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Leadership: Racial and Cultural Considerations

Center for the Study of Diversity and Social Change

Learning Objectives

At the completion of this program, participants should be able to:

1. Understand leadership theories and the concept of leadership within the context of culture
2. Identify the challenges in effective leadership, including racism, microaggressions, blind spots, and biases
3. Identify avenues for engaging empowered leadership

About the Authors

This course is provided by the **Center for the Study of Diversity and Social Change**. Contributing members include **Angela Wangari Walter, PhD, MPH, LCSW**; **Robbie Tourse, PhD, MS, LICSW**; **Yvonne Ruiz, PhD, LICSW**; **Helene Kress, MSSS**; **Betty Morningstar, PhD, MSW**; and **Bet MacArthur, LICSW**. The vision of the Center is to enhance the power for knowledge to create social change. The Center engages in a variety of ways of learning and teaching about cultural diversity that emphasize race and other social justice issues. The Center strives to integrate critical thinking, research, and creativity to promote social change.

About the Center: https://diversityandsocialchange.org/

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Left to Right: Betty Morningstar, Helene Kress, Robbie Welch Christler Tourse, Angela Wangari Walter, and Bet MacArthur. Not Pictured: Yvonne Ruiz.

Course Structure

Being a leader is a multifaceted task, and the leader must have a sense of what that entails. Understanding culture therefore, and the embedded component of race, is an important aspect of this task and is required to be a successful leader. This course will take you through what leadership entails and the theories that inform leadership, recognizing that leadership and its components are always evolving. Second, the course then examines cultural considerations leaders must address. Culture is also cogently defined and, discussed as well, is how the complexities involved in being a leader provides challenges, especially when dealing with culture and the significant component of race in the social work profession. This section of the course also amplifies for organizational leaders and for organizations how they are influenced by cultural dynamics of the broader society. Third, challenges to effective leadership with a particular focus on how organizations and their leaders are embedded within the larger context of structural racism are discussed. Fourth, unacknowledged leadership challenges and the dynamics of privilege and oppression in organizations are indicated. The course concludes with noting the value of strategic planning and being accountable. Strategic planning is a powerful process for articulating and expressing the focus of an organization in its quest to measure and embrace the many dimensions of culture, especially race.

Defining Leadership

In the 1960s, leadership became an extensive area of analysis. Since then, many institutions and researchers across industry and organizations have invested resources to formulate and describe leadership theories, including leadership models, styles, and approaches. More specifically, differentiating leadership from management became an area of focus in the 1970s, with an emphasis on effective characteristics, traits, and skills in leading organizations and providing vision and motivation for followers and populations (Araque & Weiss, 2019). Since the 1980s, much of the research on leadership has been based on theories of transformational and charismatic leadership (Yukl, 2012). Yukl (1989) states, "Leadership is defined broadly to include influence processes involving determination of the group's or organization's objectives, motivating task behavior in pursuit of these objectives, and influencing group maintenance and culture" (p. 5). However, a major difficulty in discussing leadership arises from the lack of consistency in defining leadership. As Lawler (2007) reiterates, leadership has many definitions and is constantly evolving.

It is necessary to distinguish between the concept of leadership and management. Leadership extends beyond the management of daily operations to encompass a greater functionality related to a guiding vision, influence, and power within the organization. Managers are responsible for the everyday activities, tasks, and routines that are necessary for an organization to remain viable and function smoothly (Sullivan, 2016). Brilliant (2001) argues,

> *Managers may solve problems and keep organizations functioning, but leaders have special qualities. Leaders are creative, take risks, and promote innovation and organizational growth. Thus, managers can be "good managers" without being leaders, but leaders go beyond this framework bringing entrepreneurial abilities that may be particularly needed at times in an organization's history. (p. 326)*

Some depictions of leadership emphasize the importance of ideal individual traits and suggest a level of concentration of power at the top of the organizational chart (Sullivan, 2016). Thus, a formal leader is someone who holds one of the top positions in an organization who focuses on agency improvement and change, looks to the future, and seeks innovative ideas (Araque & Weiss, 2019). Descriptions of formal leadership frequently include such words as vision, inspiration, innovation, creativity, and power (Sullivan, 2016).

As an important component of leadership, it is also necessary to recognize informal leaders and their support of organizational effectiveness through their individual performance (Shaughnessy, Treadway, Breland, & Perrewé, 2017). Informal leadership status is a product of coworkers' social perceptions and the recognition that informal leadership contributes to how the organization functions and provides motivation to other coworkers. Informal leaders are often viewed as sources of knowledge for others and more likely to be able to get important work done. Hence, there is less emphasis on formal authority and control, and more on collective action and commitment to the values and vision of the organization (Sullivan, 2016). Informal leaders may contribute to their organizations in various ways such as, implementing effective skills in creating positive change, motivating others, and communicating the vision and mission in their organizations.

Theories of Leadership

Leadership in the social work profession is essential to ensure that social workers promote social and economic justice and enhance human well-being. Leaders must understand historical and contemporary contexts that marginalized populations have and continue to experience, and how these experiences inform the ways individuals interact in the workplace and in their communities. Leaders also need to recognize contemporary theories of race and ethnicity such as critical race theory (Tate, 1997), social dominance theory (Pratto, Stewart, & Zeineddine, 2013), model minority theory (Osajima, 2000; Wong, Lai, Nagasawa, & Lin, 1998), implicit bias theory (Greenwald & Banaji, 1995) and institutional racism (Stokley & Hamilton, 1969; NASW, 2007). Effective and successful leaders need to adapt, modify, and improve their leadership styles and approaches to diverse populations.

Leaders must understand historical and contemporary contexts that marginalized populations have and continue to experience, and how these experiences inform the ways individuals interact in the workplace and in their communities.

Despite the need for exemplary leadership skills in the social work profession, leadership curriculum in social work education is lacking and little research has assessed leadership capabilities in the profession (Fisher 2009; Haworth, Miller & Schaub, 2018; Peters, Hopkins & Meyer, 2015). However, Sullivan (2016) notes that core elements of leadership in social work are comparable to those in other professions, and thus opens the opportunity to learn from other sectors. Theories of leadership seek to explain how and why people become leaders and provide a foundation for individuals to identify and improve their own leadership abilities. There are several ways to categorize leadership theories, including behavioral-based leadership related to the individual and theories that focus on relationships and organizational processes (Peters, Hopkins & Meyer, 2015). Other theories and models of leadership focus on organizations as the unit of analysis taking into account leadership complexity, distribution, and team structures (Peters, Hopkins & Meyer, 2015). It is important to point out that theoretical underpinnings inform leadership styles and that theories are not synonymous with leadership styles (e.g. authentic, servant, and social entrepreneurship styles of leadership). The leadership styles that individuals adopt may utilize one or more theoretical underpinnings. While there are many theories of leadership, the following section highlights a select set of theories that may be utilized for social change and innovation, recognizing early theories that focused on individual characteristics (e.g. trait theory) and more recent theories (e.g. transformational theory) that take into account the complex and multifaceted contexts of individuals, organizations, and their environments.

Trait theory. Originally proposed in a thesis by Thomas Carlyle (Cherry, 2016; Stodgill, 1974), trait theory of leadership suggests that there are certain personality traits and characteristics that are inherent to successful leadership in different environments and contexts. The theory suggests that effective and successful leaders have specific leadership traits such as intelligence, action-oriented judgment, people skills, a need for achievement, decisiveness, adaptability, flexibility, trustworthiness, competency, etc., that can be used in various situations (Cherry, 2016; Stodgill, 1974). In order for an organization to be successful, the leaders with the appropriate traits must be selected for individuals and groups.

Behavioral theory of leadership. Unlike trait theory, behavioral theory focuses on the behaviors of leaders and the effects these behaviors have on the workforce and the organizational culture. Two seminal research studies have informed dimensions of leader behavior. The Ohio State University Leadership Study conducted by Stogdill and Shartle from 1946 - 1956 identified behaviors indicative of strong leadership and underscored two behavioral views on leadership: (a) people oriented – the extent to which a leader demonstrates concern for individuals and groups, and (b) task oriented – the extent to which the leader sets individual expectations, schedules and plans tasks, maintains performance standards, ensures that organizational expectations are maintained (Johns & Moser, 1989; Stogdill, 1974). The Michigan Leadership Studies of the 1950s and 1960s conducted by Likert and colleagues classified leaders as either "employee-centered" or "job-centered" and identified three characteristics of effective leaders: task-oriented behavior, relationship-oriented behavior, and participative leadership (Johns & Moser, 1989; Likert 1961; Likert & Likert, 1976). These specific learned behaviors can differentiate leaders from non-leaders or successful leaders from unsuccessful leaders. This theory also suggests that leadership is a skill set that can be learned through teaching and observation, and that potential leaders can be identified and taught to be effective leaders. The theory provides opportunities for leadership development at all levels.

Situational leadership theory. This theory developed by Hersey and Blanchard (1977) posits that leaders match their behaviors with the performance needs of the individual or group that the leader is trying to influence. A core component of situational leadership theory is the leader's ability to meet the individual or group where they are, by establishing objectives, assessing the readiness of the individual or group, and determining the appropriate leadership style within the context of a given situation. The theory recognizes that each individual is unique. Situational leaders can diagnose the specific needs of individuals and groups, adapt their behavior in response to a situation, communicate by interacting with others in a manner that they can understand, and advance the performance of individuals and the organization (The Center for Leadership Studies, n.d.).

Transformational leadership theory. First introduced by James MacGregor Burns (1978), this descriptive research indicates that transformational leadership is a process in which leaders and followers help each other to advance to a higher level of moral motivation. Transformational leadership focuses attention on the relationship between the leader and staff, suggesting that organizations prosper when all their members work to maximize their potential (Lawler, 2007). This theory has been of interest in social services as a transformational leader recognizes that staff performance is motivated by providing stimulating opportunities to work toward the common good, and not driven merely by a standard reward system (Sullivan, 2016). This leads to less emphasis on formal authority, power, and control, and more on commitment to the values and vision of the organization and on collective action (Sullivan, 2016).

Leadership in social work has been an area of focus for researchers and practitioners for at least the past decade. However, social work leadership research has not yet provided a systematic and purposeful evaluation of available leadership models' applicability to social work research and practice (Peters, 2018). Social work research employs leadership theories and models that were developed for corporate and military entities, which have decidedly different goals and processes than social work organizations (Lawler, 2007).

Peters (2018) asserts there is a misalignment between business-based leadership theory and social work practice. He suggests that these models may influence social work leadership in ways that reflect corporate rather than human service processes and goals, and that may ultimately be incompatible with social work's human service goals and activities. One of the main concerns is that leadership theories have been heavily influenced by a hierarchy of white male privilege (Lawler, 2007; Peters, 2018). The primary purpose of social work is to increase human and community well-being; therefore, the values of social work differ sharply from those of business: social work emphasizes the promotion of social justice (National Association of Social Workers, 2008), while the primary objective of business is to continually increase profits. Leadership theories that are currently popular in social work, most notably transformational leadership theory, emphasize the importance of the individual characteristics of a leader without the relational and organizational framework.

An important aspect of leadership literature and research needs noting, namely that in the search for a universal model of leadership, little allowance is made for diversity and leadership. In a public sector with a strong diversity dimension to research, practice, and policy, this is an important deficiency (Lawler, 2007). Another concept and active component of leadership is cultural dynamics which interfaces with organizational dimensions.

Leadership and the Importance of Culture

Culture is an integration of variant and shared philosophies, norms, mores, beliefs, values, social, and familial customs. Culture can be understood as a social construct that has personal and societal implications (Tourse, 2016). It therefore has breadth (e.g. social, political, religious, class, societal values, and beliefs) and depth (e.g. heritage, relational values, gender identity, sexual orientation, age, race, and ethnicity). These varying subsets establish us as unique individuals. They influence how we think as members of the dominant society and how we think on the familial and social levels. These subsets, grounded in our complex cultural makeup, have positive or negative sway over our attitudes and how we relate and interact (Tourse, 2016; Tourse, Hamilton-Mason, Wewiorski, 2018).

Effective organizational leaders must understand the influential energetic nature of culture: from culture assisting in the formation of an organizational structure, to welcoming a varied clientele. Unraveling how culture impacts staff's, clinicians', and even clients' expectations will give an organizational leader an empathic observational standpoint, as well as a chance to assess their own understanding of self in context of organizational service (Steinberg, 2014; Toseland & Rivas, 2005). One of the important principles of leadership is that the leader must set the agency goals and the professional services to be attained (Trecker in Skidmore, 1983). Cultural understanding and competence by the leader must be essential also for service attainment. Leaders cannot expect their staff to be culturally astute if they themselves are not. Culture of the local environ, the societal environ, the agency environs, as well as dynamic transactions, must be omnipresent in thought and deed of the leader.

Culture is dynamic. Cultural values and beliefs in society are changing and have influence on social and familial norms, values, and customs. The major questions leaders should ask are: How does culture impact and influence the historical values of the agency or organization? Is the leader open to considering new ideas, assessing the current status, envisioning the future, and eliminating foci and "customary ways to solve problems or reach … goals" (Walter, Ruiz, Tourse, Kress, Morningstar, MacArthur, & Daniels, 2016, p.4)?

The diverse and inclusive nature of culture must be represented in the structures and systems which govern us. For organizational leaders to manage their unique organizational facility, their insights, awareness, and abilities must be culturally diverse and inclusive.

Based on these questions, leaders must also ask: Is the agency changing with the times, are staff and clinicians culturally aware and competent in meaningful and substantive ways, and is the agency in a time warp or keeping abreast of the changes around it? The interplay and cross-fertilization of cultural dimensions and subsets change the distinctiveness of an organizational setting and bring about a need to understand the diversity within, between, and outside of organizational structures. The leader sets the tone and understanding of where culture, the diversity within culture and the need to address inclusiveness lies.

Appreciating culture means realizing that culture is not homogeneous, and that diversity is a main ingredient. Diversity encompasses the multicultural subsets that represent culture's essence. This essence is what individuals absorb, embrace, and hold dear through artifacts, ancestral influences, and experiences (Schriver, 2004; Tourse, 2016; Sue, Rasheed & Rasheed, 2016). Diversity is amplified by the immigrant groups that make up the United States. Although we are a multicultural nation, the core societal culture of this country is referenced by the middle-class Anglo-Saxon Protestant cultural patterns (Bonilla-Silva, 2014; Feagin, 1989). Diversity is diminished and weakened when confronted by the core societal culture by means of conscious and unconscious bias. The most insidious is unconscious bias. Such bias influences professional decisions when individuals, even those who are the most well-intentioned, are unaware of the discriminatory feelings they may harbor (Walter et.al., 2016). Unconscious bias can alter the functions of an organization and the purposes of those served by the organization. There are many subsets (such as class, poverty, religion, race, ethnicity, and ableism) where unconscious bias prevents inclusiveness.

"[Facing] us [as professionals] is how human differences are made important in our thinking about social relations" (Luhman, 2002, p. 4). These differences, which also are manifested by labeling, must not moderate diversity but bring a sense of inclusion within society. "It is the responsibility of the [leader and] workers to remain current with the descriptive labels preferred by the range of diverse peoples" (Schriver, 2004, p. 114). The terms diversity and inclusion appear incongruent or contradictory, but they are terms that are immediately recognizable as entrenched in culture. These terms are important in establishing societal cultural values that all people can embrace and which honor and respect the irreplaceable values of people from different cultural backgrounds. Human diversity is a supplier of creative ideas as well as strength of a people. Diversity and inclusion indicate that there is more than one answer and more than one question, but many (Schriver, 2004) that form a multicultural matrix. We, therefore, must acknowledge our similarities and differences in order to embrace culture on all levels: societal, social, and familial; and by means of heritage, mores, values, race, ethnicity, class, religion, gender, etc. The diverse and inclusive nature of culture must be represented in the structures and systems which govern us. For organizational leaders to manage their unique organizational facility, their insights, awareness, and abilities must be culturally diverse and inclusive.

Structural Racism: Challenges to Effective Leadership for Change

Organizations exist and function within the context of alues and assumptions of the wider society. Historical, societal, educational, political, and economic forces push organizations to reflect the structural racism of that society (Tourse, Hamilton-Mason & Wewiorski, 2018). Effective leadership in a diverse organization requires the leader to address the issues of diversity and culture as discussed above, and institutional or structural racism as they impact the organization.

Structural racism is "a system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity" (The Aspen Institute, n.d. pg. 1). Institutional racism, which is a part of structural racism, is a historical, long-standing social condition that relies on established, traditional ways of doing business where leadership is based on a White majority and is defined by historically White values and norms; this reinforces an organizational status quo which in turn perpetuates inequalities in access and leadership (Anderson & Collins, 2013). Many leaders have internalized stereotypes about race and people of color that are built into the structures of our society and our organizations (Cross, 2000).

