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Mindfulness, Culture, and Clinical Practice: Clinician Experiences Utilizing Mindfulness and Acceptance With Hispanics/Latinos

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MINDFULNESS, CULTURE, AND CLINICAL PRACTICE: CLINICIAN EXPERIENCES UTILIZING MINDFULNESS AND ACCEPTANCE WITH HISPANICS/LATINOS

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DEDICATION

Para mi Mayita.

Gracias por su fortaleza y sabiduría que siempre me inspiraron.

Gracias por las historias, las recetas y los recuerdos que me quedan para siempre.

La extraño siempre.

To my Mayita.

Thanks for your strength and your wisdom that always inspired me.

Thank you for the stories, the recipes, and the memories that I will keep forever.

I miss you always.

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ABSTRACT

Research suggests that culturally adapted interventions are superior to unadapted interventions when used with diverse ethnic groups (Hall et al., 2016). There also exists a growing interest psychological interventions that utilize in mindfulness and psychological acceptance (Masuda, 2014). Moreover, there is a significant need to address health inequities among Hispanics/Latinos given that they comprise the fastest growing ethnically diverse population in the United States (U.S. Census Bureau, 2015). A recent comprehensive review of the literature on cultural adaptations of MBIs for Hispanics/Latinos indicated several critical gaps in the study of culturally adapted MBIs which included a need to systematically assess cultural adaptations in clinical settings (Castellanos et al., 2019). The present study investigated the intersection of culture and psychotherapy by understanding and contributing to the improvement of mindfulness-based interventions (MBIs) for Hispanic/Latino populations. Eighteen clinicians who reported utilizing MBIs with Hispanic/Latino clients completed interviews. Results demonstrated that clinicians utilize several strategies and theories to implement MBIs with Hispanic/Latino clients (e.g., functional contextualism, intersectionality, cultural humility). We also found that Bernal et al.'s (1995) domains are being widely utilized by clinicians in the U.S. Clinicians also reported on several challenges that they experience when implementing MBIs with Hispanic/Latino clients and ideas for resources that would aid in implementation. Implications for research and practice are discussed.

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CHAPTER 1

INTRODUCTION

Mindfulness-based interventions have grown in popularity and use over the past two decades. Similarly, there exists a growing interest in culturally adapting psychological interventions generally, including mindfulness-based interventions (MBIs), for minority populations (e.g., Masuda, 2014; Van Dam et al., 2018). Cultural adaptations are considered systemic modifications of evidence-based treatments or intervention protocols to "consider language, culture, and context in a way that is compatible with the client's cultural patterns, meanings and values" (Bernal et al., 2009; p. 361). Evidence has emerged to suggest that culturally-adapted interventions are superior to non-adapted interventions when used with clients from diverse ethnic groups (e.g., Hall, Ibaraki, Huang, Marti, & Stice, 2016).

A recent comprehensive review of the literature on cultural adaptations of MBIs for Hispanics/Latinos identified 20 interventions that investigated culturally-adapted MBIs for Hispanics/Latinos in the U.S., Spain, and Latin America (Castellanos et al., 2019). The authors evaluated factors contributing to the effectiveness of the MBIs for Hispanics/Latinos, including the methodological rigor of the intervention and the cultural adaptations utilized by clinicians delivering the intervention. Overall, findings confirmed the importance of conducting treatment studies on cultural adaptations. Specifically, Castellanos and colleagues (2019) found that culturally-adapted MBIs are associated with depression symptom improvement, stress reduction, stress management, and chronic

illness management. Evidence was found that suggested that cultural adaptations can improve evidence-based treatment (EBT) implementation among Hispanics/Latinos.

However, there are several critical gaps in the study of culturally adapted MBIs (Castellanos et al., 2019). For example, many studies in this area lack strong methodological rigor, with the biggest issues being a small sample size, lack of sample randomization, and lack of a comparison group. Most relevant to the proposed study, there is a need for systematically assessing cultural adaptations in clinical settings. For example, language adaptations -that is, adaptations where language was in tune with the client's background to ensure that the intervention was received as intended- were the most widely-used type of adaptation. Beyond this dimension, few studies incorporated other categories of cultural adaptations. It is unknown whether this was due to lack of adaptations used or lack of reporting them in the study description. Another issue highlighted by the literature review was the dearth of measures to evaluate cultural adaptations. That is, when clinicians do utilize cultural adaptations, they have no way to systematically assess whether their adaptation was implemented as intended or was received by the client as intended.

The current study aimed at addressing several of the gaps in the extant literature on culturally-adapted MBIs. Using a qualitative research approach, the current study examined current practices in culturally adapted MBIs among Hispanics/Latinos. However, as highlighted by our review (Castellanos et al., 2019) there are many gaps in our knowledge of culturally adapting MBIs for Hispanic/Latino clients. Currently, there is little evidence on how clinicians adapt MBIs when working with Hispanic/Latino clients. Moreover, there is little evidence from the field about what type of adaptations

are being utilized by clinicians working with Hispanic/Latino clients and utilizing MBIs. There also exists a gap regarding how clinicians perceive the process of culturally adapting MBIs when working with Hispanic/Latino clients and the challenges clinicians face when adapting MBIs for Hispanic/Latino clients. The current study aimed at filling these gaps through an exploratory lens that provides further insight on the current state of cultural adaptations of MBIs among Hispanic/Latinos. This in turn will allow us to identify priorities for future research, such as measure development.

Developing tools to systemically assess cultural adaptations is critical to further promote the use of cultural adaptations in psychological treatment. Further, the dissemination of these tools allows for the rigorous implementation of cultural adaptations among practitioners and researchers working with Hispanic/Latino clients and utilizing MBIs. Evidence suggests that the development of cultural adaptations has outpaced the identification of measurement tools (Hall et al., 2016). This lack of measurement tools, along with a growing interest in utilizing multicultural competency and the established need for cultural sensitivity in the field of psychology, highlights the pressing need for systematically assessing cultural adaptations of EBTs. The ability to systemically assess cultural adaptations utilized in EBTs is critical to promoting cultural adaptations practices and identifying key features of cultural adaptations. For example, Hall et al. (2016) suggest that an adequate evaluation of cultural adaptations should focus on substantive modifications that are likely to produce differences (e.g., cultural content and values) rather than on relatively minor variations (e.g., therapist-client ethnic match, language translation) that are not. However, there is currently no measure to assess such

adaptations, be they substantive or minor. The curse study may serve as a precursor for measure development.

It is critical for researchers in this area of study to acknowledge that there is a distinction between the terms “Hispanic” and “Latino.” Hispanic is not a race but an ethnic distinction, and Hispanics come from all races and have various physical traits; the term is usually reserved to identify people with Spanish heritage. The term Latino is commonly used by Latinos and non-Latinos when referring to both immigrant and U.S.-born Americans of Latin American ancestry. Many Latinos speak Spanish and most follow the blended cultural traditions of the Spanish colonists and the indigenous peoples of the Americas. Latinos may belong to any racial group, including those with roots in Europe, Africa, Asia, and the Middle East (Organista, 2006; Organista & Muñoz, 1996). Although there is no consensus among the research community on whether the term “Hispanic” or the term “Latino” better personifies this general ethnic minority group, the extant research on culturally-adapted MBIs suggests that both groups may benefit equally well from receiving culturally-adapted treatments (Castellanos et al., 2019). Therefore, for the purposes of the proposed study, the term “Hispanics/Latinos” will be utilized.

Hispanic/Latino Mental Health

There are important in-group distinctions when considering mental health outcomes for Hispanics/Latinos. For example, U.S.-born Hispanics/Latinos report higher rates for most psychiatric disorders than Hispanic/Latino immigrants, a phenomenon known as the “immigrant paradox” (Alegría et al., 2008). However, data suggests that this paradox does not apply to all Hispanic/Latino subgroups equally. Alegría et al. (2008) suggest that the immigrant paradox is only reliably observed for Mexicans,

particularly for depressive and anxiety disorders. However, the paradox is consistently observed among Mexicans, Cubans, and Other Hispanics/Latinos for substance disorders. No evidence for the immigrant paradox was found for Puerto Ricans in Alegría's 2008 study. Similarly, studies have shown that older Hispanic/Latino adults and Hispanic/Latino youth are especially vulnerable to psychological stress associated with immigration and acculturation (Office of the Surgeon General, 2001). Further evidence indicates that Hispanic/Latino children and adolescents are also at significant risk for mental health problems, and in many cases at greater risk than non-ethnic minority children (Center for Behavioral Health Statistics and Quality, 2016). In brief, the literature suggests that Hispanic/Latinos are vulnerable to a variety of mental health disorders depending on their nativity, immigration, and age background.

