Hispanics and Culturally Sensitive Mental Health Services.

Fordham Univ., Bronx, N.Y. Hispanic Research Center.

National Inst. of Mental Health (DHHS), Rockville, MD. Center for Minority Group Mental Health Program.

85

2-POI-MH-30569-06A1

11p.

Hispanic Research Center Research Bulletin; v8 n3-4 Jul-Oct 1985

Cuento Therapy; Cultural Sensitivity

The objective of improving mental health care for Hispanics has been reviewed, most often, as dependent upon the provision of culturally sensitive mental health services. "Cultural sensitivity," however, is an imprecise term, especially when efforts are made to put it into operation when providing mental health services to Hispanic clients. Nonetheless, there are values and choices implicit in all treatment innovations, and this paper attempts to order and define these embedded assumptions. The concept of cultural sensitivity as used by researchers and mental health practitioners working with Hispanics is examined, with a focus on three levels: 1) the process of making existing traditional treatment available to Hispanic clients; 2) the selection of therapies that fit the Hispanic culture, or the modification of the treatment modality selected by incorporating into it Hispanic cultural elements; and 3) the development of new modalities based upon an aspect of the client's own cultural context. An example of this third approach is Cuento Therapy, a treatment that takes as its medium the folktales of Puerto Rican culture. Through the relating of these folktales to Puerto Rican children experiencing psychological distress, cultural values are transmitted, the mother's role as socializing agent is reinforced, and pride in the cultural heritage is inculcated. It is believed that ego strengths weakened through the acculturative process can thus be reinstated and reinforced. (GC)

Reproductions supplied by EDRS are the best that can be made from the original document.
HISPANICS AND CULTURALLY SENSITIVE MENTAL HEALTH SERVICES

Lloyd H. Rogler, Director
Rena Blumenthal, Research Assistant
Robert G. Malgady, Research Associate
Giuseppe Costantino, Research Associate
Hispanic Research Center, Fordham University

Spanish and have little sensitivity to Spanish values; the location of mental health clinics outside the Hispanic community; and the inability of clinics to deal with the social problems confronted by clients who are not acculturated to American life or who are situated at the bottom of the socioeconomic scale. On the side of the Hispanic client, the barriers are related, in part, to cultural perceptions of mental health issues. Hispanics may perceive mental illness as a stigma or as a medical or spiritual problem and attach little credibility to traditional psychological intervention. Furthermore, they may feel intimidated by the experience of confronting an impersonal bureaucracy in a clinical setting, or may be unaware of the existence of mental health facilities.

The first level of culturally sensitive mental health services involves the adequacies of the mental health delivery system in the United States in relation to the psychological problems of Hispanics have often been noted and widely discussed. There are two theories which offer explanations of the Hispanics' utilization of mental health facilities: barrier theory and alternative resource theory. According to barrier theory, anything which keeps the afflicted person away from the agency system or delays contact with that system is, effectively, a barrier to appropriate mental health care. On the side of the mental health agency system, formidable barriers exist, such as prejudice, nation, and stereotyping directed at Hispanic clients; personal who do not speak
HISPANIC RESEARCH CENTER: RESEARCH BULLETIN

The HRC is directed by Dr. Lloyd H. Rogler, Albert Schweitzer Professor in Humanities at Fordham University.

The HRC operates under a research grant (2 POI MH 30569-06A1) from the Minority Group Center of the National Institute of Mental Health. The Research Bulletin invites comments and new items from its readers. Let us know what topics you would like to see in future issues. Address correspondence to:
Stasia Madrigal, Editor, Hispanic Research Center, Fordham University, Thebald Hall, Bronx, New York 10458. Telephone: (212) 579-2630.

©1985 Hispanic Research Center. All rights reserved

cess of rendering available to Hispanic clients existing traditional treatment. The issue here is the accessibility of treatment; i.e., the elimination of barriers which prevent Hispanics from receiving treatment. This form of cultural sensitivity may be implemented at the broadest or narrowest developmental level. For instance, it may involve the creation of mental health clinics in Hispanic neighborhoods, or the creation of treatment programs for Hispanics within broader mental health facilities or programs. Such adaptations may be effected in a variety of settings, including community clinics, Inpatient units, schools, and social facilities. Accessibility may well be the necessary prequisite to all forms of cultural sensitivity. In the examples that follow, however, it is implicitly seen as the final goal of treatment modification.