The essence of leadership is the capacity to create and communicate a vision and to mobilize an organization to achieve it. In a diverse society, it is important that both the vision and the means of achieving it reflect the values of all constituents of the organization. Effective leadership for change begins with self-awareness on the part of leaders and sensitivity to the dynamics within their organization that may promote or inhibit full participation. As stated above, competent leaders must develop an awareness of their own perspective and values as well as the perspective and values of the organization in which they work and those of the people within their organization. Significant differences may exist. This awareness will enable leaders to develop a

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CONTINUED ON PAGE 4

more inclusive style of leadership and a more unifying and productive workplace culture (Mustafa & Lines, 2013).

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The United States was founded on White Protestant values and norms. These values and norms produce certain preferences and assumptions, such as the emphasis on individualism and competition, hierarchies of authority, male privilege, and the denigration of non-white people (Anderson & Collins, 2013). The resultant biases, hidden and overt, have been identified in some studies (Banaji & Greenwald, 2013; Beattie, 2013). These biases lead to devaluing contributions that are based on divergent cultural norms. Once employees of color for example recognize this bias, they may become less confident about or interested in offering their points of view in discussions, problem solving, and creativity, depriving the organization of their insights. To the degree that leaders have internalized the racial biases of the dominant society, they may not notice the absence of participation by some members or may attribute that to personal styles or abilities. Members who are not active participants are often marginalized, thus compounding the problem. Perceiving through a biased lens reinforces bias.

Given the impact of culture and race on the dynamics of any working group (Foldy & Buckley, 2014), an effective leader must find a way to address this issue. In organizations, as in society at-large, there is resistance to talking about issues of race (Foldy & Buckley, 2014). Recognizing the racial dynamic in group process is an important step in creating an inclusive organization. Doing so can be painful. White people have not had to endure racial stress, while people of color contend with it every day (DiAngelo, 2018). An effective leader will be aware that race, ethnicity, and culture have weight and consequence, and that a productive work environment is one in which each individual is recognized and is in fact an equally empowered member of the group (Foldy & Buckley, 2014).

not necessarily imply a negative judgment. It is simply a fact. Leaders of organizations must be mindful of their own racism and that of staff members so that they can effectively address overt and covert racism within their organizations. Leaders must set norms to create opportunities to deepen the conversation that allows all members to examine their personal and communal assumptions about race and the effects of racism in the workplace. Effective leaders can guide their organizations to develop policies and create work cultures that enact their commitment to addressing racism.

Hidden or implicit bias. These terms are widely understood as the unconscious attitudes or stereotypes that influence individual cognition, perception, or behavior. Research designed to measure hidden or implicit bias has been conducted by Banaji & Greenwald (2013). These researchers have coined the term "blind spots" to refer to the unintended biases that even the most well-intentioned people possess (Banaji & Greenwald, 2013). Knowledge of hidden or implicit bias, can support organizational leaders in understanding the role of unconscious prejudicial thoughts and feelings among staff. Leaders can use the awareness of hidden or implicit bias and blind spots to ensure that it does not interfere with full participation setting priorities, decision making, and taking action in the organization.

Colorblindness (Race). Colorblindness as it relates to race is the denial of the significance of difference. It is an ideology that leaders must recognize and challenge. To dismiss the significance of race and color is not only to diminish the richness of experience in groups that are not White, but it is also to ignore the struggle of people living outside of the dominant group. To make change one must see broadly and deeply the challenges at hand. Anything less is to perpetuate racism (DiAngelo, 2018).

White privilege. The idea of privilege has a long history in the United States. In his 1935 works on Black Reconstruction In America, W.E.B. Du Bois wrote about the "psychological wage" that enabled white laborers to feel superior to black laborers and thus dividing the labor movement (Du Bois, 1995). The concept of "white skin privilege" gained significant attention in the late eighties when Peggy McIntosh provided an accounting of white privilege - a system of unearned and largely unacknowledged, advantages, and benefits even when those advantages are not discriminatory (McIntosh, 1988). Effective leaders must be prepared to recognize and acknowledge white privilege as well as be prepared to mitigate its dynamics. Since the white value of individualism underlies much of mainstream culture (DiAngelo, 2018), this makes it difficult for leaders and members of the organization to manage racial dynamics. Leaders must therefore attend to balancing contributions from all perspectives.

Figure 1:
Effective leadership: Race, culture, and inclusion

Unacknowledged Leadership Challenges

Leaders in both micro and macro settings face many unrecognized and unacknowledged challenges with respect to diversity and inclusion. Under the umbrella of overt and covert racism lie hidden or unconscious bias, white privilege, and color-blindness. Each of these factors makes it difficult to speak openly about race. To create inclusive organizations, leaders must examine their own attitudes about race and then guide their staff members to do the same, in order to make the necessary changes.

Overt and covert racism. Covert racism is subtle or disguised while overt racism is explicit or blatant. According to Kendi (2019), "Racism is a marriage of racist policies and racist ideas that produces and normalizes racial inequities" (p. 17). Kendi (2019) asserts that racism is a given, and that the term does

Dynamics of Privilege and Oppression in Organizations

Organizations, agencies, and institutions are embedded in the larger society and are influenced and affected by the prevailing social, political, and economic attitudes and events. As such, specific conditions are created whereby some individuals are in positions of privilege with the accompanying access to resources and opportunities, while other individuals have more limited access to such resources and opportunities. Based on greater access to resources and opportunities, some individuals have a higher probability of success than others. This includes the ways that individuals are impacted by social, political, and economic dynamics related to experiences of privilege and oppression. More specifically, racial, ethnic, and cultural dynamics operate on various levels that impact both the Individual and the organization and reinforce status related to privilege and oppression.

Racial and ethnic dynamics. It is important to understand that attention to diversity and integration in the workplace is a relatively new development of the past several decades, relatively recent in United States history. In the current sociocultural and political environment, society continues to experience a crisis of race, even after the immense struggles of the civil rights movement in the 1960s. Currently, there is an enormous amount of debate, confrontation, and animosity when it comes to racial and ethnic concerns in the U.S. The persistence of racially based distinctions across communities, organizations, agencies, and institutions are pervasive and detrimental to vulnerable populations of color that traditionally have experienced exploitation or oppression (Araque & Weiss, 2019). The effects of discrimination continue to be significant, which weakens the political and economic progress of racialized groups and reinforces white privilege.

> ... racial, ethnic, and cultural dynamics operate on various levels that impact both the Individual and the organization and reinforce status related to privilege and oppression.

Individual dynamics. The staff, managers, administrators, and leaders who represent the workforce of the organization bring their own personal experiences and realities to the workplace, as well as their blind spots and biases about the privilege and marginalization of racial and ethnic social groups. Race and ethnicity are often central to a person's identity and value system. For many individuals and organizations, collaborating with diverse groups is a work in progress (Araque and Weiss, 2019). Welcoming diversity means that every single person counts and workplaces need to create environments that welcome members of social groups that have traditionally been limited in their life chances.

Organizational dynamics. Cross (2000) states that everyone in the organization needs to be well educated in the realities of our society, know how the organization functions, and know how to help all people in the organization learn new information and acquire additional skills. However, in addressing organizational problems that are caused by discriminatory and oppressive attitudes and behaviors, leaders have to take additional steps to ensure that workers are educated on these social realities. An important part of the educational process is understanding the difference among bias and prejudice, which are negative attitudes between individuals; discrimination, which is the ability of one group to create barriers for members of other groups based on race, gender, or other differences; and systemic or institutional oppression, which is the embodiment of negative practices in the systems of our organizations and our society.

The Impact of Privilege and Oppression

It is not difficult to reproduce systemic dynamics of privilege and oppression in organizations when leaders are not paying attention to diversity and taking the needs of a heterogeneous workforce into account in ways that are central to the daily workings of the organization. For example, the dynamics of privilege accorded to White men result in greater access to power and resources, the ability to make the rules, and to define what is right or true. People in privileged positions are assumed to be smarter, more competent, and better natural leaders (Cross, 2000). These dynamics often result in less awareness about marginalized groups and the mechanisms of discrimination and exclusion.

In contrast, racially and ethnically marginalized groups have less access to power and resources, are more liable to have their truth and experiences questioned and often invalidated, and often struggle with finding their voice and speaking up to challenge the status quo. It is important to understand that racially and ethnically vulnerable groups have been marginalized and stigmatized for decades, or even hundreds of years, resulting in less power and fewer decision-making opportunities (Araque & Weiss, 2019). Individual members of a group that have

experienced a long history of mistreatment often find it hard to build close trusting relationships with people who belong to the privileged groups (Brown & Mazza, 2005).

One of the major obstacles in building diverse organizations arises when the leader acts in oppressive ways. Building an environment that respects diversity requires gaining the active participation of all the people in the community. People of color have often been told either that they cannot think or what they think is unimportant. As a result, it is not surprising that members of these groups often find it hard to put their ideas forward, especially when the discussion is being framed by others (Brown & Mazza, 2005).

The key to the success of a diverse organization is the commitment of leadership who understand the organizational culture, have an appreciation of the realities of oppression, and have the influence and constructive power to create change. Effective leadership demands the ability to provide vision, direction, and a sense of purpose to the amelioration of racism, sexism, heterosexism, and other forms of oppression. Only with this support can those who are charged with the daily responsibilities of implementing the vision to go forward successfully (Cross, 2000). When people feel respected and perceive the organizational leadership to be fair, then diverse individuals perform at a higher level and think less about leaving the organization, thus raising productivity and reducing turnover rates (Araque & Weiss, 2019).

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Developing Culturally Diverse Organizations: The Power of Strategic Planning and Accountability

A transformative vision of leadership that presumes and promotes diversity must look for and rely on culturally responsive behavior from every member of the leadership team (Araque & Weiss, 2019). These competencies can and should be acquired in a variety of ways – through life experience, education, and training. Partnership with diverse stakeholders inside and outside the organization who bring culturally broad experiences and competencies ought to be part of an organization's earliest mission and formulation (Brouer, Woodhill, Hemmai & van Vugt, 2015). An active program of diverse internal and external partnerships provides the essential foundation for an organization, whether newly forming or long-established.

Historically, organizations in our society have exercised the unconscious privilege of not seeing the cultural homogeneity of staff and constituents served by the organization as a critical imbalance in itself. This imbalance deeply limits the organization's validity and its ability to optimize its success. A leader or leadership group must mount the organization's vision and mission with ample planning, beginning with a focused purpose, not only for what an organization is to accomplish, but also in how it will do so. In addition, attention must be paid to the composition of the team working toward goals and objectives (Brouer et al., 2015). A great range of opportunities exists for developing culturally diverse organizations which must begin with thoughtful strategic planning and mechanisms for accountability.

Strategic Planning

Leaders are tasked with building the capacity and capability of staff and the organization to succeed and thrive in their respective environments. Strategic planning is a commonly used tool to examine the organization's current state and to create a plan of action for continued growth and sustainability. Araque and Weiss (2019) provide a definition of strategic planning:

> *…[S]trategic planning is a process in which the organizational leadership identifies their strategic intent in four levels: a broad vision of what the organization should be (aspiration), an organization's mission or core values (identity), specific goals that are operationalized (direction), and specific objectives (benchmarks, evaluation) (p.252).*

Strategic planning is where an organization's early opportunities to address systemic bias abound – in the initial vision of how ideas are solicited and power is shared in the founding or re-visioning of an organization (Brouer et al., 2015). The very basis of how strategic planning is conducted will unavoidably reflect the values of the organization (Connors & Smith, 2012). Araque and Weiss (2019) state that it is critical that strategic plans include ways and means to improve internal organizational cultures. A strategic plan that addresses racial and cultural diversity and inclusivity within the organization is an important step in recognizing the impacts of race and culture, and in being responsive to both internal and external stakeholders.

Effective leaders should promote a diversity of cultural and racial perspectives, making sure all voices and views are included. The work of recruiting, hiring, and supporting a substantially diverse team is an essential task for any organization that promotes social and workplace diversity. The opportunities to recruit an inclusive team that prioritizes a range of perspectives at the earliest planning stages are remarkably rich for any organization informed about the advantages of developing culturally diverse and responsive organizations. The work needed to assure diversity of input and leadership has to be a high priority for every member of the planning team (Brouer et al., 2015).

Regarding an organization's diversity and culture, however, too often these take one of two forms: (a) the organization is in the hands of professionals from the dominant social class who seek to "include" members of communities traditionally "granted" less power and less voice; and (b) the organization is founded from within a traditionally disempowered community, and opportunities to partner or integrate with far more powerful organizations and actors are difficult to attain (Araque & Weiss, 2019). What is similarly binary in these two modalities is the power arrangement, which often does or does not grant stakeholders the authority to influence or change organizational policies or behaviors (McNeil & Malena, 2010). Effective leaders must recognize these power differentials and address them as part of the strategic planning process - visioning, value identification, goal setting, and evaluation.

Strategic planning is a significant tool for understanding the breadth and depth of culture and race as integrated components of the organization. Otherwise, the organizational structure may remain a microcosm of the broader society. Strategic planning assists the leader, and others involved, in being accountable for the processes and procedures that sway the internal needs of the organization and the constituents the organization serves.

Accountability

Accountability means being answerable to others and is related to responsibility. Being accountable in the professional context means being personally liable or obliged to fulfill a duty to others (Thomas, 2012). In the context of organizational leadership, accountability is a process that depends on continuous communication. Accountability cannot function without "accounting," (Hansen-Turton & Torres, 2014), that is, a record of actions taken and policies applied, the history of such policies, and the record of responses to the actions and policies from those affected, defined, or regulated by them. Thus, accountability is fundamentally multidirectional – there are always two (often more) parties in the process.

In this multidirectional process, organizational leaders and staff need to account for the ways in which internal and external cultural and racial dynamics are included or excluded. As noted by Escobar-Perez & Del Mar Miras-Rodriguez (2018), if a leader, department, or organization is accountable, it must be to someone or something outside of itself; it must maintain a verifiable record of policies and actions; and it must demonstrate an ongoing dialogue with managers and other stakeholders who are themselves explicitly empowered to constrain and control the actions of the leader or organization, to prevent or address inequities. In other words, if a leader or a group is regarded as accountable, to whom is it accountable? And what standing does that respondent party have to affect, limit, or change biased policies and actions taken by the leader or institution?

In transformative organizations dedicated to confronting systemic bias and privilege, the needed communication and connection are achieved through the balanced and bilateral practice of partnership and accountability (Araque & Weiss, 2019). The skills in communication, outreach, and "inclusion" begin at the very foundation and creative origins of an organization's or agency's identity (Connors & Smith, 2012). This means that a priority of leadership in strategic planning should be dedicated to outreach and inclusion of multiple perspectives and stakeholders. This requires leaders to actively seek diverse partnerships with organizations, groups, and individuals. Such entities might have a specific interest in the organization's activities, as well as specific intelligence and experience to offer leadership in its unique environment and context (Brouer et al., 2015). This work is essential to counter institutional bias and seek out new partnerships that bring more powerful and diverse voices into the core of the organization or agency (Hansen-Turton & Torres, 2014).

Balancing power and accountability. Much is written about accountability in organizational theory, and in the fields of business, education, and social services (Connors & Smith, 2012; Hansen-Turton & Torres, 2014). However, little is written about the process of accountability itself and the power dynamics involved in making accountability more than an institutional checkbox. In the context of structural racism, the potential for accountability to function as a mechanism for appropriateness, fairness, and justice, has historically been compromised (Araque & Weiss, 2019). If organizations and leaders were functionally accountable for perpetual inequities in policy, staffing, and services, those inequities would have been resolved long ago. Thus, the concept of accountability is not meaningful without an analysis of the power dynamics involved within the organization. In addition, leaders must link accountability mechanisms to benchmarks laid out in the strategic plan in order to evaluate progress and identify areas for growth. Moreover, accountability in professional functions must recognize and include a deep commitment to racial and cultural diversity and inclusion in order to pursue equity.

Leadership Implications

Leadership has a role to play in changing the institutional structures that perpetuate racism and implicit bias. Those who intend to create change must first be able to identify those structural factors maintaining racist values and practices and then foster a workplace where these dynamics can be addressed. This will often create feelings of discomfort. The need to keep the discussion "nice" will protect the status quo. Conflict can be productive of change if it is used as a way to make the invisible visible and to open a door to understanding the unequal playing field which people of color must navigate. Confronting conflict can move an organization toward awareness of the subtle influences of race and help in the recognition and identification of acts of microaggression. The opportunity to confront differences and use conflict constructively must exist in all constituencies of the organization: governing body, leadership, staff, customers/clients, and community at-large. Racial and cultural considerations are profoundly important in grounding a leader and in understanding the totality of an agency. These considerations must be taken into account when visioning, planning, implementing, and evaluating the work of the organization.

Resources

1. **Glossary for Understanding the Dismantling Structural Racism/Promoting Racial Equity Analysis.** The Aspen Institute Roundtable on Community Change. Available at: https://assets.aspeninstitute.org/content/uploads/files/content/docs/rcc/RCC-Structural-Racism-Glossary.pdf

2. **Racial Justice Council Terms and Definitions from the National Association of Social Workers - MA Chapter.** Available at: https://cdn.ymaws.com/www.naswma.org/resource/resmgr/naswma_racial_justice_terms_.pdf

3. **White Privilege: Unpacking the Invisible Knapsack by Peggy McIntosh.** Available at: https://www.racialequitytools.org/resourcefiles/mcintosh.pdf

4. **White Supremacy Culture by Tema Okun.** Available at: http://www.dismantlingracism.org/uploads/4/3/5/7/43579015/okun_-_white_sup_culture.pdf

5. **Why Diversity, Equity, and Inclusion Matter for Nonprofits from the Council of Nonprofits.** Available at: https://www.councilofnonprofits.org/tools-resources/why-diversity-equity-and-inclusion-matter-nonprofits

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LEADERSHIP: RACIAL AND CULTURAL CONSIDERATIONS
1.5 CEUs - POST-TEST & EVALUATION

Circle the correct answers. There is only one correct answer per question.