In addition to concerns about rates of mental health disorders among Hispanics/Latinos, evidence suggests that the quality of mental health services has not kept pace with the fast growth of Hispanics/Latinos in the U.S. and their mental health needs. Some reports suggest that Hispanics/Latinos experience underutilization and disparities in mental health care when compared with individuals in the non-Latino white group (American Psychiatric Association, 2014). In like manner, data suggests that only 27.3 percent of Hispanic/Latinos receive mental health treatment in a given year. This contrasts with 46.3 percent of Non-Hispanic whites, 29.8 percent of African Americans, 41.6 percent of American Indians or Alaska Natives, and 18.1 percent of Asian Americans (Center for Behavioral Health Statistics and Quality, 2016). By the same token, approximately 1 in 10 Hispanics/Latinos with a mental disorder use mental health services from a general health care provider, while only 1 in 20 receive such services

from a mental health specialist (Office of the Surgeon General, 2001). Evidence also suggests that Hispanics/Latinos are underrepresented in outpatient treatment, have less access to evidence-based treatments, benefit less from psychotherapy, and drop out from treatment at a higher rate than non-Hispanic/Latino Whites (Alegría et al., 2004; Office of the Surgeon General, 2001; Schraufhagel, Wagner, & Byrne, 2006). Taken together, these findings underscore the significant need to improve the availability, quality, and fit of mental health services offered to Hispanic/Latinos and other minority populations (Goodell & Escarce, 2007; Sue, 1998).

Cultural match theory suggests that Hispanic/Latino clients tend to adhere to and benefit more frequently from treatment interventions that agree with their beliefs (Hall, 2001; Sue, 1998; Sue & Sue, 2012) and often reject those mental health services (e.g., traditional medical model) that do not embrace their cultural values. The lack of bilingual or Hispanic/Latino mental health providers also makes it difficult for this population to receive appropriate and effective treatment (American Psychiatric Association, 2014). Thus, the development of culturally adapted psychotherapies is needed to facilitate the delivery of treatment services that are consistent with Hispanics/Latinos' beliefs and values. The proposed study aims to provide evidence to support the development of culturally adapted MBIs for which there is little empirical work among Hispanic/Latino populations.

Mindfulness-Based Interventions

Over the last decade, mindfulness-based treatments for psychological disorders have garnered much attention. The concept of mindfulness has been borrowed from Eastern traditions and incorporated into behavioral sciences (Masuda, 2014). Often

described as the third wave of behavioral and cognitive therapies, mindfulness and acceptance-based therapies shift from reframing or changing dysfunctional cognitive process and negative emotions (e.g., Cognitive Behavior Therapy, or CBT) to emphasizing the importance of acknowledging and recognizing one's contextual demands and emotions without attempting to avoid or change them. This third wave of therapies aims to increase an individual's awareness and clarify what is most important to them (Masuda, 2014). Kabat-Zin (1994) defined mindfulness as "paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally" (p. 4).

There are several psychological interventions and protocols that utilize mindfulness practices.

Dialectical Behavioral Therapy (DBT). DBT was developed by Marsha Linehan for the treatment of borderline personality disorder (BPD). Linehan (2015) developed DBT to treat adult women with histories of suicide attempts, suicidal ideation, and non-suicidal injury. She found that traditional CBT was not effective in treating these individuals, and in developing DBT, she sought to address these limitations. DBT has also been used to treat other types of mental health problems such as eating disorders, substance use disorders, and treatment-resistant depression (Lineham, 2015). As described by Linehan (2015) DBT was the first form of psychotherapy to include mindfulness as a core component. DBT protocols teach mindfulness skills in addition to distress tolerance, interpersonal effectiveness, and emotion regulation. Linehan (2015) states that much of the mindfulness skills found in DBT draw from Zen practices. Mindfulness skills are considered "core" skills, meaning they are central to DBT. However, most DBT studies include a majority of Caucasian female samples, and little

attention has been paid to developing cultural adaptations for this treatment modality (Germán et al., 2015). While DBT has been studied internationally (Canada, Germany, Netherlands, Turkey, New Zealand, Australia, Argentina, and Puerto Rico), there is little research about cultural considerations of DBT for Hispanic/Latino patients (Germán et al., 2015).

Mindfulness Based-Stress Reduction (MBSR). MBSR was developed by Jon Kabat-Zinn to assist medical patients with chronic conditions (Kabat-Zinn, 1982). Kabat-Zinn developed an 8-week program to teach stress reduction, relaxation, and the applications of mindfulness meditation in everyday living to optimize one's capacity to face stress, pain, and illness across the lifespan (Kabat-Zinn, 1990). Participants in this program are encouraged to practice for at least 45 minutes a day, six days a week. Since it was developed, MBSR has been related to promising outcomes such as stress, depression, and anxiety reduction (Grossman, et al., 2004). However, little evidence has been found regarding cultural adaptations of MBSR for Hispanic/Latino populations (Masuda, 2014).

Mindfulness Based Cognitive Therapy (MBCT). MBCT combines the principles of Cognitive Behavior Therapy and MBSR. MBCT was developed by Segal, Williams and Teasdale to prevent depression relapse in patients with recurring depression and typically consists of a six-week protocol (Segal et al., 2012). Since its development, it has also been applied to the treatment of other issues such as generalized anxiety, post-traumatic stress disorder, and overall psychological well-being (Bergen-Cico et al., 2013; Omidi et al., 2013; Evans et al., 2008). There are also several studies that point to the effectiveness of MBCT in preventing depression relapse (Piet & Hougaard, 2011). Little

research has been conducted with Hispanic/Latino populations, and little is known about cultural adaptations for this type of intervention.

Acceptance and Commitment Therapy (ACT). ACT was developed by Hayes, Wilson and Strosahl as an orientation to psychotherapy, meaning that ACT is not a set protocol of skills and/or numbered sessions. Instead ACT targets core behavioral processes that are theorized to promote quality of life (Hayes et al., 1999). ACT emphasizes six basic processes, including cognitive defusion, expansion and acceptance, contact and connection with the present moment, the observing self, values clarification, and committed action (Harris, 2006). These principles also emphasize mindfulness practices. Much attention has been paid to the empirical evidence supporting ACT. Some outcomes associated with the effectiveness of this therapeutic approach include treatment of psychosis, workplace stress, chronic pain, anxiety, depression, smoking cessation, diabetes self-management, and trichotillomania (Powers, Vörding & Emmelkamp, 2009). Although some have suggested that the six ACT processes are unrestrained by the bounds of culture, others have questioned whether ACT is culturally sensitive and suggest that there is need for empirical evidence to promote best practices among minority populations (Masuda, 2014). As with other mindfulness-based treatment modalities, there is little evidence on cultural adaptations of ACT for Hispanics/Latinos. There is also evidence that there exists interest in the ACT community to promote treatment for this population. A review of the Association for Contextual and Behavioral Sciences (ACBS) website displays many resources in Spanish, moreover, per their demographic data reports about 4% of their members speak Spanish. Displaying potential for this MBI

modality to be adapted for the Hispanic/Latino community (E. Rodrigues, personal communication, August 26, 2018).

To date, Dialectical Behavioral Therapy (DBT), Mindfulness-Based Cognitive Therapy (MBCT), Mindfulness-Based Stress Reduction (MBSR), and Acceptance and Commitment Therapy (ACT) have been applied to diverse treatment settings such as independent practices, Veterans Affairs clinics, university counseling services centers, substance use treatment clinics, medical settings, and e-health settings (Bach & Moran, 2008; Grossman, Niemann, Schmidt, & Walach, 2004; Hayes & Levin, 2012; Kearney, McDermott, Malte, Martinez, & Simpson, 2012; Kurash & Schaul, 2006; Ljótsson et al., 2010; Marra, 2005; McCracken, 2011). Similarly, these treatments have been used to promote quality of life for individuals who are struggling with a wide range of issues, such as depression, anxiety, disordered eating, substance use and addiction problems, and physical health issues (Arch et al., 2012; Grossman et al., 2004; Hayes & Levin, 2012; Safer, Telch, & Agras, 2001; Segal et al., 2002; Telch, Agras, & Linehan, 2001).

