Clinical Algorithms as a Tool for Psychotherapy With Latino Clients

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Clinical algorithms have the advantage of being able to integrate clinical, cultural, and environmental factors into a unified method of planning and implementing treatment. A model for practice is proposed that uses 3 algorithms as guides for conducting psychotherapy with Latino clients, the uses of which are illustrated in a single, ongoing case vignette. The algorithm format has the additional advantage of easily adapting itself for data gathering for research purposes.

Recent writing and research on Latino mental health concerns have assisted in sharpening issues regarding Latino mental health needs and in identifying service delivery features that enhance effectiveness of services. What was once framed as underutilization of services is now conceptualized as disparities in service delivery (Acosta, 1979; Barrera, 1978; Padilla & Ruiz, 1973; Sue, Fujino, Hu, Takeuchi, & Zane, 1991). This shift has broadened inquiry on improving services to include appraisal of institutional and organizational factors that may affect the relevance and fit of services for Latinos (U.S. Department of Health and Human Services, 2001, p. 143). There is evidence that Latinos are at higher risk for some major mental illnesses (Moscicki, Rae, Regier, & Locke, 1987; Rogler, Malgady, & Rodriguez, 1989), but not others (Canino, Hector, Shrout, & Rubio-Stipec, 1987). When such elevated risk is present, there is a strong suggestion that it is associated with duration of time in the United States (Hough, Landsverk, Karno, & Burnam, 1987; Ortega, Rosenheck, Alegria, & Desai, 2000; Vega, Kolody, Aguilar-Gaxiola, & Alderete, 1998) and that primary care providers are the point of access to mental health care for many Mexican Americans (Karno, Ross, & Caper, 1969; R. F. Munoz & Ying, 1993; Vega et al., 1998). The excessively high dropout rate of Latinos receiving mental health services suggests significant efforts are needed in making mental health services more relevant to this diverse population. Research with a focus on multiple factors such as help-seeking behavior, the effectiveness of specific interventions, acculturation levels, and service models will be most helpful in informing the development of future services.

The dual mandates of managed care and cultural competence have prompted many clinicians to ponder what contributes to effective practice with Latinos. This article focuses on the individual clinical encounter in the mental health outpatient setting and proposes a model for practice using decision tree formats known as algorithms as guides for conducting psychotherapy with Latino clients. Algorithms dealing with engagement, assessment–formulation, and treatment–intervention are presented. Factors relevant to assessment and intervention decision making are explored using a single, ongoing case vignette. We identify qualities in this case that we believe are significant, not for the purpose of generalizability but rather for demonstrating the applicability and heuristic value of the algorithms. We believe it is important to keep perspective on the heterogeneity within the diverse Latino population, even in relation to those who share a national origin. Social and economic class, gender, level of acculturation, language dominance, regional differences, and social identity factors contribute significantly to one's worldview and require careful attention in the therapeutic encounter.

Some Factors Relevant to Psychotherapy With Latino Clients

Clinician Factors

One vastly understudied area in our understanding of "what works" in psychotherapy with Latinos is those characteristics that have come to be aggregated

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as *therapist factors*. Several researchers have examined the relationship between therapist matching, treatment outcomes, and dropout rate (Atkinson, Poston, Furlong, & Mercado, 1989; Jones, 1982; Sue et al., 1991). Sue et al. found better outcome and fewer dropouts when Latinos and Asian Americans low in acculturation were ethnically matched. Ponce and Atkinson (1989) and Pomales and Williams (1989) have found a preference among Mexican American students for a more directive counseling style. Gamst, Dana, Der-Keraberian, & Kramer (2000) found higher posttreatment Global Assessment Functioning scores (American Psychiatric Association, 2000) for Latino clients when they were matched with Latino therapists. In a study of Chicano clients at two community mental health centers, Gomez, Zucker, Farris, and Becker (1985), in an uncontrolled study of 58 Chicano psychiatric outpatients, found client satisfaction to be associated with certain clinician behaviors that included supporting the client's strengths, seeking information on events between sessions, and asking the client for a review of learning. In an attempt to understand the ways in which Latino clinicians work with Latino clients, Manoleas, Organista, Negron-Velasquez, & McCormick (2000) surveyed 65 mental health clinicians working in outpatient agency settings specifically geared to serving Latino clients. Although results of the survey were mixed, it was generally found that the clinical techniques of these therapists were based on a combination of common theoretical orientations, clinical methods, and Latino cultural traits. Manoleas et al. also found that Latino clinicians' practice was distinguished by an overall focus on family context and functioning, a tendency to focus on strengths, contextual assessment of problems, and the clinician's taking a strong advocacy role. Barrio (2000) proposed that two assessments are necessary in practice with Latinos, one involving a cultural assessment of the client and the other an evaluation of the match between provider culture and client profile.

The Practice Environment

The overwhelming majority of outpatient psychotherapy for Latino clients occurs in one of four settings. First, publicly funded outpatient clinics that are part of a community mental health agency provide a large portion of the services. Second, psychotherapy is provided by private practitioners in outpatient offices, with sessions paid for by insurance coverage or by employee assistance programs. Third, some

hospitals have hospital-based outpatient clinics, where sessions are paid for by either public or private insurance. Finally, some clients are able to take advantage of private sector therapy on a self-pay basis. It is likely that the majority of outpatient visits include some measure of insurance support. This is noteworthy in light of the fact that most insurance providers, both private and, increasingly, public, are now involved in some model of managed care.

