CHAPTER 12

The Influence of Race and Ethnicity on Consumer Behaviors

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INTRODUCTION

Hispanics, interchangeably identified as Latinos, are one of the fastest-growing ethnic groups in the United States. The Latino population in the United States increased by 43% between 2000 and 2010 to 50.5 million, representing 16.3% of the total population (Pew Hispanic Center, 2011). The overall youthfulness, birthrate, and levels of immigration have contributed to the growth of the Hispanic population. In addition, the diversity of national-origin groups among Latinos has increased. Hispanics can be of any race and from over 20 national origins, with emerging communities of Dominicans, Colombians, Salvadorans, Nicaraguans, and Peruvians, for example, adding to the larger and more established communities of Mexicans, Puerto Ricans, and Cubans. According to the Pew Hispanic Center (2011), Mexicans are by far the largest Latino immigrant group, accounting for more than half of the Hispanic immigrant population, and they are the largest foreign-born group in the nation.

Hispanic immigration to the United States has reached unprecedented levels and has dispersed across the nation, including states, regions, cities, and towns that previously had virtually no Latino residents. Hispanics are concentrated in a number of metropolitan areas. The largest Latino immigrant groups—Mexicans, Cubans, Dominicans, and Colombians, as well as island-born Puerto Ricans—are located in four metropolitan areas: New York City, Los Angeles, Miami-Dade, and Chicago. Each area has a significant Latino population with a diversity of Hispanic national-origin groups. These areas are traditional destinations for the largest and most longstanding Latino groups (Mexicans, Puerto Ricans, and Cubans) and are the chosen destination of emerging Latino groups such as

Dominicans, Colombians, Salvadorans, and Guatemalans (Suro & Singer, 2002). Mexicans live largely in Los Angeles and several cities in Texas. Caribbean-born Latinos tend to live in New York or Miami.

Hispanics are one of the poorest ethnic groups in the United States. Latinos have high rates of poverty among full-time workers and poverty among working husbands in intact families with children, and may suffer from the effects of economic downturns more than non-Latinos and benefit less from periods of economic growth (Suro, 1998). In their report *Wealth Gaps Rise to Record Highs Between Whites, Blacks and Hispanics,* Kochhar, Fry, and Taylor (2011) found that median household wealth among Hispanics fell from $18,359 in 2005 to $6,325 in 2009. The percentage drop—66%—was the largest among all racial and ethnic groups. Low levels of educational attainment among Hispanics compound this negative economic shift.

In light of these demographic shifts, and the differences between and within the various Hispanic national-origin groups, including linguistic diversity and immigration status, understanding how race and ethnicity affects consumer or client behaviors within the helping process takes on increased significance. The mental health and psychosocial issues associated with the emigration experience are reason enough to justify integrating race and ethnicity into the clinical care of Hispanics and all persons of color. Drawing from the fields of health and mental health, the general objectives of this chapter are (1) to examine the sociocultural factors that influence the health, mental health, and illness behavior of Hispanics, including their use of medical, mental health, and general social work services; (2) to demonstrate how knowledge of social and cultural influences—including race and ethnicity—on health, emotional well-being, illness, and disability affects the accuracy of assessment and psychosocial diagnosis and the appropriateness of treatment planning and intervention; and (3) to explore how the use of health, mental health, and social services is enhanced by assisting individuals and families of color to mitigate the impact of negative factors and to tap into the positive influences of protective social and cultural factors. The general objectives of this chapter are consistent with the overall aim of the book: to address difficult service-delivery issues that are informed and sustained by interpersonal bias and institutional and structural racism and that contribute to persistent ethnic and racial disparities among marginalized and vulnerable populations treated within health and human service systems of care.

"HISPANIC" VERSUS "LATINO": DOES IT REALLY MAKE A DIFFERENCE?