1. Leadership extends beyond the management of daily operations to encompass a greater functionality related to a guiding vision, influence, and power within the organization.
a. True
b. False

2. A formal leader is someone who:
a. Focuses on agency improvement and change
b. Looks to the future and seeks innovative ideas
c. Both A and B
d. None of the above

3. The difference between the concept of leadership and management includes:
a. Managers provide a guiding vision within the organization
b. Managers are responsible for the everyday activities, tasks, and routines
c. Managers are not problem solvers
d. None of the above

4. Informal leadership status:
a. Contributes to how the organization functions
b. Provides motivation to other coworkers
c. Are often viewed as sources of knowledge
d. All of the above

5. Informal leadership places less emphasis on formal authority and control, and more on collective action and commitment to the values and vision of the organization.
a. True
b. False

6. The theory that posits that leaders match their behaviors with the performance needs of the individual or group that the leader is trying to influence is:
a. Trait theory
b. Behavioral theory of leadership
c. Situational leadership theory
d. Transformational leadership theory

7. Which theory suggests that effective and successful leaders have specific leadership characteristics such as intelligence, action-oriented judgment, people skills, a need for achievement, decisiveness, adaptability, flexibility, trustworthiness, and competency that can be used in various situations?
a. Trait theory
b. Behavioral theory of leadership
c. Situational leadership theory
d. Transformational leadership theory

8. Transformational leadership theory includes:
a. Commitment to the values and vision of the organization and collective action
b. Lower emphasis on formal authority, power, and control
c. A recognition that staff performance is motivated by providing stimulating opportunities to work towards the common good
d. All of the above

9. Leaders cannot expect their staff to be culturally astute if they themselves are not.
a. True
b. False

10. Effective organizational leaders must understand the influential energetic nature of culture, including how culture assists in the formation of an organizational structure, how to welcome diverse clients, and understanding how culture impacts staff's, clinicians', and even clients' expectations.
a. True
b. False

11. An effective leader is aware that:
a. Race, ethnicity, and culture have weight and consequence
b. Individuals do not need to be recognized in a productive work environment
c. Racial dynamics are not important in staff interactions
d. None of the above

12. Factors that make it difficult to speak openly about race include:
a. Hidden or unconscious bias
b. White privilege
c. Color-blindness
d. All of the above

13. It is not difficult to reproduce systemic dynamics of privilege and oppression in organizations when leaders are not paying attention to diversity and taking the needs of a heterogeneous workforce into account in ways that are central to the daily workings of the organization.
a. True
b. False

14. The key to the success of a diverse organization is:
a. The commitment of leadership who understand the organizational culture
b. An appreciation of the realities of oppression
c. The influence and constructive power to create change
d. All of the above

15. The work of recruiting, hiring, and including a substantially diverse executive and planning team is the first task for any organization that promotes social and workplace diversity.
a. True
b. False

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Please indicate whether the following learning objectives were achieved:

1. Understand leadership theories and the concept of leadership within the context of culture

Achieved in full 5 4 3 2 1 *Not Achieved*

2. Identify the challenges in effective leadership, including racism, microaggressions, blind spots, and biases

Achieved in full 5 4 3 2 1 *Not Achieved*

3. Identify avenues for engaging empowered leadership

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Herbs, Energy, Aromatherapy… Oh My! The Ins and Outs of Complementary and Alternative Medicine (CAM) for Social Work Practice

Pam Szczygiel, DSW, LICSW, CHHC, CYT-500

Learning Objectives

At the completion of this program, participants should be able to:

1. Understand the main categories and types of CAM
2. Explore the use and effectiveness of CAM for a variety of physical, mental, and behavioral issues encountered in social work practice
3. Identify best practices with regard to CAM, as well as possible ethical concerns and contraindications

About the Author

Pam Szczygiel, DSW, LICSW, joined the faculty in the School of Social Work at Bridgewater State University in Fall 2018. Prior to this faculty position, she held a variety of clinical positions in school, agency, and private practice settings since 2003. She is a certified yoga instructor and a certified holistic health coach and integrates a mind-body-spirit philosophy in her practice, teaching, and scholarship. She currently maintains a small psychotherapy practice and is an American Red Cross Services to the Armed Forces Resiliency Volunteer.

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Introduction

Complementary and Alternative Medicine (CAM) is any form of healthcare or healing practice considered *un*conventional. Over 38 percent of adults and 12 percent of children in the U.S. use some form of CAM. The use of CAM by race/ethnicity is as follows: 50.3 percent American Indian/Alaskan Native, 43.1 percent White, 39.9 percent Asian, 25.5 percent Black, and 23.7 percent Hispanic. Further, over 53 percent of U.S. physicians recommend CAM to their patients, with osteopathic and chiropractic manipulation, massage therapy, and herbal/non-vitamin supplements among the most common. Psychiatrists recommend mind-body-spirit modalities at a rate of 53 percent (Stussman, Nahin & Ward, 2019).

This course provides an overview of the main categories and types of CAM and explores their efficacy in the promotion of mind-body-spirit health and, in some cases, as 'stand-alone' treatment modalities for specific mental and physical health issues. The course will pay particular attention to the use of CAM practices for mind-body-spirit issues commonly encountered by social work practitioners and discuss possible ethical issues and contraindications for CAM within the scope of social work practice.

Before launching into an overview of the popularity and use of CAM within the U.S. it is important to acknowledge that, while the practices explored in this course are typically labelled 'complementary and alternative (CAM),' not everyone agrees that this label properly captures the rich philosophy, culture, tradition, and *centrality* of these health and wellness modalities for diverse populations. Raheim and Lu (2014) argue that the use of the term CAM sends the message that these practices are merely biomedicine's sidekicks, when in fact many forms of CAM are evidence-based and carry more meaning and healing power for clients of varying cultural paradigms. This is a critical point and it will be re-emphasized time and again in this course, especially as the issue of *how* best to understand, study, and measure the effectiveness of these culturally rich, holistic practices emerges. While 'mind-body-spirit' practice is arguably a fairer, more accurate label for these practices, in large, much of the literature still clings to the term CAM, making it difficult to stray from this term when providing a comprehensive overview of the literature and research. For this reason, this author will adhere to the term CAM.

By virtue of its core values and theoretical underpinnings, the profession of social work is uniquely aligned with the holistic framework inherent within many CAM practices (Raheim, 2015; Raheim & Lu, 2014). Social work's adherence to a biopsychosocial, ecological, and systems framework for both conceptualizing and working with client issues fits the frame of CAM philosophies, which attend to the dynamic, multifaceted nature of illness, health, and well-being. Further, given the profession's commitment to understanding diverse cultural frameworks, applying a strengths-based perspective to client care, and striking a balance between postmodern and medical model perspectives, the social work profession is quite compatible with CAM (Gant, Benn, Gioia & Seabury, 2009; Ranheim & Lu, 2014).

CAM: Categories, Types, Uses, and Effectiveness

Alternative Medical Systems: Allopathic vs. Holistic

Prior to exploring two ancient, alternative healing systems -acupuncture and Ayurveda- it is important to draw some general philosophical distinctions between *allopathic* medicine, commonly called biomedicine or Western medicine, and healing systems commonly referred to as *holistic* medicine. Allopathic medicine grew out of a tradition placing high value on objectivity and reductionism, key components of empirical study (Micozzi, 2015). Within this framework phenomena are observed and measured, and conclusions regarding causation and correlation may be drawn. From here, treatments can be researched, tested, approved, and generalized as effective for a larger group. Anyone who has suffered from an acute medical condition with an evidence-based, allopathic course of treatment can attest to the strengths of this model. An individual with a fatal allergy to bee stings will likely benefit from an EpiPen. Likewise, someone with chronic, debilitating tonsillitis may be cured when their tonsils are surgically removed. This system if often described as reductionistic because it seeks to locate a specific cause and remove, treat, or fix the identified problem (Micozzi, 2015).

The various forms of CAM explored in this course fall under a *holistic* healing framework, placing high value on understanding the whole person (the human body as an entire system), the connection between the body and the physical-energetic environment as well as conditions that create or diminish well-being. These practices underscore the body's wisdom and its ability, in some cases, to heal itself. Generally speaking, within such a framework, ailments and health issues cannot be understood *fully* through reductionistic study. Rather, they are understood within the context of a *whole person* system. In this model, the mind, the body, and the spiritual self cannot be compartmentalized and studied apart from one another (Micozzi, 2015; Ranheim & Lu, 2014).

By virtue of its core values and theoretical underpinnings, the profession of social work is uniquely aligned with the holistic framework inherent within many CAM practices

Diligent social work students may recall struggling through coursework on Ludwig von Bertalanffy's General Systems Theory (GST). This theory is famous for positing: *a system is greater than the sum of its parts* (Hudson, 2000; Lewis, 2005). In other words, we cannot understand a complex, nonlinear system by simply adding up all of its components, because the entire system is impacted by the environment in which it exists and also by the way in which the individual parts dynamically interact with and respond to one another (Hudson, 2000; Lewis, 2005). Let us take an example from the realm of mental health diagnostics. Major depressive disorder has an array of mental, physical, and emotional symptoms that interact in a complex manner for each person with depression. And, the etiology of depression is unique from one person to the next (i.e. One may become depressed due to a series of losses and transitions and another may have a form of depression that seems to 'run in the family') (APA, 2013). Further, many evidence-based practices have been identified for depression, yet they certainly do not work for *all* depressed individuals to the same degree. All this to say, holistic approaches prioritize a whole person understanding, with regard to *both* the etiology *and* treatment of health issues, as well as a focus on the promotion of *all* factors leading to health and well-being (Gant et al, 2009; Raheim & Lu, 2014).

Acupuncture and Traditional Chinese Medicine (TCM). Acupuncture is one of the most utilized and identifiable forms of CAM in the United States. In 2014, ten million acupuncture treatments were administered in the U.S. (Hao & Mittelman, 2014). The treatment involves inserting thin needles into the skin at targeted acupuncture points throughout the body to address various mind-body-spirit ailments and promote well-being. It is one of many Traditional Chinese Medical (TCM) practices. Within the U.S., acupuncture is often stripped from its cultural context and meaning, a key facet to understanding its philosophy and healing benefits (Ergil & Ergil, 2015). Acupuncturists differ in the way they conceive of, diagnose, and deliver the treatment. For example, some acupuncturists in the West refer to themselves as 'medical acupuncturists,'

practitioners with an additional allopathic background. These practitioners combine aspects of the ancient healing practice with conventional diagnostic and treatment procedures (Helms, 1997). Thus, before exploring the popular uses of and general effectiveness of acupuncture, it is important to discuss a few key cultural and philosophical underpinnings of this fascinating, ancient healing art.

Acupuncture, *zhen jiu*, means *needle moxibustion*. Moxibustion is the ancient practice of burning *mugwort*, an herb, and either placing it directly on or near an acupuncture point on the skin to stimulate healing. While not all acupuncturists incorporate moxibustion into their practice, it is an interesting example of how an ancient healing practice may vary from one cultural context to the next, and/or from one practitioner to the next. Regardless, the use of needles and moxibustion are linked by virtue of their therapeutic purpose and healing philosophy, which revolves around the following elements: *yin* and *yang*, *qi (pronounced 'chee')*, and the *five phases* (Ergil & Ergil; Mayo Clinic, 2018).

Yin and yang refer to phenomena that are simultaneously complementary and opposing: the heart is yin and the stomach is yang, the outer body is yang and the inner, yin. The stimulation of qi is a primary focus of all traditional Chinese medicine. In Western society, qi is generally understood to be *energy*, though the real meaning is, unsurprisingly, far more nuanced. There are many types of qi in the body. Ergil (2015) explains: "the body is pervaded by subtle material and mobile influences that cause most physiological functions and maintain the health and vitality of the individual" (p. 484). Ergil (2015) also eloquently captures the nature of qi: "Qi is sometimes compared with wind captured in a sail; we cannot observe the wind directly, but we can observe its presence…" (p. 486). All this to say, acupuncture is a systems-approach to healing. Such a healing philosophy can be likened to the tenets of General Systems Theory and Ecological Social Work Theory: when one part of a system changes, the entire system is impacted; it is all interconnected (Hudson, 2000; Gitterman & Germain, 1976).

The cause of disease within TCM is an imbalance of yin and yang, leading to a disturbance of qi. The philosophy of acupuncture purports that, when qi runs freely throughout the body, the individual has well-being. Channels running throughout the body are connected through specific acupuncture points. The placement of needles into these points, triggers the flow of qi throughout the channels, addressing specific pain and fostering healing and wellness. Acupuncture uses the following diagnostic procedures: observing the patient's skin tone, tongue, gait, emotional expression, behaviors, listening to the patient's voice, asking about the patient's digestion, and feeling the rhythm and rate of the patient's pulse (Ergil & Ergil, 2015).

In addition to acupuncture and moxibustion, other common forms of TCM include cupping and bleeding. Cupping involves creating a vacuum force with a small glass or bamboo cup and placing it on strategic areas on the body, inducing blood flow to those areas. Bleeding involves expressing very small amounts of blood from points on the body. Chinese massage, Qigong, and the use of Chinese herbal medicine also adhere to the philosophies of qi and yin and yang. Qigong will be explored later in this course.

Acupuncturists treat an array of mind-body ailments: headaches, back pain, infertility, asthma, anxiety, depression, PTSD, and post-operative pain, to name just a few. Pain management is the most common condition treated by acupuncture and it is here where acupuncture appears to have the most clinical effectiveness. *Appears* is the operative word here, as research on acupuncture is a complicated endeavor for a variety of reasons. According to the National Center for Complementary and Integrative Health (NCCIH) (2016) several studies indicate promise for acupuncture as a tool to manage chronic pain. Though, it is important to mention that systematic reviews of acupuncture often yield mixed conclusions (Linde, Brinkhaus, Manheimer, Vickers & White, 2009).

According to Linde et al (2009), clear evidence for acupuncture's effectiveness for migraine pain is lacking, due in part to the difficulty of designing high quality, Randomized Controlled Trials (RCT) to study the issue, especially with regard to determining placebo procedures for control groups. Imagine receiving sham acupuncture! Related to this point is the fact that acupuncture is a complex, ancient system of healing and operationalizing *parts* of this ancient system for biomedicine research is baffling. The idiom *fitting a square peg in a round hole* comes to mind here. Despite the dilemmas of empirical research, Linde et al (2009) conclude that non-RCT research does point to acupuncture's effectiveness and that this ancient healing practice should stay on the table as a viable treatment option for pain.

Ayurveda. The term Ayurveda is translated to mean *science of life* or *longevity*. It is an ancient Indian medical system focusing on total wellness, harmony, and interconnections between the inner and outer worlds (Micozzi, 2015; National Ayurvedic Medical Association (NAMA), n.d.). The art and science of Ayurveda is estimated to be five thousand years old and is often described as a 'sister science' to yoga; it is based on principles said to bring mind-body-spirit balance to the individual (Micozzi, 2015).

Primary principles of Ayurveda include the *five elements*, the *three doshas*, the *seven dhatus*, the *three malas*, and *agnis* and *ama*. The five elements (earth, air, fire, water, and space) interact and manifest within individuals in the form of the three doshas: *Vata, Pitta, Kapha*. The three doshas maintain harmony and balance in the body and when one or all become imbalanced, normal functioning is interrupted and disease or illness may occur. The seven dhatus are tissues, correlating to muscles, fat, bone, blood, etc. The three malas are the body's waste products (i.e. sweat, urine). The three agnis are enzymes that aid in digestion and ama refers to the main cause of disease. Ama is detected by diagnostic tests such as examining the tongue, skin, nails, taking the pulse, and inquiring about the individual's digestion and bodily waste products (Micozzi, 2015).

While an in-depth examination of this complex art and science is well beyond this CE course, it is important to lay out a few basics regarding how an Ayurvedic practitioner approaches treatment. According to Ayurveda, all individuals have a mixture of the three doshas, and most have one dominant dosha. One's primary dosha carries with it certain mental, physical, and spiritual characteristics, some positive and some negative, that predispose the individual to certain health issues when it is out of balance. For example, an individual with a primary vata dosha is highly influenced by the element of air, and as such tends to be cold and gravitate toward warm weather. This person is prone to fluctuating moods as well as anxiety and insomnia (Micozzi, 2015).

> ... holistic approaches prioritize a whole person understanding, with regard to both the etiology and treatment of health issues, as well as a focus on the promotion of all factors leading to health and well-being.