Concerns about the efficacy of treatment are increasingly complicated by structural elements of managed care that include allocation of number of therapy sessions. In addition to the specification of a maximum number of sessions, most clients must meet some standard of "medical necessity" that is determined by meeting certain *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; American Psychiatric Association, 2000) diagnostic criteria. Any extension of the one to three initially approved sessions that are used to conduct an evaluation and determine medical necessity must be justified by the clinician and often involve active negotiation and outright advocacy by the clinician. The task-oriented protocol necessary to meet managed care requirements can alienate clients, such as Latinos, who are not socialized into engaging in the therapeutic exchange.

Latino Culture in the Context of Service Delivery Imperatives

Practice imperatives necessitated by managed care require that the clinician gather specific information in a brief amount of time. This places extraordinary pressure on the clinician to interact on a level of familiarity that is not culturally syntonic and could be perceived as intrusive by the client. Effective assessment and psychotherapy with Latino clients, of necessity, flows from successful engagement and relationship building between the therapist and the client. The therapeutic relationship must be based on traits of cultural awareness and competence as demonstrated through the clinician's behavior. The value placed in Latino culture on interpersonal skills characterized, for example, by *personalismo* (intensely personal relationship; Chavez, 1979) represents culturally based expectations that practitioners need to be cognizant of. The value of *respeto* (respect; Romero, 1980) suggests that one would not ask highly intrusive questions of Latino clients until it is clear that a level of trust and safety have been reached. Similarly, one might ask clients how they prefer to be addressed or assume the formal tense (in Spanish) until invited to do otherwise.

Hayes-Bautista and Chiprut (1998), in an ethnographic study of the ways in which Latino physicians deal with their Latino patients, concluded that the doctor's interactions with the patients were guided by specific cultural adaptations of clinical algorithms such as a personal, informal manner while taking medical histories. Although certain information clearly had to be gathered, an informal style and careful timing of sensitive questions was in evidence. This paradigm also appears to be useful in conceptualizing the ways in which many Latinos work in outpatient psychotherapy with Latino clients, with the relationship as the basis for all future work. An entire algorithm is therefore devoted to the stepwise elements of relationship formation.

Proposed Culturally Relevant Algorithms

Algorithms have long been used in medical settings to guide physicians in the clinical decision-making process by making use of decision tree formats. The decision tree format identifies decision points with a yes or no response or provides ranges of laboratory values. The use of algorithms in mental health has been focused on specific diagnoses or syndromes, generally providing guidelines for somatic therapies such as medications, electroconvulsive therapy, and so forth (Trivedi & Kleiber, 2001). The use of algorithms in psychotherapy has been scantly studied, with research usually addressing consensus-derived "steps" (Klein, 1994) or postulating mechanisms for cognitive processes (Wessler & Hankin-Wessler, 1989). Our algorithms are proposed as guidelines for cross-culturally competent practice because of the advantage of being able to integrate standard clinical parameters and cultural considerations. Such parameters are proposed not as formulaic responses but rather as a basis to explore client characteristics and risk factors and to provide some guidance for clinician thinking. For example, the algorithms can guide exploration of trauma related to immigration or substance abuse and evaluate strong affective expression in linguistic context. They also provide a convenient training tool for clinicians and, as is explored below, give us convenient templates for application to research.

The proposed algorithms are used in this article to guide us through a serial case vignette. The case study presented here is of a 40-year-old Chicana, born in Texas but with family on both sides of the Mexico–Texas border. The setting is a private practice outpatient office where the majority of referrals are made from public sources such as Medicaid.

Engagement Algorithm

The engagement algorithm (see Figure 1) is used to assess the clinician's readiness and ability to engage and develop a positive therapeutic relationship with the Latino client. Issues to be addressed at this stage include an appraisal of any mistrust that the client may be experiencing related to differences or similarities in race–ethnicity with the clinician (Whaley, 2001) or whether any special family-oriented engagement strategy should be used (Santisteban, Szapocznik, Perez-Vidal, & Murray, 1996). An initial concern involves an assessment of the client's language dominance, or the best language for the clinical encounter. In the 1990 census, 40% of U.S. Latinos reported that they did not speak English or did not speak it well (U.S. Census Bureau, 1998). Language selection will affect not only the course of the therapy but also the diagnostic process itself. Marcos (1976), for example, found that Spanish-dominant clients were less verbally fluent and more likely to switch languages, emit unfamiliar sounds, have long silent pauses, and speak slowly during English interviews than during Spanish interviews. In a similar vein, Marcos and Alpert (1976) noted a tendency among proficient bilingual individuals to use their independence between the two languages to compartmentalize feelings. Price and Cuellar (1981), in a study of 32 patients with schizophrenia, found that verbal fluency, acculturation, and self-disclosure were significant multiple predictors of the difference in expressed psychopathology between English and Spanish interviews. Consequently, the first questions to be asked by the clinician are "Is the client monolingual or bilingual?" and "What is the client's dominant language?" In the case of monolingual Spanish or Spanish-dominant clients, clinicians must decide whether or not they are competent enough in Spanish to conduct the assessment and attempt to initiate the therapeutic process. If yes, they continue; if no, the client should be referred to another clinician who can practice in the client's preferred language. Below is an illustrative scenario.