MBIs for Hispanic/Latino Populations

Some authors argue that the value-based nature of mindfulness based interventions may make them a better fit than other forms of interventions for Hispanic/Latinos (Masuda, 2014). Evidence in support of this argument suggests that, despite variability within Hispanic/Latino culture, there is a tendency for a more collectivistic orientation and certain shared values and attitudes (e.g., familismo, personalismo, simpatía, respeto). For example, familismo refers to prioritizing and keeping strong ties to the family (Falicov, 2014; Smith & Montilla, 2013). While some evidence suggests that the consequence of this is that Hispanics/Latinos tend to

underutilize sources of support outside of the family, such as mental health treatment, mindfulness-based treatments could offer a bridge by utilizing these values as an asset in treatment (Falicov, 2014; Smith & Montilla, 2013). Some MBIs emphasize client's values (e.g., ACT, DBT), which allows the intervention to utilize cultural values, such as familismo, to benefit and engage clients.

Given the rising evidence supporting the utilization of MBI and the fit between MBIs and Hispanic/Latino cultural values, it is imperative to study aspects of implementing MBIs among Hispanic/Latino populations. The proposed study will provide further evidence on how clinicians are implementing MBIs among Hispanics/Latinos in the "real world."

Cultural Adaptations

Cultural adaptations are considered systemic modifications of evidence-based treatments or intervention protocols to "consider language, culture, and context in a way that is compatible with the client's cultural patterns, meanings and values" (Bernal et al., 2009; p. 361). It is important to make a distinction between cultural adaptations and cultural competence, which occurs at the individual level and concerns the therapist or counselor; these two terms are sometimes used interchangeably and a review of the literature suggests that there is some overlap (Sue et al., 2009). Cultural competency involves personal characteristics (awareness, knowledge, and skills) that a counselor or therapist should have, while adaptations refer to changes made to the intervention being utilized by counselor, therapists or researchers (Cardona et al., 2012; Sue et al., 2009).

Despite the widespread use of MBIs, most studies examining their effectiveness have been carried out primarily with non-Hispanic, white, female, and middle-to-upper

class participants (Woidneck, Pratt, Gundy, Nelson, and Twohig, 2012). The literature on cultural considerations and adaptations of MBIs for Spanish-speaking individuals is limited (Germán et al., 2015; Masuda, 2014); thus, there is currently no consensus on the empirical evidence to support the use of MBIs among Hispanics/Latinos. This represents a significant gap in the MBIs literature given that Hispanics make up the fastest growing ethnically-diverse population in the United States (U.S. Census Bureau, 2015). As such, evaluating the appropriateness and effectiveness of MBIs for Hispanics is imperative (Goodell & Escarce, 2007; Sue, 1998).

There is substantial evidence supporting the importance of cultural adaptations. Some authors state that cultural adaptations are necessary when there are community-specific cultural contexts of risk and resilience that influence disorders (Hall et al., 2016; Sue, Zane, Nagayama Hall & Berger, 2009). For example, Forehand and Kotchick (1996) point to how all parenting occurs within a context. Parenting interventions that are effective in European American contexts may not be as effective in another cultural context. The rationale behind this is that associations between parent behaviors and child behaviors may differ between groups.

Authors have made efforts to clarify what constitutes a cultural adaptation. Bernal et al. (1995), considered eight dimensions necessary to developing cultural adaptations. These dimensions are meant to fit clients' cultural perspectives, meanings and values. Bernal et al. (1995) proposed language, people, metaphors, content, concepts, goals, methods, and context; as the dimensions that should be considered in making a cultural adaptation.

Language. Bernal et al. (1995) consider language to be the "carrier of culture." Without shared language, treatment is difficult if not impossible to deliver. Oftentimes, shared language presumes greater familiarity with cultural knowledge. Additionally, because language is related to the expression of emotional experiences, it is important in the treatment process. Translating interventions is an important element to adaptation but it is not the only aspect that comes into consideration when referring to language. Use of familiar words or less specialized language can be part of this adaptation. In brief, language must be in tune with the client's background to ensure that the intervention is received as intended (Bernal et al., 1995). Hall et al. (2016) is one of the few studies that assessed language when evaluating cultural adaptations of psychological interventions. In their review, fifty percent of studies conducted in the U.S. included therapy conducted in a language other than English. In our review (Castellanos et al., 2019), ninety-one percent of interventions utilized language adaptations, making this the most common form of cultural adaptation. However, authors suggest that simple translations are inadequate to make interventions culturally responsive (Hall et al., 2016); thus, it is important to explore how language is adapted in clinical settings as well as exploring how other dimensions are applied.

Persons. This dimension often refers to the cultural "match" between clients and therapists. This refers to client and therapist characteristics as well as the relationship between these individuals. Some characteristics that might influence the relationship include differences in terms of social, economic, historic, and political factors (Bernal et al., 1995). This is another dimension that was assessed by Hall et al. (2016) in their meta-analysis of cultural adaptations of psychological interventions. The meta-analysis

concluded that therapist-client ethnic matching did not significantly moderate the overall effect that culturally adapted interventions produced substantially better outcomes than other conditions. Ibaraki and Hall (2014) considered that cultural match might be salient at the beginning of therapy, but that it subsides as the client begins to fully understand other components of psychotherapy such as the therapeutic alliance. Our review (Castellanos et al., 2019) found that eighteen percent of studies utilized cultural match between facilitators and participants. Overall, studies that have studied the cultural match of clients and therapists have found mixed results (Hall et al., 2016).

Metaphors. Symbols and concepts shared by a population are examples of metaphors. Some authors have suggested that welcoming clients in a such a way that they feel understood, comfortable, and in familiar surroundings with objects and symbols of their culture in their office, or utilizing sayings or idioms can be helpful ways of introducing metaphors in therapy (Bernal et al., 1995). Twenty-seven percent of investigations included in our review (Castellanos et al., 2019) utilized Metaphor adaptations; these adaptations typically utilized metaphors or symbols that were culturally relevant to the treatment population. For example, Paéz et al. (2007) utilized Wilson and Luciano's ACT handbook, which included metaphors adapted in Spanish; additionally, they created exercises that were relevant to cancer patients. Our review highlighted the importance of continuing to explore how this dimension is being utilized by clinicians.

Content. Content refers to knowledge about the cultural background of the client and how it is explicitly included in treatment. For example, when working with Hispanic/Latino populations, some authors suggest that being familiar with values such

as allocentrism, simpatía, or familism may be helpful. Often, incorporating cultural knowledge has been an additive process to regular treatment, but this should not be the case as all therapeutic work involves a cultural adjustment between the client and society (Bernal et al., 1995). This dimension often represents a challenge for treatment researchers in a multicultural society because it involves handling information about values, customs and traditions in a way that displays appreciation of cultural differences as well as a commitment to clinical change. Our review (Castellanos et al., 2019) found only thirteen percent of interventions utilized content adaptions. For example, Flores and Pascual (2013) utilized functional analysis to understand contextual and individual factors associated with gender violence and later incorporated this information into their intervention design. While Hall et al. (2016) emphasized the importance of studying content adaptations, our study (Castellanos et al., 2019) appears to be the only one to systematically assess for this domain. Thus, it remains essential to explore how content adaptations are being applied in the field.

Concepts. This dimension refers to the constructs utilized by different psychosocial models that inform treatment. This dimension relates to case conceptualization and how clinical researchers and therapists identify the presenting problem, and more importantly, how it's explained to the client. Authors suggest that consonance in concepts of treatment must be evaluated for cultural sensitivity. For example, dependence (e.g., fusion, attachment, enmeshment) is a negative feature in some cultures, but cultures that value collectivism may not perceive dependence as negative. Clinicians who might traditionally perceive fusion as unhealthy could assess the client's culture conceptualization of this notion when making clinical decisions (Bernal et

al., 1995). Hall et al. (2016) stressed the importance of these type of substantive modifications in making cultural adaptations, however, they didn't report on any studies that had carried out concepts adaptations. Similarly, our review (Castellanos et al., 2019) found no studies that had utilized concept adaptations showing the need for more exploration of this dimension.

Goals. Authors suggest that in addition to goal congruence between therapist and client, it is desirable to frame goals within the values, customs, and traditions of the client's culture. The literature also suggests the transmission of positive and adaptive cultural values and support for the adaptive values from the culture of origin are helpful considerations when establishing treatment goals (Bernal et al., 1995). Nine percent of the studies included in our review (Castellanos et al., 2019) carried out Goal adaptations. For example, some studies included discussions with participants to agree on individual treatment goals and individual values to incorporate into the broader context of the group intervention (e.g. Delgado et al., 2012; Flores & Pascual, 2013).

