Integrating Cultural Assessments into Substance Use Treatment with Hispanic and Latino Populations

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Behavioral Health and Primary Care Integration for Latinos: Assessment, Treatment and Recovery Symposium

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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.

Source U.S. Census Bureau: State and County QuickFacts. Data derived from Population Estimates, American Community Survey, Census of Population and Housing, Small Area Income and Poverty Estimates, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits, Consolidated Federal Funds Report

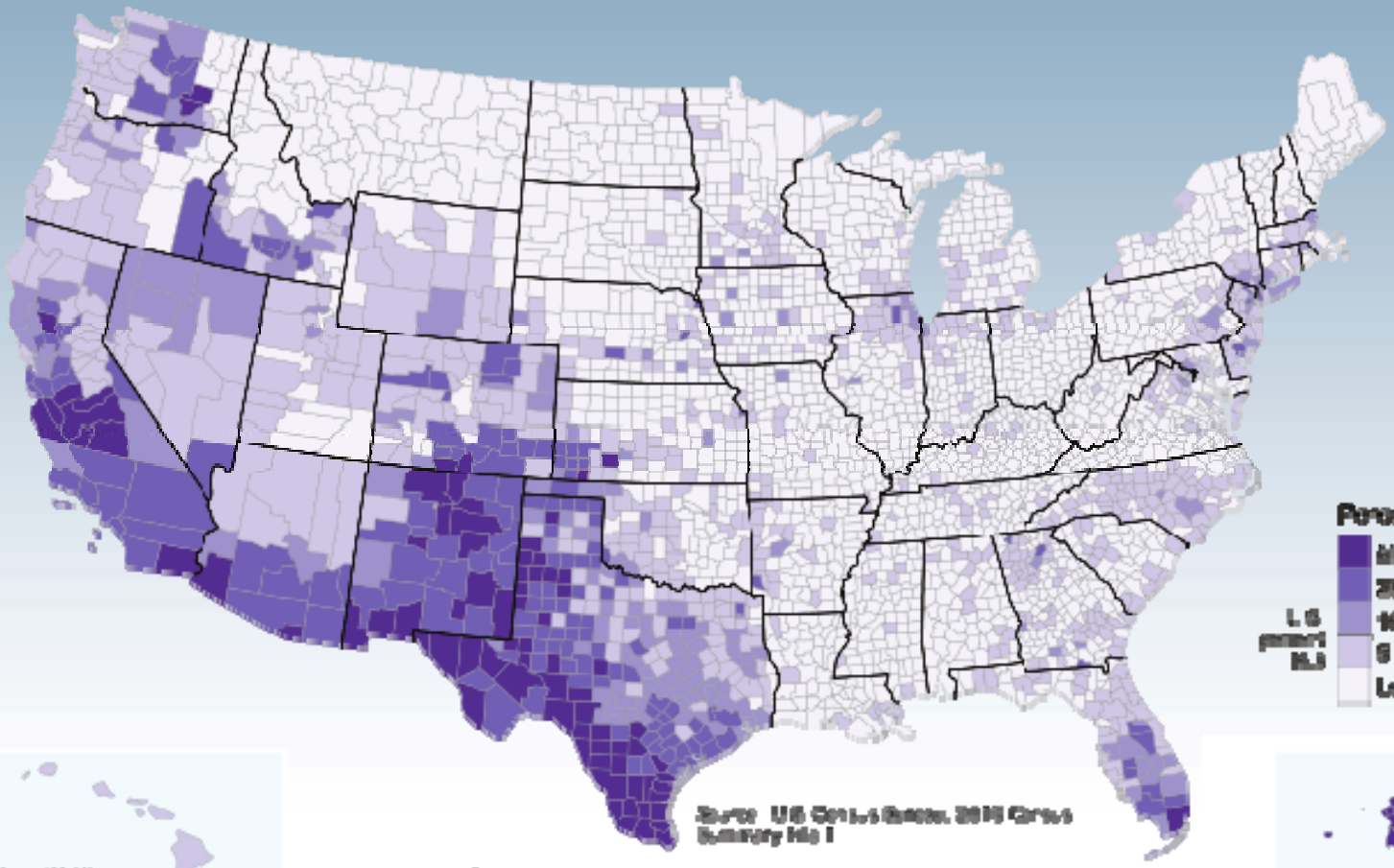
Hispanic Origin by Type: 2013

Type of origin	Number	Percent
Total	53,986,412	100.0
Mexican	34,586,088	64.0
Puerto Rican	5,138,109	9.5
Cuban	2,013,155	3.7
Dominican	1,757,961	3.2
Central American	4,802,410	8.8
South American	3,260,031	6
Other Hispanic	2,428,658	4

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

Hispanic or Latino Population as a Percent of Total Population by County: 2010

(For information on confidentiality protection, nonsampling error, and definitions, see www.census.gov/prod/cen2010/doc/sf1.pdf)



Objectives

- Participant will be able to identify specific cultural elements that impact the assessment and diagnostic process of substance use disorders of Latino individuals;

- Participant will be able to describe specific clinician factors that may impact the assessment process of substance use disorders.

- Participant will be able to describe specific client factors that may impact the assessment process of substance use disorders;

ASSESSMENT

Primary and Substance Use Assessment Integration

- As many as 70% of primary-care visits are triggered by underlying mental-health or substance abuse issues but patients often don't raise the issue and providers are too busy to ask.

- As evidence grows about the complex interrelationship between mind, brain and body, it is clear that the artificial divisions that have fragmented healthcare delivery fail to serve our patients.

- In order to provide high-quality care, we must create strong partnerships that allow for collaborative practice.