Karno and Morales describe the creation of a mental health clinic especially modified to fit the perceived needs of Hispanics in an East Los Angeles Chicano community. First, Spanish-speaking staff were recruited who were familiar with and committed to the Mexican American community. A site was chosen in the heart of residential East Los Angeles, close to transportation, and in a building with a noninstitutional atmosphere. Preventive services, consultation with other community agencies, and crisis intervention were Incorporated into the program along with traditional services. The authors found that "in a context of cultural and linguistic familiarity and acceptance" Mexican Americans responded just as well to traditional treatment as Anglos. This method exemplifies the accessibility model of cultural sensitivity, as implemented on the broadest developmental level.

On an intermediate level of development, programs can be designed specifically for Hispanic needs, but within existing mental health facilities. Scott and Delgado discuss the issues and problems which arose during the creation of a mental health program for Hispanics within a community clinic in Worcester, Massachusetts. The initial effort was ineffective allegedly because the professional supervisor projected traditional views of mental health and displayed little understanding of Hispanic culture. The program was viewed as more effective after the recruitment and orientation of a bicultural and bilingual staff, the integration of the program into the structure of the host facility, and the coordination of the program's efforts with the needs of the Hispanic community.

Cuellar et al. provide an example of a related program within an inpatient setting. A ward in a psychiatric hospital in San Antonio, Texas, was designed specifically for Mexican American patients. The staff of this ward were all bilingual and bicultural, the customs and beliefs of Chicanos were integrated into the treatment process, and the ward decor was designed to be congruent with Chicano culture. Many authors demonstrate, accessibility may be achieved by the development of programs within existing institutional settings, with the treatment format modeled on those of the host facility or, as the first example illustrates, as an independent facility within the Hispanic community.

In addition to broadly based programs like those above, there are more narrowly delineated efforts specifically designed to render treatment accessible in already established, and otherwise unchanged, mental health programs. Norman and others describe a group therapy program designed to improve utilization of mental health services in a New York outpatient clinic. The purpose of the group was to provide help for immediate problems and to help patients understand problems in psychosocial terms so that they would use mental health services more readily. Rodriguez provides an example of a similar group in an inpatient setting. This group was targeted toward Spanish-speaking psychiatric patients who were alienated from the hospital system, primarily because of language barriers. The purpose of the group was to acquire Spanish-speaking patients with the social services provided by the hospital, facilitate community placement, and create a forum for these patients to express their questions and needs. Both of these groups served to make existing services and programs comprehensible and accessible to Hispanic clients.

The lowest common denominator of cultural sensitivity with Hispanics is generally that of linguistic accessibility. Indeed, for many treatment innovators, their primary efforts have focused on hiring bilingual/bicultural staff, thus overcoming the most blatant communication barriers that exist between clients and staff. The importance of even such minimal outreach efforts is dramatized by the Innovative use of paraprofessionals devised by Acosta and Cristo. These authors begin with the assumption that Hispanics' demands for mental health treatment are likely to continue to exceed the availability of Hispanic therapists. Accordingly, they proceeded to develop a bilingual interpreter program in a Los Angeles psychiatric clinic located in a large Mexican American community. The interpreters were recruited from the same community as the clients. They were given a training program which sharpened their skills at back and forth translation between Spanish and English and taught them key concepts of psychotherapy and the nomenclature used in clinical settings. At the same time, they acted as cultural consultants, explaining to the English-speaking therapist meanings embedded in the community culture which the patient conveyed during therapy. The interpreters also served as advocates in relation to the Los Angeles service structure. The awkwardness inherent in this approach to the therapist relationship was recognized and discussed by the authors. Nevertheless, the success of this program in increasing accessibility of services was thought to justify the difficulties involved. In recent years, the percentage of Spanish-speaking patients admitted to the clinic has doubled due to their efforts.

It is hardly surprising that the medium through which accessibility is achieved often involves the recruitment of bilingual/bicultural personnel. Although the focus is usually on finding Hispanic professionals, the hiring and training of indigenous paraprofessionals are often considered of almost equivalent value. Such personnel can forge a bridge between the native culture and the clinical services, provide concrete forms of social assistance and clarify to clients the expectations and purposes of the mental health program. At a more personal level, members of the client's own family network can serve a similar purpose.

Thus, one method of increasing cultural accessibility involves incorporating into the mental health system bilingual/bicultural staff, paraprofessionals indigenous to the ethnic community or, at the most personal and direct level, a member of the client's own familial network. In all of these examples, the Indigenous ethnic network is socially and structurally intertwined with the mental health system, and the cultural discrepancy between the two is inevitably reduced. The implications of incorporating indigenous personnel into treatment can be further elucidated by exploring the role of the lay referral system in the provision of mental health care.