Amparo was referred for treatment by the local county mental health program. In the initial session, it was immediately clear to the therapist that Amparo was very fluent in English. As the session proceeded, however, it became apparent that much of Amparo's intense and unresolved feeling had to do with the constant belittling and insulting she received from her mother, who, although living in another state, was in frequent phone contact. The mother's ongoing demeaning comments to Amparo were considered
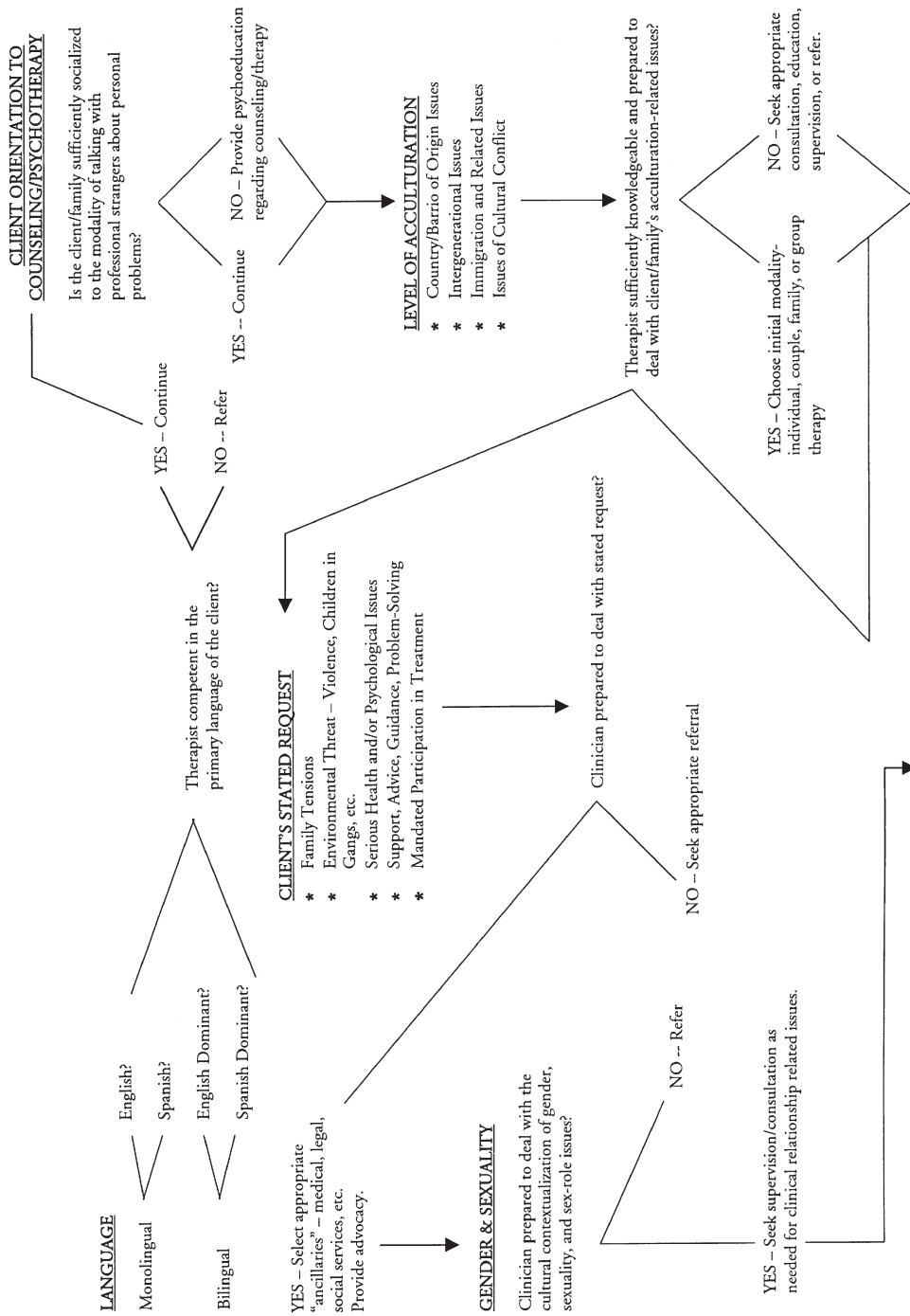
CLIENT ORIENTATION TO
COUNSELING/PSYCHOTHERAPY

Is the client/family sufficiently socialized
to the modality of talking with
professional strangers about personal
problems?

YES – Continue

NO -- Refer

NO – Provide psychoeducation
regarding counseling/therapy

YES – Continue

LEVEL OF ACCULTURATION
* Country/Barrio of Origin Issues
* Intergenerational Issues
* Immigration and Related Issues
* Issues of Cultural Conflict

Therapist competent in the
primary language of the client?

Therapist sufficiently knowledgeable and prepared to
deal with client/family's acculturation-related issues?

NO – Seek appropriate
consultation, education,
supervision, or refer.

YES – Choose initial modality-
individual, couple, family, or group
therapy

LANGUAGE
Monolingual   English?
                     Spanish?
Bilingual   English Dominant?
                     Spanish Dominant?