Methods. This domain refers to how cultural knowledge is integrated into therapy to achieve treatment goals, including method, tasks, and procedures (Bernal et al., 1995). For example, Szapocznik et al. (1989) concluded that structural family therapy allows Hispanic cultural values to be integrated with therapy goals. They reached this conclusion given that structural family therapy provides a good match between the values of the structural approach and the value orientations and interpersonal style of preference by Hispanics (Bernal et al., 1995). In our review (Castellanos et al., 2019), Method adaptations were defined as the pragmatic and practical aspects informed by knowledge of the culture and context. These adaptations were not directly related to the therapy

process itself but may increase the likelihood of participants engaging in the intervention. Forty percent of studies in our review utilized method adaptations. One excellent example of this process was Rathus and Miller's (2002) study which adapted a DBT intervention for suicidal adolescents with sixty-seven percent Hispanic participants. In their intervention, they added a multi-family skills training component to their protocol, which ensured a match between cultural values such as familismo –an individual's strong identification with and attachment to nuclear and extended families– and treatment. In this case, parents and family members were trained to serve as skills coaches to enhance treatment strategies, and they were also included in individual therapy when familial issues seemed paramount.

Context. This dimension entails considering processes such as acculturative stress, phases of migration, developmental stages, availability of social supports, as well as social, economic, and political contexts of the intervention. Our review (Castellanos et al., 2019) found seven interventions that reported the use of Context adaptations. For example, Santamaria and colleagues' (2006) implemented a parenting intervention for mothers of children with conduct issues; the authors included a description of how modern families are having children later in life and have less support and mentoring from extended family, thus, limiting the availability of models of parenting skills.

Studies have highlighted the potential benefits of cultural adaptations for MBIs. Hall et al. (2016) conducted a meta-analysis that included almost 14,000 participants, 95% of whom were non-European American. Across 78 studies, Hall et al. (2016) found that culturally responsive interventions are more effective among minority populations. However, this review only included one MBI, and it did not focus solely on

Hispanics/Latinos. Woidneck et al. (2012) conducted a review that explored cultural competence in ACT outcome research. This review included 2,075 participants across 36 randomized controlled trials and 4 controlled trials. They included research from 10 different countries. This study provides support for implementing culturally-adapted MBIs by demonstrating that ACT interventions result in effective outcomes for managing chronic pain, treating mood disorders, anxiety and psychotic disorders for diverse populations. However, only 9 of the studies had more than 20% participants from a single non-Caucasian ethnic or racial group. Importantly, it did not address Hispanics/Latinos exclusively, and it focused solely on ACT interventions. Finally, Fuchs et al. (2013) conducted a review highlighting the elements of MBIs that may be congruent with culturally responsive treatment and briefly outlines the general principles of cultural competence and responsive treatment. This meta-analysis included 35 studies from 33 peer-reviewed articles and one dissertation. Their review consisted of studies that included only individuals who were either: (a) non-White, (b) non-European American, (c) older adults, (d) non-heterosexual, (e) low-income, (f) physically disabled, (g) incarcerated, and/or (h) individuals whose first language is not that of the dominant culture. They found that when compared to treatment as usual, culturally-adapted interventions had better outcomes, thus demonstrating support for culturally adapting MBIs to minority populations. However, only two of the studies in this analysis included full samples of Hispanic/Latino populations. Although an important first step, this body of work limits our ability to make meaningful conclusions as to the effectiveness of MBIs for Hispanic/Latino populations, and the cultural adaptations that may enhance engagement.

Our recent systematic review of the literature on cultural adaptations of MBIs for Hispanic/Latino populations identified some of the gaps in the extant literature (Castellanos et al., 2019). Our review established that MBIs are being adapted for Latinos/Hispanics both in the U.S. and worldwide to target varied outcomes. The review highlighted how MBIs are effective at targeting varied outcomes among Hispanic/Latinos (i.e. depression, stress management, anxiety, chronic illness management), which shows promise for future MBI research with this population. However, our review concluded that cultural adaptations being reported by studies are superficial at best. For example, most studies included in our review utilized primarily language adaptations, which may not be sufficient to guarantee cultural fit between intervention and clients (Hall et al., 2016). The review showed that incorporating more elements of cultural adaptations may improve implementation and engagement of MBIs among Hispanics/Latinos. Briefly, the review concluded that while MBIs are being adapted for Hispanic/Latino populations both in the US and worldwide, there is evidence needed to determine *how* they're being adapted, *what* works best when adapting them, and for *which* outcomes they are most effective.

The Current Study

This study is relevant to the intersection of culture and psychotherapy by addressing and contributing to the improvement of mindfulness-based interventions for Hispanic/Latino populations. The study is in line with the concept that to maximize treatment retention and outcomes when providing mental health services to Hispanic/Latino clients, we need to provide culturally adapted treatment. Moreover, this study focused on the "real world" aspects of implementing psychotherapy practices by

consulting clinicians who are currently implementing MBIs with Hispanic/Latino populations in the practice field.

Specific research questions are as follows:

1. How are clinicians in the U.S. utilizing MBIs with Hispanic/Latinos? What types of issues are they treating with MBIs?
2. How are clinicians in the U.S. adapting MBIs for Hispanic/Latinos? What type of adaptations – utilizing Bernal et al.'s dimensions- are they utilizing? How are they implementing these adaptations?
3. What are some advantages of culturally adapting MBIs? What are some challenges of culturally adapting MBIs?
4. What type of resources or guidelines would make implementation of cultural adaptations of MBIs more feasible for clinicians?

CHAPTER 2

METHOD

Study Design

Qualitative methodology was utilized to investigate how mindfulness-based interventions were culturally adapted by clinicians working with Hispanic/Latino populations in the U.S. In psychosocial research, quantitative research methods are appropriate when factual data are required to answer the research question; when general or probability information is sought on opinions, attitudes, views, beliefs or preferences; when variables can be isolated and defined; when variables can be linked to form hypotheses before data collection; and when the question or problem is known, clear and unambiguous (Hammarberg, Kirkman & de Lacey, 2016). In contrast, qualitative methods are used to answer questions about experience, meaning and perspective, most often from the standpoint of the participant. These data are usually not amenable to counting or measuring. Qualitative research techniques include 'small-group discussions' for investigating beliefs, attitudes and concepts of normative behavior; 'semi-structured interviews', to seek views on a focused topic or, with key informants, for background information or an institutional perspective; 'in-depth interviews' to understand a condition, experience, or event from a personal perspective; and 'analysis of texts and documents', such as government reports, media articles, websites or diaries, to learn about distributed or private knowledge (Hammarberg, Kirkman & de Lacey, 2016; Creswell & Creswell, 2017). Thus, we selected qualitative research due to the exploratory

nature of the study and identified common themes for implementing mindfulness-based interventions with Latino/Hispanic populations based on participants' experiences. We utilized open-ended questions as an analytic device to elicit themes derived from views of the participants (Creswell & Creswell, 2017).

Sampling and Recruitment Strategies

Considering the aims of this study, it was important that participants had experience both in working with Hispanic/Latinos and in utilizing MBIs with them. This led to choosing expert sampling to recruit participants for this study. Expert sampling is a type of purposive sampling technique that is used when research needs to glean knowledge from individuals that have expertise (Etikan et al., 2016). Expert sampling is particularly useful where there is a lack of empirical evidence in an area and high levels of uncertainty such as the topic being investigated in this study. Because participants in this study were required to have experience in working clinically with Hispanic/Latino populations and in implementing MBIs, we primarily recruited clinicians who provide services in Spanish. Considering language alone, data suggests that there are only about 5,000 psychologists in the U.S. who are Hispanic and who can provide services in Spanish; that is 5% of all psychologists (American Psychological Association, 2018). Data from the Association of Contextual Behavioral Sciences, an international association focusing on MBIs, suggests that only about 100 of their members (about 3%) are Spanish speakers (E. Rodrigues, personal communication, August 2018).