Eliot Freldson identifies two characteristics of a cultural subpopulation which are likely to influence the utilization of the professional medical system. The first characteristic involves the congruence between the ethnic and
It is our contention that the Hispanic community largely fits into the latter categorization. The value incongruence can be demonstrated by the fact that many Hispanic view mental illness in somatic terms and attach a stigma to any form of emotional problems. In addition, among Hispanics the lay referral system, which often includes ritual compadres along with an extended family network, exerts a strong and pervasive effect on individual decision-making. Within the Hispanic community, people are unlikely to seek help for personal problems without the guidance and advice of other community members. What is more, the Hispanic community has alternative coping resources, such as spirituality, which are congruent with cultural values, and to which the lay referral system would be likely to guide the individual in distress. According to Freidson's classification system, the Hispanic community would thus be low in value congruence and high in lay referral cohesiveness, and would therefore be likely to manifest low utilization rates of the professional health system.

Thus, a culturally accessible treatment program for Hispanics should be one which increases the congruence between its form of treatment and indigenous values, and one which incorporates members and methods of the lay referral system to further its own purpose. Indeed, there is ample evidence based on both longitudinal and cross-sectional research that such innovations do increase utilization rates in Hispanic communities. For example, Bloom found that the utilization of psychiatric services by Mexican Americans went from under-representation in 1960 to overrepresentation in 1970 in Pueblo, Colorado. Two key elements in bringing about this change were the improvement of the image of the mental health system (increasing congruence) and an increase in the number of Chicano staff (incorporating the lay referral system). Trevino et al., using a cross-sectional approach, found that a community that had reduced linguistic, cultural, and economic barriers to treatment had higher utilization rates for Mexican Americans than would be expected according to census tract figures, and concluded that the underrepresentation of Mexican Americans in community mental health centers reflects barriers to utilization rather than lower need for service.

By reaching out to the ethnic network, the professional system has found that it can interest and attract people to use and retain its services, advance professional conceptions of mental health, and partially bypass alternative coping patterns. At the same time, by incorporating elements of the ethnic network into the professional system, key elements of the lay culture are assimilated, thereby inevitably increasing the congruence between the system and the culture. Such elements may include language, cultural allusions, social service assistance, culturally congruent decor, or an easing of transportation and bureaucratic obstacles. On more subtle levels, they may include an ease of communication based on familiarity, shared values, and mutual recognition. What they do not involve is any shift in professional goals, values, or conceptions of mental illness, nor any substantive innovations in treatment format. All such forms of increasing accessibility therefore represent the first general level of culturally sensitive mental health care.

Level 2: Selection or Modification of Traditional Psychotherapy

In addition to treatment accessibility, the actual treatment Hispanics receive in the mental health system has been an additional area of concern which has called for a display of cultural sensitivity. Without such a concern, the logically incongruous but realistic situation could occur wherein Hispanics have greater accessibility to culturally inappropriate therapeutic modalities. This signifies the second level of culturally sensitive mental health care: therapies are selected to fit the Hispanic culture, or the therapy selected is modified by incorporating into it Hispanic cultural elements.
There have been some researchers and therapists who have defended the use of psychoanalytic concepts and techniques with ethnic minority clients. Maduro and Martinez present a cogent argument for the value of self-exploration among Hispanics, claiming that "more self-aware individuals are needed to confront insidious social realities in our environment and to integrate unconscious themes in the inner world" (p. 461). In accord with these values, they lead Jungian dream analysis groups, in which the key goal is the development of an integrated ethnic identity. The authors believe that dream work is congruent with Mexican culture because some folkhealers specialize in the analysis of dreams.

Nonetheless, the attitudes of Maduro and Martinez represent a minority opinion, and much criticism has been leveled at insight-oriented psychoanalytic therapy as being both unconscionable and irrelevant to the context of Hispanic life. Frontline mental health practitioners working in inner-city, economically depressed Hispanic neighborhoods were among the first to level such criticisms. Their widely shared image of the psychologically distressed Hispanic was of a person pressed and harassed by problems of poverty, slum life, and lack of acculturation. The image of such a client taking his or her place on the psychoanalytic couch for a long-term therapy designed to nurture insight into repressed analytic couch for a long-term therapy designed to nurture insight into repressed needs for nurturance and discipline has been thoroughly repudiated.