YES – Select appropriate
"ancillaries" – medical, legal,
social services, etc.
Provide advocacy.

CLIENT'S STATED REQUEST
* Family Tensions
* Environmental Threat – Violence, Children in
  Gangs, etc.
* Serious Health and/or Psychological Issues
* Support, Advice, Guidance, Problem-Solving
* Mandated Participation in Treatment

Clinician prepared to deal with stated request?

NO -- Seek appropriate referral

GENDER & SEXUALITY
Clinician prepared to deal with the
cultural contextualization of gender,
sexuality, and sex-role issues?

NO -- Refer

YES – Seek supervision/consultation as
needed for clinical relationship related issues.

PROCEED TO ASSESSMENT ALGORITHM

Figure 1. The engagement algorithm.

important by the therapist and were all conveyed by Amparo to the therapist in (Mexican) Spanish. The client relayed these comments with the same intonation, intensity, and language as used by her mother. The therapist decided that his facility with Mexican Spanish was good enough to not lose any of these significant clinical data.

The second issue in the engagement algorithm is an assessment of the client's comfort level in a counseling–psychotherapy activity. This involves an assessment of the degree to which the client believes that talking with a professional stranger about personal and family problems will be helpful and can assist in changing his or her circumstances. It is also necessary to assess the degree to which the client believes that talking about problems is valuable and can result in feeling better. J. Munoz (1981) made important contributions to our understanding of both the concept of psychological mindedness and that of help-seeking behavior (McMiller & Weisz, 1996; Rodriguez, 1989) by examining the impact of culture on the cognitive conceptualization of illness. McMiller and Weisz's main thesis was that "individuals inherit from their cultures structured vocabularies of health and illness that limit the possibilities for the interpretation of physical and psychological states and structure help-seeking options" (p. 1088). They further elaborated this as a "process by which individuals (a) notice physical or emotional changes; (b) label and evaluate them as psychological or physical, or trivial; and (c) decide upon a course of action" (p. 473). The clinician must get a sense of the clients' evaluation of their own distress, their beliefs about causation, and the degree to which clients identify with the "illness" metaphor of psychological distress. If the client appears to have been socialized to the psychotherapy mode of help seeking or is open to engaging in this interaction, the work can continue. If the client is not open to this, the clinician can initiate psychoeducational discussion regarding the counseling process with the client and/or family members. If spiritual causality dominates their belief system, the clinician may want to refer clients to a more appropriate helping person who practices within a spiritual framework (Skaer, Robison, Sclar, & Harding, 1996).

The third part of the engagement algorithm involves an assessment of the client's degree of acculturation, or, more properly stated, *transculturation,* which refers to the case and comfort with which the client can alternatively function, and be, in both Latino and European American cultural situations (A. O. Miranda & Matheny, 2000). A client's level of acculturation has been postulated to affect stress levels (A. O. Miranda &

Matheny, 2000), self-efficacy (A. O. Miranda & Umhoefer, 1998), depression and low social interest (Miranda, 1995; A. O. Miranda, Frevert, & Kern, 1998), and many other indicators of disrupted functioning (Vega et al., 1998). A brief assessment of the client's acculturation level is necessary and entails learning about the client's national origin, determining dates and circumstances of immigration if applicable, determining which generation the client represents in this country, and exploring his or her social identity. Also important is gaining an understanding of the environmental context of the client's childhood experiences and perceptions including the client's experience of his or her particular barrio and/or community. Clinicians must ask themselves what resources they need to feel culturally competent to deal with the many issues presented by the client's background, such as social class, colorism (i.e., discriminatory treatment by other Latinos based on phenotypic qualities such as skin shade or hair texture), national background, racism, immigration turmoil, or intergenerational conflict (Falicov, 1996). The level of acculturation can provide important insights regarding the client's reciprocal relationships with family members and significant others (Hovey & King, 1996). On the basis of this awareness, the clinician can decide on an initial modality for treatment. This decision is based on whether the client before the clinician is the "identified patient," and should be treated as such, or whether couple or family therapy is indicated. This often requires a reassessment of language, because the client's family members may require therapy sessions to be conducted in Spanish. If the clinician feels he or she is not culturally competent to deal with the issues presented by the client, the clinician has two options. The first is to consult with a colleague who is culturally competent, and the second is to refer the client to another clinician.

Amparo reported that she was born and raised in a south Texas town along the Mexican border. Her early years had been spent being raised by a variety of extended family members from both sides of the border. She reported memories of early abuse of both a physical and psychological nature, as well as a very difficult childhood that involved being sent to harvest onions in the fields at a very early age. She subsequently moved back and forth, for a variety of reasons, between this environment and a larger urban environment in California. She had been raised in a fairly strict Catholic way, but upon becoming a young adult, embraced elements of Chicano Nationalism, clearly identifying herself as Chicana rather than Mexican American. She also came to believe in some traditional practices related to *santeria* and

espiritismo, which refer to different spiritual beliefs embracing elements of the supernatural, communication with the dead, and other ways of explaining her current realities. The therapist felt sufficiently knowledgeable about these issues to have a feel for the complex roles they played in the client's life, the development of her identity, and the conflicts they presented.

