



## Examining Cultural Mental Health Care Barriers Among Latinos

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**Abstract:** The proliferation of the Latino population in the United States portends the urgency to understand their mental health care needs. It is well documented that Latinos are the largest ethnic minority group in this country, yet Latinos are the least likely to utilize mental health care services. This paper identifies and examines cultural barriers and current practices that may affect mental health care service utilization among Latinos. It presents a discussion and conclusion and implications to enhance cultural sensitivity in education and training for the next generation of mental health care practitioners.

**Key Words:** Latino, mental health, barriers, disparities, education

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### Introduction

Numerous studies have attempted to understand the underutilization of mental health care among Latinos (Cabassa et al., 2014; Keyes et al., 2012; SAMHSA, 2015). These studies have identified language, socioeconomic status and/or income, and health insurance as some of the barriers to accessing mental health care. More recent research shows that culturally related factors are crucial determinants of the help-seeking behaviors amongst Latinos. This manuscript attempts to add to the knowledge base surrounding terminology, informal care, and other cultural concepts that play a role in Latinos' behavioral health by documenting and exploring cultural factors that will be critical as the Latino population continues to grow. In addition, the disconnection between mental health service delivery and the Latino community also needs attention. This manuscript provides insights into how practitioners and educational institutions can better serve Latino clients. It is important to note that not all Latinos share the same experiences of mental distress; however, the authors feel that the content in this manuscript is worth documenting as these experiences are prevalent in many Latino communities, especially along the United States/Mexico border.

### Ethnic Self-Identifying Terminology

The terms *Latino/a* and *Hispanic* have received growing attention due to the historical and political contexts that are rooted in each of the terms (Alcoff, 2005; Delgado-Romero, 2001; Velazquez, 2006). For example, the term *Hispanic* has been seen as emphasizing White European heritage with regard to the harming or neglect of indigenous, slave, mixed (*mestizo*), and non-European heritage (Delgado-Romero, 2001). The Spanish term *Latino/a*, on the other hand, has

been seen as a more politically progressive term, as it refers to individuals derived from Latin American countries that once belonged to Europe (Delgado-Romero, 2001). According to Alcoff (2005), self-named Latinos have criticized the term *Hispanic* for more than 35 years, stating that it receives more Anglo approval and is more widely accepted by the middle-class. The debate about the background and meaning of both terms is noted in the *Los Angeles Times*' decision to completely omit the term *Hispanic* from its newspaper (Alcoff, 2005). Both terms will be used interchangeably in this manuscript.

### **Latino Demographics**

According to the Pew Research Center, the U.S. Latino population increased 2.1% to an estimated 54 million (as of July 1, 2013) in just one year (Brown, 2014). Estimates project that, by July 2050, Latinos will make up almost one-fourth of the U.S. population (U.S. Census Bureau, 2012). The shifting rise of Latinos in the United States, also referred to as the “Latino Nativity Shift” by the Pew Research Center, has been attributed to the growing number of Latino children who are born in the United States (Krogstad & Lopez, 2014). The states with the largest Latino populations are New Mexico, 972,000 (47%); California, 14,358,000 (38%); Texas, 9,794,000 (38%); Arizona, 1,950,000 (30%); Nevada, 738,000 (27%); Florida, 4,354,000 (23%); Colorado, 1,071,000 (21%); New York, 3,497,000 (18%); and New Jersey, 1,599,000 (18%); Chicago, with 2,078,000 Latinos (16%), has a similarly high number of Latinos (Pew Research Center, 2015).

### **Economic Costs of Mental Illness**

According to the Centers for Medicare and Medicaid Services (2015), approximately 15% of all Medicare fee-for-service beneficiaries had a depression diagnosis in 2012. These beneficiaries included American Indian/Alaska Natives (approximately 17%), Latinos (16%), non-Latino Whites (15.5%), Black/African Americans (14%), and Asian/Pacific Islanders (7.5%). The report does not give an actual dollar amount associated with the costs, although Insel (2008) estimated the nationwide economic costs of mental illness in the United States to be approximately \$193.2 billion in lost earnings per year. More current financial numbers project lost earnings and public disability insurance payments associated with mental illness to be approximately \$467 billion in the United States in 2012 (National Institute of Mental Health, 2015).