Ayurvedic diagnosis and treatment is multifaceted. Diagnosis of disease is made by examining the tongue, complexion, voice, eyes, urine, pulse, and inquiring about the patient's digestion and stool. Such physical features reveal important data about one's primary dosha and *to what degree* the doshas are imbalanced. Ayurvedic treatment seeks to balance the individual's doshas through a process known as *Panchakarma*, purification therapy, involving a variety of treatments: special diets, herbs, minerals, gems, special oils, yoga, meditation, and massage therapy (Micozzi, 2015). As is the case with any unregulated substance, consumers should use caution when taking ayurvedic herbal and mineral-based products. Breeher et al (2015) surveyed 115 people taking ayurvedic preparations and found that 40 percent of the group had increased levels of lead and a small percentage had increased mercury levels. Other individual case reports have corroborated these findings (NCCIH, 2019).

Furst, Venkatraman, McGann, Manohar, Booth-LaForce, Sarin, …(2011) reported Ayurveda's effectiveness as a treatment for rheumatoid arthritis in a study with 43 participants. In a Cochrane Database Review, ayurvedic treatments yielded significant glucose-lowering effects for diabetics, though the authors of the review highlight research design flaws in some of the studies (Sridharan, Mohan, Ramaratnam & Panneerselvam, 2011). Finally, an herb commonly used in ayurveda, turmeric, showed promise as an effective intervention for a variety of inflammatory conditions (White & Judkins, 2011).

Mind-Body-Spirit Practices

For the purpose of this course, mind-body-spirit practices refer to modalities that may or may not stem from a larger philosophical or religious tradition, but that all contain an emphasis on mind-body awareness, staying present with one's visceral, emotional and mental experience, and using movement or mental focus to manage difficult experiences and promote the body's relaxation response. Modalities falling under this category include mindfulness, meditation, yoga, T'ai chi, biofeedback, hypnosis, as well as therapies utilizing art, music, and dance. Because of their popularity in social work and other mental health related treatment settings, this section will take a closer look at mindfulness, meditation, and yoga.

Mindfulness and meditation. The terms *mindfulness*, *mindfulness meditation*, and *meditation* have been tossed around quite a bit lately, especially in the context of clinical literature in the West. The conflation of these terms is partially related to the fact that they stem from a cultural, religious tradition - Buddhism- that has many sects/traditions. Thus, the full translation and meaning of these terms, in their adaptation for clinical use, is often lost (Robins, 2002; Van Dam, van Vugt, Vago, Schmalzl, Saron, Olendski, … 2018). Further, specific treatment modalities have adapted these concepts differently. For example, Dialectical Behavior Therapy (DBT), includes Zen Buddhist principles (Robins, 2002).

In Buddhist philosophy, *Right Mindfulness* is the seventh step on the *Noble Eightfold Path*. The Eightfold Path is the fourth (and last) of the *Noble Truths* and serves as a guide to end human suffering (Hanh, 1998). When mindfulness is discussed within the context of the clinical literature, it is close to a sure bet that the definition used is at least partially based upon Jon Kabat Zinn's (1990): "the awareness that emerges through paying attention, on purpose, in the present moment, and non-judgmentally to the unfolding of experience moment by moment" (p. 145). Kabat Zinn pioneered the development of Mindfulness Based Stress Reduction (MBSR) programming, an eight week course that consists of various mind-body practices such as the body scan, sitting meditation, yoga-based movement, and breathing exercises. The program originally targeted patients with chronic pain (Kabat-Zinn, 1990; Janssen, Heerkens, Kuijer, Heijden & Engels, 2018). Since the creation of MBSR, mindfulness, in general, has received much attention as a clinical tool for approaching an array of mental and physical health conditions. Mindfulness has been studied as both a 'stand-alone' intervention and also within the context of larger treatment frameworks such as DBT, Acceptance and Commitment Therapy (ACT), and Mindfulness Based Cognitive Behavioral Therapy (MCBT) (Groves, 2016; Hayes, Masuda, Bissett, Luoma & Guerrero, 2004). It has also been explored, in its own right, as a theoretical lens for treatment (Brown, Ryan & Creswell, 2007).

Assessing the efficacy of mindfulness as a treatment tool is complicated business since there are many 'brands' of mindfulness. Some mindfulness is studied within the context of the larger treatment frameworks discussed above and thus research studies define mindfulness in different ways, leading to semantic ambiguity that may blur research evidence (Van Dam et al, 2018). For example, some study the effectiveness of *mindfulness meditation* and some look specifically at *MBSR* programming. And, when mindfulness is studied as a general concept, it may be conceptualized differently (Groves, 2016; Van Dam et al, 2018). Again, this is one of the problems with trying to operationalize a concept for research that stems from a rich cultural-philosophical tradition. Nevertheless, it is important to take a look at some recent findings regarding the effectiveness of various mindfulness-based interventions (MBIs).

In a recent systematic review, Schell, Monsef, Wockel and Skoetz (2019) concluded that MBSR programming reduces depression for women with breast cancer and may also lead to a slight reduction in anxiety and a slight improvement in sleep, though, the authors note that long- term impacts are unknown. In another systematic review and meta-analysis, Schumer, Lindsay and Creswell (2018) found modest, positive results for brief mindfulness as a tool for reducing negative affectivity. A third systematic review revealed positive outcomes for mind-body interventions for individuals with fibromyalgia, yet also highlighted that the quality of the evidence is low (Theadom, Cropley, Smith, Feigin & McPherson, 2015). A systematic review that assessed the impact of MBSR on employee mental health

CONTINUED ON PAGE 10

concluded that MBSR improved mindfulness, self-compassion, quality of sleep, relaxation, and personal accomplishment. The general consensus of these studies further corroborates the conclusions made by Van Dam et al (2018): mindfulness research has a long way to go in terms of operationalizing mindfulness definitions for empirical study and understanding how best to measure the effectiveness of an intervention that is not yet fully understood. To this point, it is important to consider how individuals may vary in terms of their relationship with mindfulness practices, why they engage with such practices to begin with and whether or not the practices have a deeper spiritual or cultural meaning for them (Chiesa, 2012).

Suffice it to say, meditation and mindfulness go hand in hand. Engaging in mindfulness practice arguably calms the mind and therefore supports meditation practice, which typically involves sitting with stillness. In turn, meditation practice may support a more mindful lifestyle. Similar to mindfulness, meditation varies widely from one tradition and type to the next. Meditation also varies across the different sects of Buddhism (not to mention many other religious and philosophical traditions) -Vajrayana, Tibetan, Theravada, Mhayana- and each sect also has its unique array meditation practices and traditions ((i.e hand mudras (gestures), sitting postures, chants, mantra (repetitive words/phrases)). In the Zen tradition, for example, (a form of Mhayana Buddhism) a Zen teacher guides the student in meditation practice, *zazen*, focusing on the breath, present moment, and nonattachment to thoughts. Transcendental meditation typically involves the use of mantra and aims to transcend the individual's current state. Metta meditation is lovingkindness meditation, which focuses on sending intentions of love and compassion to oneself and others (Chodron, 1991; Hanh, 1998).

Some of the most convincing meditation research focused on long-term meditators and investigated the impact of meditation on brain structure and function. Studies found that long-term meditation practice increased cortical thickness (Kang, Jo, Jung, Kim, Jung, Choi, … 2015), reduced affective response to pain (Orme-Johnson, Schneider, Son, Nidich & Hee Cho, 2006), and positively changed brain function with regard to attention (Newberg, Wintering, Waldman, Aman, Khalsa & Alavi, 2010).

Yoga. Yoga is a five-thousand-year-old Indian philosophy and the earliest yoga text, *Yoga Sutra* by the Indian sage, Patanjali, is two thousand years old. Yoga means 'yoke,' mind-body-spirit union and has six branches: Hatha (physical practice/asana), Raja (meditation and strict adherence to the eight limbs of yoga), Karma (path of service), Bhakti (path of devotion), Jnana (path of wisdom and scholarship), and Tantra (path of ritual and ceremony, especially in terms of sexuality and human relationships) (Carrera, 2006; Staples, 332). To varying degrees, diligent yogis and yoginis attend to all six branches of yoga. The branch most familiar in the U.S. is Hatha yoga, which simply refers to the physical practice/postures of yoga; though, in the U.S. it is common for yoga studios to label their gentler classes, relying on more static postures as 'Hatha.' Herein lies just one of the many examples of how classical yoga terminology is translated differently in the West. While the physical practice of yoga is far more mainstream in the U.S. than the philosophical and other lifestyle elements of this ancient tradition, many yoga studios offering a yoga teacher certification program will introduce Raja yoga to students, adherence to the eight limb path of yoga: yama (moral discipline), niyama (duty), asana (physical posture), pranayama (breath work), pratyahara (withdrawal of senses), dharana (concentration), Dhyana (meditation), and samadhi (absorption/bliss/enlightenment) (Staples, 2015).

It is important to emphasize that, in its entirety, yoga is a comprehensive lifestyle with its own ethical and moral code, exercise regimen, and unique philosophy about the path to enlightenment. For example, the yamas include an emphasis on non-violence and truthfulness and the niyamas include duties toward oneself, such as cleanliness, contentment, and self-study/reflection. As the final limb of yoga suggests, all yoga practice has the goal of quieting the body and mind for state of meditation/enlightenment: *yogas chitta vritti nrodhah* (yoga quiets the waves of the mind-body). Yoga has its own array of meditation practices, rituals, and procedures (Carrera, 2006; Staples, 2015).

Anyone who has ventured to try a yoga class for the first time at their local gym or yoga studio can attest to the sheer confusion involved in deciphering among the various types of yoga classes and styles offered in the U.S.: Hatha, vinyasa, yin, Ashtanga, Iyengar, Kripalu, Svaroopa, gentle, power yoga, hot yoga, to name a few (and this is the short list). Suffice it to say, some in this list are styles of yoga developed by specific yogis/yoginis (i.e. Iyengar was developed in 1960s/70s by B.K.S Iyengar) and others refer to general styles of yoga practice (i.e. vinyasa yoga entails flowing movement from one pose to the next; yin yoga targets the joints/joint tissue and involves longer held passive stretches, done mostly on the floor) (Cook, 2017).

Yoga is making its mark both as a primary treatment and an adjunctive treatment for an array of mind-body health issues. In recent years, there has been a surge of interest in somatic therapies for individuals struggling with Post-Traumatic Stress Disorder (PTSD) and complex trauma symptoms. In their meta-analysis, Gallegosa, Crean, Pigeon and Heffnera (2017) investigated the effect of yoga and meditation on mitigating symptoms of PTSD and found both to have promising results as an adjunctive treatment. Rhodes, Spinazzola, and van der Kolk (2016) studied yoga's efficacy as a tool to reduce PTSD symptoms and found that women who continued their yoga practice 1.5 years after an initial intervention benefitted from a reduction of trauma-related symptoms. The original investigation on which this follow-up study is based, found significant decreases in self injurious behaviors, depression, and dissociative symptoms immediately following the ten-session yoga intervention (van der Kolk, Stone & West, 2014). A systematic review and meta-analysis of yoga for low back pain revealed that yoga reduced low back pain in the short term and found moderate evidence for its longer-term effectiveness (Cramer, Lauche, Haller & Dobos, 2013). Further, Cramer, Lange, Klose, Paul, and Gustav (2012) found yoga to be an effective adjunctive treatment for improving the psychological health of breast cancer patients receiving treatment, though the authors do caution that some studies show evidence of selection bias. As is the case with many of the therapies explored in this course, study participants may already be sold on the positive impact of the CAM practice, increasing the likelihood of a 'placebo effect.'

Yoga teacher certification involves the successful completion of a minimum two hundred hour certification program from a yoga school accredited by the National Yoga Alliance. Many teachers also become registered through the Yoga Alliance, which has standards such as the completion of continuing education credits and proof of active teaching (National Yoga Alliance, n.d.).

Manipulative Body-Based Treatments

Osteopathic manipulation medicine. Osteopathic Manipulation Medicine (OMM) is a signature form of medicine practiced within the osteopathic medical community. In the 1870s, American physician Andrew Taylor Still, a strong opponent of standard medical practices focusing solely on disease rather than prevention and the treatment of the whole person, developed the osteopathic model. Osteopathic physicians use all the techniques, skills, and tools of modern medicine and are licensed to practice medicine in the same manner as MDs, though their treatment philosophy continues to honor the holistic framework championed by Dr. Still, such as OMM (American Association of Colleges of Osteopathic Medicine, n.d.).

OMM is a hands-on intervention that re-adjusts the body's musculoskeletal system and, therefore, the body's function. It is often confused with chiropractic manipulation though, as explained by Degenhardt (2000), it is quite different as only osteopaths have training in the underlying OMM philosophy of treatment and specialized diagnostic procedure known as palpation (diagnostic touch) that involves advanced training in anatomy and physiology, careful oral case taking and various therapeutic touch techniques to re-align the body: amplitude thrusts (quick movements often producing popping noises), muscle energy (doctor guides the patient to contract targeted muscles), strain-counter-strain (doctor moves patient's body into certain positions to alleviate pain) and myofascial release (doctor gently touches the body to alleviate neurologically mediated tightness). Additionally, while chiropractic adjustments focus on the spine and nervous system, OMM adjustments can target any area of the body and stem from the idea that wellness is related to quality arterial blood flow (Degenhardt, 2000).

As evidenced by one randomized controlled trial published in the New England Journal of Medicine, OMM was found to have pain reduction benefits for patients with subacute low back pain comparable to standard care (Andersson, Lucente, Davis, Kappler, Lipton & Leurgans, 1999). In a smaller RCT, OMM was found efficacious in reducing acute low back pain in active duty military (Cruser, Maurer, Hensel, Brown, White, Stoll, 2012). Other systematic reviews of OMM, for a variety of health issues, have yielded mixed results due to problems with study design and methodology (Steel, Sundberg, Reid, Ward, Bishop & Leach, … 2017). In the face of critiques often fueled by allopathic research methods, McCombs (2006) offers a powerful defense of OMM. While he concurs that clinical research of OMM has often lacked the scientific rigor of drug studies, he argues that applying the same research methods to OMM as clinical drug trials is inherently flawed as OMM is not a drug; rather, it is a set of procedures difficult to operationalize.

Chiropractic treatment. The word chiropractic comes from the Greek words *cheir* and *praktos*, meaning "done by hand." The treatment was developed by Daniel David Palmer in the late 1890s who believed that adjustments to the spine could impact the overall health and well-being of patients. There are over 70,000 chiropractors in the U.S. today and all 50 states recognize chiropractic care as a health care profession (Redwood, 2015). Chiropractors earn a Doctor of Chiropractic (DC) degree from a program accredited through the Council on Chiropractic Education (CCE) and receive 4 years of postbaccalaureate training (some programs may not require an undergraduate degree for admission but have stipulations on the number of undergraduate credits necessary for admission). To practice they must pass a National Board of Chiropractors Examination exam and acquire a state license (Bureau of Labor Statistics, 2019).

Chiropractors assess and diagnose in ways similar to other health professionals. They may do comprehensive intakes, acquire patient histories, and use X-rays and other diagnostic tools to understand the extent of the patient's musculoskeletal issue. Conditions commonly treated through chiropractic are sciatica, low back pain, neck pain and headaches but this is, by no means, an exhaustive list. The techniques are similar in nature as OMM, though the hallmark treatment is spinal manipulation which involves the use of quick, controlled hand thrusts on the spine or joints to relieve pain. Though, some chiropractors prioritize other techniques such as acupressure, needling (acupuncture-like techniques), massage, cupping, and the use of kinesiology tape and traction (Redwood, 2015).

Salehi, Hashemi, Imanieh and Saber (2015) completed a critical review of 23 systematic reviews on the effectiveness of chiropractic for an array of health issues and found evidence for its effectiveness on neck pain, shoulder issues, and sports injuries. Paige et al (2017) reviewed several studies and found manipulative therapy modestly effective, in the short term, for low back pain. In the case of other conditions -asthma, infant colic, autism spectrum disorder, gastrointestinal problems, fibromyalgia, back pain, and carpal tunnel syndrome- conclusive evidence for its effectiveness was unfounded (Ernst, 2003).

Some studies have looked at the effectiveness of Spinal Manipulation Therapy (SMT) against usual pain management care treatments and found no clinically significant difference between treatment as usual and SMT (Rubinstein, van Midlekoop, Assendelft, de Boer & van Tulder, 2011). It should be noted that studies looking at SMT do not always specify whether the SMT is solely chiropractic or done by other professions (i.e. osteopaths). The most common adverse effects of SMT include muscle soreness and increased pain and stiffness, as well as dizziness, fainting, and headaches (Paanalahti, Holm, Nordin, Asker, Lyander & Skillgate, 2014). The incidence of stroke following cervical manipulation was low even in older patient populations, 66 years and above (Whedon, Song, Mackenzie, Phillips, Lukovits & Lurie, 2015).