Purposeful and snowball sampling methods were utilized to target potential participants. Participants were recruited via word of mouth, email listservs (e.g., National Latino/a Psychology Association, Association for Contextual Behavioral Sciences,

Association for Cognitive Behavioral Therapies), and advertisement of the study on social media (e.g., Facebook). Fifteen potential participants – people who responded to our ads vie email or social media– were recruited through these methods; 11 of these leads were participants in our sample, 4 dropped out. Additionally, we recruited participants who listed their services on two specialized Latino Therapy websites which are aimed at Latinx/Hispanic therapists and clients (i.e., Latinxtherapy.com and Therapyforlatinx.com); 55 therapists who listed MBIs in their list of services were individually invited to participate in the study. Twelve potential participants were recruited through this method; seven of these leads were participants in our sample, 5 dropped out. See Figure 1 for details on recruitment and dropout.

Twenty-three total participants completed the pre-interview questionnaire which aimed at screening for eligibility and were scheduled for interviews. Five participants dropped out after multiple contact attempts by the P.I. Eighteen participants completed all data collection procedures and are therefore the final sample for this study. Data collection was discontinued once the PI and coders had determined saturation. Saturation was determined through three different methods: (1) The PI and coders determined that no new emergent codes were occurring in the data, and there were mounting instances of the same codes, also known as *inductive thematic saturation* (Given, 2016; Saunders et al., 2018), (2) Data related to Bernal et al.'s domains of cultural adaptations became increasingly redundant; that is, new data appeared to be redundant with data already collected, (Grady, 1998; Saunders et al., 2018), and (3) Code saturation was also established with the PI and coders determining that the codebook had stabilized; that is,

codes developed within the codebook had been given meaning and there were several examples for most codes in the codebook (Hennik et al., 2017; Saunders et al., 2018).

Participants

Participants included 18 mental health professionals and graduate students in the fields of social work (n= 2, 11%), clinical psychology (n=9, 50%), counseling psychology (n=6, 33%), and cognitive neuroscience (n=16%). Seventy-two percent of the sample (n=13) had attained a master's degree at the time of the interview, while five percent held a Doctorate degree. Seventy-two percent of the sample was female (n=13). Further details can be found on Table 2.1.

Procedures

Potential participants were asked to complete a four-item screening questionnaire to ascertain whether they met inclusion criteria. Inclusion criteria were as follows: (1) mental health professionals, graduate students, master's level or PhD level clinicians in Clinical Psychology, Counseling Psychology, Social Work, or Marriage and Family Therapy, or related fields; (2) working in any region in the U.S.; (3) had experience utilizing mindfulness-based interventions with Hispanic/Latinx clients (e.g., Acceptance and Commitment Therapy, Dialectical Behavioral Therapy, Mindfulness-Based Cognitive Therapy, Mindfulness-Based Stress Reduction, Flow Meditation, etc.); (4) utilized an MBI (at least 1 client in the last year) with clients that identify as Hispanic or Latino/a/x.

Upon being contacted by potential participants, P.I. assigned an ID number selected at random and sent a brief screener via Google Forms to clinicians who responded to the recruitment ad. The screener asked: (1) Are you currently a Graduate

Student, Master's level, or Ph.D.-level clinician in Clinical Psychology, Counseling Psychology, Social Work, or Marriage and Family Therapy?; (2) Are you currently practicing in the U.S.?; (3) Are you currently utilizing mindfulness-based interventions with Hispanic/Latinx clients (e.g., Acceptance and Commitment Therapy, Dialectical Behavioral Therapy, Mindfulness-Based Cognitive Therapy, Mindfulness-Based Stress Reduction, Flow Meditation, etc.)?; (4) Have you utilized a mindfulness-based intervention with at least 1 Hispanic/Latinx client within the last calendar year (last 365 days)?). Upon determining eligibility, participants were scheduled for a follow-up phone interview and were asked to complete a brief online demographic questionnaire. Each participant was emailed a copy of informed consent, and the P.I. also went over the consent procedure with participants at the beginning of each phone interview.

A semi-structured interview was utilized as the primary data collection approach. Three pilot interviews were conducted at the beginning of data collection to test the adequacy of the items on the semi-structured interview and the data collection process. This was achieved by asking for participants' feedback at the end of each pilot interview. Participants in the pilot were two graduate students in clinical psychology and one clinical psychologist, all participants in the pilot were female. Pilot interviews lasted an average of 50 minutes. Participants expressed consensus regarding clarity and comprehension of interview procedures, and they did not indicate that additional interview items were needed. Subsequently, data collection procedures with the rest of the sample ensued. Since no changes were made to the study procedures after the pilot participants, the three pilot participants are included in the 18 total participants. Recruitment and data collection occurred between February and May of 2019. All

interviews were audio recorded following verbal consent procedures (see appendix C). Phone interviews ranged from thirty to sixty-two minutes and lasted forty-two minutes on average. All interviews were conducted in English. Data collection stopped once the PI and coders had determined saturation of deductive codes, as described above. All study procedures were approved by the University of South Carolina Institutional Review Board. Participants did not receive compensation for study participation. Data collection procedures are depicted on Figure 2.2.

Instruments

Demographic questionnaire. Demographic information was collected using an online questionnaire powered by Redcap (https://redcap.healthsciencessc.org), a secure web application for building and managing online surveys and databases which is available free of charge through the University of South Carolina. Data collected from this questionnaire included: gender, degree, age of participant, racial/ethnic identity, years in training or in practice, first language, languages spoken and language fluidity, language primarily utilized with Latino/Hispanic clients, area of practice (geographical and type of dwelling), therapeutic orientation, number of years as a therapist, number of years working with Hispanic/Latino clients, and the average number of Hispanic/Latino clients per month.

Semi-structured interview. A semi-structured interview was also carried out to identify themes. A semi-structured interview guide was utilized to collect data; see Appendix A for the questions on this guide. Bernal's (1995) cultural adaptations dimensions were utilized to inquire about how MBIs are being adapted by clinicians. Each of Bernal's dimensions - proposed language, people, metaphors, content, concepts,

goals, methods, and context -were explored via open-ended questions. Additionally, participants were asked about advantages and challenges related to implementing MBIs with Hispanic/Latino clients, and outcomes associated with these interventions.

Data Analysis

Studies of cultural adaptations among Hispanic/Latinos have proposed various dimensions to be considered when implementing cultural adaptations (Bernal et al., 1995). However, as these dimensions have not been thoroughly examined, it was important to identify any unique themes of messages present among clinicians implementing MBIs with Hispanic/Latino clients. Accordingly, the current study utilized a two-step approach to identify distinct themes of cultural adaptations emerging from interview data followed by a second analysis guided by existing theory to look for specific themes suggested by Bernal's dimensions of cultural adaptations literature (Kloos et al., 2005; Miles and Huberman, 1994). Emergent coding was first employed as it allowed for themes of cultural adaptations and MBIs within the data to be revealed organically without a framework guiding the identification of themes (Strauss & Corbin, 1990). Beginning with pre-existing theory could potentially obscure observation of themes not anticipated by the researchers; thus emergent coding was carried out as specified by Strauss and Corbin (1990). After emergent coding, deductive coding (Elo & Kyngäs, 2008; Hsieh & Shannon, 2005) ensued. Deductive coding focused on Bernal et al.'s dimensions of cultural adaptations and on the emergent codes identified previously. Data analysis and management procedures are depicted on Figure 2.2.

Data Management. Four research assistants were trained by the primary investigator to assist with transcribing individual interviews and qualitative coding.

Additionally, Trint (https://trint.com/) was utilized to aid with transcription. Trint is an automated transcription service. After audio interviews had been transcribed by Trint, a research assistant checked each transcript for accuracy. When participants spoke briefly in Spanish to explain a concept, the PI, who is a native Spanish speaker, listened to the audio recording, translated, and completed verbatim transcription. Any conflicts in transcription were resolved by the PI. The three other research assistants completed a two-hour training on qualitative research methods and coding led by the PI. Training consisted of brief review of qualitative methods research relevant to the study (e.g. coding methods, data collection methods) and an overview of the coding framework. PI provided research assistants with readings on qualitative research and explained the rationale behind utilizing qualitative research methods for the current study. PI also went over definitions of cultural adaptations, MBIs and covered Castellanos et al.'s systematic review.

Emergent coding. Following transcription, each interview was read in its entirety by research assistants so that they would become familiar with the content. A framework of themes emerging from participant interviews was constructed. This first step in emergent coding occurred with a subset of five interviews, which were re-read for emergent patterns and themes pertaining to the research questions. As possible themes were identified, each reader made notations in the margins of the transcript. A list of potential emergent themes was compared among readers and reviewed by the team for consistency, coverage, and applicability across interviews. Once a framework of emergent themes was agreed upon and no new thematic content was identified in interviews, the coding criteria for the emergent codes was finalized. The actual coding of

interviews for emergent themes was applied systematically to all interview transcripts to create a codebook. The codebook consists of a list of codes that emerged from coders for each interview as well as an operational definition of each code, examples, and quotes from the interviews.