### **Behavioral Health Barriers/Underutilization**

Key studies conducted in previous decades have found that Latinos have a very low rate of utilizing mental health care. In 2009, the National Survey on Drug Use and Health (NSDUH) found that Latinos utilized mental health care services less frequently than African Americans and Whites (SAMHSA, 2010). Cabassa, Zayas, and Hansen (2006) reviewed seven epidemiological studies and concluded that Latino adults were less likely to seek formal mental health care compared to White adults. Research supports the fact that disparities exist in health and health care utilization between Latinos and Whites, especially in medical conditions such as psychiatric disorders (Keyes et al., 2012).

It is critical that the underutilization of mental health care by Latinos be examined as explanations for this underutilization have not been substantial. Some disparities in such underutilization have been explained by financial and health insurance reasons (Keyes et al., 2011). To better explain why Latinos tend to underutilize mental health services, Keyes et al. (2011) conducted a survey that examined the degree to which markers of immigrant adaptation, such as only speaking Spanish and stronger ethnic identities, affect mental health service

experiences. The researchers interviewed 6,359 Latino participants using the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), which is a nationally representative face-to-face survey of only residents in the United States (U.S). Keyes et al. (2011) found that “greater levels of Latino ethnic identity, the use of Spanish language, and less time living in the U.S.” predicted a lower use of mental health services for some mood disorders, even if the Latino individuals had medical insurance, some income, or if the severity of symptoms was higher (p. 51). They also noted that Latinos are more likely to distrust the medical community due to past experiences of discriminatory treatment or ineffective care, as well as cultural stigmas and attitudes toward psychiatric disorders and mental health services. It is, therefore, important to examine possible explanations or causes of the low rate of utilization of mental health care by Latinos.

### **Latino Cultural Factors**

According to Guarnaccia, Martinez and Acosta (2005), in many Latino communities, mental illness is associated with people suffering from being “loco” or crazy. Being “loco” has strong negative implications. It implies that the person is often dangerous to the community and experiencing an incurable disease that can lead to feelings of helplessness and a failure to seek help. In many Latino communities, mental or emotional problems can be attributed to experiences out of their control, such as *fatalismo* (supernatural phenomena). Such phenomena are *susto* (shock/fright), *mal de ojo* (evil eye), *nervios* (nerves/anxiety), *espanto* (spooked), and *miedo* (fear), which have very similar symptoms of diagnosable mental disorders (American Psychiatric Association, 2005; Baer et al., 2003; Guarnaccia et al., 2003; Kramer, Guarnaccia, Resendez, & Frances, 2009).

Many times, Latinos may state that they are experiencing *susto* or *nervios* and grumble about somatic complaints. According to the American Psychiatric Association (2005), *nervios* is a common idiom of distress among Latinos, and *susto* is a culture-bound syndrome that includes psychological and somatic symptoms (p. 7). Barrio, Yamada, Hough, Hawthorne, and Jeste (2003) reported a higher rate of somatic symptoms among Latino, compared to White and African-American, patients diagnosed with schizophrenia. Racial and ethnic minority groups are underserved by the mental health system due to the common mistake of mental health practitioners failing to accurately “read relevant cultural cues” of their mental illness (Dow, 2011, p.145). According to Dow, it is important for mental health professionals to learn the beliefs and perceptions minority ethnic individuals have surrounding mental illness from a cultural context. Dow added that this is important for working with ethnic minority individuals because “people from different cultures explain [mental] illness differently; therefore, their way of dealing with it is different too” (p. 176). Furthermore, “the manner in which individuals present their symptoms, how they communicate about their health problems, and the decisions they make about health care are all influenced by cultural beliefs and values concerning [illness]” (p. 177). It is therefore important to understand the cultural variables that may affect or impact the way ethnic minority individuals, such as Latinos, perceive mental health services and treatments, such as gender constructivism’s *machismo* (regarding men) and *marianismo* (regarding women), *familismo* (family-oriented), *personalismo* (personable-oriented), *individualismo* (self and/or individualistic focus), and *fatalismo* (fate-oriented) (Paniagua, 2005).