The Assessment Process

1. Engage Clients
2. Familiarize Clients and Their Families with Treatment and Evaluation Processes
3. Endorse Collaboration in Interviews, Assessments, and Treatment Planning
4. Integrate Culturally Relevant Information and Themes
5. Gather Culturally Relevant Collateral Information
6. Select Culturally Appropriate Screening and Assessment Tools
7. Determine Readiness and Motivation for Change
8. Provide Culturally Responsive Case Management
9. Incorporate Cultural Factors into Treatment Planning

(SAMHSA, 2014.)

DSM 5

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."

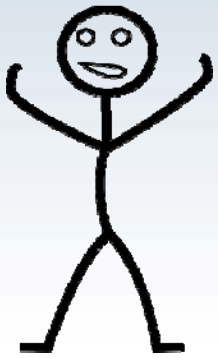
(*DSM–5, p.750;* APA, 2013)

What causes substance use disorders?

Culture can significantly influence psychoactive substance use (Rebhun, 1998).

Ethnicity and culture have even been called the "strongest determinants of drinking patterns in a society" (Klatsky, Siegelaub, Landy, & Friedman, 1983, p. 372).

Why do people use?



Motivation

Internal Barriers

i.e. Values
Ethics
Norms
Beliefs
Goals, etc.

External Barriers

i.e. Support Persons, Laws, Availability, Money etc.

Substance Use of Hispanic/Latino Men

- More Hispanic (35%) than White (26%) men abstain from alcohol. Hispanic men (15%) are less likely to be frequent drinkers than White men (31%), but they are more likely to be frequent heavy drinkers (18% and 12%, respectively) (Caetano & Clark, 1998a).

- Hispanic men and White men have similar rates of alcohol use disorders (abuse and dependence) (Kessler et al., 1998a); however, Hispanic men now have the highest rates of alcohol-related cirrhosis mortality (Stinson et al., 2001). Rates differ substantially by Hispanic subgroup.

- In some Hispanic communities, men's excessive drinking may be tolerated, though they are generally expected to be able to hold their liquor and fulfill their family responsibilities (Aguilar et al., 1991; Baron, 2000; Caetano et al., 1998).

Substance Use of Hispanic/Latino Women and Teens

- In the U.S. , more Hispanic (57%) than White (39%) women abstain from alcohol. Fewer Hispanic women (9%) are frequent drinkers than White women (19%). Frequent heavy drinking rates are similar (3% and 2%, respectively) (Caetano & Clark, 1998a).