Deductive coding. Deductive coding is a coding technique in which an existing theory informs a coding structure that is used to guide coding. In this phase of coding, research assistants used codes created by the PI based upon the theory of cultural adaptation domains through a process of deductive coding (Elos & Kyngäs, 2008; Hsie & Shannon, 2005). Codes were created for cultural adaptation domains as suggested in the literature review, see Appendix B (Castellanos et al., 2019). In order to determine agreement, we utilized the kappa statistic for interrater reliability. The importance of rater reliability lies in the fact that it represents the extent to which the data collected in the study are correct representations of the variables measured. Measurement of the extent to which raters (coders) assign the same score to the same variable is called interrater reliability. While there have been a variety of methods to measure interrater reliability, traditionally it was measured as percent agreement, calculated as the number of agreement scores divided by the total number of scores (McHugh, 2012). Coders were trained in using this coding system and when 0.70 agreement was reached in coding a subset of five interviews, coders independently applied deductive coding framework to all the interviews.

Analyzing adequacy of coding. Across emergent and deductive coding, each transcript was coded by at least two coders and checked for reliability using the formula: Reliability=Number of Agreements/(Total number of Agreements + Disagreements)

(Miles & Huberman, 1994). In the case that reliability was less than 70% between coders, coders met to discuss differences in coding. Following discussion, coders re-coded transcripts and re-checked interrater reliability. Reliability across coders ranged between 0.71 and 0.91

After coding procedures were completed, the data set of emergent and deductive coding frameworks (i.e., codebook) was complete. A codebook is a set of codes, definitions, and examples used as a guide to help analyze interview data. Codebooks are essential to analyzing qualitative research because they provide a formalized operationalization of the codes (Decuir-Gunby, et al., 2011). Data analysis of research questions were utilized to guide organization of codes and themes. Coding procedures are depicted on figure 2.1.

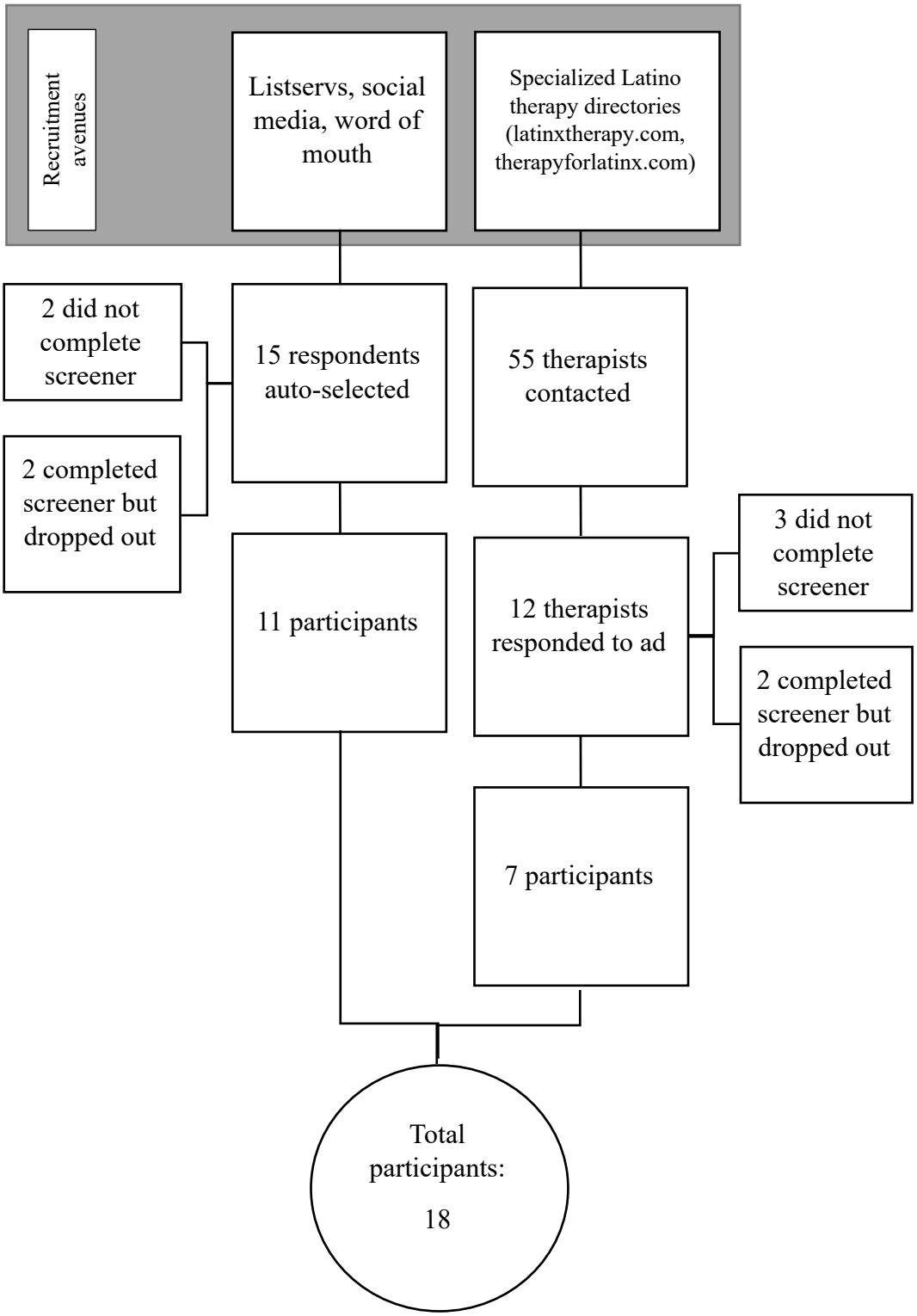

Figure 2.1. Recruitment flowchart

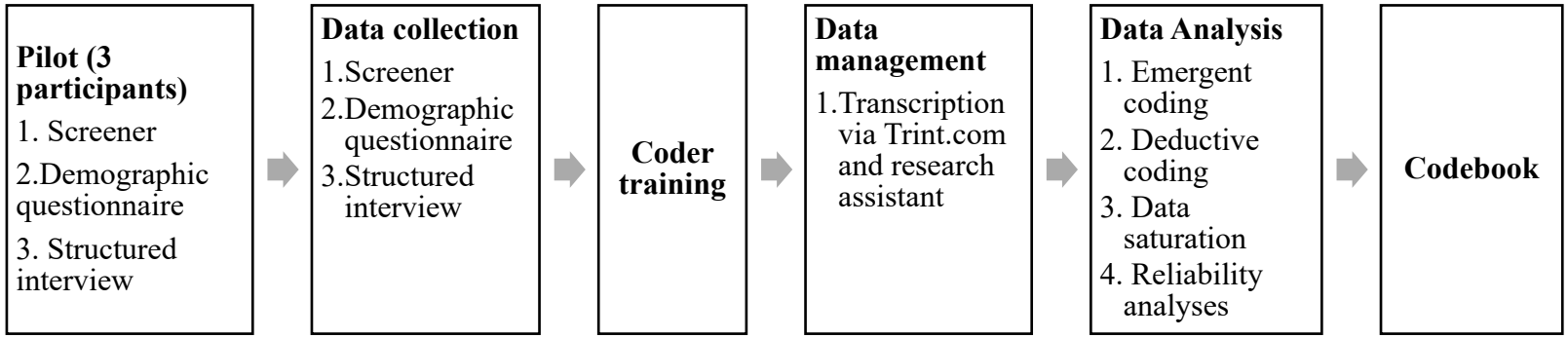

Figure 2.2. Flowchart of data collection, data management and data analysis procedure