Before addressing the specific problems of Hispanic populations, therefore, it is worth exploring therapeutic efforts that have been tailored to lower socioeconomic status clients. The work of Minuchin and his collaborators stands as the prototype of how new therapeutic interventions can be developed, sensitively and meaningfully, to address the problems of the most disorganized, disadvantaged slum families. Underlying their efforts is a clear understanding of the socioeconomic features of such families; recurring interpersonal dynamics between family members, as well as the predominant level of communication skills, and patterns of affective expression. The development of Minuchin's Structural Family Therapy techniques grew directly out of the articulation and understanding of the patterns that characterize disadvantaged families. An extension of this same philosophy forms the premise for Unitas, a program which has been the object of systematic evaluation at Fordham University's Hispanic Research Center.

Unitas is a therapeutic community in the South Bronx which was developed out of the specific perceived characteristics of the surrounding disadvantaged community. Several hundred black and Hispanic youngsters ranging in age from 5 to 16 participate in the program. About half of the Unitas participants are referred to the program by parents or teachers as "problem children," usually evidencing withdrawn or bizarre behavior. Unitas is founded upon the concept of the family unit as the most important institution that can satisfy a child's needs for nurturance and discipline. It is further assumed that the disintegration of many slum families is at the core of many of the psychological and social problems developed by disorganized youth.

In order to counteract the adverse effects of this social disorganization, the Unitas Therapeutic Community tries to compensate for the failures of the real community through a system of symbolic families, each composed of up to 15 boys and girls usually living on the same street. Each symbolic family is headed by one or two older neighborhood teenagers who play the roles of symbolic mother, father, aunts and uncles. These teenagers receive intensive training in psychological therapy and clinical skills and become the primary ca.eterators and therapists of the younger children, assuming many of the roles and functions that the traditional families have abdicated or lost. The symbolic nuclear families are loosely tied together as a community through extended family circles that meet on a weekly basis to further reinforce positive familial values.

Unitas' highly active system of sanctions, which rewards valued behavior and the mastery of interpersonal skills while discouraging undesirable conduct, creates pressures upon the participants aimed at making the anxious and depressed youngsters less fearful and withdrawn, the acting-out, aggressive youngsters more socially acceptable, and the youngsters with bizarre behavior more attuned to reality. Officially, Unitas youngsters participate in the program one afternoon a week during the school year and, during the summer months, four full days a week. Away from the Unitas meeting place, however, the symbolic parents minister to their "children's" needs as both confront the vicissitudes of life in the South Bronx. Within the innovative community structure, a variety of traditional forms of therapy are employed. Unitas provides individual and group therapy, remedial education, sports activities, arts and crafts, and social advocacy for children who require such services. The concept that is unique to the Unitas community, however, is the creation of a symbolic family structure to fill the social gaps in the South Bronx community.

Both Structural Family Therapy and Unitas are integrated treatment programs which respond to the perceived needs of the lowest socioeconomic class into which many Hispanic clients fall. Although most of the features addressed characterize impoverished families generally, other patterns are recognized as aspects of the families' ethnicity. Thus, Puerto Ricans differ from blacks in confronting problems stemming from their acculturated status and the disparities they experience between their values and language, on one hand, and those which prevail in the host society, on the other hand. Whereas inner-city Puerto Ricans and blacks share many characteristics, such as a family structure that is increasingly based on a single parent and in which siblings operate as the primary socializing agents, they are many crucial distinctions. Much has been written about the greater stability of Puerto Rican family roles that emanate from strong cultural traditions and the dynamics of the Anglo-Hispanic culture clash that many Puerto Rican families experience. In the discussion of cultural sensitivity, therefore, it is important to distinguish between treatment adjustments made in the interest of
often based on bias and misinformation. The authors do not assume that cases" In their discussion of a counsel-

ting program for Chicano college students. The authors do not assume that all students identified as Chicano are necessarily candidates for a bicultural therapy program. Instead, they define the various forms of "marginalization" that may be manifest among this population according to the degree of identification with both the minority and majority society. Based on such assessment, they then conclude that it is only those students whose commitment to their own culture is stronger than to the majority culture who are appropriate candidates for the forms of culturally sensitive counseling they propose.

Another example of this relativistic, individualized approach is provided by Gomez and the Sen Antonio model. Gomez developed a framework for the kind of objective cultural assessment that Ruiz advocates. Through the use of a Cultural Assessment Grid, a typology of four cultural/therapeutic dilemmas is articulated. The need for culturally sensitive treatment is thought to depend on whether the cultural factors are part of the individual or the environment and on whether they contribute to the problem or are resources that can help resolve the problem. Depending on the interaction of these two dimensions, culturally sensitive treatment can mean different things for every client. Individualized or modified treatment plans can more easily be constructed, while minimizing the value judgments endemic to the interview process.