The fourth part of the engagement algorithm involves an assessment of the client's stated request and the clinician's ability to properly deal with it. Oftentimes, clients report severe environmental threats such as a violence or possible violence, children in gangs, threats of deportation, discrimination, or serious acculturation conflicts. They may have serious physical and or psychological problems, seeking support, guidance, or help in negotiating the dominant culture. The difference between the client's stated problem and the presenting problem may be related to the differences between the client and therapist in cultural values that shape their perception of "the problem." The successful negotiation of these initial differences in perception will, in part, determine the success of the subsequent treatment. The clinician must also determine whether or not the client is mandated to attend therapy and whether he or she is equipped to deal with the resultant feelings on the part of the client. Such feelings will affect the initial therapeutic alliance by influencing whether the client sees the therapist as an ally or more as part of "the system." If the clinician feels equipped to deal with the stated request(s), he or she must then select an intervention approach that is appropriate, such as a supportive approach, a problem-solving approach, a cognitive–behavioral approach, a psychodynamic approach, and/or case management, and decide which collaterals to involve, such as teachers, clergy, or agencies (e.g., child protective services, probation, or other treatment agencies). If the clinician does not feel equipped to do this, he or she should seek an appropriate referral. Some examples of clinicians' not feeling equipped to deal with stated requests might be in responding to a client who seems to be seeking therapy as evidence of positive parenting skills in a custody case or to a client who is a mandated abuse perpetrator.

The following vignette, taken from Amparo's case, illustrates a case in which the clinician modifies, or reframes, the client's stated request for treatment. This reframing proved crucial to the subsequent unfolding of the treatment.

In the initial session, when the clinician asked Amparo what he could do for her, she responded with "Help me accept my diagnosis." When he asked her

what this was, she said, "Bipolar." After questioning her further about this, the clinician suspected that what she was really saying was "Help me understand, and fully accept, the complexities of who I am." He did this suspecting that poor self-esteem had played a role in Amparo's feeling that her self-image was reduced to a psychiatric diagnosis. In this case, culturally competent psychotherapy necessitated that the clinician respond to a variation of the client's stated request. For Amparo, this required moving beyond identification with the psychiatric diagnosis given to her by her Anglo psychiatrist and embracing the elements of a strong, spiritual, goddess-oriented, poetic, ethnically proud Chicana.

The fifth part of the engagement algorithm has to do with gender and/or sexual orientation. The clinician must confront the question of whether or not he or she is able to deal with culturally contextualized gender or sexual orientation issues. Such skills will flow from the acknowledgement that attitudes and values regarding gender roles and sexual preference may be part of traditional cultural traits for some Latino clients and that changes in such values and attitudes are a part of the transculturation process. Bracero (1998, p. 264) noted that

> Latino cultures have relatively rigid sex role expectations and norms that privilege men at the expense of women. Experiences of emotional intimacy threaten this Latino cultural discourse of boundaries between men and women and may lead to impasses in therapy and enactments of pathogenic aspects of machismo and marianismo in the therapeutic relationship. (p. 264)

This might have implications for a Latino clinician attempting to deal with the issues of a Latina client who has experienced sexual abuse, a European American clinician with a client whose issues stem from his or her psychosexual development in a Latino family, or any clinician's attitudes toward gay or bisexual issues. If the clinician's answer to the question of whether he or she is able to deal with such issues is yes, the clinician should proceed and pursue consultation and supervision around transference and countertransference as needed. If the answer is no, a referral should be made.

Finally, in the development of the clinical relationship, the clinician must ask whether or not there are shared cultural metaphors for communicating. Zuniga (1992) explored the use of culturally relevant metaphors in the clinical process, and Costantino, Malgady, and Rogler (1994) reported on the clinical usage of storytelling with Latino youth. Cultural metaphors like colloquialisms and other features

unique to particular languages capture the richness of a language through sayings and images. If the clinician is familiar with the metaphors, sayings, and ways of communicating of the client, he or she can then seek common terms and metaphors for communicating. If the answer to the question of whether there are shared cultural metaphors is no, the therapist must endeavor to use strategic personal disclosure in order to foster *personalismo* and discover shared idioms for communicating.

Amparo would frequently find herself confronted with vivid memories of past abusive situations. At these times she was overcome with an almost uncontrollable anger and felt like she could find relief only by drinking alcohol to the point of almost passing out. She sometimes referred to these as episodes of *coraje,* meaning a rage that, in the moment, can be experienced as consuming the entire being and spirit. The therapist subsequently referred to this whole cognitive chain of events as *coraje,* and they both knew precisely what was meant.

Assessment–Formulation Algorithm

Evidence of the dangers of making diagnostic errors when the patient's culture is not considered is abundant (Guarnaccia & Rogler, 1999; Mezzich,

Berganza, & Ruiperez, 2001). A competent assessment of Latino clients goes beyond both psychiatric symptoms and the effects of culture and should clearly outline the direction of the treatment. The assessment algorithm (see Figure 2) specifies the hierarchical order in which problems should be addressed in the realms of individual behavior, family dynamics, and/or effects of external environment factors (e.g., internalization of racism and negative stereotypes, threats of violence in home life, etc.). It suggests what information from the client is relevant to gather, how it should be prioritized, and how to implement the interventions. Information gathering is needed in order to view the individual behavior from a historical, developmental point of view as well as in relation to systems in which the individual or family function. The assessment is therefore much broader than a psychodiagnostic workup. Symptoms are contextualized, and "symptom management" will invariably become but one of a series of goals for treatment.