From an ethnic-sensitive perspective, it is important for practitioners to be attuned to what members of ethnic groups prefer to be called. As an

anthropological construct, ethnicity—which is the key variable that informs the ethnic-sensitive perspective in the helping professions—underscores the importance of cultural differences among groups of people. It focuses on culture as a shared meaning as well as being rooted in individual lives. It is as fluid or stable as the culture of which it is a part. It is both an individual and a collective phenomenon that is externalized in social interaction and personal at the level of self-identification (see Devore & Schesinger, 1999). In their classic monograph *Bridging Ethnocultural Diversity in Social Work and Health*, Kumabe, Nishida, and Hepworth (1985) observed that ethnicity deals with an individual's sense of identification and provides a sense of belonging to a reference group. As a sociocultural variable, ethnicity is often displayed in the values, attitudes, lifestyles, customs, rituals, and personality types of individuals who identify with particular ethnic groups. Ethnicity points to a common heritage shared by a specific cultural group, and it includes the cultural phenomena of music, religious beliefs, history, worldview, language, preference for food, and perceptions of health and emotional well-being (U.S. Department of Health and Human Services, 2001). As a fluid and dynamic construct, ethnicity intersects with other key sociocultural variable such as race, gender, ability status, social class, and acculturation and immigration status (see Marsiglia, Flavio, & Kulis, 2009).

Informed by an understanding of ethnicity and its impact on service delivery, it is important to note that the terms "Hispanic" and "Latino" are used to describe people of Spanish descent who come from different countries, cultures, and sociopolitical histories (González & González-Ramos, 2005). Individuals of Spanish descent primarily identify themselves in relation to their specific country of origin (e.g., Cuban, Puerto Rican, Dominican, Mexican). Identifying with a specific country of origin is very important for many individuals of Spanish descent because it provides a sense of pride and uniqueness that is often reflected in their music, poetry, and food. Therefore, an important point to keep in mind when providing psychosocial services to Spanish-speaking individuals is that Hispanics prefer to be asked questions that allow for the unfolding of their journey from their homeland to the United States. Mental health clinicians and health care providers may find the following questions helpful when treating or working with individuals of Spanish descent:

- What is your country of origin?
- What do you miss the most from your homeland?
- How different is the United States from your country of origin?
- Do you travel frequently to your homeland?
- By what means of transportation did you come to the United States (e.g., ship, plane)? For example, many Puerto Ricans who migrated to the United States before World War II did so by ship and not air travel.

- What specific reasons or factors influenced your decision to leave your country and come to the United States?
- Do you plan to return to your homeland at some point in the future?

These questions give practitioners the opportunity to learn about the homeland that the client, consumer, or patient has left behind, the differences and similarities found within the Hispanic culture, and the reasons for moving to the United States (e.g., poverty, political persecution, limited access to health or educational opportunities). This type of questioning may also enhance the effectiveness of engagement in the helping process, assessment, and intervention planning.

Although the terms "Hispanic" and "Latino" are often used interchangeably in the United States to refer to individuals of Spanish descent, there appears to be an increasing debate among politicians, community activists, and Hispanic scholars as to which term is "politically correct" (see Engstrom & Piedra, 2006). The debate appears to be centered on the following points:

- "Hispanic" is a U.S. Census label developed to track the population growth of individuals of Spanish descent as well as trends in their level of education and socioeconomic status. For individuals of Spanish descent, the Hispanic label symbolizes a loss of identity by not recognizing the importance of a specific ethnic nationality, such as Cuban, Costa Rican, or Colombian.
- "Hispanic" is an English term that does not acknowledge gender, unlike the terms "Latino" and "Latina," which are gender specific.
- "Hispanic" is a politically conservative term, while "Latino/Latina" is viewed as a more progressive label.
- Many individuals of Spanish descent may oppose the use of "Latino" and "Latina," however, because the terms are historically linked to Spain and its conquering empire during the 15th and 16th century.

While recognizing this political debate, it is important to note that individuals of Spanish descent may prefer one term over the other, may use the terms interchangeably, or may choose to self-identify by ethnic nationality. Thus, in providing psychosocial services practitioners should simply ask individuals of Spanish descent their preference for self-identification: Hispanic, Latino/Latina, or a specific ethnic nationality. Offering a choice of preference for self-identification will not only assist in ensuring the effective implementation of specific interventions, but will also demonstrate respect for the diversity and difference often found within the Hispanic culture and communities of color.