Individualized treatment plans can also be derived through the use of personality tests that have been specially tailored to Hispanics. The cultural bias inherent in traditional psychological tests has been well documented, and has deterred some clinicians from their use with minority patients. Nonetheless, there have been sporadic efforts through the years to develop culturally sensitive diagnostic tools as an aid to the provision of mental health care to minority populations. The recent development of TEMAS, a thematic apperception test designed for urban minority children that is now being evaluated at the Hispanic Research Center, suggests that culturally sensitive assessment can be achieved through the use of culturally fair psychological instruments. The significance of this research is based on the assumption that individualized and sensitive assessment can provide a useful first step to the development of culturally sensitive treatment decisions.

Nonetheless, despite the acknowledged desirability of individualized treatment plans and sensitive personality assessment, and despite the dangers of stereotyping that arise in the discussion of ethnic traits, generalization about cultural tendencies can provide valuable clinical guides. As the following examples show, the observation of repeated cultural patterns can lead to innovative and effective treatment. The presentation of these cases is a further attempt to incorporate differences in ethnic expression and the way in which cultural activity is interpreted to provide another dimension into which this technique is incorporated. It is an attempt to help therapists understand the cultural differences inherent in ethnic expression and the way in which cultural activity is interpreted.
their therapeutic role, but utilize a perceived characteristic of their patient population in order to buttress their chosen therapeutic medium.

A third way that culturally sensitive treatment can incorporate an element of the client's culture is through the enactment of culturally familiar roles during therapy, as shown by Maldonado-Sierra and Trent's work6 with Puerto Rican schizophrenic patients. They used a three-member therapeutic team which was designed to reproduce what they assumed to be the typical Puerto Rican family structure. A semi-psychiatrist played the role of the authoritative, aloof father; a mature psychiatric social worker, the role of a submissive, nurturant, maternal-like mother; and a psychiatric resident, the role of an older sibling who functioned as a bridge connecting the other siblings; i.e., the schizophrenic patients, to the surrogate parents. As an older sibling, the psychiatric resident developed a sense of family by trying to speed the therapeutic process by side-stepping the deep and repressed hostility of Puerto Rican patients to authority figures, which is thought to be a major reason for therapeutic resistance.

Thus, Maldonado-Sierra and Trent have taken a perceived characteristic of Hispanic patients and employed it to facilitate a traditional form of therapeutic intervention, i.e., inpatient group psychotherapy. The cultural characteristic employed is a generalized model of the Puerto Rican family, one which disregards social class and regional variations in the island. Unlike Kreisman and Pitta et al., these authors do not use a cultural characteristic that the patients have already introduced into the treatment, but are instead imposing their own perceptions of Puerto Rican culture onto the client, thus risking the possibility of stereotyped misjudgment. It is to avoid just such forms of stereotyping that authors such as Ruiz69 and Gomez70 advocate individualized assessment of cultural status and traits. Clearly, there are both benefits and risks to the utilization of perceived cultural traits in the adaptation and facilitation of established therapeutic modalities.

The examples provided so far designate limited or small-scale adaptations of therapy based on singular aspects of the Hispanic client's culture that have been noted and addressed by clinicians in the field. Far more ambitious and programmatic has been the work of the Family Guidance Center in Miami, which from its inception in 1972, has proceeded with the clear recognition that the demographic, ecological, and cultural attributes of its Cuban constituency had to be understood if the community were to be served through therapeutic interventions. Szapocznik and his collaborators have been exceptionally systematic in thinking their way through the issue of adaptation of treatment modalities to the cultural characteristics of Miami's Cuban population. Their work encompasses broad theoretical issues, controlled research programs, and practical clinical considerations, in an integrated and logically consistent way. Their work begins with research that seeks to determine the Cubans' value orientations and the ways in which such orientations differ from those of other racial and ethnic groups. An attempt is then made to operationalize the concept of acculturation, a problem widely experienced by Miami's Cubans as immigrants from a different sociocultural system. The concept and its measures then form the basis of a theory of intrafamily tension: the greater the disparity in acculturation between family members, the greater the family tensions, the acculturation process tending to occur more quickly in younger persons and males than in older persons and females.