### **Machismo and Marianismo**

According to Paniagua (2005), *machismo* can be defined by Latino males’ belief that

*respeto* (respect) should be given to them through the submission of people such as their wife or children. *Machismo* is also defined by having physical strength, sexual attractiveness, masculinity, aggressiveness, and the ability to consume an excessive amount of alcohol without “getting drunk” (Paniagua, 2005). *Machismo* most often causes *marianismo*, which is defined by a woman’s expectation to be submissive, obedient, timid, sentimental, gentle, and virgins until marriage as well as to cook/clean/care for their children/husband (Paniagua, 2005).

Paniagua (2005) asserted that, when Latinos move from their country of origin, where *machismo* is more commonly accepted, to the United States, where *machismo* is not such a common normality, conflict may arise. Latino families that hold on to the qualities of *machismo* and *marianismo* are more likely to have conflicts within the family, such as “marital” or “child–father” conflicts (Paniagua, 2005). In terms of engaging Latino families, Aviera (2002) suggested that a practitioner always assess the hierarchical structure of the client’s family. When working with families, it is important to speak to the father—or other male considered to be the head of the household—during the treatment process as a way to engage the client and his/her family (Aviera, 2002; Paniagua, 2005).

*Machismo* also has positive characteristics and values. According to Englander, Yáñez, and Barney (2012), patriarchal characteristics such as “respect, generosity and machismo are also associated with responsible fatherhood” (p. 68). Unfortunately, the negative characteristics seem to be adopted more readily by the new generation of male Latinos. The combined practice of *machismo* and *marianismo* increase risky behaviors and jeopardize both physical and mental health development (Jezzini, 2013).

According to Jezzini (2013), *marianismo* is the principal predictor of depression in Latina women. Furthermore, Thompson (2014) stated that *marianismo* and *machismo* are barriers to the prevention of diseases such as colorectal cancer (CRC). A 2011 report from the National Center for Health Statistics reported that “47% of Latino respondents reported any colorectal cancer screening procedure compared to 59% of all adults, age 50–75 years, regardless of race” (p. 1) The author stated that a qualitative study investigated the influence of *machismo* on CRC screenings. The study reported that Mexican men felt that getting a colonoscopy was “embarrassing” (p. 4). Likewise, Latino women who displayed behaviors associated with *marianismo* were not able to make their own decisions; instead, they were more likely to be submissive.

## **Familismo**

According to Mulvaney-Day, Alegría, and Sribney (2007), family is a strong support system within the Latino population. *Familismo* is an important value for Latino individuals and can be defined as the high importance that is placed on family (Caballero, 2011). Latinos rely heavily on their families in order to get their psychological, social, and emotional needs met; they also seek advice and direction from their families during important times in their lives or when making important life decisions (Caballero, 2011). Conally, Wedemeyer, and Smith (2013) asserted that Latino individuals place their families’ needs above their own individualistic needs because aiding each other is considered an important moral responsibility. Paniagua (2005) added that, when a mental health practitioner attempts to begin an assessment or treatment process without the consideration of their Latino client’s nuclear or extended family, the service delivery may result in failure. This is due to the fact that Latino individuals most often “turn to” and “rely on” their family during times of stress or difficulties in their lives (Organista, 2000; Paniagua, 2005). Usually when issues arise within *la familia* (the family), especially mental health issues, these are dealt with privately within the family and remain private. This demonstrates the strong

commitment and loyalty that members in the family have toward *la familia*. By considering *familismo*, practitioners can understand some potential barriers to treatment, such as if a family member disapproves of the treatment; it can also offer the practitioner a tool to better motivate the client and his/her family during the treatment process (Interian & Diaz-Martinez, 2007). By utilizing culturally adaptive techniques that are accepted by family members involved in the treatment process of an individual family member or the entire family altogether, the practitioner can develop a strong therapeutic alliance between the practitioner and the client (Añez, Paris, Bedregal, Davidson, & Grilo, 2005; Organista, 2000).