CULTURAL CHARACTERISTICS OF HISPANICS

Because Hispanics constitute a racially diverse group, any examination of their primary cultural characteristics must first be informed by an understanding of

race and its impact on psychosocial functioning (see Borell & Rodriguez, 2010). Service delivery that is sensitive to the reality of race and ethnicity must be predicated on inclusiveness of the client's social reality, which includes the way specific cultural values or characteristics directly affect effective treatment. In fact, Proctor and Davis (1996), in discussing the challenge of racial difference in clinical practice, noted that racial differences in the helping encounter cannot be treated via a colorbind practice paradigm. They contend that colorblind practice is unrealistic because "race, reflected in skin color, is readily apparent and cannot be easily ignored" (p. 100). Race cannot be separated from an individual's self-definition, social reality. and sense of the world. Understanding the ethnocultural characteristics of people of color—and their impact on the helping encounter—requires a practice framework that places race and racial differences at the core of any therapeutic or service delivery initiative. As a socially constructed concept with profound implications for service delivery and the psychosocial treatment of people of color, it is important to underscore that race is not a biological category, and it ought to be viewed as a societal idea that has been used to divide groups of people into distinct racial categories (Borrell & Rodriguez, 2010; Marsiglia, Flavio, & Kulis, 2009; U.S. Department of Health and Human Services, 2001). Genetic studies (see Barbujani, Magani, Minch, & Cavalli-Sforza, 1997; Paabo, 2001) have confirmed that race, as a biological concept, has not survived the test of scientific investigation. Describing this scientific confirmation, Marsiglia and colleagues (2009, p. 9) write:

> Humans cannot be categorized reliably based on phenotypical characteristics, such as those aspects of physical appearance like skin color, hair texture, and bone structure that are often thought to be markers of one's racial background. This is a discredited idea that is a vestige of nineteenth-century phrenology, the study of the human skull based on the belief that mental faculties and personality could be determined from its shape.

In examining the cultural characteristics of any ethnic group through a racial lens, it important to recognize that racism and discrimination negatively affect health and mental health outcomes and place people of color at risk for specific mental health disorders such as depression and anxiety (see U.S. Department of Health and Human Services, 2001). Williams and Williams-Morris (2000) have identified the ways in which racism and discrimination may jeopardize and adversely affect the mental health of people of color. These include the following:

1. Racial stereotypes and negative images can be internalized, denigrating individuals' self-worth and adversely affecting their social and psychological functioning.
2. Racism and discrimination by societal institutions have resulted in lower socioeconomic status for minorities and poorer living conditions, in which poverty, crime, and violence are persistent stressors that can affect mental health.

3. Racism and discrimination are stressful events that can lead directly to psychological distress and physiological changes affecting mental health.

Many Hispanic scholars (see Sandoval and De La Roza, 1986; Gil & Vasquez, 1997; González & González-Ramos, 2005; Santiago-Rivera et al., 2002) have identified salient cultural characteristics that inform treatment strategies for the amelioration of distressed psychological social functioning among Hispanics. Key values or characteristics are *simpatia, personalismo, familismo, respeto,* and *confianza.* Two gender-specific roles (see Gil, 1980) also influence how attuned clinicians approach their Hispanic clients: *marianismo* (female self-sacrifice) and *machismo* (male selfrespect and responsibility). *Marianismo* and *machismo* have acquired such common pejorative usage that their actual centrality in the Hispanic maintenance of intrapersonal and interpersonal coherence is obscured. Religion or a sense of spirituality also informs the traditional Hispanic experience and may serve to enhance, or at times challenge, the curative process inherent within the helping process.

Hispanics' level of acculturation, socioeconomic class, family, and gender roles affect their adherence to traditional cultural values or characteristics and their utilization of psychosocial care. Examples include:

- *Simpatia* relates to *buena gente* (the plural form of a nice person). Hispanics are drawn to individuals who are easygoing, friendly, and fun to be with. Politeness and pleasantness, and avoidance of hostile confrontation, are valued, guiding social work clinicians to demonstrate these qualities in their demeanor and to anticipate the same in their client as the basis of engagement.
- *Personalismo* describes the tendency of Hispanic patients to relate to their service providers personally rather formally or as part of an institution. This serves the relational theory goals of authenticity and mutuality. It may not be reflected in the busy agency culture, requiring an outreach attitude by clinicians as they meet their Hispanic clients.
- *Familismo* is a collective loyalty to the nuclear and extended family that outranks the individual. Clinicians who are trained in individual techniques need to extend the relational perspective, in particular not-knowing and co-construction of meanings, to validate the significance of family. This includes *compadres* (godparents) as vital resources, particularly during times of crisis when instrumental and emotional support may be needed. *Familismo* remains strong even among highly acculturated families (Santiago-Rivera et al., 2002).
- *Respeto* (respect) dictates appropriately deferential behavior toward others based on their age, gender, social position, economic status, and authority. Clinicians must keep in mind that *respeto* implies mutual and reciprocal deference. The clinician receiving respect as a professional is equally obligated to

observe deferential courtesies to the patient based on age, gender, and other sociocultural characteristics.

