Developing a DSM 5 Cultural Formulation and Intervention for the Latino Client

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The Latino Population

What does the Latino population in North America look like?

- U.S. Population: 316,789,000 million as of December 2012
- Approximately 50,994,735 consider themselves Hispanic or Latino (approximately 16.3%)
- Within the U.S., 12.8% of persons over 5 years old report speaking Spanish in the home.


The Latino Population

Hispanic Origin by Type: 2013

<table>
<thead>
<tr>
<th>Type of origin</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>53,986,412</td>
<td>100.0</td>
</tr>
<tr>
<td>Mexican</td>
<td>34,586,088</td>
<td>64.0</td>
</tr>
<tr>
<td>Puerto Rican</td>
<td>5,138,109</td>
<td>9.5</td>
</tr>
<tr>
<td>Cuban</td>
<td>2,013,155</td>
<td>3.7</td>
</tr>
<tr>
<td>Dominican</td>
<td>1,757,961</td>
<td>3.2</td>
</tr>
<tr>
<td>Central American</td>
<td>4,802,410</td>
<td>8.8</td>
</tr>
<tr>
<td>South American</td>
<td>3,260,031</td>
<td>6.0</td>
</tr>
<tr>
<td>Other Hispanic</td>
<td>2,428,658</td>
<td>4.5</td>
</tr>
</tbody>
</table>

Source: U.S. Census Bureau, 2013 American Community Survey

Objectives

- Participant will be able to use a diagnostic cultural formulation, based on the recommendations of the DSM 5.

- Participant will report an increase in their understanding of the cultural norms of Latino cultures that may present during assessment.

- Participant will understand the 8 areas where treatment can be modified in order to maximize the benefit to the Latino or culturally diverse client.

DSM 5 Cultural Formulation
The DSM 5 defines culture as:

- “The values, orientations, knowledge, and practices that individuals derive from membership in diverse social groups (e.g., ethnic groups, faith communities, occupational groups, veterans groups).
- Aspects of an individual’s background, developmental experiences, and current social contexts that may affect his or her perspective, such as geographical origin, migration, language, religion, sexual orientation, or race/ethnicity.
- The influence of family, friends, and other community members (the individual’s social network) on the individual’s illness experience.”

(DSM-5, p.750; APA, 2013)

Assessment

DSM-5 provides an outline for a cultural formulation to supplement the diagnostic assessment. This allows the clinician to assess the effect that cultural issues will have on treatment.

- Cultural identity of the individual
- Cultural conceptualizations of distress
- Psychosocial stressors and cultural features of vulnerability and resilience
- Cultural features of the relationship between the individual and the clinician
- Overall cultural assessment for diagnosis and care

(DSM-5, p.749; APA, 2013)

Cultural Formulation Interview (CFI)

The Cultural Formulation Interview (CFI) is a set of 16 questions that clinicians may use during an interview to assess the impact of culture on key aspects of an individual’s clinical presentation and care.

(DSM-5, p.750; APA, 2013)

Cultural Concepts of Distress

The DSM 5 also includes a Glossary of Cultural Concepts of Distress.

Cultural groups experience, understand, and communicate suffering, behavior problems, or troubling thoughts and emotions differently.

The DSM IV TR referred to cultural-bound syndromes. This term ignored the cultural explanations, terms, and experience of symptoms. DSM 5 more thoroughly explores and defines these syndromes.

(DSM-5, p.758; APA, 2013)
Cultural Identity

- Within the Hispanic/Latino communities, cultural identity cannot be assumed. Frequently, more than one race and nationality live within the same Hispanic household.

- Additionally, acculturation levels vary between generations of family members that can significantly impact their understanding of American treatment norms.

Cultural Identity

- Literature has documented a set of characteristics shared by most Latinos, including:
  - Spanish language
  - Cultural ideal of personalismo (personal contact)
  - Simpatía (social engagement, charm)
  - Familismo (familialism or collectivism)
  - Machismo (manliness) and marianismo (womanliness)

  (Bernal & Enchaustegui-de-Jesus, 1994; Dana, 1998; Rivera-Ramos & Buki, 2011)

Cultural Conceptualization of Distress

Depending on the specific nationality, the cultural explanation of distress can vary. Some common themes are:

- Latinos may believe that physical symptoms are more serious than mental health symptoms. (Kouyoumdjian, Zamboaga & Hansen, 2003)

- Latinos are more likely to believe that their symptoms are caused by outside environmental, spiritual, or personal problems. (Kouyoumdjian, Zamboaga & Hansen, 2003)

- Latinos are less likely to endorse a biological etiology of depression and mental illness and they tend to view medication as addictive and harmful. Therefore, many prefer counseling over medications. (Cooper et al., 2003; Givens et al., 2007; Karasz & Watkins, 2006).