### **Personalismo**

*Personalismo* is defined as the relationship between a Latino client and the people with whom he or she has contact, which can include family members, individuals in society, or even a service provider (Anez et al., 2005). A form of *personalismo* occurs in the act of accepting gifts, which occurs often when a Latino individual is trying to express gratitude and generosity (Paniagua, 2005). If a gift is not accepted by the intended recipient, Latino individuals may have hurt feelings. *Personalismo* is often promoted and encouraged when providing services to Latino individuals and families. Some researchers state that Latino clients can perceive the distance between them and their practitioner when they feel that there is a lack of warmth, which is caused when a hug is not accepted, when shaking hands, or when the practitioner avoids sharing basic and non-intimate personal information, such as food preferences (Guarnaccia & Martinez, 2003; Paniagua, 2005). Actions of *personalismo* may include appropriate touching of clients when a greeting takes place, sharing stories, or exchanging gifts. *Personalismo* presents a contradictory scenario to the policies and procedures of many mental health agencies. In fact, many of these institutions have policies that prohibit such actions as warranted by *personalismo*.

### **Individualismo**

In the Latino community, an emphasis is placed on the person's *individualismo*, or individualism. *Individualismo* emphasizes the unique set of qualities each Latino individual has in a variety of settings, whether in the family or community (Paniagua, 2005). *Individualismo* states that a person's uniqueness is important and is essential in obtaining cooperation with others, rather than competition within the Latino community (Paniagua, 2005). For example, *individualismo* can be found in the instance of mothers in the Latino community being regarded as amazing cooks, which therefore becomes a commonly positive quality for most mothers in the community. During the treatment process, mental health practitioners should explore *individualismo* because if Latino clients perceive that they are being asked to change who they are, their sense of *individualismo* may be jeopardized (Paniagua, 2005).

### **Fatalismo**

*Fatalismo* is a strong belief some Latino individuals have regarding the occurrence of problems because they believe they are determined by fate and/or destiny and, as such, are out of their control (Interian & Diaz-Martinez, 2007). *Fatalismo* often implies a sense of vulnerability and lack of control when such adverse events occur, which are also seen as unchangeable (Interian & Diaz-Martinez, 2007; Paniagua, 2005). Religion often plays a role in the belief of *fatalismo*, such as when Latino clients reference *si dios quiere* ("if God wills") and view their problems as part of God's will (Interian & Diaz-Martinez, 2007). It is important for mental health practitioners explore any beliefs Latino clients may have in regard to *fatalism*, such as *brujeria* (witchcraft),



*envidia* (envy), and *mal de ojo* (evil eye) (Paniagua, 2005).

According to Paniagua (2005), some Latino clients will not admit to their religious or folk beliefs in the first session, but it is important for the mental health practitioner to explore this subject in order to understand the client. Latino clients may believe that prayers will cure a physical or mental problem and may seek help from a priest, minister, *espiritista* (spiritual healer), *el curandero* (male folk healer), *la curandera* (female folk healer), or *el/la brujo/a* (witch doctor) in order to solve their physical or mental distress (Paniagua, 2005). Most Latino clients feel more comfortable reverting to these practices because have been used and passed down from previous generations in their families. It is suggested that practitioners assess and incorporate their Latino clients' religion, if applicable, during the engagement phase of the treatment process because religion may play an important role in how the client views mental illness and the practitioner altogether (Gallardo, 2012; Paniagua, 2005). According to Paniagua (2005), the practitioner should modify their therapeutic strategies during the engagement phase so that they are aligned with the client's belief system; if practitioners cannot work from both a scientific and folk belief perspective, they should refer the client out.

### **Language**

Psychotherapy may be viewed as talk therapy, and its success depends on clients' ability to articulate their feelings (Preciado & Henry, 1997). As a result, language is a significant factor for providing effective mental health care. According to Vega and Alegria (2001), the language barrier plays a significant role in the underutilization of mental health care by Latinos, and this barrier appears to have no solution in sight as the number of Spanish-speaking people continues to increase while the number of bilingual mental health professionals remains comparatively low. A census brief in 2003 indicated that "Spanish speakers grew by about 60% and Spanish continued to be the non-English language most frequently spoken at home in the United States from 1990 to 2000" (Shin & Brunno, 2003, p. 3). In fact, approximately eight million Spanish-speaking individuals have poor English-speaking skills—a number that will increase with the expanding Spanish-speaking population (Shin & Brunno, 2003). Having a poor English-speaking ability presents challenges to Latinos seeking mental health care services. The inability to communicate their service or treatment needs results in a greater chance of dropping out of treatment programs. A study by Laval, Gomez, and Ruiz (1990) supported the view that Spanish-speaking, monolingual clients who have communication difficulties with English-speaking, monolingual mental health professionals tend to drop out early from treatment or may not seek treatment altogether (Alegria et al, 2002).