- *Confianza* (trust) refers to the intimacy and interpersonal comfort in a relationship. The empathic attunement and mutuality of the relational approach are particularly central with Hispanic clients. *Confianza* generates interpersonal resilience overall, based on willingness to engage with the clinician and apply experiential learning.

Clinical practitioners ought to be mindful that these Hispanic-specific concepts offer practical guidance in racially and ethnic-sensitive practice with *all* populations. Their conscious centrality in work with Hispanic clients or patients may call for more overt demonstration of cultural protocols, particularly where there is diversity between clinician and client in cultural orientation. However, the essential features of sympathy/empathy, respect, individuality, and trust apply across most—if not all—helping encounters.

GENDER-SPECIFIC ROLES

From a clinical point of view in both health and mental health care, gender role expectations and values constitute an area where transference and countertransference may create the strongest potential for cultural misalignment. These rational dynamics may be exacerbated by racial and ethnic factors (see Lum, 2004). Traditional gender roles within the Hispanic family structure are intrinsically linked to the concepts of *marianismo* and *machismo. Marianismo,* the term associated with Hispanic female socialization, implies that girls must grow up to be women and mothers who are pure, long-suffering, nurturing, pious, virtuous, and humble, yet spiritually stronger than men (Gil & Vasquez, 1997). *Marianismo* is associated with the Virgin Mary and therefore directly tied to the Roman Catholic faith. Although *marianismo* has contributed to a view of Hispanic women as docile, self-sacrificing, and submissive, it is clear from a family systems viewpoint that women (particularly mothers) are the silent power in the family structure.

Clinicians need to be alert to the temptation to view Hispanic female clients' deference to the clinician or submission in gender roles as a deficiency in self-esteem or self-assertiveness. Deconstructing and co-constructing the ways the client's posture toward others are the relational approach to seeing what is or is not inherent to the problem for clinical attention. In his seminal paper *Masochism, Submission, and Surrender,* Ghent (1990) clearly distinguishes deference from powerlessness or self-devaluation. The ethnic-sensitive and racially minded practitioner, seeking empathic attunement to the client's meanings and methods rather than superficial evaluation of manifest behavior, is well advised to regard

surrender of dominance as a legitimate relational-interpersonal paradigm when matched by reciprocal protection and provision for the *machismo* role.

This observation underscores the importance of diversity practice in clarifying the value of an approach that recognizes that client behaviors are informed by ethnocultural processes that include racial and ethnic dynamics as well as individual psychological factors. Surrendering to the cultural and individual attributions of meaning and worth of the client does not represent submission as a professional but rather serves as a cornerstone of constructivist, nonpositivist, and clinical practice (Tosone, 2004). Similarly, clinical authority does not require dominance.

Hispanic *machismo*, contrary to being a cult of the gender role socialization of Hispanic males, has centered on the construct of manhood. *Machismo* has been defined in the social science literature as the cult of virility, arrogance, and sexual aggressiveness (Santiago-Rivera, 2002), and it refers to a man's responsibility of loyalty to friends, family, and community. He must provide for, protect, and defend his family (Sandoval & De La Roza, 1986), and in turn he commands respect from others. If clinicians are to succeed with Hispanic males, they must be skilled at proffering respect as a means of engagement, addressing any resistance in themselves as a countertransference phenomenon. Acculturation may conceal the degree to which Hispanic males and females adhere to *machismo* and *marianismo*, but the clinician's attunement to and acceptance of such important dimensions of self are needed to offset disruptions and impasses in clinical services with Hispanics (Sandoval & De La Roza, 1986).

RELIGION AND SPIRITUALITY

Religion and spirituality are sociocultural domains that are informed by the variables of race and ethnicity. They may greatly influence how people of color seek psychosocial services, adhere to prescribed treatment plans, and engage with service providers in health, mental health, and other systems of care (see Congress & González, 2013; González & González-Ramos, 2005). Research studies (see Department of Health and Human Services, 2001) have shown a possible positive association between religion and spirituality and mental health promotion and mental illness prevention. Subjective well-being and life satisfaction are two important variables that appear to have a strong link with reported and/or observed levels of spirituality. For specific people of color, such as African Americans, religion and spirituality have been identified as predictors of improved self-perception, self-esteem, and adherence to health-related behaviors (Taylor, Mattis, & Chatters, 1999).