The first question the clinician must confront in the assessment algorithm should be "Is the client and/or the client's family currently stabilized?" (i.e., "Is the client in crisis?"). Latino clients and their families confront enormous pressures in U.S. society that may result in personal, familial, and/or economic instability. The notion of stability encompasses a multitude of
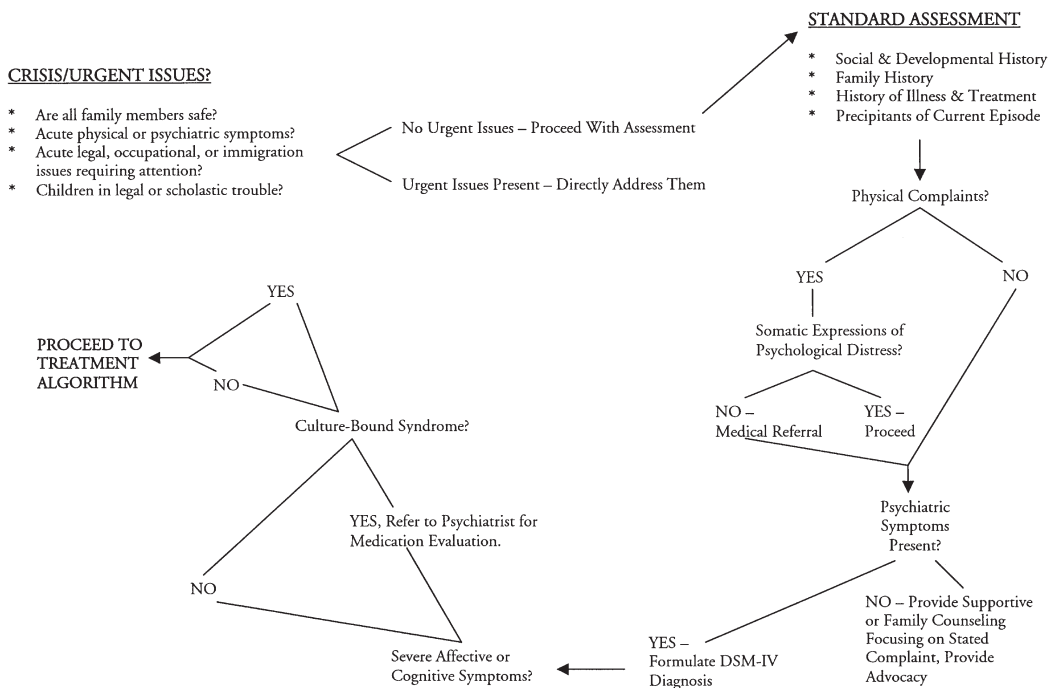
Figure 2.   The assessment algorithm.

questions such as "Are there any safety issues with the client and/or his or her family?" "Is there any violence or threat of violence?" "Is there current or frequent intoxication?" "Are there currently acute physical or psychiatric symptoms?" "Are there current pressing legal, occupational, or immigration issues?" "Are any minors in current legal or scholastic trouble?" If the answer is that the client and his or her family are currently stable, the clinician proceeds to the next part of the algorithm. If not, the clinician must carefully gather more information in the relevant area and initiate the appropriate interventions that may involve other individuals or agencies such as police, child protective services, and so forth.

The second part of the assessment algorithm involves identification of problems and symptoms using standard intake and assessment guidelines such as determining psychiatric history and current stressors. Though the diagnostic guidelines are standardized, conducting the assessment occurs in the context of the relationship based on the engagement algorithm. Clinician style is a part of this, and effective diagnostic interviews with Latino clients often appear more like a *charla* (informal conversation) than like a structured interview. Some studies have documented the effects of culture and acculturation on the psychodiagnostic process itself (Kleinman, 1996; Malgady & Zayas, 2001). Ostrosky-Solís, López-Arango, and Ardila (2001), in a study using a Mexico City sample that controlled for acculturation, found the greatest correlation between socioeconomic status and major psychiatric diagnoses. It is particularly important to proceed with the biopsychosocial focus on exploration of physical factors by inquiring specifically about the client's physical health. If the client has physical complaints, the clinician must make a determination as to whether a medical referral is warranted or the complaints are the expression of psychological distress in the somatic sphere (Escobar, Burnham, Karno, Forsythe, & Golding, 1987; Kirmayer & Young, 1998). In the latter case, therapy can proceed; in the former case, a medical referral should be included. The mental status assessment can be of assistance in evaluating whether, in fact, symptoms are present that constitute a *DSM–IV* diagnosis, a culture-bound syndrome (Guarnaccia, Rivera, Franco, & Neighbors, 1996; Koss-Chioino & Canive, 1993), or "problems in living."