Table 2.1. Participant Demographic Information

		N	%
Highest Academic Degree (completed)			
	Master's Degree	13	72.2
	Doctorate Degree	5	27.8
Field of study			
	Social Work	2	11.1
	Clinical Psychology	9	50
	Counseling Psychology	6	33.3
	Other	1	5.6
Clinician Country of Origin			
	Colombia	1	5.6
	Mexico	1	5.6
	El Salvador	1	5.6
	Puerto Rico	1	5.6
	Peru	1	5.6
	Guatemala	1	5.6
	United States	12	66.7
Clinician Ethnicity*	Caucasian/European	5	27.8
	Latinx/Hispanic	16	88.9
	Middle Eastern	2	11.1
	Native American	1	5.6
	Mixed	1	5.6
Clinician Language Proficiency*			
	English	16	88.9
	Spanish	16	88.9
	Other	2	11.1
Primary language used with Hispanic/Latinx clients	English	5	27.8
	Spanish	5	27.8
	Both equally used	8	44.4
Clinician Practice Region			
	South	5	27.8
	Northeast	5	27.8
	Midwest	2	11.1
	West	6	33.3
MBIs used with Hispanic/Latinx clients*			
	ACT	9	50
	DBT	10	55.6

		N	%
	MBSR	6	33.3
	MBCT	5	27.8
	Flow Meditation	1	5.6
	Other (unified protocol, loving-kindness/ mindful self-compassion, brain spotting)	3	16.7
Client country of origin (most common)			
	Cuba	1	5.6
	Puerto Rico	4	22.2
	Dominican Republic	1	5.6
	Mexico	8	44.4
	United States	4	22.2
Client age range*			
	Under 12 years old	5	27.8
	12-17 years old	7	38.9
	18-24 years old	13	72.2
	25-34 years old	14	77.8
	35-44 years old	12	66.7
	45-54 years old	9	50
	55-64 years old	10	55.6
	65-74 years old	7	38.9
	75 and above (2	2	11.1
Client presenting problems*			
	Depression	18	100
	Anger Management	7	39
	Post-Traumatic Stress	13	72
	Substance Abuse	6	33
	Adjustment Disorder	9	50
	Interpersonal Problems	14	78
	Acculturation issues	7	39
	Serious Mental Illness	4	22
	Anxiety	16	89
	Personality Disorders	3	17
	Other	1	6

* Participants were allowed to select more than one response

CHAPTER 3

RESULTS

Demographics

Participants in this study had a mean age of 31 years old (*SD*= 3.4) and seventy-two percent identified as female (*N*=13). Additionally, they reported working an average of 6.6 years as therapists (*SD*=3.5), an average of 6 years working with Hispanic/Latinx clients (*SD*=4.23), and 50 percent reported holding a license or certification in a mental health field, while the rest were trainees and did not hold a license or certification. They also reported working with an average of 11 Hispanic/Latinx clients per month (*SD*=11.7). Further demographic information about the participants and their client composition can be found in Table 1.

Research Question 1

How are clinicians in the U.S. utilizing MBIs with Hispanic/Latinos? What types of issues are they treating with MBIs?

Flexibility, function, and active ingredients.

Interviewees explained that they generally approach implementation of MBIs with Hispanic/Latinx clients by applying flexibility and making changes to session as events occur. The theme of flexibility came up five times across interviews and was mentioned by 22 percent of participants. Clinicians explained that in order to maintain this model of flexibility they often consider functionality, or what works for whom. ACT

clinicians mentioned utilizing functional contextualism -a theory that looks at how people function within a specific context (Biglan & Hayes, 1996)- as a tool to implement MBIs with flexibility and to tailor interventions. The theme of functionality came up 11 times across different interviews and was mentioned by 50 percent of participants.

> *"So, for me, working with the Hispanic/Latino community, I know the principle of flexibility and functional contextualism and ACT it's not necessarily about culture, race, ethnicity, of language. It's about you adapt to what's showing up in front of you and what's working or not." (16:57, MC7E)*

Additionally, one clinician applying Unified Protocol with Hispanic/Latinx clients explained that they try to maintain active ingredients or essential elements of the intervention to ensure that they are delivering the intervention as intended.

Cultural humility, colonization, and intersectionality.

Clinicians expressed utilizing cultural humility as an approach to mindfulness-based interventions. Clinicians expressed that they approached cultural humility by avoiding assumptions regarding client's cultural backgrounds. The theme of cultural humility was identified 11 times in 33 percent of interviews.

> *"Whenever cultural, well cultural is all the time present, of course. But one of them is my position of how I am understanding what the client is saying. So, for me cultural humility is very important. How am I allowing the client to tell me from his or her cultural point of view? How they understand the world, right. And therefore, like right or wrong for them. OR what should be appropriate, appropriate for them." (26:48, WC1L) Lines 24-28 (using it in case conceptualization)*

"This idea of making sure you're respectful of their cultural beliefs […]and preventing yourself from falling into this colonizing psychology idea that we have, that we have the power, and they should be doing exactly what we're telling them to do. Because that's just a formula for failure in treatment. " (WC1L, 36:53)

One clinician stated that when approaching MBIs with Hispanic/Latinx clients, they make efforts to avoid colonizing their clients – that is imposition of Euro-, cis-male-, Christian-, or hetero-centric norms onto counseling and psychology practices - by being respectful of their cultural beliefs. This approach was associated with the recognition of power and oppression structures by the clinician. Similarly, 16 percent of clinicians explained that they keep intersectionality in mind when implementing MBIs with Hispanic/Latinx clients. Descriptions around intersectionality usually involved clinicians describing different social categories that they consider when approaching their Hispanic/Latinx clients.

"Then, I think also intersectionality is another very important aspect because intersectionality allows you to understand not how problems add for an individual but how they multiply for an individual. Right. So, it's not just the fact that she's female or that she is Latina or that she is very low SES. It's how these three things are multiplying in a specific way, then how this multiplication is related to the clinical presentation that they have and the concerns that they have." Page 8, 36:53, Lines 14-18 WC1L

Family Approaches.

Sixteen percent of clinicians explained that they often had to approach mindfulness-interventions by involving their clients' family. Clinicians explained that

they often involved the families via psychoeducation or, in the case of one clinician applying Unified Protocol, teaching behavioral strategies to parents.

> *"All that to say that what was hard about these interventions was that it needed to be more of a family approach than just for the individual because there is such an educational component to how we see mental health as a culture." Page 1, 1:55, Lines 35-38 (YE2G)*

Considering individuality and differences within Latinx culture.

Some clinicians explained that they are cautious of considering individual differences when approaching Latinx clients. There were different approaches to this consideration. On one hand, certain therapists explained that they were mindful of steering clear from generalizing characteristics.

> *"Something that really bugs me is hearing people will say... Other clinicians say that, well like Latinx populations don't like this or they, they just don't get it, or it doesn't work with them." (TEPL, 37:31)*

On the other hand, clinicians often explained that they tend to examine the context from which their clients come from in order to avoid generalizations.

> *"Yeah, I think well at least for me, I really take the time to, to know where my client population is coming from. So, consideration is looking at the historical components of that particular Latino group to really getting to know the history not only in the country but also the history, their history in the US." WK95, 34:26*

Considering Religious Beliefs and Practices.

Clinicians also expressed that they often have to consider religious beliefs when approaching MBIs with their Hispanic/Latinx clients. This consideration was described in

two ways. Some clinicians explained that they often steer clear from mentioning the word ‘mindfulness’ with certain clients that endorse affiliation to certain religious groups, as this can be considered to be going against their religious beliefs.

> *"But for our clients, it's more like if you talk to them with this idea about opening themselves up. They, they wouldn't buy it because their culture, their religious beliefs that allow them like Pentecostal, they believe that if you're opening up yourself, then you're opening yourself to the devil. So, you make, you're more vulnerable to being attacked by the devil and the devil taking control. And then you therefore you are allowing evil spirits to enter your realm. So, I don't teach this idea of opening yourself up to the experience. It's more of more guided more mantras, more, more of a breathing kind of way. Like learning how to breathe. That's how I kind of sold it to them, but not talking about like opening yourself up because of the fear that the devil may come in and take hold of you. I don't use." Page 10, 36:23, Lines 10-19*

On the other hand, some clinicians expressed that they utilize their client’s religious beliefs to implement mindfulness practices (e.g., counting rosary beads). This theme came up 21 times across interviews and was mentioned by 30 percent of participants.

> *"For example, like I know that prayer is a way that a lot of people, especially Latinx clients, use to, to calm themselves, to relax in a way that that could be a form of acceptance work." (TEPL, 7:59)*

Considering transgenerational trauma.

Twenty-two percent of participants explained that they consider the impact of transgenerational trauma in their work when applying MBIs with Hispanic/Latinx clients. Broadly, clinicians described transgenerational trauma as trauma that is transferred from the first generation of trauma survivors to the second and further generations.

