurring at four points of the migration process: events before migration (e.g., extreme poverty, war exposure, torture); events during migration (e.g., parental separation, physical and sexual assault, theft of the money they saved to immigrate with, exploitation at the hands of a human smuggler, hunger, and death of traveling companions); continued rejection and suffering while seeking asylum (e.g., chronic deprivation of basic needs); and survival as an immigrant (e.g., substandard living conditions, lack of sufficient income, racism).

**Permanency:** In the child welfare context, permanency is one of the three goals of the Child and Family Services Reviews (CFSRs). Permanency refers to the child's stability in placements.

**Personalismo:** Latino cultural value that describes the valuing and building of interpersonal relationships. *Personalismo* encourages the development of warm and friendly relationships, as opposed to impersonal or overly formal relationships.

**Practice-Based Evidence:** A range of treatment approaches and supports that are derived from, and supportive of, the positive cultural attributes of the local society and traditions. Practice-based evidence services are accepted as effective by the local community, through community consensus, and address the therapeutic and healing needs of individuals and families from a culturally-specific framework. Practitioners of practice-based evidence models draw upon cultural knowledge and traditions for treatments and are respectfully responsive to the local definitions of wellness and dysfunction.

**Promising Practices:** A term used to describe useful practices. A promising practice indicates a practice or approach that has not been evaluated as rigorously as an evidence-based practice, but that still offer ideas about what works best in a given situation.

**Promotores:** A term used to refer to community members who promote health in their own communities.

**Protective Factors:** These are those factors that promote resilience (see Resilience). Several factors have been found to be the most critical for promoting resilience, including: (a) positive attachment and connections to emotionally supportive and competent adults within a child's family or community, (b) development of cognitive and self-regulation abilities, (c) positive beliefs about oneself, and (d) motivation to act effectively in one's environment. Additional individual factors associated with resilience include an easygoing disposition, positive temperament, and sociable demeanor; internal locus of control and external attributions for blame; effective coping strategies; degree of mastery and autonomy; special talents; creativity; and spirituality. Additional familial and environmental factors that have been found to foster resilience include parenting with warmth, structure, and high expectations of the child; socioeconomic resources; ties to extended family; involvement with pro-social community organizations; and effective schools.

**Psycho-education:** Psycho-education is the provision of education within the therapeutic environment.

**Race:** The term race or racial group usually refers to the concept of categorizing humans into populations or groups on the basis of various sets of characteristics. The most widely used human racial categories are based on visible traits (especially skin color, cranial or facial features and hair texture), and self-identification.

**Refugee:** An individual seeking asylum in a new country due to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion. A refugee includes persons who had fled war or other violence in their home country.

**Resilience:** Psychological resilience refers to an individual's capacity to withstand stressors and not manifest psychology dysfunction, such as mental illness or persistent negative mood. This is the mainstream psychological view of resilience, that is, resilience is defined in terms a person's capacity to avoid psychopathology despite difficult circumstances. Resilience is promoted by protective factors (see "Protective Factors.")

**Religion/Spirituality:** Refers to the critical role that faith plays in the everyday life of most Latinos.

**Respeto:** Latino cultural value that implies deference to authority or a more hierarchical relationship orientation. *Respeto* emphasizes the importance of setting clear boundaries and knowing one's place of respect in hierarchical relationship.

**Safety:** In the child welfare context, safety is one of the three goals of the Child and Family Services Reviews (CFSRs). Safety refers to the child's ability to protect himself or herself from abuse or for the agency to do so. This can be interpreted as physical safety and psychological safety.

**Second-Generation Immigrants:** Refers to individuals whose parents immigrated to the new country. They are the second generation of individuals to live in the new country and are born in the new country.

**Simpatía:** A cultural value that emphasizes the importance of being polite and pleasant, even in the face of stress and adversity.

**Social Marketing:** The systematic application of marketing along with other concepts and techniques to achieve specific behavioral goals for a social good. Social marketing can be applied to promote, for example, merit goods, make the society avoid demerit goods and thus to promote that considers society's well being as a whole. This may include asking people not to smoke in public areas, for example, ask them to use seat belts, prompting to make them follow speed limits.

**Socioeconomic Status (SES):** A combined measure of an individual's or family's economic and social position relative to others, based on income, education, and occupation.

**Somatization:** A tendency to experience and communicate somatic distress in response to psychosocial stress and to seek medical help for it.

**Trauma Reactions:** There are short- and long-term reactions to trauma. Short-term reactions include shock, fear, and terror. Long-term reactions include hyperarousal (hypervigilance, irritability and poor concentration), intrusive (nightmares, re-experiencing, and distressing memories) and avoidance (not talking about the trauma, avoiding trauma reminders, and emotional numbing).

**Traumatic Loss:** A type of child trauma that includes one or more of the following: (1) Death of a parent, primary caretaker or sibling; (2) Abrupt, unexpected, accidental or premature death or homicide of a close friend, family member, or other close relative; and (3) Abrupt, unexplained and/or indefinite separation from a parent, primary caretaker, or sibling, due to circumstances beyond the child victim's control (e.g., contentious divorce; parental incarceration; parental hospitalization; foster care placement)

**U-Visa:** The U-Visa is designed for noncitizen crime victims who (1) have suffered substantial physical or mental abuse from criminal activity; (2) have information regarding the criminal activity; (3) assist government officials in the investigation or prosecution of such criminal activity; and (4) the criminal activity violated US law or occurred in the United States (including Indian country and military installations) or the territories and possession of the United States. Your abuser does not need to be a U.S. citizen or lawful permanent resident, and you do not have to have been married to the abuser to be eligible for a U-Visa. You are not required to be physically present in the U.S. to qualify for a U-Visa. You can apply from abroad as long as the criminal activity violated U.S. law or occurred in U.S. territories.

**Violence Against Women Act (VAWA):** VAWA is an act that was passed by Congress in 1994 that, among other things, created special routes to immigration status for certain battered noncitizens. These provisions were updated in 2000 in the Battered Immigrant Women's Protection Act. Under VAWA, there are two ways for women who are married to US citizens or lawful permanent residents to get their residency. The first way to get residency through VAWA is called "self-petitioning." Instead of depending upon a spouse to apply for an individual's residency, an individual can apply on his/her own for himself/herself and his/her children. The spouse plays no role in the process. The second way to obtain residency under VAWA is called "cancellation of removal." This is available to individuals who are in, or can be placed into, deportation proceedings. If an individual qualifies for cancellation, the court may waive the deportation and grant the individual lawful permanent residency.

**Well-Being:** In the child welfare context, well-being is one of the three goals of the Child and Family Services Reviews (CFSRs). Well-Being refers to both the short- and long-term consequences for the child's mental health, physical health, and life trajectory.