Herbal Remedies, Homeopathy, and Naturopathy

Homeopathy and Naturopathy both involve the use of herbal remedies. While many think of these terms interchangeably, there are important distinctions. Naturopathy is an entire medical system developed in the 19th century in Europe and is practiced by those who have received a four-year graduate degree in Naturopathic medicine from an accredited program; allopathic and osteopathic physicians may also incorporate naturopathy. Naturopaths focus on prevention, diagnostics, and treatment. Not all states require Naturopaths to be licensed in order to practice. Naturopathy adheres to a specific therapeutic order:

remove obstacles to health, stimulate self-healing, strengthen weakened systems, use natural substances to restore, use pharmacologic substances to halt disease progression, use high force invasive modalities like surgery or radiation (American Association of Naturopathic Physicians (AANP), n.d.). Naturopaths use a variety of traditional, conventional, and homeopathic treatments, including exercise, lifestyle and diet counseling, mental health counseling, detoxification practices, herbal remedies, supplements, and other forms of homeopathy (Pizzorno & Snider, 2015).

Homeopathy is a medical system developed in Germany in the 18th century and is based on the core belief that the body can self-heal. It adheres to the notion that the lower the dose of medication, the greater the effectiveness as well as the notion that an illness can be cured by a substance that actually creates the same symptoms in a healthy person. For example, a homeopathic treatment for allergies may include the ingestion of bee pollen or very small amounts of poison ivy. Another principle is the focus on administering a single remedy first, studying its effects and then introducing something else, if needed. Homeopaths rely on homeopathic remedies, natural elements -herbal, vegetable, mineral- in a diluted form. They come in the form of small tablets placed under the tongue, salves, and drops (i.e. Bach Flower Remedies) (AANP, n.d). Homeopathy is practiced by lay people as well as by licensed allopathic, osteopathic, and naturopathic physicians whom have received additional certification in homeopathy. There are doctoral programs in homeopathy but, as of yet, no formal licensing requirements ((American Institute of Homeopathy (AIH), n.d.)).

Herbal remedies. Approximately 80 percent of people worldwide rely on herbal medicinal products and supplements (Ekor, 2014). And, one in five people in the U.S. report taking herbal products; these include remedies coming from a plant's stems, leaves, flowers, or roots. Echinacea, ginseng, ginkgo biloba, garlic, St. John's wort, peppermint, ginger, and soy are among the most commonly used herbal remedies in the U.S. This section will take a closer look at ginkgo biloba and St. John's wort. It will also explore the burgeoning use of aromatherapy in healing various mind-body ailments (Ekor, 2014; Micozzi & Meserole, 2015).

Gingko biloba is one of the most widely sold plant-based treatments in Europe and one of the most commonly used herbal supplements in the U.S. It is often used within the context of TCM and is made from the leaves of the gingko tree, one of the oldest living tree species native to China. Its therapeutic benefits derive from the *flavonoids* (antioxidants) and *terpenoids* (improve circulation) in the leaves. It is sold in a variety of forms: capsules, tablets, liquid extracts, and dried tea leaves and powders. Its possible health benefits include improved cognition, reduced anxiety, reduced pain, and improved vision for those with glaucoma; though, most scientific research has focused on its effect on memory and cognition. Common, possible side effects of gingko include headaches, dizziness, heart palpitations, stomach upset, constipation and allergic skin reactions. It is contraindicated for those taking the following medications: Xanax, anticoagulants, anticonvulsants, some antidepressants, statins, certain diabetes drugs, and ibuprofen (Mayo Clinic Staff, 2017).

Perhaps the most notable study on gingko is the 'GEM' (Gingko Evaluation on Memory) study. Published in the *Journal of the American Medical Association (JAMA)*, it is the largest clinical trial evaluating gingko's impact on the occurrence of dementia. The study enrolled over 3,000 participants with mild cognitive decline and found that gingko was not effective in preventing further cognitive decline and warding off Alzheimer's disease (Dekosky, Fitzpatrick, Ives, Saxton, Williamson, Lopez, … 2008). Another study found gingko more effective than placebo in treating Alzheimer's disease and vascular and mixed dementia (Weinmann, Schwarzbach, Vauth & Willich, 2010).

St. John's Wort (SJW) is a yellow-flowering shrub native to Europe named after St. John the Baptist; it is said to bloom around the time of St. John's birthday. Its main therapeutic ingredient is *hyperforin*, a mood regulator. It has been used to treat mental health issues in Europe for centuries and is commonly used today in the treatment of mild to moderate depression and menopausal symptoms. It is widely prescribed in Europe. In the U.S., it is sold as a dietary supplement and governed by far less restrictions and standards than prescription or over-the-counter medicines. Before exploring its effectiveness with depression, it is important to note that SJW is known to interact negatively with several medications and it is recommended that individuals consult with their health care provider to discuss possible contraindications. For example, there is evidence to suggest that SJW should not be taken with other antidepressants (namely, SSRIs) as this can lead to serotonin toxicity nor should it be taken with birth control pills, as it may render birth control ineffective (Linde, Berner & Kriston, 2009; Mayo Clinic Staff, 2017).

SJW is widely studied for its effectiveness in mild to moderate depression. The research is far too abundant to summarize in a paragraph or two, so a few key points about the research on SJW and its effectiveness will be presented. Micozzi and Cassidy (2015) underscore that SJW's efficacy with *mild-to-moderate* depression was on its way to being well established until a study published in JAMA (Shelton, Keller, Gelenberg, Dunner, Hirschfeld, Thase, … 2001) concluded that SJW was ineffective in treating severe depression. Micozzi and Cassidy (2015) discuss the politics surrounding the Shelton et al (2001) study, including the study authors' openness about wanting to refute earlier claims of SJW's effectiveness and their strong belief, going into the study, that the substance would not be effective (as cited in Micozzi & Cassidy, 2015). This raised important ethical concerns, as SJW never had a history of efficacy with severe depression and it appeared that the authors knew this prior to the start of their research. Micozzi and Cassidy (2015) also cite other inconsistencies with the study's findings, including general mathematical errors and suspicious record keeping. Putting aside this juicy empirical research drama, in a systematic review of 29 trials from various countries, SJW was *more effective* than placebo and as effective as standard antidepressants, with less side effects (Linde, Berner and Kriston, 2008, as cited in Micozzi & Cassidy, 2015).

Aromatherapy simply refers to the use of plant-based essential oils in the promotion of mind-body-spirit wellness. The modern use of essential oils as therapeutic agents is attributed to the French in the 1930s. Common aromatherapy methods include applying them directly to the skin, inhaling them from a bottle, or diffusing them through steam. Essential oils are commonly used in massage and can be added to creams, lotions, and gels. Their therapeutic benefit has been widely studied, especially for the following issues and populations: cancer and palliative care, elder care, midwifery, and mental health. Essential oils are relatively safe, though, as is the case with any plant-based substance, allergic reactions can occur for certain individuals and it is critically important to purchase from a supplier that sells high quality oils. To this last point, essential oils are unregulated therapeutic substances, so it is important to do research on their quality prior to use or receive aromatherapy from a competent practitioner who understands their potency and the importance of quality (Lewis, 2015; National Cancer Institute (NCI), 2019).

Aromatherapy is commonly used by midwives and *doulas* (traditional birth attendants) to reduce pain and stress for mother and child. Aromatherapy, along with light touch, music, acupuncture, and other herbal therapies, is often used during palliative care and cancer treatment (Lewis, 2015). Kohara, Miyauchi, Suehiro, Ueoka, Takeyama, and Morita (2004) found aromatherapy, reflexology, and foot soak effective in relieving fatigue in cancer patients. A systematic review of research on aromatherapy for cancer patients (Boehm, Bussing & Ostermann, 2012) found evidence that aromatherapy decreased anxiety and depression and increased overall well-being. This review also noted the limited adverse effects of the therapy. Another study found aromatherapy massage effective in reducing cancer patients' anxiety and depression for up to two weeks (Wilkinson, Love, Westcombe, Gambles, Burgess, Cargill, …2007).

Lavender essential oil is one of the most commonly used oils to reduce stress for elders in elder care settings (Lewis, 2015). Lavender and other essential oils were found to be effective in reducing negative emotions among elders in a community care setting (Tang & Tse, 2014).

With regard to mental health, in a systematic review of the literature, aromatherapy demonstrated promise in aiding the reduction of depressive symptoms, with aromatherapy massage more helpful than inhalation aromatherapy alone (Sanchez-Vidana, Ngai, He, Chow, Lav & Tsang, 2017). A systematic review revealed the positive impact of aromatherapy on sleep quality (Lin, 2019). One word of caution is that it is difficult to discern aromatherapy's general benefit for whole populations, (i.e. depressed persons, cancer patients) as the effectiveness does depend on which essential oil is used, for how long, and the methods of the therapy; it may also depend on the quality of essential oils used as well as whether other therapies were employed during the aromatherapy session (Lewis, 2015).

Energy Therapies

Common energy therapies include reiki, Therapeutic Touch (TT), and Healing Touch (HT). Due to its focus on harnessing vital energy, qi, qigong is often discussed within this category, so this section will also explore qigong. TT and HT, both developed by nurses, are commonly used in medical settings and are included as diagnostic therapies in the North American Nursing Diagnosis Association (NANDA). Reiki is a Japanese pre-World War II era therapy. The philosophy of dynamic interconnectedness among the individual, others, and the larger environment is a key tenet of energy therapies. Another key premise of energy therapy is the belief that health problems -physical, mental, emotional, or spiritual in nature- will manifest within the individual as well as within their biofield - energy fields surrounding and penetrating the body. Generally, these therapies restore balance by removing blockages from the person's biofield and allowing energy to flow with vitality through and around the person. Typically, the practitioner's hands either hover over the person's body or are placed very gently on the body - distance work may also be used. By balancing the person's biofield, healing and health can be restored (Ives & Jonas, 2015).

> Given that social workers practice in a diverse array of settings -hospitals, community mental health agencies, schools, hospice care, primary care offices, private practice, integrative healthcare, etc.- where CAM practices are incorporated, it is incumbent upon social work professionals to be well-versed in mind-body-spirit philosophies, traditions, and techniques.

Reiki was developed by Mikau Usui in the 1920s in Japan. Reiki practitioners lay their hands lightly on or just above the person's body. They may move their hand(s) to different areas on or around the body. They typically allow the person's energy to interact with their (practitioner's) hand, creating a change in energy flow. Some reiki practitioners will notice cold, heat, or other sensations arising from the person's body/biofield and may make hand motions to remove blockages, though in general, reiki tends to be more passive in nature than other energy therapies. Reiki practitioners are typically trained by other master practitioners who have received extensive training in the practice. Master practitioners may offer certification or licensing in the practice though most states do not require actual certification or licensing to practice (Ives & Jonas, 2015). Some states do require that reiki practitioners be licensed massage therapists in order to practice (International Center for Reiki Training, n.d.).

In exploring the effectiveness of energy medicine, it is important to note the complexity of studying 'biofield therapies,' as the research world struggles to empirically prove or validate the existence of a biofield. One study revealed a decrease in systolic blood pressure and an increase in immunoglobulin following reiki (Engebretson & Wardell, 2002, as cited in Ives & Jonas, 2015). The authors speculate that the positive changes were, in part, due to the ritualistic and holistic nature of the practice. A systematic review of reiki, TT, and HT practices revealed a small, positive effect on pain relief, with reiki fairing slightly better than the other approaches, especially if the practitioner was advanced (So & Qin, 2008).

TT is a specific therapeutic technique; whereas, HT is generally considered a collection of energy healing techniques ranging from chakra (energetic anatomy system) work to lymphatic release. TT was developed by Delores Krieger, a doctoral-level nurse, who combined shamanic healing with the principles of yoga, qigong, and acupuncture to create TT. The Therapeutic Touch International Association (TTIA) (2020) describes TT as a "holistic, evidence-based practice that incorporates the intentional and compassionate use of universal energy to promote balance and well-being in all aspects of the individual: body, mind, and spirit." A typical TT session begins with the practitioner setting a healing intention for the restoration of balance and harmony within and around the patient, then lightly touching the patient or hovering their hands right above the patient, making sweeping movements (Ives & Jonas, 2015).

CONTINUED ON PAGE 12

It was the intention of Delores Krieger to empirically validate this healing technique from the onset and there have been enough studies to yield meta-analytic reviews of TT (Ives & Jonas, 2015; TTIA, 2020). Two meta-analyses (Peters, 1999; Winstead-Fry & Kijek, 1999) concluded that TT produces a moderately positive effect on psychological and physiological symptoms associated with pain and anxiety (as cited in Ives & Jonas, 2015). Additional studies of TT on wound healing yielded mixed results (O'Mathuna & Ashford, 2012). Again, it is important to note that a common theme among meta-analyses and systematic reviews of reiki, TT, and HT is that it is quite challenging to design gold standard research studies for these practices, as their philosophies and concepts do not lend themselves to the type of research often valued in conventional or allopathic approaches (Ives & Jonas, 2015). The TTIA credentials TT practitioners and teachers and sets standards including hours of training and practice for receiving various levels of credentialing. Many TT practitioners are already licensed healthcare providers (i.e. nurses) and thus primarily follow their own discipline's licensing requirements (TTIA, n.d.).

Qigong is an ancient Chinese bioenergy healing modality. As discussed previously, *qi* refers to *life force and/or vital energy*. *Gong* refers to *training or cultivation with steady practice*; thus, qigong is the cultivation of universal lifeforce (Ives & Jonas, 2015; National Qigong Association (NQA), n.d.). As noted by the NQA (n.d.), there are many qigong styles, traditions, schools, etc., though, generally, the practice can be described as a "mind-body-spirit practice that improves one's mental and physical health by integrating posture, movement, breathing techniques, self-massage, sound, and focused intent."

Lee, Pittler, Guo, and Ernst (2007) found some evidence suggesting that qigong lowers systolic blood pressure for patients with arterial hypertension. Lee, Byeongsang, and Ernst (2011) studied 10 systematic reviews on qigong's effectiveness for a variety of health conditions and cited an array of methodological errors with various studies, about half of them concluding the effectiveness of qigong and the other half revealing inconclusive evidence. A systematic review of qigong's effectiveness with anxiety and depression revealed its efficacy in lowering depression (Wang, Man, Lee, Wu, Benson, Fricchione, … 2013). Ives and Jonas (2015) report qigong's relative safety as an intervention and also stress the difficulty of measuring the impact of qigong for many of the same reasons discussed throughout this course.

Considerations for Social Work: Best Practices, Ethical Implications, Social Justice, and Final Thoughts

CAM and the Social Work Paradigm

Given that social workers practice in a diverse array of settings -hospitals, community mental health agencies, schools, hospice care, primary care offices, private practice, integrative healthcare, etc.- where CAM practices are incorporated, it is incumbent upon social work professionals to be well-versed in mind-body-spirit philosophies, traditions, and techniques. Since the practices explored throughout this course are holistic in nature, they resonate with the biopsychosocial perspective and ecological-systems framework championed by the social work field. In the words of Raheim (2015): "Social work operates beyond the(se) boundaries of medicine, focuses on multiple systems, and is positioned to bridge the gap between the limits of medicine and the community level interventions that are required to promote health" (p. 37). It is easy to envision the adaptability of CAM practices for micro level social work practice. CAM also resonates well with the primary social justice goal of the profession. CAM philosophies and practices span sociocultural dimensions and frameworks regarding health and well-being and thus centralize healing paradigms often relegated by the medical model. In this way they may attend to the mind-body-spirit well-being of marginalized individuals and entire communities.

Best Practices and Ethical Considerations

What follows are some basic guidelines for best practice when discussing CAM with clients, referring clients to CAM providers, and incorporating CAM modalities into social work practice. First, the ability to acquire unlimited information through internet searches is both a benefit and a curse when it comes to finding reputable information about various CAM modalities. There is a sea of conflicting evidence and testimony out there!

Many of the modalities discussed in this course have national accreditation or licensing organizations that may offer valuable information about where to find a provider with the proper credentials and training, as well as comprehensive information about the modality, its history, and its efficacy with certain mind-body health issues. The National Center for Complementary and Integrative Health (NCCIH), a subsidiary of the U.S. Department of Health, is a clearinghouse of research and information about CAM. NCCIH has been cited several times in this course and is a valuable resource for client and practitioners seeking information about CAM. One word of caution regarding NCCIH is that it does not always offer a comprehensive picture of the efficacy of every form of CAM for specific health issues. It may offer general, 'bottom-line' conclusions about the effectiveness of various modalities but does not always discuss the nuances of modalities and their successes as evidenced by case-based studies and other smaller sample size studies often ostracized by the research world. This problematic for the reasons explored in this course. That is, operationalizing an entire health philosophy for empirical study is very difficult, as is designing studies with control groups that properly mimic the holistic intervention without either completing replicating or misinterpreting it.

Second, with regard to referring clients to CAM practitioners it is important to understand which modalities require certification or licensing. This course has given the reader a broad overview in this regard, though really only scratches the surface. Another side of this issue is that clients may already have strong personal, spiritual, or cultural belief systems regarding health providers and healing practices that we may or may not comprehend. Indigenous healers and shamans, for example, do not typically follow standardized certification and licensing processes yet their work, to the client, may be profoundly meaningful. In these cases, social workers often have far more to learn than to 'teach' clients. This is an opportunity to champion client empowerment and client-centered care.