Clinical practitioners or providers of care might anticipate culturally normative ambivalence and confusion about how to use the clinical process without violating

religious tenets. Ethnic-sensitive practice principles that are guided by an appreciation for racial differences and an understanding of marginalized and oppressed groups prescribe open and co-constructed exploration at all times to determine how a problem can be approached in ways congruent with the client's outlook (Ecklund & Johnson, 2007). When working with an Hispanic client, if the practitioner isn't open about the different outlooks between practitioner and client—the client may forgo treatment to keep his/her religious beliefs intact. (Flores & Carey, 2000; González & González-Ramos, 2005; Santiago-Rivera et al., 2002).

Religion and spirituality often are separated by the theoretical-treatment models that inform the helping process and psychosocial treatment. Fortunately, emerging psychosocial intervention approaches with culturally diverse populations—such as relational therapy—are stressing the integration of faith with physical and emotional well-being (see Rosenberger, 2014). Relational theory's nonjudgmental embrace of all contents, seeking only to identify its utility in the maintenance of self-fulfillment and functioning, poses no barrier to religious or spiritual beliefs in the helping process. From an interpersonal and relational perspective, Urrabazo (2000), for instance, has noted the curative potential of faith and religion in therapeutically assisting Hispanic clients, and more specifically undocumented Hispanic immigrants who have been robbed, raped, and beaten while crossing the border into the United States. Religion appears to emotionally sustain Hispanics who are continuously subjected to racism, discrimination, and social injustice. During times of psychological crisis or environmental distress, the religious belief systems of Hispanics may be used as an adjunct to conventional clinical practice, providing a healing community where self-validation, connection to others, guidance, and social support may be found.

LANGUAGE

For many people of color, including Hispanics, language represents the primary means for retaining a sense of heritage, safeguarding cultural identity, and expressing emotionality. Language is an important element in the clinical treatment of Hispanics and other ethnic groups. It informs how this specific cultural group accesses, navigates, and utilizes services across systems of care. Similar to the variables of race and ethnicity, it serves to elucidate client behaviors within the helping process. Language, for example, has always assumed a central role in the provision of mental health care. Clinical theoreticians (see Woods & Hollis, 2000) have stressed the importance of understanding and assessing the client's language, as well as communication style, both at the manifest and latent level. In fact, the psychodynamic literature (see Fox, 2001) has even underscored the importance of comprehending and working with clients' preverbal and unconscious language.

Language, to a great extent, structures the creation of reality (Anderson, 1997). It is through the use of language that both mental health practitioners and clients are able to build and sustain a therapeutic relationship. The therapeutic relationship, in turn, becomes the medium through which change in the client's life can occur (Woods & Hollis, 2000). Because language has such a central place in the treatment of Hispanics, Castex (1994) has stressed that practitioners who wish to communicate effectively with Spanish-speaking and bilingual clients must first find out what language the client communicates best in, and then must demonstrate sensitivity to the fact that people who are in a state of crisis or who are experiencing significant psychological symptoms may struggle to communicate in a second language—namely, English.

Research studies (see Malgady & Zayas, 2001) have suggested a relation between linguistic inaccessibility and underutilization of mental health services by Hispanics. Treatment agencies, therefore, must ensure that Hispanics have access to competent bilingual mental health practitioners. In the absence of bilingual practitioners, agencies should employ or have access to well-trained translators who are proficient in English and Spanish. From an ethnic-sensitive practice perspective, it is not sufficient for human service organizations to employ bilingual/bicultural practitioners. Systems of care must ensure that the development and implementation of mental health policies and the delivery of clinical services reflect the Hispanic cultural values of *personalismo* (preference for personal contact/interaction), *bondad* (kindness), *respeto* (respect), and *dignidad* (dignity) (González & González-Ramos, 2005).