To treat the acculturative problems of Cuban families while being faithful to their cultural value orientations, the researchers of the Family Guidance Center purposefully introduce adaptations into their therapy of choice, ecological structural family therapy. This therapy integrates the approaches of ecological systems and structural family therapy in order to permit the therapists to effect reorganization and restructuring by working with and utilizing the client's familial and extra-familial sociocultural systems.32 The selection of family therapy is guided by the familialistic tradition of Cuban culture, and a therapist's modality is chosen which coincides with the institutional structure of the client's culture. At all times, the underlying premise is that treatment should respect and preserve the cultural characteristics of the Latin client.33

The point Szapocznik and his collaborators wish to advance is that the treatment utilized should stand in an isomorphic, mirrorlike relationship to the clients' cultural characteristics: "...the Cubans' value structure must be matched by a similar set of therapeutic assumptions."34 The selection of family therapy as the treatment of choice is predicated on the notion that Cubans are family-oriented. Having determined through their research that the Cuban value system prizes linearity, which is "...the preference for linear relationships based on hierarchical or vertical structures..."35 the family therapist places himself or herself in a position of authority within the family. In order to restore or reinforce parental authority over the children. Szapocznik and his colleagues outline a detailed sequence of therapeutic interventions, logically deduced from their empirical findings on the values of Cuban clients. Based on a respect for their clients' cultural heritage, this treatment replicates and reinforces essential elements of the Cuban value system and is, therefore, assumed to be culturally sensitive.

Other treatment adjustments with Hispanic clients, however, do not follow such a direct isomorphic pattern. Sometimes treatments are introduced which constitute a dialectical inversion of the assessed characteristics of the client. For example, Boulette37 notes the frequency of a subassertiveness pattern in Mexican American women, and judges this pattern to be psychologically dysfunctional. Research has demonstrated that this general sex-role pattern prevails in other Hispanic groups; for example, among Puerto Rican women of humble social class it is a reflection of culturally induced conformity. In the case of the woman being expected to passively accept her lot in life,38 Boulette has targeted this culturally prevalent pattern as the focus of a therapeutic program that trains Mexican American women to be more assertive. The ultimate purpose of this behavioral training is for the women to overcome the somatic complaints, depression, and anxiety that are thought to result from culturally prescribed submissiveness.

The juxtaposition of the assumptions of Szapocznik and his collaborators with those of Boulette raises critical questions. Once the characteristics of a cultural group have been adequately documented and researched, what should be the treatment? Should it attempt to preserve traditional cultural elements, or should acculturation, assimilation, or adaptation to
the surrounding society sometimes take priority? Perhaps advocacy on behalf of preserving traditional cultural elements, no matter how well intentioned, should not always or exclusively shape the character of the therapeutic intervention. On the other hand, the values of the host society should similarly not be idealized as reflecting universal standards of mental health. It is our contention that when a therapy is modified to meet the needs of Hispanic clients, it need not isomorphically reflect or counteract the client's cultural characteristics. We hypothesize that therapeutic gains can sometimes be made when traditional cultural patterns are bent, changed, or redirected according to predetermined therapeutic goals.

Thus, the first step in any process of treatment modification is to acknowledge or empirically determine the special ethnic "traits" that exist within a group; this trait-recognition is then transformed into a culturally sensitive treatment. The kind of innovation that emerges depends, however, not only on the ethnic characteristics identified, but also on the value system of the therapist and the therapeutic system being administered. Research seeking to test various cultural traits and the therapies being developed to reflect the intricacies of the group, hypotheses must be carefully sensitive treatments.

In terms of the construction of culturally sensitive treatments, it is our contention that when a therapy is modified to meet the needs of Hispanic clients, it need not isomorphically reflect or counteract the client's cultural characteristics. We hypothesize that therapeutic gains can sometimes be made when traditional cultural patterns are bent, changed, or redirected according to predetermined therapeutic goals.

Thus, the first step in any process of treatment modification is to acknowledge or empirically determine the special ethnic "traits" that exist within a group; this trait-recognition is then transformed into a culturally sensitive treatment. The kind of innovation that emerges depends, however, not only on the ethnic characteristics identified, but also on the value system of the therapist and the therapeutic system being administered. Research seeking to test various cultural traits and the therapies being developed to reflect the intricacies of the group, hypotheses must be carefully sensitive treatments.

In order to modify a treatment program according to the needs of a cultural group, hypotheses must be carefully developed to reflect the intricacies of the many possible connections between various cultural traits and the therapies being administered. The cultural adaptations made in an attempt to test such hypotheses may well indicate the value of sometimes preserving and sometimes altering the client's adherence to traditional cultural elements. The ultimate aim should be the adaptation of the Hispanic client to the new host society in such a way that ethnic identity and pride are not negated or belittled.

The acceptance of this approach implies that culturally sensitive treatment can recognize and respect cultural values without isomorphically reflecting the quality of the ethnic milieu. Nevertheless, all therapeutic metaphors judgments suffer from a lack of rigorous empirical bases. Moreover, they involve a basic adherence to traditional methods, with the cultural adaptations made in order to facilitate the traditional treatment format. Although there are clear benefits to maintaining established therapeutic conceptions, the question still remains as to whether nonisomorphic, cultural sensitivity can be developed through new and innovative, culturally-specific treatment modalities.