  Endorsing the belief that depression is a chronic condition is negatively associated with individuals' sense of treatment and personal control over their illness. (Cabassa, Lagomasino, Dwight-Johnson, Hansen & Xie, 2008)

Latino Cultural Syndromes

- Ataque de nervios – characterized by symptoms of intense emotional upset (including anxiety), screaming, shouting, crying, trembling, may include verbal and physical aggression.

- Nervios – general state of vulnerability to stressful experiences. It is a broad idiom that may be accompanied by somatic symptoms.

- Susto – cultural explanation for an illness attributed to a frightening event that causes the soul to leave the body and results in unhappiness and sickness, as well as difficulties functioning in key social roles. This syndrome may occur with somatic symptoms.

Psychosocial stressors and cultural features of vulnerability and resilience

Statistics show that Latino ethnic groups are more likely to experience the following high risk factors:

- Poverty
- Inadequate housing
- High proportion of single parent families
- Alcohol/drug addiction
- Acculturative stress
- Discrimination
- Relatively low educational and economic status
- History of conquest, oppression, defeat, and struggle for liberation

  (Bernal & Saez-Santiago, 2010; Dana, 1998; U.S. Department of Health and Human Services, 2000.)
Depending on their acculturation level and immigrant status, they may also face barriers of:

- English proficiency level
- Legal status issues
- Family separation due to immigration
- Issues of loss and trauma due to the immigration process
- Loss of status in the community and loss of self esteem due to undocumented immigrant status

These are factors that may affect the second and third generation immigrant just as much as it affects the first generation immigrant.

Psychosocial stressors and cultural features of vulnerability and resilience

Cultural features of the relationship between the individual and the clinician

- Many Latinos only go to the doctor when something is wrong and when pain is unbearable. (Rivera-Ramos & Buki, 2011)
- Latinos are more likely to seek help from a medical professional than a psychologist or psychiatrist due to the stigma associated with receiving mental health treatment. Latinos from rural areas may also wish to involve a folk healer (curandero) and other holistic treatments. (Kouyoumdjian, Zamboaga & Hansen, 2003)
- Latinos are more likely to see medical professionals as authority figures and are less likely to overtly disagree or express discomfort with a plan of action.
- As many Latinos hold the cultural ideal of personalismo, they expect personal contact with the clinician who is diagnosing and treating their condition. They may also expect more self disclosure than non-Latinos. (Bernal & Enchautegui-de-Jesus, 1994)
- Latinos expect to include family members in the relationship with their clinician.

Cultural features of the relationship between the individual and the clinician

Intraethnic Transference
- The omniscient-omnipotent therapist
- Denial of ethnicity and culture
  - Savior
  - Folk hero
- The traitor
- The autoracist
- Ambivalence

Intraethnic Countertransference
- Overidentification
- Us and them
- Distancing
- Cultural myopia
- Ambivalence
- Anger
- Survivor’s guilt
- Hope and despair

Overall cultural assessment

The aggregate of these factors lead to an overall assessment of the diagnosis in a culturally appropriate way, which in turn sets a solid foundation for culturally appropriate treatment.

Culture Centered Treatment Interventions
Culture Centered Treatment

The term, culture centered, is used to encourage the use of a “cultural lens” as a central focus of professional behavior.

In culture centered practices, all individuals, including the treatment provider, are influenced by different contexts, including the historical, ecological, sociopolitical, and disciplinary.

The best approach to working within a culture centered context:
- Knowledge about specific cultures
- A “not knowing” stance that incorporates the cultural and personal

This creates the ability to see the specific individual or family norms which impact the individual which may or may not be congruent with the person’s color, class, ethnicity and gender, while simultaneously recognizing and respecting culture-specific differences that exist due to color, class, ethnicity and gender.

Ethnically Sensitive Treatment

1. Recognizing and expressing the existence of cultural differences between the client and clinician;
2. Having a knowledge of the client’s culture;
3. Distinguishing between culture and pathology in the assessment phase;
4. Modifying the treatment as necessary to accommodate the client’s individual culture.

Zayas, Torres, Malcolm, and DesRosios 2006

Modifying Treatment

- There are eight areas in which you can adapt treatment to be more effective with ethnically diverse clients. (Bernal & Saez-Santiago, 2010)
  - Language
  - Persons
  - Metaphors (Monochronic vs. Polychronic)
  - Content
  - Concepts
  - Context (High vs. Low Context)
  - Methods
  - Goals

These eight areas focus on three primary frameworks: Experiential, Existential, and Social Justice.