OPERATIONALIZING RACE AND ETHNICITY IN THE HELPING PROCESS

"Outline for Cultural Formulation"

In its 1994 edition of the *Diagnostic and Statistical Manual of Mental Disorder* (DSM-IV), the American Psychiatric Association (APA) acknowledged the significant role of culture in shaping the symptom presentation, expression, and course of mental disorders. This acknowledgment—which was evident by the development of the DSM-IV "Outline for Cultural Formation" and a glossary of specific idioms of distress and culture-bound syndromes—was an important milestone in systematically incorporating and operationalizing the sociocultural variables of race and ethnicity in the helping process, and in assisting clinicians to formulate a culturally informed assessment, diagnosis, and treatment plan (APA, 1994). Ecklund and Johnson (2007, p. 357) note that "the cultural formulation provides a systematic overview of a client's cultural background, the role of cultural context in the client's expression of distress or disturbance, and the effect that cultural differences may have on the relationship between client and

professional." The major categories or components of the "Outline for Cultural Formulation" are (a) the cultural identity of the individual, (b) cultural explanations of the individual's illness, (c) cultural factors related to the psychosocial environment and levels of functioning, and (d) cultural elements of the relationship between the individual and the clinician.

In operationalizing the variables of culture, race, and ethnicity—via the use of the "Outline for Cultural Formulation"—the clinician is encouraged to do the following:

1. Inquire about the patient's cultural identity to determine their ethnic or cultural reference group, language abilities, language use and language preference.
2. Explore possible cultural explanations of the illness, including patients' idioms of distress, the meaning and perceived severity of their symptoms in relation to the norms of the patients' cultural reference group, and their current preferences for, as well as past experiences with, professional and popular sources of care.
3. Consider cultural factors related to the psychosocial environment and levels of function. This assessment includes culturally relevant interpretations of social stressors, available support, and levels of functioning, as well as patients' disability.
4. Critically examine cultural elements in the patient–clinician relationship to determine differences in culture and social status between them and how those differences affect the clinical encounter, ranging from communication to rapport and disclosure.
5. Render an overall cultural assessment for diagnosis and care, meaning that the clinician synthesizes all of the information to determine a course of care." (U.S. Department of Health and Human Services, 2001, p. 11)

It is important to the underscore that using the "Outline for Cultural Formulation" in health, mental health, and other systems of care enables practitioners to examine the impact of sociopolitical oppression, internalized racism, immigration and migration trauma, race-related stress, and acculturation on the adaptive or maladaptive functioning of Hispanics and other people of color. It also provides a means for practitioners to explore their own internalized bias and overt prejudices while developing a level of self-awareness that will facilitate competent cultural care of diverse client populations (see Ecklund & Johnson, 2007). Predicated on the DSM-IV "Outline for Cultural Formulation," the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) incorporates a greater degree of cultural sensitivity throughout (see APA, 2013). DSM-5 provides more detailed and structured information about cultural concepts of distress and culture-specific clinical syndromes. Included in the updated manual

is a cultural formulation interview guide that is aimed at assisting clinicians to assess cultural factors influencing patients' perspectives of their symptoms and treatment options. It includes questions about patients' background in terms of their culture, race, ethnicity, religion, and geographic origin. The interview provides an opportunity for patients to define their distress in their own words and then relate this to how others, who may not share their culture, see their problems. This gives the clinician a more comprehensive foundation on which to base both diagnosis and care.

Clinical Skills for Racially and Ethnic-Sensitive Practice

Proctor and Davis (1996) have identified a set of core practice skills that facilitate the helping encounter between clients of color and racially and ethnically dissimilar practitioners. The skillset is aimed at addressing the three overarching questions that many clients of color have when seeking health, mental health, or social service intervention:

> "Is the helper a person of goodwill?"
> "Is the help offered valid and meaningful to me?"
> "Is the helper trained and skilled?"

Answering these questions will facilitate the development of a cross-racial and cross-ethnic helping relationship that is qualitatively different from any racially dissimilar relationship that has been experienced by the client and service provider.

Drawn from person-centered and ecological approaches to clinical care (see Gitterman & Germain, 2008), the skills of respect, professional courtesy, tuning-in, and empathic attunement are critical in answering the first question. In addition to these skills, Proctor and Davis (1996, p. 99) note that "maintaining topic consistency, paraphrasing accurately, assuring confidentiality, and providing follow-up to the client's comments affirm the worker's sincere interest in the client." These skills are vital for engaging marginalized and oppressed clients who have had to adopt a sense of "healthy paranoia" to protect themselves from the reverberating affects of social injustice, inequality, powerlessness, and discrimination (see Grier & Cobbs, 1968).