Third, given the increase in CAM popularity and use, more social workers are integrating an array of mind-body-spirit approaches into their practice and it behooves all professionals to practice mindfulness with regard to knowing which practices can be incorporated without specialized training, certification, or licensing versus those practices that do not require formalized training. For example, any practitioner can incorporate mindfulness into their practice, yet only practitioners certified in MBSR can say they are MBSR instructors or experts (Center for Mindfulness Studies, n.d.). Additionally, it is not advisable to practice any form of mindfulness with clients unless one has experienced it personally (Stauffer & Pehrsson, 2012). In order to fully understand the ins and outs of a CAM practice, and all the possible contraindications, it is always *best practice* to have experience with the modality before 'trying it out' on clients. Further, when integrating CAM in practice settings, it is important to discuss this with clients via the process of informed consent. And last, it behooves all of us to question everything! Fads come and go, even in the world of clinical practice and research. Some approaches fade away, even when they still have clinical utility, and some continue to persist, even when they do not.

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HERBS, ENERGY, AROMATHERAPY… OH MY! THE INS AND OUTS OF COMPLEMENTARY AND ALTERNATIVE MEDICINE (CAM) FOR SOCIAL WORK PRACTICE

1.5 CEUs - POST-TEST & EVALUATION

Circle the correct answers. There is only one correct answer per question.

1. All of the following are reasons why complementary and alternative practices are difficult to empirically validate EXCEPT:
   a. Many are 'whole health' philosophies with an array of treatments
   b. Western, allopathic methods of research do not properly capture many CAM philosophies
   c. Most have already been proven ineffective
   d. It is difficult to design 'sham' versions of CAM practicese

2. Which of the following BEST defines qigong?
   a. A Chinese form of mind-body energy medicine
   b. A 'whole health' healing system with a focus on herbal and mineral treatments
   c. A Chinese version of yoga's eightfold path
   d. None of the above describe qigong

3. St. John's Wort should be avoided if:
   a. The individual is taking birth control pills
   b. The individual is taking an SSRI
   c. The individual is menopausal
   d. Only A and B

4. All of the following are true of Osteopathic Physicians EXCEPT:
   a. They cannot prescribe medication in the same way MDs can
   b. They have the same medical training as MDs as well as additional training in manipulation medicine
   c. They practice OMM, which includes procedures such as myofascial release and palpation
   d. None of the above are true

5. Empirical research consistently validates yoga's effectiveness for the following condition:
   a. Narcissism
   b. PTSD
   c. Diabetes
   d. Alcoholism

6. Which of the following is true of ayurvedic treatment?
   a. It often incorporates Chinese traditional medicine
   b. It centers around balancing a person's doshas
   c. It focuses on bhakti yoga
   d. It is classified as a form of energy medicine

7. It is important for social workers to be well-versed in CAM practices because:
   a. CAM encompasses various cultural paradigms that may be consistent with an array of client belief systems
   b. Social workers practice in diverse settings where CAM practices are often used
   c. Many CAM practices are evidenced-based and therefore offer viable treatment options for clients served
   d. All of the above are true

8. The following practice is typically labelled an 'energy' medicine:
   a. Yoga
   b. OMM
   c. Reiki
   d. Panchakarma

9. The controversy over whether or not to label CAM practices 'MBS (mind-body-spirit) practices' is BEST explained by the following:
   a. The term CAM sends the message that these practices are marginal rather than central in the lives of social work clients and within social work practice settings
   b. 'Mind-body-spirit' is an outdated term
   c. The term 'complementary and alternative' is superior
   d. None of these capture the controversy about terminology

10. A main difference between allopathic and holistic medicine is:
   a. Allopathic is biomedicine while holistic medicine is quackery
   b. Allopathic medicine is more inclusive in that it attends to various client cultural belief systems
   c. While unconventional, holistic medicine attends to the full biopsychosocial and spiritual dimensions of the individual, as well as between the individual and his/her/their environment
   d. Only allopathic medicine has been proven through randomized controlled trials

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2. Explore the use and effectiveness of CAM for a variety of physical, mental, and behavioral issues encountered in social work practice

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3. Identify best practices with regard to CAM, as well as possible ethical concerns and contraindications

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Latinx Social Work Over the Lifespan

Yvonne Ruiz, PhD, LICSW

Learning Objectives

At the completion of this program, participants should be able to:

1. Be familiar with the diversity and demographic profile of the Latinx population in the United States
2. Increase their understanding and cultural sensitivity to developmental concerns and psychosocial challenges of Latinx families and adults, children, adolescents, and older adults
3. Identify best practices and clinical approaches to social work with Latinx

About the Author

Yvonne Ruiz, PhD, LICSW, is Associate Professor of Social Work at Salem State University, a member of NASW-MA's Racial Justice Council, and a founding member of the Center for the Study of Diversity and Social Change. Her research examines the well-being of Latinx children, families, and individuals. Her clinical experience includes community mental health, behavioral health, school-based services, and medical social work

Introduction

With the dynamic growth of the United States Latinx population over the past several decades, it is likely that a majority of social workers will encounter members of this population at some point in their work. Many social workers will provide services on a regular basis to Latinx individuals and families in various settings, including human service agencies, mental health clinics, schools, child welfare, hospitals, and private practices. The Hispanic population is very diverse covering a range from recently arrived immigrants from over 20 countries to those whose ancestors have lived in the U.S. for many generations. In order to practice effectively with Latinx populations, practitioners must be knowledgeable about issues and concerns specific to this population, be familiar with the norms and values that are commonly accepted by Latinos, and skilled in implementing culturally appropriate interventions.

This program provides an overview of the U.S. Latinx population from a lifespan perspective in an effort to further social work's, as well as other helping professions, understanding of Latinx in the U.S. A description of the Latinx community is presented, including demographics, cultural strengths and values, developmental psychosocial challenges, and social work best practices. It is important to note that one program is not sufficient to capture the rich diversity complexity, and intersectionality of the U.S. Latinx population. The aim of this program is to help practitioners develop knowledge, skills, and values that aid in providing effective services in a variety of settings

The theoretical lens that informs the course material is Latino critical theory (LatCrit) which is consistent with the professional mission and values of social work. LatCrit asserts that Latinos are marginalized and underrepresented in society and aims to expose discrimination originating from intersectional aspects of identity that marginalize Latinos, including national origin, skin color, generational status, language, immigration status, socioeconomic status, gender, and sexuality. LatCrit complements social work practice in that it calls for increased professional emphasis on environmental factors, identifies sources of discrimination and oppression that leads to disparate outcomes for Latinos in the U.S., and promotes social justice and equality (Kiehne, 2016).

Terminology

The terms "Hispanic" and "Latino" are pan-ethnic terms used interchangeably to describe the population of people living in the U.S. of Hispanic or Latino ethnic origin or heritage. How Hispanics or Latinos are identified has long been an area of contention. In the 1970s, the federal Office of Management and Budget (OMB) developed a new term: Hispanic, which was operationalized to include persons of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, regardless of race (Hayes-Bautista & Chapa, 1987). Hayes-Bautista and Chapa (1987) identified the term "Latino," derived from "Latin American," as the term that best reflects the diverse national origins of Latinos in the U.S., operationalizing this term to include all persons of Latin American origin or descent, irrespective of language, race, or culture.

A recent Pew Research Center survey identifies various terms that Latinos prefer for self-identification (Lopez, Gonzalez-Barrera, & López, 2017). The 2015 survey found that 50 percent of Hispanics most often describe themselves by their family's country of origin; 23 percent use the terms Latino or Hispanic; and 23 percent most often describe themselves as American. As for preference between the terms Hispanic or Latino, the survey found that 32 percent of Hispanics prefer "Hispanic," 15 percent prefer the term "Latino," and the rest (51 percent) have no preference.

While "Latino" has been a commonly accepted term for over a generation, it has also been criticized for its' masculine emphasis. In Spanish, the masculinized version of words is considered gender neutral with the term Latino referring to both masculine and feminine. Currently, the term "Latinx" has been adopted by many as a gender-neutral label for Latino and Latina (Salinas Jr. & Lozano, 2017). The 'x,' is a way of rejecting the gendering of words. Latinx embraces the intersecting identities of Latin American descendants and is inclusive of people who identify as trans, queer, agender, non-binary, gender non-conforming, or gender fluid (Ramirez & Blay, 2017).

Salinas, Jr. and Lozano (2017) find that there is a significant trend towards usage of Latinx in social media, including activists and journalists, and emerging use within higher education institutions. While Latinx is gaining popularity, many people may not identify with the term for various reasons. For example, older adults and more conservative individuals may not choose to identify as Latinx. Allowing for individual self-identification is recommended (i.e. country of origin, Hispanic, Latino, Latina, Latinx). This program uses Latinx, Latino, Latina, and Hispanic as interchangeable terms.

Demographic Profile

According to the United States Census Bureau (2019), the Hispanic population of the U.S. stands at 59.9 million as of July 1, 2018, making people of Hispanic origin the nation's largest ethnic or racial minority. Hispanics constitute 18.3 percent of the nation's total population and are an important part of the nation's overall demographic story. Latinos account for about half (52 percent) of all U.S. population growth between 2008 and 2018 (Flores, Lopez, & Krogstad, 2019). Population growth among Hispanics continues to outpace that of White and Black populations (Flores, Lopez, & Krogstad, 2019).

National origin. The total U.S. Hispanic population can be broken down into people born in the U.S. who are of Hispanic or Latino ancestry or heritage, and foreign-born Hispanics or Latinos who may or may not have acquired U.S. citizenship or permanent legal residency. Latinos can be divided into three groups: first generation, second generation, and third generation or higher. First-generation Latinos were born outside the U.S., second-generation Latinos were born in the U.S. to immigrant parents, and third- or higher-generation Latinos were born in the U.S. to U.S.-born parents (Lopez, Gonzalez-Barrera, & López, 2017). The majority of Latinos, 67 percent, are U.S. born, with the remaining 33 percent foreign-born originating from Mexico, South or Central America, and the Caribbean (Noe-Bustamante & Flores, 2019). People of Mexican origin account for slightly over 60 percent (36.6 million) of the nation's Hispanics. Those of Puerto Rican origin are the next largest group, at 5.6 million. Five other Hispanic origin groups have more than 1 million people each: Salvadorans, Cubans, Dominicans, Guatemalans, and Colombians (Krogstad & Noe-Bustamante, 2019). These diverse national origins contribute to the rich diversity within the culture of Latinos in the U.S., including such factors as heritage, traditions, cuisine, clothing, and regional language differences. It is noteworthy to acknowledge that each country has distinct political and economic circumstances, as well as historical legacies, which contribute to the within-group differences among Latinos.

> Currently, the term "Latinx" has been adopted by many as a gender-neutral label for Latino and Latina (Salinas Jr. & Lozano, 2017). The 'x,' is a way of rejecting the gendering of words.

Language use. Language fluency varies among Hispanic subgroups. United States Census 2017 data (as cited by the Office of Minority Health, n.d.) shows that 72 percent of Hispanics speak a language other than English at home: 71.6 percent of Mexicans, 59.2 percent of Puerto Ricans, 78.1 percent of Cubans, and 86.7 percent of Central American. Overall, 29.8 percent of Hispanics state that they are not fluent in English. According to a report by the Pew Research Center, U.S. Hispanics break down into three groups when it comes to their use of language: 36 percent are bilingual, 25 percent mainly use English, and 38 percent mainly use Spanish. Among those who speak English, 59 percent are bilingual (Krogstad & Gonzalez-Barrera, 2015). Of note, Spanglish, an informal hybrid of both languages, is widely used among Hispanics ages 16 to 25. Among these young Hispanics, 70 percent report using Spanglish (Krogstad & Gonzalez-Barrera, 2015).

Regional distribution. As of 2018, ten states have a population of 1 million or more Hispanic residents — Arizona, California, Colorado, Florida, Georgia, Illinois, New Jersey, New Mexico, New York, and Texas (U.S. Census Bureau, 2019). The South saw the fastest Latino population growth of any U.S. region, growing 33 percent during this period, reaching 22.7 million in 2018, up 5.6 million from 2008. This growth was part of a broader increase in the Latino population in regions across the country since the 1990s. States in the Northeast (25 percent increase), Midwest (24 percent) and West (19 percent) also experienced growth in the number of Latinos from 2008 to 2018 (Flores, Lopez, & Krogstad, 2019).

Median age. The median age of the Hispanic population is 29.5 years of age (U.S. Census Bureau, 2019). Patten (2016) suggests that youth is a defining characteristic of the Hispanic population. For example, among all racial or ethnic groups in the U.S., Hispanics are the youngest

CONTINUED ON PAGE 16

with approximately one-third, or 17.9 million, of the nation's Hispanic population younger than 18, and about a quarter, or 14.6 million, of all Hispanics between the ages of 18 to 33 (Patten, 2016).

Educational attainment. According to a 2017 U.S. Census Bureau report (as cited by the Office of Minority Health, n.d.), 68.7 percent of Hispanics in comparison to 92.9 percent non-Hispanic whites had a high school diploma. Sixteen percent of Hispanics in comparison to 35.8 percent of non-Hispanic whites had a bachelor's degree or higher. Five percent of Hispanics held a graduate or advanced professional degree, as compared to 13.8 percent of the non-Hispanic white population.

Hispanic households. As of 2018, 13.3 million families of Hispanic descent were residing in the U.S., with 72 percent living in households with three or more members related by birth, marriage, or adoption (Duffin, 2019). Over half of the total Hispanic population, 58 percent lives in a married-couple household and 9 percent live in a multigenerational household consisting of two or more adult generations or one that includes grandparents and grandchildren (Noe-Bustamante & Flores, 2019). There are approximately 16 million Latinx individuals living in families comprised of members with different immigration statuses, known as mixed status (Rodriguez, 2018), which means that many of these families experience varying levels of adaptation to, and familiarity with, the U.S. culture among the individual family members. Mixed status families face unique challenges related to variations among the timing of migration, legal status, acculturation dynamics, and social supports and resources.

Household income. Among full-time year-round workers in 2017, the average Hispanic/Latino median household income was $49,793, in comparison to $65,845 for non-Hispanic whites. In 2017, the unemployment rate for Hispanics was 6 percent, as compared to 4.2 percent for non-Hispanic whites (as cited by the Office of Minority Health, n.d.). It is notable that 19 percent of Hispanics are living in poverty. Children and adolescents under the age of 18 are especially vulnerable with 27 percent living in poverty (Noe-Bustamante & Flores, 2019).

Health. The Centers for Disease Control and Prevention (as cited by the Office of Minority Health, n.d.) identifies some of the leading causes of illness and death among Hispanics as heart disease, cancer, unintentional injuries (accidents), stroke, and diabetes. Some other health conditions and risk factors that significantly affect Hispanics are asthma, chronic obstructive pulmonary disease, HIV/AIDS, obesity, suicide, and liver disease. It is important to note that Hispanic health is shaped by such factors as language/cultural barriers with providers, lack of access to preventive care, and the lack of health insurance. These factors often prevent Hispanics from receiving adequate health care.

Health insurance. Hispanics have the highest uninsured rates of any racial or ethnic group within the U.S. In 2017, the Census Bureau (as cited by the Office of Minority Health, n.d.) reported that 49 percent of Hispanics had private insurance coverage, as compared to 75.4 percent for non-Hispanic whites. In 2017, 38.2 percent of all Hispanics had public health insurance coverage, as compared to 33.7 percent for non-Hispanic whites. Also in 2017, 17.8 percent of the Hispanic population was not covered by health insurance, as compared to 5.9 percent of the non-Hispanic white population. These disparities place Latinos at greater risk for disease that is undiagnosed and untreated.

Some of the factors that contribute to the within-group diversity include country of origin, migration experiences, legal status and documentation, generational status, ecological contexts and stressors, and integration into U.S. culture.

While demographic information represents aspects of the U.S. Latinx population, statistics do not capture nor describe the dynamic diversity of the Latino community. Some of the factors that contribute to the within-group diversity include country of origin, migration experiences, legal status and documentation, generational status, ecological contexts and stressors, and integration into U.S. culture. It is important to recognize that Latinos may be immigrants or U.S.-born, may be of any race, may speak Spanish, English, be bilingual or not speak Spanish at all, may possess a college degree, be a professional or a day laborer, and may have various religious affiliations, including Catholic, Jewish, Pentecostal, or identify as non-religious. In particular, the shifting macro-level influences of social, economic, and political forces impact the adaptation and well-being of individuals, families, and communities.

Immigrant Roots

Since 2016, the shifting landscape of U.S. immigration policies and legislation have created an uncertain environment for many U.S. Latino/as, and legal status has become an area of scrutiny for both documented and undocumented individuals. With the number of Latinos residing in mixed-status families, it is important to understand legal status. Lawful immigrants are defined as naturalized citizens, people granted lawful permanent residence, people granted asylum, people admitted as refugees, and people admitted under a specific authorized temporary status who are eligible for long-term residence and work. Unauthorized immigrants are all foreign-born noncitizens residing in the country who are not "lawful immigrants" (Chany-Muy & Congress, 2016). It is critical to understand the experiences, struggles, and challenges of both documented and undocumented Latino/a immigrants in order to target services and resources that can effectively increase their well-being and successful outcomes.