Again, returning to Amparo's case, Amparo initially came to the therapist with the diagnosis of bipolar disorder given to her by the European American psychiatrist she was seeing for medication. The therapist's culturally sensitive diagnosis ran more along the lines of posttraumatic stress disorder with depressed features and recurrent *coraje.* She had been given a selective serotonin-reuptake inhibitor (SSRI), an antimanic agent, and some benzodiazepines to be taken as needed for her strong emotional episodes. The standard stance of the therapist would have been to work with the client on medication compliance and immediate abstinence from alcohol as primary treatment goals. Instead he chose to work actively with the psychiatrist on the diagnostic formulation and medications. The antimanic agent made Amparo feel "groggy" and "crazy." The therapist was concerned that Amparo was internalizing a "chronically crazy" image into her identity in a way that caused her to feel desperate and like "giving up." The psychiatrist agreed to reconsider his diagnosis and discontinue the antimanic agent. Given Amparo's addictive nature, the therapist was also concerned about habituation to benzodiazepines. The psychiatrist agreed instead to give her Navane, which she had successfully used in the past during emotional outbursts. She continued to take her SSRI, but the need for any medication decreased, and her self-medication with alcohol decreased to zero as the therapy proceeded. Medications were thus used to appropriately manage symptoms and provide relief but were not allowed to disrupt the development of Amparo's healthy, culturally syntonic self-image.

Treatment–Intervention Algorithm

Latinos are less likely than Whites to receive evidence-based treatment, that is, care that is consistent with guidelines established by recognized psychiatric and psychological organizations (U.S. Department of Health and Human Services, 2001, p. 145; Young, Klap, Sherbourne, & Wells, 2001). Few studies on the response of Latinos to mental health care are available. The three small-scale studies of depression that have been published indicate that those who were treated had favorable results (Alonso, Val, & Rapaport, 1997; Comas-Diaz, 1981; Rossello & Bernal, 1999), but the sample sizes were far too small to establish the response of Latinos to care for depression. Telles and Karno (1995) examined interventions for schizophrenia among Latinos and speculated that their participants may have found highly structured treatment too intrusive. Studies examining specific therapeutic techniques with Latinos have been either uncontrolled (J. Miranda & Munoz, 1994; Organista, 1995) or prevention focused (Lieberman, Weston, & Pawl, 1991; Malgady, Rogler, & Costantino, 1990; Szapocznik, Santisteban, Rio,

Perez-Vidal, & Kurtines, 1989). It is therefore important to respond to client needs as they unfold in the treatment process and avoid rigid adherence to any particular theoretical orientation. The following discussion of proximal and distal sources of client problems may provide a tool for selecting particular orientations or techniques as the treatment unfolds. The treatment algorithm described below (see Figure 3) also stresses the importance of ongoing assessment of cultural contributions to every phase of the psychotherapeutic process.

The treatment–intervention algorithm involves identifying and prioritizing symptomatic behavior that will be addressed and selecting treatment modalities, orientations, and interventions with and/or on behalf of clients in relation to other systems that affect their lives. This also involves specifying a time frame for the treatment and interventions. The basic consideration in the selection of treatment method and intervention planning is addressing whether the main problems and/or symptoms the client is experiencing are attributable to proximal causes (e.g., those currently existing or those that are in the recent past) or distal causes (e.g., recurrent, intrusive memories or cognitions of distant past events that result in currently serious symptoms, behavior, or distress). If the clinician decides that proximal causes are primary, then the indicated interventions may be crisis management of recent or current events, a "present-oriented" approach

such as cognitive–behavior therapy (Organista, 1995), or solution-focused therapy. If the clinician decides that distal events are most causative, or contributory, then a more dynamic approach to addressing the intrusive memories or current cognitions or patterns is indicated. This would invariably require more sessions. A narrative approach has been found to be a culturally syntonic way of working with Latinos in this regard (Hernandez, 1996). In either case the clinician may decide to initiate individual, couple, or family therapy depending on the symptoms targeted and the strategy used, as all of these modalities may be appropriate for proximal or distal orientations.

The process of culturally competent therapy with Latino clients involves flexibility on the part of the clinician in order to switch back and forth between traditional psychological interventions; use of culturally based strengths; and use of advocacy, problem solving, and psychoeducational approaches. Cross-cultural competency requires knowledge, values, and skills that encompass awareness of self, knowledge of others, and the ability to apply this awareness to interactions with others (Arredondo et al., 1996).