**Level 3: Developing a New Treatment Modality from the Culture**

So far we have discussed two types of efforts to develop culturally sensitive mental health services for Hispanics. The first involves improving the accessibility of such services by incorporating elements of Hispanic culture. The second involves the selection and alteration of available treatment modalities to fit the Hispanic client's culture. The third effort involves the development of new modalities which take as their point of departure not the existing armamentarium of traditional therapies, but an aspect of the client's own cultural context. A program recently evaluated at the Hispanic Research Center, Cuento Therapy, is an example of a singular and delimited form of treatment developed out of material specific to the Puerto Rican community. It takes as its medium the folktales of Puerto Rican culture. The importance and value of the traditional transmission of such tales is the premise of therapeutic intervention.

Yesterdays' Puerto Rican culture was suffused with the traditions of folktales which were told from one person to another and handed down from one generation to the next. Latin American people have been acknowledged for the richness and importance of their folktales traditions. Various folktales were told and retold until, however, Puerto Ricans occupy a special place, judging by the results of efforts to collect their folktales. Over 70 years ago, Dr. J. Alden Mason undertook the prodigious task of collecting folktales in the island. He concluded that the collection "... is by far the most abundant and most important Spanish folktales material collected in Spanish America. Its importance for American-Spanish folklore studies is inestimable."

The importance of folktales to the process of cultural transmission has also been recognized by scholars. As parents and grandparents, neighbors and friends, all recounted folktales to the children, the children learned the traditions of their Puerto Rican culture while enjoying the plots of the stories. Bettelheim has written extensively on the role folktales play in the psychological development of children. Arbutnot, writing on the cultural value of folktales, states: "Folktales have been the cement of society. They not only expressed but codified and reinforced the way people thought, felt, believed, and behaved."

Understanding the folktales of Cuento Therapy is the assumption that the psychological distress experienced by many children who grow up within an alien culture is partly due to a weakened cultural value system, a sense of distance from the surrounding society, lack of pride in ethnic roots, and the family's diminished role as a cultural agent of socialization. Through the relating of folktales, cultural values are transmitted, the mother's role as socializing agent is reinforced, and pride in the cultural heritage is inculcated. It is believed that efforts which are oriented toward the acculturative process can thus be reinstituted and reinforced.

Throughout Puerto Rican history, as folktales were told and retold they underwent change, with additions and subtractions being made, the stories sometimes bent in one direction or another. Whatever the changes, however, the folktales retained their fidelity to Puerto Rican culture. The malleability of the Puerto Rican folktales was seen as a distinct advantage in the development of Cuento Therapy. Children participated in the study were told folktales as they appeared in scholarly listings without alteration. For these children, an isomorphic relationship was established between the children's ethnicity and the cultural values embedded in the therapeutic message. However, since we argue that the value of such an isomorphic relationship should be viewed as a hypothesis, and not as an axiom, other children were exposed to folktales which had been changed in order to convey the knowledge, values, and skills which were deemed useful in coping with the demands of the sociocultural environment of New York City. In this final adaptation, Cuento Therapy embodies the criteria of our final definition of cultural sensitivity.

Nothing precludes Cuento Therapy from taking form of a much broader institutional program incorporating diverse therapies, but as used thus far it has been delimited. The folktales were presented to Puerto Rican children over a short period of time and separately from any other formal therapeutic intervention. This third level of culturally sensitive treatment might also be instituted on a programmatic scale, but it would require greater efforts and greater innovation than the first two styles of cultural adaptation. The development of new therapeutic modalities out of specific cultural traits is an ambitious and difficult task. Efforts to render therapeutic modalities culturally sensitive, no matter how persuasive or attractive they are, must ultimately attend to the final objective of relieving the client of psychological distress and improving his/her level of effective functioning in society. In order to
determine if this has been achieved, research must be conducted. As Padilla et al. \( ^{42} \) stated, \( \ldots \) an innovative treatment program is self-defeating unless validating research is conducted \( \ldots \) to guide the development of programs with the greatest probability of success." It is particularly important that innovative modalities such as Cuento Therapy do not become part of the vast pool of other untested therapies. However, the task of validation should not deter us from the attempt to create new therapeutic programs that stem directly from the cultural milieu of an ethnic clientele.