### **Current Practices**

Many mental health professionals may diagnose a client without ever taking into consideration the client's culture (Barrera & Jordan, 2011). This can lead to serious consequences and can exacerbate the symptoms a client is experiencing. For example, it would not be surprising to hear Latino clients state that they have had some close encounter with *La Virgen* (the Virgin Mary) or some other saint or prophet that is venerated within their respective religion. According to Diller (2014), the majority of Latinos are Catholic, and it is not uncommon to have an altar in their homes. The altar often has an image of the Virgin Mary, a crucifix, a rosary, and/or candles. According to Diller (2014), Catholicism is sometimes mixed with African beliefs. If a mental health professional does not recognize that *La Virgen* is seen as a powerful and influential religious icon, this may lead to a serious misdiagnosis and possibly enhance or create false symptoms of

mental illness.

Understanding the language is also an important factor in working with Latinos because it allows the practitioner to understand how Latino individuals perceive or interpret words. For example, if a Mexican client with paranoid schizophrenia attends therapy and states that she/he is sure that somebody put a curse on them by using *brujeria* (witchcraft), the practitioner must recognize that this is related to the patient's cultural beliefs. The failure to recognize this could lead to a disconnect between the Latino client and the practitioner.

It is vital that mental health professionals take cultural beliefs into account when working with Latinos as these beliefs have been held for many years and have been a significant factor in the low use rates of mental health services by Latinos (Torrey, 1972).

## Discussion

Most literature addresses the use of folk healers for mental health care as an alternative. However, the author refers to this as informal care as opposed to alternative healers as many Latinos are descendants of civilizations in which the use of folk healers was not the alternative, but rather the standard. Latinos may seek treatment for their symptoms of mental distress by visiting a *curandero* (folk healer) or *esperitista* (spiritual healer). These individuals perform folk healing using various methods of treatments that include "herbs, massage, diets, advice, prayer, suggestion, and persuasion" (Acosta & Evans, 1982, p. 65). They are also able to provide mental health care even though it is different than that provided through the Western/traditional mental health care system. Furthermore, *curanderos* have a long history of working with Latinos, in particular Mexican Americans. According to Galarraga (2007), folk medicine has a long history in the Latino culture. For example, *curanderos* and *santeros* are extensively consulted by the first Latino generation. The *curanderos* use natural medicine such as plants and herbs to cure illnesses and conduct spiritual rituals of "limpias" (cleaning) (p. 3); meanwhile, *santeros* use the power of saints to heal and "prescribe herbs, ointments, lighting of candles for saints, incense and Florida water that can be bought in a spiritual pharmacy" to have major effect (p. 3). *Curanderos* have established trusting relationships with the Latino community and, as a result, are better able to understand cultural phenomena such as *nervios* (nerves), *susto* (shock, fright), and *mal de ojo* (evil eye). Cuellar, Arnold, and Gonzalez (1995) reported that making use of folk healers can lead to the underutilization of mental health care. The U.S. Department of Health and Human Services (2011) found that some studies have shown as many as 44% of the respondents use "*curanderos* or other traditional healers for their general and mental health care" (p. 22). A study conducted in the Rio Grande Valley, Texas (n=230) by Barrera (2010) found that 25% of Mexican American participants had been treated by a *curandero* in the past. Other cultural characteristics of *personalismo* are *respeto* (respect), *dignidad* (dignity), and *confianza* (trustworthiness). Respect is an important aspect of the Latino culture because it involves associating elders with wisdom, from which *consejos* (advice) are usually sought. These occurrences can make it challenging for elders to seek mental health treatment, especially if mental health professionals are younger than older Latino clients. It is not uncommon for them to express themselves by saying *cómo me van a decir a mí de la vida, si yo ya viví* ("how are they going to tell me about life, if I have already lived life"), indicating that young people are incapable of being wise enough to give *consejos* (advice). According to Anez et al. (2005), the rule of thumb for any initial contact with a Latino and/or Latino client is to address the client formally until told otherwise, as *a falta de respeto*, or act of disrespect, is considered offensive and can lead to a negative outcome, such as the client not returning for services.