The second dimension of the treatment algorithm involves ongoing treatment issues. With each issue confronted, the clinician must decide whether or not culture is contributory. This determination includes exploration of the degree to which the client's behavior is perceived as "normal" within his or her culture
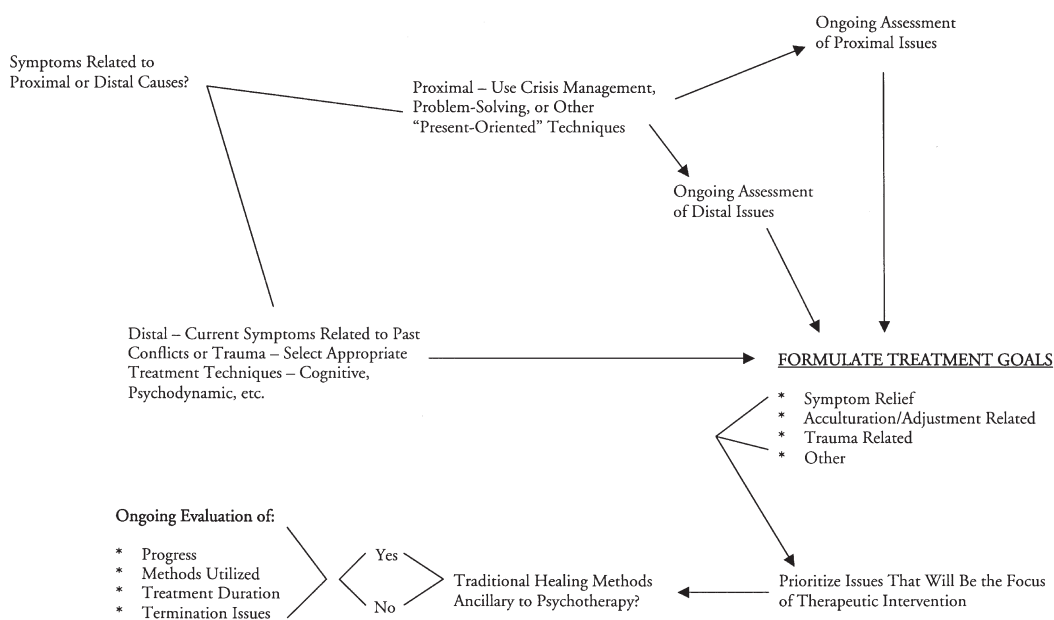

Figure 3. The treatment algorithm.

and involves an ongoing interpretation of issues within the cultural context. For example, exploration of the client's culturally based expectations of his or her experience may result in a determination that a particular client's reaction to an environmental situation is within the limits of expectation (e.g., is a normative form of expression given the discrimination or oppression the client may have experienced). On the other hand, the behavior may be an overreaction and a function of individual maladaptive behavior or a diagnosable disorder as with anger that can be so immobilizing as to render the client socially impaired. Clearly, whatever the cause, culturally sensitive work with such anger is needed in order to resolve dysfunctional expression of it so the client can get on with his or her life.

Work with Amparo involved managing her outbursts in the short term with the objective of reducing her engagement in self-destructive and other symptomatic behavior while she was in one of her rages, thereby managing problems attributable to current and recent (proximal) causes. At the same time, ongoing work was also oriented toward decreasing the frequency and intensity of the outbursts in a permanent way by working through earlier traumatic experiences, thereby changing the symptomatic responses to painful memories. Basic cognitive restructuring techniques were used with Amparo. The cognitive chains of intrusive memories leading to strong emotional flooding leading to an alcohol binge were reduced in both frequency and intensity. There was, however, another major issue that had to be worked through. The therapist was apparently one of the first men in Amparo's life to treat her with consistent *respeto* and demand nothing in return. Late night drunken calls to the therapist's voice mail professing her love for him decreased in frequency and evolved into her being able to discuss these issues in the session while sober. The therapist had shared very little of a personal nature with Amparo up to this point. He decided to tell her simply that he was involved with someone. Although this level of personal disclosure on the part of the therapist is generally contraindicated, the therapist's feel for the client's need for some level of *personalismo* led to this limited and calculated personal disclosure. This disclosure brought an enormous sense of relief to Amparo, who was able to abandon fantasies of a personal relationship with her therapist and accept the limits of the clinical relationship. She mentioned how important it was that he had shared this information because she was the product of a relationship her mother had had with a man who was married to someone else, and Amparo had

promised herself throughout her adult life that this was something she would never do. Flexibility in the therapist's clinical orientation was thus required as he momentarily shifted from his basic cognitive approach to address the transference issues more characteristic of a psychodynamic approach and, at a strategic moment, addressed a key cultural trait.

Interrelationships Between the Algorithms

The division of the therapeutic process into the three algorithms outlined above is for conceptual convenience. These algorithms are presented with the assumption that each of the algorithms is present in the other two rather than being mutually exclusive. For example, the engagement process and the relationship development processes develop and change throughout the duration of the therapeutic process. Similarly, ongoing assessment and refinement of problem definition continues throughout the course of therapy.

Conclusion

Although the highest quality of mental health care for Latinos would no doubt be enhanced by the availability of more bilingual and bicultural psychotherapists, a shorter term improvement can focus on culturally competent services. Clinical algorithms provide a convenient conceptual method of thinking about culturally competent outpatient psychotherapy services for Latino clients. They have the advantage of being able to integrate clinical, cultural, and environmental factors into a unified method of planning and implementing treatment. Another advantage gained from use of the clinical algorithm format is that the format lends itself to easy data gathering for research purposes. The yes–no junctures in the decision trees are easily codable, and, in many cases, the responses of no may document the need for a certain type of service or skill set. In the very first algorithm, for example, tabulating the number of responses of no to the language proficiency item documents and highlights a need for more bilingual staff.

The algorithms are not intended to constitute a "cookbook" approach to service provision. They can, however, provide a systematic way of making clinical decisions. They offer a way of determining which elements of culturally competent services may not be available and, therefore, when a referral to another clinician is warranted. Outpatient services, being almost entirely driven by the constraints of managed care, require clear thinking and treatment planning in order to make effective use of limited sessions. The

case of Amparo illustrates how clinical algorithms can help to do this in a culturally competent manner. Her treatment lasted for the better part of a year, but the same algorithms can be effectively used in cases in which 10 to 20 sessions, or even as few as 1 to 5 sessions, are authorized.

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