Conclusions

Three levels of cultural sensitivity have been defined and portrayed, but it must be stressed that these categories are not mutually exclusive. Therapeutic programs and modalities exist on a continuum of cultural sensitivity and cannot be easily pigeon-holed. A program may begin by making minor adjustments that may make the treatment more accessible, and at some point, make so many changes as to be considered a new form of therapy. Moreover, any treatment plan, no matter how innovative, must be located near a Hispanic neighborhood, employ Spanish-speaking staff, and be accessible to the client. Clearly, it would be simplistic to view our definitions as a rigid system of classifying efforts aimed at enhancing the cultural sensitivity of mental health services.

Perhaps a more useful image than that of a continuum would be that of a pyramid structure. At the base lie the numerous therapeutic programs that have made efforts toward accessibility of mental health services to Hispanic populations. Up the pyramid are those programs which have gone several steps further in this process, choosing treatments according to perceived Hispanic needs and modifying them according to an evaluation of ethnic characteristics. Finally, at the top and most ambitious level of cultural sensitivity are those therapeutic modalities that are derived from the cultural milieu. No program could possibly accomplish this level of cultural relatedness without a melding of Hispanic traits and without modifications in the interest of greater accessibility. Although no clear-cut divisions exist between the programs so defined, the distinctions are conceptually useful.

Thus, from our attempt to conceptually order the many uses and meanings of "cultural sensitivity," the concept of therapeutic isomorphism emerges as a major contribution to the field. Rarely are attempts made to empirically delineate and define the values embedded in Hispanic treatment programs. It should no longer be sufficient for a clinician to merely assert cultural sensitivity based on good intentions alone; as an alternative, we invite our colleagues to situate clinical innovations both in terms of level of accessibility and the implicit goals of ethnic affirmation or flexible acculturation. The distinction we have drawn between isomorphic reinforcement and counteraction provides an initial framework for studying these phenomena, and it is our hope that others will supplement and enrich this formulation by applying it to concrete research designs. In the endeavor to provide fair and equal mental health services to the Hispanic minority, explicit hypotheses must be constructed that define and test both the goals and the methods of treatment efforts. It is our belief that if we address the many ramifications of challenging culturally based isomorphic therapies much can be added to such investigations, and thus to the overall adjustment of the Hispanic ethnic community.

REFERENCES

8. Acosta, F.N. and Cristo, M.A. Development of a bilingual interpreter pro-


29. Ruiz, see Ref. 21.

30. Gomez, see Ref. 23.


32. Szapocznik et al., see Ref. 31, p. 113.

33. Ibid.

34. Szapocznik et al., see Ref. 31, p. 116.

35. Szapocznik et al., see Ref. 31, p. 114.

36. Szapocznik et al., see Ref. 31, p. 119.


38. Rogler and Hollingshead, see Ref. 11.


No. 9: The Minority Foster Child: A Comparative Study of Hispanic, Black and White Children
By Douglas T. Gurak, David Arreder Smith, and Mary F. Goldson
A comparative study of the New York City and New Jersey foster care systems focusing upon institutional discrimination. 122 pages.

No. 10: A Conceptual Framework for Mental Health Research on Hispanic Populations
By Lloyd H. Rogler et al.
A five-stage conceptual framework is presented for clinical service research. The framework ranges from the emergence of mental health problems to termination of treatment. Selected portions of the literature are discussed in terms of problems faced by Hispanics in going through each of these stages. Hardcover. 101 pages.

No. 11: Puerto Rican Families in New York City: Intergenerational Processes
By Lloyd H. Rogler and Rosemary Santana Cooney
An examination of the lives of 100 intergenerationally linked Puerto Rican families from the parent generation's birth in Puerto Rico to the lives of the child generation in New York City. 211 pages.

No. 12: Cuento Therapy: Folktales as a Culturally Sensitive Psychotherapy for Puerto Rican Children
By Giuseppe Costantino, Robert Malgady and Lloyd H. Rogler
Presents a study of the effectiveness of a new therapy modality for Puerto Rican children: mothers recount to their children folktales taken from the island's cultural heritage. 84 pages.

No. 13: Unitas: Evaluating a Preventive Program for Hispanic and Black Youth
By Mary E. Procidano and David S. Glenwick
Psychotherapeutic evaluation of a program for children in the South Bronx which examines how they change as a result of participating in the program. 80 pages.

Please send me the following monographs at $10.00 each.

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>11</td>
<td>12</td>
<td>13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trapped $12.95.</td>
<td>Migrant in the city $9.95.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Order Now!

* I enclose a □ check □ money order for the amount of ____________________, payable to the Hispanic Research Center

MAIL TO — Elizabeth Ospina, Hispanic Research Center, Fordham University; Thebaud Hall, Bronx, New York 10458.