- Since Hispanic cultural norms place women at the center of family life, women are expected to refrain from drinking and especially drunkenness or illicit drug use (Caetano, 1994; Melus, 1980).

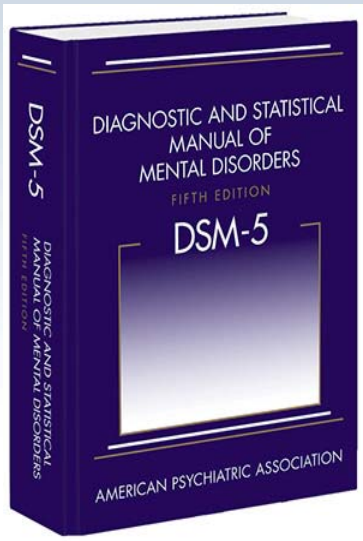
- Among those aged 12 to 17, Hispanics are slightly less likely than Whites but substantially more likely than Blacks to have ever used alcohol, to binge drink, and to use alcohol heavily. Hispanics youth are as likely as White youth and slightly more likely than Black youth to have ever used an illicit drug (Substance Abuse and Mental Health Services Administration, 2001a).

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.

Rather than approaching culture as a checklist of traits, factors, or dimensions, the CFI was intended to be based on a "mini-ethnography" that explores the patient's own interpretation of the 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)

CFI

Emphasizes four domains of assessment:

- Cultural Definition of the Problem (Q. 1-3)
- Cultural Perceptions of Cause, Context, and Support (Q. 4-10)
- Cultural Factors Affecting Self-Coping and Past Help Seeking (Q. 11-13)
- Cultural Factors Affecting Current Help Seeking (Q. 14-16)

(*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. (*DSM–5, p.758;* APA, 2013)

Should the commonality of a culture supported behavior affect the way we evaluate that behavior?

Cultural Concepts of Distress

Cultural concepts of distress are expressed through three concepts:

- Cultural syndromes: Groups of symptoms that co-occur among individuals in specific cultural groups, communities, and contexts.
- Cultural idioms of distress: Ways that symptoms are expressed which provide a collective, shared ways of experiencing and talking about personal and social concerns.
- Cultural explanations (perceived causes): Labels, attributions, or features of an explanatory model that indicate culturally recognized meaning or etiology for symptoms, illness, or distress.

(*DSM–5, p.758;* APA, 2013)

Cultural Norms of Latinos that Impact Substance Use Assessment

Cultural Identity

- Within the Hispanic/Latino communities, cultural identity can not 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 (familiarity)
  - Simpatia (social engagement, charm, kindness)
  - Familismo (familialism or collectivism)
  - Machismo (manliness) and marianismo (womanliness)

(Bernal & Enchautegui-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. (Kouyoumdjjian, Zamboaga & Hansen, 2003)

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

- Latinos are less likely to endorse a biological etiology of 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 illness as a chronic condition is negatively associated with individuals' sense of treatment and personal control over their illness. (Cabassa, Lagomasino, Dwight-Johnson, Hansen & Xie, 2008)

TRANSFERENCE AND COUNTERTRANSFERENCE IN THE ASSESSMENT PROCESS

Culture Centered Assessment

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.

Interethnic Transference

- Overcompliance and Friendliness
- Denial of Ethnicity and Culture
- Mistrust, Suspician and Hostility
- Ambivalence

Intraethnic Transference

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

Ambivalence

Interethnic Countertransference

- Denial of Cultural Differences
- The Clinical Anthropologist Syndrome
- Guilt
- Pity
- Aggression
- Ambivalence

Intraethnic Countertransference

- Overidentification
- Us and them
- Distancing
- Cultural myopia
- Ambivalence
- Anger
- Survivor's guilt
- Hope and despair

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. (Kouyoumdjjian, 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.

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.

Ethnically Sensitive Treatment Planning

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

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.

(Diaz-Martinez, Interian & Waters, 2010)

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