Experiential

LANGUAGE AND PERSONS:
Through our language and persons, we are able to understand the experiences of our clients and change their understanding of their experiences.

METAPHORS:
Narratives may be incorporated to assist clinicians with the integration of change concerning self-awareness about all human diversity variables.

<table>
<thead>
<tr>
<th>Monochronic People</th>
<th>Polychronic People</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do one thing at a time</td>
<td>Do many things at once</td>
</tr>
<tr>
<td>Concentrate on the job</td>
<td>Can be easily distracted and manage interruptions well</td>
</tr>
<tr>
<td>Take time commitments seriously</td>
<td>Consider an objective to be achieved, if possible</td>
</tr>
<tr>
<td>Are low context and need information</td>
<td>Are high context and already have information</td>
</tr>
<tr>
<td>Are committed to the job</td>
<td>Are committed to people and human relationships</td>
</tr>
<tr>
<td>Adhere religiously to plans</td>
<td>Change plans often and easily</td>
</tr>
<tr>
<td>Are concerned about not disturbing others; follow rules of privacy and consideration</td>
<td>Are more concerned with those who are closely related than privacy</td>
</tr>
<tr>
<td>Show great respect for private property; seldom borrow or lend</td>
<td>Borrow and lend things often and easily</td>
</tr>
<tr>
<td>Emphasize promptness</td>
<td>Base promptness on the relationship</td>
</tr>
<tr>
<td>Are accustomed to short term relationships</td>
<td>Have strong tendency to build lifetime relationships</td>
</tr>
</tbody>
</table>
EXPERIENTIAL

CONTENT:

Deconstructing the dominant cultural narrative allows the client to externalize the problem, re-author it, re-author the story, and develop a context for the new story.

Existential

CONCEPTS:

When an individual or family goes through changes, the therapist must be aware of the differences in the personal involvement (or meaning) of the clinician and client.

CONTEXT:

This awareness is essential to identify the metaphors, content, and context of the client and the therapist in the client’s perspective.

The main points of adaptation are within the metaphors, content, and context of the theories used.

High Context vs. Low Context Culture

<table>
<thead>
<tr>
<th>Factor</th>
<th>High-context culture</th>
<th>Low-context culture</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overexpression of messages</td>
<td>Many covert and explicit messages, with use of metaphor and reading between the lines</td>
<td>Many overt and explicit messages that are simple and clear</td>
</tr>
<tr>
<td>Locus of control and attribution for failure</td>
<td>Weak focus of control and personal acceptance for failure</td>
<td>Other focus of control and blame of others for failure</td>
</tr>
<tr>
<td>Use of non-verbal communication</td>
<td>Much nonverbal communication</td>
<td>More focus on verbal communication than body language</td>
</tr>
<tr>
<td>Expression of reaction</td>
<td>Reserved, inward reactions</td>
<td>Visible, external, outward reaction</td>
</tr>
<tr>
<td>Cohesion and separation of groups</td>
<td>Strong distinction between in-group and out-group; strong sense of family.</td>
<td>Flexible and open grouping patterns; changing as needed</td>
</tr>
<tr>
<td>People bonds</td>
<td>Strong people bonds; with affiliation to family and community</td>
<td>Fragile bonds; between people with little sense of loyalty</td>
</tr>
<tr>
<td>Level of commitment to relationships</td>
<td>High commitment to long-term relationships. Relationship more important than task.</td>
<td>Low commitment to relationship. Task more important than relationships.</td>
</tr>
<tr>
<td>Flexibility of time</td>
<td>Time is open and flexible. Process is more important than product</td>
<td>Time is highly organized. Product is more important than process</td>
</tr>
</tbody>
</table>

Social Justice

METHODS AND GOALS:

When an individual or family goes through treatment, the therapist must be aware of the differences in the perception of social justice of the clinician and client.

The main points of adaptation are within the methods and goals of the theories used.

Summary of Best Practices

• Treatment needs to focus on developing rapport with the patient.
• Treatment may include multiple members of the patient-defined family.
• Treatment should include patient empowerment with a firm plan of action, with the clinician as a guide.
• Treatment needs to explore the patient’s story as understood by the patient.
• Treatment needs to be holistic and may need to incorporate spiritual or other elements from the patient’s culture.

(Díaz-Martínez, Interian & Wissers, 2010)

Questions?
Speaker Information

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Bibliography