Latino/a immigrants vary widely in patterns of immigration, including the circumstances of leaving their home country and the process of resettling in the U.S. Factors that may contribute to the decision to leave their home country include unemployment; low wages; limited social, economic, and educational opportunities; family obligations; and the desire for a better life. Falicov (2014) discusses the process of migration as a multi-determined event that is multi-motivated by the intersection of economic, occupational, life cycle, family organization, and personal issues, all of which vary according to the individual.

Migration means uprooting and experiencing social, economic, and cultural insecurity (Berger, 2011). The transitions of migration are often disruptive and includes many losses, which renders immigrants vulnerable, isolated, and susceptible to individual and family distress. Even in the best of circumstances, there are losses associated with the process of migration, such as separation from family members, friends left behind, the lack of understanding of how jobs, schools, banks, or hospitals work, and disruptions of social, educational, and occupational networks (Falicov, 2014). These stressors are often transmitted throughout the family system, affecting not only first-generation family members, but subsequent generations as well.

Latinx immigrants face numerous psychosocial challenges, including fear of deportation, losing legal status, lack of knowledge of U.S. laws and systems, maintaining traditional family roles, the importance of family loyalty, saving-face and taboo on sharing family secrets, interpersonal loss, wanting a better life for their children, and desire to be part of the American dream (Chang-Muy and Congress, 2016). First and second generation Latinx face challenges to health and wellness, including adjustment and acculturative stress, discrimination, under- employment, and low-paying positions. It is important to acknowledge that not all Latinx individuals struggle with any or all of these issues. There is a large degree of individual variation and diversity in their lived experiences; however, these types of challenges have been well-documented in the research literature.

Acculturative Stress

Acculturation is the term used to describe the cultural changes that result at the individual psychological level from ongoing contact between two or more distinct cultures (Berry, Trimble, & Olmedo, 1986). Berry (1986) identified various ways of coping with acculturating, including assimilation or relinquishing one's original cultural identity and adopting that of the new culture; integration or combining components of both the culture of origin and the new culture; and rejection or separation when one withdraws from the new culture. The dissonance between the home and new culture requires a complex process of progressive adjustment and adaptation (Díaz-Lazaro, Verdinelli, & Cohen, 2012) that can result in distress due to the stressors of acculturating to a new sociocultural environment. Acculturative stress is defined as psychological stress that results from the process of acculturation (Berry & Annis, 1974).

The process of acculturation presents challenges for most, if not all, foreign-born Latinos given that they often enter the U.S. with limited English-speaking ability and cultural experiences, behaviors, and values that differ from mainstream U.S. culture. For Latinos, acculturative stress emerges from trying to adapt to opposing cultures; the traditional, patriarchal, collectivistic cultures of Latinos and the modern egalitarian, and individualistic culture of the U.S. (Falicov, 2014). Furthermore, research findings suggest that Latinos are more likely to maintain the Spanish language and cultural values and traditions for multiple generations, which increases the likelihood that acculturation stress is experienced by Latino parents, as well as their children (Umana-Taylor & Alfaro, 2009).

Acculturative stress is commonly a factor in Latino/as well-being and mental health status in the U.S. Acculturative stress could result in various emotions and behaviors, including depression and anxiety, feelings of marginality and alienation, heightened psychosomatic symptoms, and identity confusion (Williams & Berry, 1991). While there are potentially negative effects of acculturative stress, social supports and use of active coping skills have been found to moderate the association of acculturative stress and psychological functioning. Research points to individuals and families that demonstrate successful adaptation despite stressful conditions (Umana-Taylor & Alfaro, 2009). As Falicov (2014) points out, the process of adaptation to a new culture can also be an adventure that opens possibilities of living a better life, thus it is important to recognize the cultural and personal resilience displayed by immigrants in the processes of acculturation.

Cultural Strengths

In addition to the challenges and risks that immigrant Latinos and their families encounter, cultural strengths must also be recognized. Cultural strengths are defined as collective traits embraced in shared sociocultural values and traditions which may become psychosocial resources for group members to draw their strengths (Ai, Carretta, & Aisenberg, 2017). From this perspective, the cultural strengths of the Latino population may include, but are not limited to, social support, racial/ethnic identity, and religious involvement. Evidence has shown that collective strength factors may benefit Latino/as through enhanced self-esteem and mental health, physical health, or coping skills for dealing with life stressors, including discrimination (Ai, Carretta, & Aisenberg, 2017). Identification with one's ethnic and cultural background is associated with positive outcomes for both immigrant and U.S.-born Latinos, including higher levels of self-esteem and psychological health (Fuligni & Perreira, 2009).

Saleebey (1996) asserts that a strengths perspective views individuals, families, and communities in the light of their possibilities, values, and hopes. Latino/a immigrants come to the U.S. with a strong desire to succeed despite the odds, and they seek to instill these hopes and dreams in their children (Fuligni & Perreira, 2009). Saleebey (1996) identifies the aspirations of the family and their capacities and adaptive skills as strengths. Latino Parents often hold social, occupational, and educational aspirations for their future and that of their children. In their research, Fuligni & Perreira (2009) find that:

> *The aspirations and motivation of immigrants and their children, in turn, are fueled by a strong value placed upon family togetherness, sacrifice, and support, as well as a high level of identification with their ethnic and cultural backgrounds (p.110).*

Cultural Values

The retention of traditional values and practices are strengths and sources of resiliency that help buffer immigrants from the risks, stressors, and challenges of adapting to a new culture. Understanding the cultural values and beliefs that inform Latinx realities and relationships is critical to understanding their lived experiences. *Familismo, marianismo, personalismo, confianza, religion, and spirituality* are commonly shared values that signify loyalty to family, gender role behaviors, social connections, and religious practices. A collective cultural orientation explains the ways that Latino/as understand themselves as interdependent members of their family, social groups, and communities (Zambrana, 2011). These culturally shared, ethnic-specific beliefs, values, and practices provide Latino/as a common ground for their experiences, interpretations of life, and responses to daily challenges (Gloria & Castellanos, 2016).

Table 1. Types of Latino Families	
Unauthorized or undocumented	These families often bear the brunt of the criminalization and exclusion associated with illegality
Mixed-status	These families may experience unique tensions as a result of internal stratification of their members according to legal status
Documented	These families can be 1st, 2nd, 3rd generation or more; may have issues and concerns related to both cultural and non-cultural identities

- ***Familismo*** emphasizes the importance of family attachment, loyalty, and support, including extended family relationships, and has long been recognized as a traditional cultural value among Latinos (Delgado, 2007). Latinas are often characterized as strongly valuing family, motherhood, and close connections to extended family members (Zambrana, 2011). Berger (2011) suggests that immigrant women play an additional role within the family as that of maintaining their cultural heritage and tasked with transmitting the values, beliefs, and norms of their culture to their children.

- ***Marianismo*** is a concept that represents modesty and virtue among Latinas with the role of mother the most valued (Delgado, 2007). Latinas are often willing to sacrifice their personal needs for the needs of their family (Zambrana, 2011). Latina immigrants encounter many stressful events during their immigration process, including sexism, the devaluation of gender-specific characteristics, and negotiating gender roles within their families. These experiences can challenge their perceptions of themselves and lead to lower levels of self-esteem (Panchanadeswaran & Dawson, 2011). The emphasis on marriage and motherhood contributes to the conceptualization of separation and divorce as a cultural threat among Latino families due to the departure from traditional family roles (Arditti & López, 2005).

- ***Personalismo and confianza*** represent a distinct interpersonal style that emphasizes the importance of personal connection, warmth, and trust (Delgado, 2007; Gloria & Castellano, 2016). There is an active effort to minimize social distance and an emphasis on the promotion of behaviors and attitudes that promote friendliness (Delgado, 2007). Personalismo is an orientation in which personal exchanges are centralized and embodied by respect and dignity regardless of personal or social status (Gloria & Castellanos, 2016). Confianza taps into a sense of trust, belief, and strong friendship bonds (Delgado, 2007) and denotes a sense of intimacy and familiarity within relationships (Gloria & Castellanos, 2016).

- ***Religion and spirituality*** are a way of life for many Latino/as. Spirituality has always been an important aspect of Latino culture whether practiced in the form of Catholicism, or other varieties of Christianity, indigenous religions, folk healing, or a deep connection with spirits (Shorkey, Garcia, & Windsor, 2010). While Latinos share a common faith, with Catholicism being the predominant religion, a growing number of Latino/as identify with Christian affiliations such as Pentecostal (Detlaff, Johnson-Motoyama, & Mariscal 2016). The Pentecostal church is a center for religious worship, education, community organization, socialization, and social support (Delgado, 2007). The role and importance of spiritual beliefs serves as a way to understand the universe and gives meaning and purpose to life as both a way to celebrate significant life events and mitigate losses and suffering (Delgado, 2007; Shorkey, Garcia, & Windsor, 2010).

It is necessary to acknowledge that cultural values and beliefs are not static, but dynamic processes that change over time and geographic location. Culture is a dynamic construct that helps individuals and groups to adjust to changing circumstances while maintaining a bridge to the past (Delgado, 2007). Zambrana (2011) points out that gender role attitudes and behaviors, as well as social norms, are in transition among Latinx due to economic necessity and access to education, that in turn provides access to alternative life perspectives and options.

Latinx Families

The impact of the Latino population on the cultural life of the U.S. goes beyond demography, to include cultural influences (e.g., food, music, language), and political, economic, and social contributions (Cabrera, Karberg, & Fagan, 2019). The strength and stability of the Latino community is a deeply rooted cultural belief in the importance of the family and the high value placed on preserving the family structure, affiliative bonds, and kinship ties. Falicov (2014) describes three types of Latino families:

Family connectedness or familismo, the obligation to care and support one another is a feature of extended Latino family life and plays a role in supporting individual family members through difficult periods and crisis situations. Familismo can also be understood as a survival strategy, especially in situations of marginalization and poverty. Familismo drives a concern for one another's lives, pulling together to weather crises, a socio-centric child rearing that makes children care about others around them, and the pooling of money and resources (Falicov, 2014).

As a group, Latinos endorse family cohesion and loyalty and, traditionally, are involved and engaged with their children. This cultural orientation strongly supports foreign-born Latino parents who are more likely to stay together because of strong cultural values about the importance of the family (Cabrera, Karberg, & Fagan, 2019). The cultural tendency toward family connectedness persists in some form or another for at least one or two more generations (Falicov, 2014).

Falicov (2014) describes Latino families as a hierarchical family structure with the parents commanding respeto (respect). The traditional pattern is father as the disciplinarian and mother as mediator between father and children. There is an idealization of the role of the mother as one dedicated to her children and this is a respected social role. The influence of birth order places the oldest children in positions of responsibility with the eldest boy expected to protect females and younger siblings, and the girl expected to help with housework, cooking, and childcare. The mother-son bond can be a powerful, mutual attachment, especially with the oldest or favorite son.

Extended family living arrangements are common within the Latino culture and households may consist of parents, children, grandparents, aunts, uncles, cousins, and other kin. These extended family relationships serve to maintain Latino values, as well as providing social supports and economic benefits, and can be sources of stress as well. The needs of the family are more important than the concerns of the individual members, and the individual's self-esteem and identity is strongly affected by his or her relationship with family members. Falicov (2014) identifies extended family stressors that impact individual well-being as conflictual relationship dynamics between two or more family members, subsystem conflicts, overstressed systems of care, resentments about lending money, favors asked and received, and group pressures such as, gossip, favoritisms, envy, and jealousy.

Increasing contact with U.S. cultural values and norms emerge as dynamic cultural changes over time. Cultural changes can result in power shifts within the family along with associated changes in family structure, gender roles, and individual development (Suárez-Orozco and Suárez-Orozco, (2002). For example, family structure may need to alter due to the necessity of a two-income household to meet daily expenses; traditional gender roles may need to adjust to the demands of new family responsibilities and roles; and children may need to take on new tasks based on family needs.

Table 2. Culture-Bound Syndromes	
Nervios (Nerves)	Increased susceptibility to mental stress and symptoms of nervousness, decreased ability to concentrate, emotional distress, headaches, insomnia
Ataque de Nervios (Panic Attack)	Symptoms include attacks of crying, trembling, uncontrollable shouting, physical or verbal aggression; attacks are often associated with stressful events
Susto or Espanto (Fright)	Tiredness and weakness resulting from frightening and startling experiences
Mal de Ojo (The Evil Eye)	Medical problems, such as vomiting, fever, diarrhea, and mental problems (e.g. anxiety, depression), could result from the evil eye the individual experienced from another person

Latinx Young Adults

In Latino families, there is an emphasis on young, single adults staying home rather than leaving to live on their own or with their peers. When they do leave home, they generally do so in the context of forming a new family of their own (Falicov, 2014). However, for a growing number of Latinx, courtship and marriage are not the only pathways to adulthood. Education and job opportunities also present alternative pathways for young adults to become more autonomous and make their own decisions, especially when individuals are more acculturated. The influences of gender socialization and gender expectations within the family must be taken into account.

There is documentation that young Latinas are aspirational, are far more concerned about getting an education, and taking care of themselves then about finding a husband or remaining close to family. A 2009 survey by Meredith Hispanic Ventures (Ramos, 2009) found that, of those Latinas surveyed, 80 percent said that higher education is a top personal goal and 72 percent said that career development was a priority. The survey results found that the key factors determining Latinas success in life were education, being fluent in English as well in Spanish, and owning a business. Latinas described themselves as optimistic and self-confident.

While many Latino men achieve success and maintain strong family and cultural ties, many encounter psychosocial challenges. For example, Latino men lag behind Latinas in educational attainment. As reported in Excelencia en Education (n.d.): Two-thirds of Latino male adults only have a high school education or less. However, they also report promising statistics: as of 2014, 20 percent of Latino males had earned an associate degree or higher and between 2005 and 2014, Latino males increased baccalaureate degree attainment by 103 percent. The reasons for low rates of post-secondary education are based on a variety of reasons, including family obligations, financial need, sub-par schooling experiences, lack of family and community support, and educational marginalization. As an alternative pathway to success, some young men join the armed forces in search of opportunities.

Latinx Children

As of 2018, there are 73.4 million Children ages 0–17 in the U.S., with 25.5 percent, or almost 19 million, of these identified as Hispanic (Federal Interagency Forum on Child and Family Statistics, n.d.). They are the largest racial/ethnic minority group of children and youth, and also the fastest growing. Currently, one in four children is Hispanic and it is projected that by 2050, it will be more than one in three (Federal Interagency Forum on Child and Family Statistics, n.d.). While the majority, 70 percent, have family origins in Mexico, the heritage of America's Latino children includes Puerto Rico (a U.S. territory), Caribbean countries, and countries in Central and South America (Murphey, Guzman, & Torres, 2014).

Almost all Latino children younger than 5 years old are born in the U.S. and are likely to live in two-parent families (Wildsmith, Scott, Guzman, & Cook, 2014). For many Hispanic children, strong family traditions anchor their upbringing. For example, Latino children are more likely than children in other racial/ethnic groups to eat dinner with their families six or seven nights a week (Murphey, Guzman, & Torres, 2014). Cultural traditions and practices may contribute to resiliency in childhood and mitigate experiences of discrimination and marginalization (Falicov, 2014).

Challenges to the well-being of children need to be recognized by practitioners in order to provides effective services. Latino children may be exposed to familial stressors that impact their mental health, including acculturation, parent-child culture and language discordance, rigidly defined gender and family roles, and parenting styles (Ramirez, Gallion, Aguilar, & Dembeck, 2017). One of the main challenges is the high

CONTINUED ON PAGE 18

Figure 1. MECA's Four Domains of Latinx Assessment

rate of poverty among Latino families with children. The Federal Interagency Forum on Child and Family Statistic (n.d.) reports that 25 percent, or 4.7 million, of Hispanic children were living in poverty in 2017; 14.8 percent of Hispanic children in married couple families were living in poverty, compared with 48.3 percent in female-headed household families; and Hispanic children were more likely to lack health insurance (8 percent). Murphey, Guzman, and Torres (2014) point out that nearly one-third of Latino children live below the poverty line, and one-third live in families with incomes just adequate to meet basic needs. This suggests that Latino children disproportionately live in neighborhoods of concentrated poverty, where poor housing, poor schools, and crime further threaten their well-being and mental health. Latino children are less likely to receive help for mental health problems, and their parents are less likely to recognize and seek help for their children's mental health issues (Ramirez, Gallion, Aguilar, & Dembeck, 2017).

Falicov (2014) suggests that as children enter school, a fundamental transformation of the families' ecological context is set in motion, with implications for internal and external family functioning. For many first-generation families, school may be the first direct, sustained, and structured contact with U.S. institutions and this transition requires flexibility at a time when parents and children may still be experiencing migration stresses and cultural adjustments. These stressors may include linguistic and cultural differences, cultural learning styles, and socioemotional readiness for school. Difficulties in elementary and/or middle school may persist into adolescence and high school

Latinx Adolescents

Adolescence is commonly understood as a stage of transition and transformation with identity confusion, anxiety, depression, mood swings, and rebellion considered normative aspects of the adolescent experience. Acculturation and cultural identity create additional psychosocial challenges for Latino youth, and especially poverty and discrimination contribute to high levels of stress. For Latino families, adolescence is compounded by experiences of cultural tensions within the family due to differential acculturation levels among family members which may contribute to conflicts over adolescent attitudes and behaviors. For example, differences in language and cultural values between parents who were socialized in traditionally more conservative values and norms, and youth who have been socialized in the context of more liberal U.S. norms.