Many Latinos have a strong sense of *dignidad* (pride). As a result, Latinos may find themselves being too proud to seek help as it would jeopardize their dignity. In the meantime, they repress their symptoms of mental illness and do not seek mental health care. *Confianza* (trust) can also affect the likelihood that they will seek mental health care. If Latinos are unable to establish a trusting relationship with mental health professionals, they are unlikely to return for treatment and will possibly forfeit any future attempts to seek help. Therefore, it is crucial that mental health professionals who provide mental health care to Latinos understand these cultural concepts, especially as many social work programs do not provide adequate training or follow a curriculum to work with Latino clients. Most textbooks that are used as the primary text for a course are written by non-minority authors who include little emphasis on the cultural elements among Latino clients. Furthermore, general, academic curricula provide little, if any, cultural training; when it is offered, it is a one-day workshop in which the participants are then assumed to have the necessary skills to be competent in working with Latino clients. This has the potential to do more harm as participants may then think that they have all of the necessary skills to work with Latino clients and seek no further education or training.

Being culturally competent is a lifelong learning experience. Gallegos (1982) first introduced the definition of being competent to work with different ethnicities in social work education and defined it as “a set of procedures and activities to be used in acquiring culturally relevant insights into the problems of diverse clients and the means of applying such insights to the development of intervention strategies that are culturally appropriate for these clients” (p. 4). The term *cultural competence* has since had various definitions, some including an actual set of standards. The National Association of Social Workers (NASW) defined cultural competence as “a set of congruent behaviors, attitudes, and policies that come together in a system or agency or among professionals and enable the system, agency, or professionals to work effectively in cross-cultural situations” (2000, p. 61). Furthermore, Cross, Bazron, Dennis, Isaacs, and Towards (1989) see cultural competence falling along a negative (cultural destructiveness) to positive (cultural proficiency) continuum and define it as “a set of cultural behavior and attitudes integrated into the practice methods of system, agency, or its professionals that enables them to work effectively in cross cultural situations” (p. 13).

## Conclusion and Implications

The growing number of Latinos in the United States poses a major challenge for all mental health professionals, including educational institutions. Therefore, it is imperative that the field of social work play a vital role in finding creative and feasible solutions to the behavioral health disparities that exist among Latinos. For example, mental health practitioners can utilize *dichos* when trying to engage their Latino clients through *personalismo*. *Dichos* are analogies, proverbs, or popular sayings that are used as a common means of communication in the Spanish language (Anez et al., 2005). In Latino communities, *dichos* are a way of spreading socialization patterns so that values such as courage, responsibility, and traditions are passed on from generation to generation (Interian & Diaz-Martinez, 2007). Because communication patterns amongst the Latino communities sometimes occur indirectly, *dichos* provide an avenue to introduce advice and feedback without offending the individual (Anez et al., 2005; Interian & Diaz-Martinez, 2007). The use of *dichos* with Latino clients can be effective, especially when engaging first-generation clients (Anez et al., 2005; Interian & Diaz-Martinez, 2007), and can be utilized throughout the treatment process in the beginning, to validate the client’s feelings and establish rapport; midway, to provide feedback, suggestions, or make a point; and at termination, to help draw conclusions or



perspectives. *Personalismo* becomes an important component of the established relationship between a Latino client and the therapist. For example, a Latino client may utilize *personalismo* when seeking to establish a relationship with the therapist by getting to know the therapist, such as knowing what hobbies or music he/she enjoys, rather than wanting to know what professional credentials the therapist may have (Paniagua, 2005). A mental health practitioner can utilize *personalismo* as a tool in order to engage the Latino client and build *confianza*, which is the level of trust that may lead to deeper disclosure in treatment (Arredondo, Gallardo-Cooper, Delgado-Romero, & Zapata, 2014). By using *personalismo* as a tool, a practitioner is able to enhance the *intimidad*, or intimacy, in order to make the Latino client feel comfortable in addressing difficult themes during the treatment process (Arredondo et al., 2014). The following implications are also recommended:

- 1) The knowledge base of this manuscript should be included in social work curriculum, especially in geographical areas where there is a large Latino population.
- 2) Social work programs need to attract more bilingual/bicultural educators into their master's and doctoral programs.
- 3) Mandatory trainings should focus on Latino behavioral health cultural factors as part of the clinical licensure requirements for social work practitioners who practice in an area of high population of Latinos.

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