Exploring and understanding the contextual factors that impinge upon the lives of people of color will assist clinicians or service providers to respond to the second question: "Is the help offered valid and meaningful to me? Does the practitioner have sufficient knowledge of my world to be of real assistance to me?" For instance, in their study of the impact of race on the health of Hispanic man, Borrell and Rodriguez (2010) found that Hispanic black men exhibit worse

health outcomes than white Hispanic men along specific medical dimensions that measured diabetes, hypertension, feelings of sadness or hopelessness, and serious mental illness. Competent care of people of color requires mastery of both a broad and in-depth knowledge base that is predicated on a comprehensive understanding of the dynamics of race, racism, and discrimination. In fact, Borrell and Rodriguez (2010, p. 41) contend that "Ignoring racial heterogeneity among Hispanics may result in missing a great deal of information with regard to the role that race or color play in the health status of these individuals." From a clinical perspective, a culturally sensitive examination of the person-in-situation gestalt will assist practitioners to offer valid and meaningful care to individuals and families who have been marginalized by the dominant society because of racial and ethnic differences, and it will increase the practitioner's ability to engage and sustain these individuals in a meaningful helping relationship (see Woods & Hollis, 2000).

Giving something that works to clients during the initial phase of the helping process (e.g., the partialization of the presenting problem, information about a specific entitlement program, or concrete suggestions about financial or housing assistance) demonstrates that the practitioner possesses specialized knowledge and skill and gives the client a positive answer to the question: "Is the helper trained and skilled?" Proctor and Davis (1996) note that this question leads many racially diverse clients to wonder "Does the worker have professional expertise or mastery of skills that can resolve my problems?" The belief in the practitioner's ability is a cornerstone in the formation of the working alliance, an important dimension of the helping relationship (see Gitterman & Germain, 2008; Woods & Hollis, 2000). Without a working alliance with the practitioner, change in the client's life and situation may not be possible. The sociopolitical history of diverse populations and the unfair and inequitable treatment of people of color have created feelings of mistrust in the credibility of helping professionals. It is only through skill and competence in the context of an empathic helping relationship that feelings of mistrust can be carefully examined and managed.

In describing the importance of professional competence in the care of racially diverse populations, Proctor and Davis (1996, p. 102) state the following:

> The client's perception that the worker is competent has consequences far beyond the worker's own comfort level . . . Clients who view their helpers as competent are more likely to trust the worker, are more likely to be influenced by the worker, are more likely to continue in treatment, and are more likely to expect treatment to have a positive effect on the presenting problem. In short, a perception of worker competence appears to be critical to the success of the helping endeavor. [Practitioners] may wish that clients came to the helping situation already accepting their competence. Yet

workers may have to deliberately work toward a perception of their competence, particularly when perceptions are affected by societally based racial biases.

Professional competence may be conveyed in a number of ways, such as office arrangement, display of degrees and certificates, professional dress and comportment of the practitioner, and the display of journals and books on the office shelves.

CONCLUSION

Providing psychosocial care to racially and ethnically diverse client populations is a challenging and rewarding professional endeavor. It requires skill, empathy, and an awareness of the socioeconomic and political factors that affect the lives of people of color in the United States. Health and human service practitioners must have an awareness of the impact of race and ethnicity on the behaviors of consumers or clients who seek services from health, mental health, or other systems of care. The primary objectives of this chapter were (1) to examine the sociocultural factors (e.g., cultural characteristics, language, gender roles, religion and spirituality) that influence health, mental health, and illness behaviors of Hispanics, including their use of medical, mental health, and general social services; (2) to demonstrate how knowledge of social and cultural influences—including race and ethnicity—upon health, emotional well-being, and illness affects the accuracy of assessment, psychosocial diagnosis, and the appropriateness of treatment planning and intervention; and (3) to explore how the use of health, mental health, and social services is enhanced by assisting individuals and families of color to mitigate the impact of negative factors and to tap the positive influences of protective social and cultural factors. The use of the "Outline for Cultural Formulation" and specific clinical skills in the care of diverse clients were identified as useful tools for assisting Hispanics and other racially and ethnically diverse individuals in acquiring adaptive behaviors that are consistent with protective cultural factors.

DISCUSSION QUESTIONS

1. Identify and describe how race, language, and religion and/or spirituality influence the health, mental health, and illness status of Hispanics, including their use of medical, mental health, and general human services.
2. How might clinical practitioners in health and mental health settings incorporate or integrate the noted cultural characteristics of Hispanics (e.g., *familismo, personalismo, respeto, confianza*) in the helping process?

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