Latinx adolescents often have to find a way to integrate two cultures and a meeting of two worlds (Falicov, 2014). Questions of identity may arise: Who am I? Where do I belong? Collisions and conflicts between two cultural and social realities can be a source of strength and creative energy or a source of difficulties. Some adolescents wish to reject, or at least not identify with, their parents' generation, culture, and immigrant status. Acculturation and generational tensions affect cultural continuity and change within the family system. Furthermore, marginalized status and institutional racism has an effect on self-esteem and motivation.

Latino youth are far more likely than their peers to have mental health issues, which often go unaddressed and untreated (Ramirez, Gallion, Aguilar, & Dembeck, 2017). Hispanic adolescents are at significant risk for mental health problems, and in many cases at greater risk than white youth (The American Psychiatric Association, 2017). 22 percent of Latino youth have depressive symptoms, a rate higher than any minority group besides Native American youth. Yet, Latino youth are less likely to receive and utilize mental health services (Ramirez, Gallion, Aguilar, & Dembeck, 2017) and half as likely than white adolescents to use antidepressants (The American Psychiatric Association, 2017).

Unhappiness and intense depression, including suicidal thoughts, appear with frequency among Latinas of all national origins (Zayas, 2011). Latina adolescents have the highest rates of suicidal ideation and suicide attempts. 18.9 percent had seriously considered attempting suicide, 15.7 percent had made a plan to attempt suicide, 11.3 percent had attempted suicide, and 4.1 percent had made a suicide attempt that resulted in an injury, poisoning, or overdose that required medical attention (The American Psychiatric Association, 2017). Latino adolescent males have higher rates of suicidal ideation and suicide attempt than their white peers. Most suicide attempts by Latinos occurred prior to age 18, with Latino females twice as likely as males to attempt suicide.

It is important for practitioners to realize that across Latino/a national origin, youth may experience similar, yet distinct social and cultural stressors (Malott & Paone, 2016). An example is provided by Malott and Paone (2016) where a third-generation, English-speaking, middle-class adolescent with blond hair and Argentinean roots will experience a set of challenges unique from a dark-skinned youth of Nicaraguan origins who recently entered the U.S. without documentation, is living in poverty, and is just beginning to learn English. In particular, these youths will experience racial/ethnic discrimination in very different ways.

> The inclusion of the client's perspectives requires an understanding of their cultural perspective because culture influences the way in which individuals see themselves and their environment throughout the treatment process.

Social workers must be aware that Latinx youth will be exposed to many forms of discrimination in school, community, and society. These discriminatory experiences range from overt formations such as profiling and/or hassling by the police and exclusion or mistreatment by peers, teachers, and community members, to subtle formations reflected in the attitudes and assumptions others may hold about them (Malott & Paone, 2016). Practitioners can foster the resilience of Latinx youth through a culturally responsive approach that supports their identities, recognizes their strengths and resources, and offers tools for survival and success in society (Malott & Paone, 2016).

Latino/a Older Adults

According to The Administration for Community Living (2017), the Hispanic American population (of any race) age 65 and over was 3,968,763 in 2016 and is projected to grow to 19.9 million by 2060. In 2016, Hispanic Americans made up 8 percent of the older population. By 2060, the percentage is projected to be 21 percent. Cultural norms associated with the core values of familism, collectivism, and respect strongly influence how the aging process and older people are viewed. Elders are considered to be vital members of their communities and are expected to actively fulfill essential roles such as those of mentors, cultural transmitters, providers of care for grandchildren, and civic and religious leadership (Falicov, 2014; Ramos & Wright, 2010). As stated by Falicov (2014):

> *In Latino culture, being old doesn't strand people on an experiential island – it allows them to remain in the mainstream of life (p. 425).*

Older Latinos tend to rely on family and informal networks for support and caregiving. Respect for elder autonomy, preservation of elder dignity, and maintenance of the elder's role within the family is a major value among Latinos. Latino caregivers often embrace their role and view caregiving as an opportunity to give back to those who sacrificed for them. However, it must also be noted that caring for elders can also be challenging for Latino families who struggle with lack of social supports and financial resources (Ramos & Wright, 2010).

One scenario that is common in the Latino community is when older adults are encouraged to move to the U.S. by their adult children who are first-generation immigrants. This often occurs when they become ill, widowed, isolated, or too old to work (Falicov, 2014). Another scenario is when older adults move to the U.S. to help their adult children with caretaking their growing families. In either case, the elder arrives in a new country and social context, without knowledge of the language (Falicov, 2014). Multiple factors may place Latino elders at risk for acculturative stress (Falicov, 2014), including age, minority status, language use, lack of knowledge about institutions, lack of transportation and support networks.

A study by Hilton, Gonzalez, Saleh, Maitoza, and Anngela-Cole (2012) suggests a more optimistic outlook. Their study found that older Latinos focus on maintaining a positive outlook, living in the present, enjoying a sense of community, and relying on spirituality and family for comfort and meaning as they age. The majority of Hispanics in the U.S. identify as Catholic or Evangelical (Houben, 2012). Religious and/or spiritual belief can play an important role in how older Latinos deal with transitions and can be an effective source of social support. The ability to express their faith and have their views validated and supported by practitioners is an important component of working with Latino older adults.

Latinx Mental Health

There is a lack of understanding and knowledge regarding mental health in the Latino community. One reason for this is the cultural taboo on talking about emotional difficulties with professionals and providers (Falicov, 2014). It is culturally sanctioned to cope with emotional difficulties and mental health issues by seeking advice and support from family members or spiritual advisers, and not necessarily from mental health professionals due to the stigma associated with mental health needs and mental illness. Latino communities display a similar susceptibility to mental illness as that of the general population (Anxiety and Depression Association of America. (n.d.), however the symptoms may be understood through a cultural lens.

A culture-bound syndrome is a combination of psychiatric and somatic symptoms that are considered to be a recognizable disease only within a specific society or culture. The following chart presents the culture bound syndromes that are commonly associated with Latinos (American Psychiatric Association, 2013).

Evans (2014) summarizes Latino research findings relevant to culture-bound symptoms: Latinos may believe that physical symptoms are more serious than mental health symptoms; are more likely to believe that their symptoms are caused by outside environmental, spiritual, or personal problems; and are likely to endorse a biological etiology of depression and mental illness and they tend to view medication as addictive and harmful.

Approximately 33 percent of Latino adults with mental illness receive treatment each year compared to the U.S. average of 43 percent. (National Alliance on Mental Illness, n.d.). Common mental health conditions among Latinos are generalized anxiety disorder, major depression, posttraumatic stress disorder (PTSD), and excessive use of alcohol and drugs. As aforementioned, suicide is a concern for Latino youth. However, only 20 percent, or 1 in 5, of Latinos who experience symptoms of a psychological disorder talk to a doctor about their symptoms, and only 10 percent, or 1 in 10, contact a mental health professional (Anxiety and Depression Association of America. (n.d.). Therefore, it is not surprising that Latinos underutilize mental health services.

Disparities in access to treatment, as well as in the quality of treatment, puts Latinos at a higher risk for more severe and persistent forms of mental health conditions. Barriers may include lack of health insurance, legal status, misdiagnosis and medical mistrust--suspicion and low perceived supportiveness of health systems. Language usage may also be a barrier as many medical professionals do not speak Spanish, and those that do may not fully understand the cultural issues

Table 3. Model of Cultural Adaptation (Magaña, 2019)

SURFACE LEVEL ADAPTATION	DEEPER STRUCTURE APPROACH
Identified sociocultural needs of the family	Also embed values, practices, traditions that reflects help-seeking behaviors and view of the world
Use bilingual/bicultural staff	How social, cultural, environmental and historical factors influence health related behaviors & practices
Use of culturally specific interpersonal styles	

that Latinos face (Anxiety and Depression Association of America. (n.d.). Social work practitioners and other helping professionals must be culturally responsive in recognizing and respecting culture, identity, and awareness of the client's worldview in the working relationship, including awareness of one's own values and biases.

Engagement with Latino/as

Social work approaches that are preferred by Latinos include comfort with conversation, ability to listen, and curiosity, particularly as related to Latino culture (Smith, Bakir, & Montilla, 2006). They find that stability, harmony, constancy, humor, and purposefulness are additional practitioner qualities that are desired by Latino clients. Many Latinos prefer smooth social relations based on warmth, respect, and avoidance of confrontation and criticism (Delgado, 2007). Jiménez, Alegría, Camino-Gaztambide, and Zayas (2014) suggest that a shift towards a more collaborative stance fosters clients' empowerment and is particularly suitable for working with disenfranchised populations such as Latinos. A practitioner who assumes a respectful role, emphasizing a collaborative perspective rather than a role as an expert is often more successful in engaging Latinx clients. Latinos are often suspicious of mental health treatment; therefore, a more respectful and collaborative approach may ameliorate some of the stigma attached to mental health treatment.

The MECA Assessment Framework

Many, if not all, agencies use their own formal biopsychosocial assessment tool that is part of the agency's procedures and protocol. The assessment tool that is offered here is consistent with social work's emphasis on the person-in-environment and can be easily integrated with existing biopsychosocial practices. Falicov (2014) presents the Multidimensional Ecosystemic Comparative Approach (MECA) for use as an assessment with Latinx. This assessment tool is based on a relational-cultural relationship between the practitioner and client in various contexts, such as clinical, education, counseling, and mentoring.

The MECA approach contains four domains: 1. Migration-acculturation; 2. Ecological context; 3. Family organization; and 4. Family life cycle. A key point is that MECA proposes that individual and family processes need to be understood through interaction with various levels of the social and cultural environment. This framework offers practitioners the opportunity to incorporate the impact of migration and cultural change into the helping relationship. The domains are presented in more detail in Figure 1.

> Culturally adapting an existing intervention entails reviewing and revising the structure of a program or practice to more appropriately fit the Latinx needs and preferences (Magaña, 2019).

MECA integrates cultural awareness at every step in the process of engagement, assessment, and intervention between social worker and client system. A relational-cultural relationship is based on collaboration between practitioner and client and integrates a strengths-based perspective. The practitioner is not the expert on the clients' experience, rather, they are both collaborative partners in the process. Cultural diversity and social justice are integral to the MECA framework. Cultural diversity is explored in the domains of family organization and family life cycle as cultural identity, beliefs, and values are part of culture. Social justice is explored primarily in the domains of migration/acculturation, and ecological context as a social justice position directs attention to life conditions, power differentials, and contextual stressors such as discrimination that limit opportunities and affect physical and mental health (Falicov, 2014).

Cultural Adaptation

Evidence-based practice requires the integration of evidence and scientific methods with practice wisdom, the worldview of the practitioner, and the client's perspectives and values (Evans, 2014). The inclusion of the client's perspectives requires an understanding of their cultural perspective because culture influences the way in which individuals see themselves and their environment throughout the treatment process. However, the majority of evidence-based interventions are not tested with culturally diverse populations.

Diverse groups have unique needs and often fall through the cracks of service and healthcare systems. Effective work with Latinx populations requires social workers to implement interventions that are culturally responsive. Existing interventions that are specifically adapted for Latinx needs and outcomes can ensure cultural responsiveness. Culturally adapting an existing intervention entails reviewing and revising the structure of a program or practice to more appropriately fit the Latinx needs and preferences (Magaña, 2019). Table 3 presents a framework for cultural adaptation.

Culturally adapted interventions are advantageous because they allow the clinician to address culturally specific risk factors and build on identified protective factors, such as cultural beliefs, behaviors, norms, and values. Culturally adapting interventions allows practitioners to adapt a cultural lens as a central focus of professional behavior. The following recommendations are designed to support cultural adaptation and promote effective practice with Latinx.

Recommendations

Practitioners ought to:

- Recognize and respect culture-specific differences that exist due to Latinx nationality, generational status, cultural identity, acculturation level, gender roles, and socioeconomic status
- Be knowledgeable about Latinx cultural influences relating to cultural beliefs, values, and behaviors
- Be curious about the reasons for migration and psychosocial experiences throughout the transition and resettling processes
- Be aware of the impact of varying levels of acculturative stress on individuals and within the family system
- Be aware of the impact that immigration, linguistic, and cultural adaptation are having on the family as a system, as well as on individual family members
- Be skillful in establishing engagement and rapport with Latinx clients that is based on a collaborative approach, including a communication style that reflects comfort with conversation, ability to listen, and curiosity about the Latino culture
- Be skillful in exploring the client's story as understood by the client
- Implement a strengths-based perspective, including sources of resilience, cultural identity, and pride
- Avoid minimizing the risks to which individuals and families are exposed given migration, acculturation, and other psychosocial stressors
- Be aware of the importance of familismo and that services may include multiple members of the client-defined family
- Be aware that treatment needs to be holistic and may need to incorporate spiritual or other elements from the client's community and culture
- Implement interventions that foster empowerment and psychoeducation about the sociopolitical and economic environmental factors that are often sources of discrimination and oppression leading to disparate outcomes
- Promote social justice and equality
- Ensure materials are culturally responsive and available in Spanish and English

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LATINX SOCIAL WORK OVER THE LIFESPAN
1.5 CEUs - POST-TEST & EVALUATION

Circle the correct answers. There is only one correct answer per question.

1. Latino Critical Theory (LatCrit) complements social work practice:
a. In that it calls for increased professional emphasis on environmental factors
b. Identifies sources of discrimination and oppression that leads to disparate outcomes for Latinos
c. Promotes social justice and equality
d. All of the above

2. It is recommended that practitioners allow clients to self-identify their preferred term (i.e. country of origin, Hispanic, Latino, Latina, Latinx):
a. True
b. False

3. Acculturative stress could result in all of the following EXCEPT:
a. Depression and anxiety
b. Individualization
c. Feelings of marginality and alienation
d. Identity confusion

4. Latino cultural values include:
a. The importance of family attachments and loyalty
b. An interpersonal style that emphasizes the importance of personal connection, warmth, and trust
c. An emphasis on assimilation
d. Both A and B

5. Young Latinas are more aspirational, they take care of themselves, and are concerned with completing their education prior to marriage and starting a family.
a. True
b. False

6. Challenges to the well-being of Latino children and adolescents include all EXCEPT:
a. Acculturation
b. Parent-child culture and language discordance
c. Ethnic identity
d. Rigidly defined gender and family roles

7. Practitioners can foster the resilience of Latinx youth through:
a. A culturally responsive approach that supports their identities
b. Recognition of their strengths and resources
c. By offering tools for survival and success
d. All of the above

8. Older Latinos do not rely on family and informal networks for support and caregiving.
a. True
b. False

9. The ability to express their faith and have their views validated and supported by practitioners is an important component of working with:
a. Latino families
b. Latino children
c. Latino older adults
d. Latinx adolescents

10. The lack of understanding and knowledge regarding Latino mental health is due to:
a. The cultural taboo on talking about emotional difficulties with practitioners
b. The stigma associated with mental health needs and mental illness
c. Both A and B
d. None of the above

11. Research findings relevant to culture-bound symptoms suggest that Latinos:
a. Believe their symptoms are caused by supernatural forces
b. Do not believe mental health providers are professionals
c. Both A and B
d. Are more likely to believe that their symptoms are caused by outside environmental, spiritual, or personal problems

12. Disparities in access to treatment, as well as in the quality of treatment, puts Latinos at a higher risk for more severe and persistent forms of mental health conditions.
a. True
b. False

13. Social work approaches that are preferred by Latinos include:
a. Comfort with conversation
b. Ability to listen
c. Curiosity about Latino culture
d. All of the above

14. The Multidimensional Ecosystemic Comparative Approach (MECA) for use as an assessment with Latinx:
a. Proposes that individual and family processes need to be understood through interaction with various levels of the social and cultural environment
b. Offers practitioners the opportunity to incorporate the impact of migration and cultural change into the helping relationship
c. Cultural diversity and social justice are integral to the assessment framework
d. All of the above

15. Culturally-adapted interventions are advantageous because:
a. They allow the clinician to address culturally specific risk factors and build on identified protective factors
b. Allow practitioners to implement favored practice models
c. Are evidence-based
d. Integrate the worldview of the practitioner and the client's perspectives and values

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Please indicate whether the following learning objectives were achieved:

1. Be familiar with the diversity and demographic profile of the Latinx population in the United States

Achieved in full 5 4 3 2 1 *Not Achieved*

2. Increase their understanding and cultural sensitivity to developmental concerns and psychosocial challenges of Latinx families and adults, children, adolescents, and older adults

Achieved in full 5 4 3 2 1 *Not Achieved*

3. Identify best practices and clinical approaches to social work with Latinx

Achieved in full 5 4 3 2 1 *Not Achieved*

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