> *"Because one thing like culture is like one thing but then also these like learned behaviors that we pass down. I mean I don't even want to bring up generational trauma. That's a whole other, that's a whole other thing." Page 8, 24:16, Lines 6-8, HGA6*

Some clinicians explained that there is an impact on how clients, especially Hispanic/Latinx clients, display behaviors or thoughts that can be linked back to the trauma experiences of their parents or grandparents. This theme came up nine times across interviews.

> *"Yeah it felt like we needed to do a lot heavier work to work on the transgenerational trauma with the family. Because... I mean it's such a big question. It feels like so much of our community have trans generational trauma from like all of the immigration experiences. And the generations that grow up here, it's such a different experience so it feels like there is a... There is a break in communication between what those experiences are and how the other party receives it." Page 1, 1:55, Lines 30-35, YE2G*

Describing mindfulness/presenting the idea of mindfulness to clients.

Thirty-three percent of clinicians stated that they take special considerations when presenting the construct of mindfulness. Many clinicians explained that they break down

the concept of mindfulness and explain its components (e.g., breathing, present moment awareness, meditation) before mentioning the word mindfulness itself. Some clinicians expressed that they take a constructs approach and that they ask clients what they know about mindfulness before introducing an exercise or presenting its components. This theme came up 10 times across interviews.

> *"And then explaining it like breaking it down more basically. So, breaking down what I mean about what is mindfulness. What does it mean to be in the present moment? So, then I'll have them do an experiential activity that demonstrates that this is... You know as we were doing this activity where were you? Were you thinking about your future? Thinking about your past? No, you were in the present moment right. And then recognizing, oh that's what that's what you mean. More so than the conceptual being in the present moment without judgment, paying attention on purpose."*

MBIs as a complement for trauma treatment.

Across eight instances, 30 percent of clinicians explained that they utilize mindfulness or MBIs as a complement for trauma treatment. It is important to highlight that clinicians did not consider mindfulness or MBIs as a treatment for symptoms associated with traumatic experiences but as a way to enhance treatment or complement trauma-focused treatments. There was some consensus on utilizing mindfulness to help clients manage distress.

> *"And often times my clients come for evidence-based trauma treatment are so overwhelmed and it's hard to just take a moment and stop and notice, right? And so traditional evidence-based trauma treatment doesn't really have a mechanism*

to address this autopilot other than doing deep breathing right. So, I feel like I've augmented prolonged exposure and CPT treatment for example with present-moment awareness exercises. I've noticed it helps my clients better engage in imaginal exposure and in vivo exposure so it's just an add-on to just deep breathing and-and PMR (progressive muscle relaxation.)" Page 3, 8:43, Lines 17-23, MC7E

Reception of MBIs by clients.

Clinicians were split in their opinions regarding how MBIs have been received by their Hispanic/Latinx clients. Some clinicians stated that while interventions are received with openness and willingness, sometimes Hispanic/Latinx clients needed more support than other clients.

"Yeah. So overall, I would say, I get the initial reaction, overall I would say it's pretty skeptical. They, they're very skeptical of them for I think a lot of reasons. One they, you know, they think, my clients often think well it's kind of, it's just breathing, how will that help me? And a lot of the time, so they're referring to very real structural problems they're experiencing out in the world. So, poverty, immigration, domestic abuse, employment, and so their initial thoughts are how can... Like that's ridiculous. Like I need somebody to help me deal with these issues not, not teach me how to relax necessarily in the moment. I think that part of where some skepticism comes in." Page 1, 2:32, Lines 23-30 TEPL

One clinician explained that their Hispanic/Latinx clients would sometimes receive MBIs with skepticism and that they had clients express that MBIs were too “new age”, not concrete enough, or that MBIs don’t address the structural problems that

Hispanic/Latinx clients often face. Sixteen percent of clinicians commented on how MBIs were received by clients. This theme came up five times across interviews.

> *"The other part is, I think for some clients for some of my Latinx clients, they associate mindfulness and acceptance-based interventions with kind of like new age, like millennial stuff, or something like white people do. Like, like that's not something we do, we Latinx people do. Page 1, 2:32, Lines 30-32 TEPL*

Research Question 2

How are clinicians in the U.S. adapting MBIs for Hispanic/Latinos? What type of adaptations – utilizing Bernal et al.'s dimensions- are they utilizing? How are they implementing these adaptations?

Implementing Language adaptations.

All participants agreed that they have adapted the language of their intervention to fit the needs of their Hispanic/Latinx clients. Participants reported that language adaptations often imply more than translation or interpretation. One often-reported strategy was to explain concepts instead of translating theoretical terms. One interesting finding is that no clinicians-including monolingual English-speaking clinicians- reported utilizing interpreters with their clients. This was primarily because these providers worked in settings with bilingual Latinx populations. One of them stated that they will sometimes ask clients to express difficult emotions or situations in Spanish, even if that means they as a clinician don't understand or have to sit with discomfort of not understanding what their client is saying.

Checking in.

Seventy percent of clinicians, across 28 instances, agreed that they "check in" with their clients to corroborate appropriate language use. Clinicians also reported that they check-in with their clients to ascertain whether they're delivering information as intended. Two clinicians explained that they ask clients to repeat back the information in order to check whether clients have understood what they are trying to say.

> *"So I do a translation and then once I'm with a client and I bring my worksheet or any other information that I'm providing to them. All the time asking them, do you understand? Is this clear to you? Is there any other way in which you would phrase this?" (Page 3, 13:04, Lines 38-40 WC1L)*

This theme included clinicians being in-tune with their clients' body language, and asking follow-up questions regarding concepts of mindfulness, and other aspects of therapy. This theme held across clinicians making adaptations in English and in Spanish.

> *"First of all, I slow down. I slow down for myself, so that I can give myself time to check in with the client. So I'll check in and I'll just simply say, what do you think about this metaphor for example? Can you give me an example of how this fit in with your life? Or how it doesn't fit in with your life?" (TEPL, 19:11, page 4, lines 40-44)*

Challenges of implementing Language adaptations.

Several clinicians explained that many of the difficulties associated with implementing Language adaptations are due to them being the only Spanish-speaking clinician in their clinics. Clinicians explained that this often entails lack of Spanish-speaking supervisors or colleagues that could aid in translation or interpretation.

"And to just make sure that I'm using... because I have no one, absolutely no one to check in with on the translations that I do. So, I'm basically like validating my translations with the clients themselves." (Page 1, 2:43, Lines 42-44, WC1L)

Some clinicians also noted that while they are fluent in Spanish (and for some of them Spanish was their native language), they were trained in English, making it challenging to explain specific concepts or constructs to clients. This was tied to a general lack of resources in Spanish (e.g., books, tapes, video, worksheets). Clinicians explained that while there are some Spanish resources for implementing MBIs, they are often available in formal Spanish which many clients have difficulty grasping.

"So even though Spanish is my first language, I learned psychotherapy in English. So, learning how to practice ACT in Spanish um has been a lot of trial and error for me a lot of using terms that are literal translations from English and noticing the client giving me a blank stare. So absolutely, um everything I just told you probably took me two years to figure out." (15:50, page 4, lines 25-29, TEPL)

Additionally, several clinicians explained that they have difficulty translating specific terms such as mindfulness.

"What I think too, and speaking of mindfulness, I've noticed that it's more acceptable with my English-speaking patients to use the term mindfulness, where with my Spanish speaking patients when I've used the formal translation, they usually give me a blank stare and don't really know what I mean." (Page 1, 1:48, Lines 42-4, MC7E)

Persons and experiences with cultural match.

Seventy-seven percent of participants, across 25 instances, reported having experiences with cultural match – that is interventions where there was an ethnic match between clinician and clients. Many clinicians explained that cultural matching was advantageous to the therapeutic relationship, particularly because it allows clinicians to understand certain aspects of their clients' cultural background.

> *"When a client hears you speak Spanish for the first time and they you know that you're a bilingual clinician, they just-they just immediately feel connected to you. And so I feel like that bypasses country of origin, and just makes us match ourselves right away if that makes sense." (18:58, MC7E)*

Many clinicians believed that cultural matching allowed their clients to feel more comfortable and to establish rapport due to shared heritage. Some clinicians also reported that while they might not have cultural match with their clients, other identities became salient in therapy (e.g,. being a sexual minority) which also allowed them to build a relationship with their clients based on different aspects of their identity.

> *"Exactly, like you can, you can almost see how the client almost like lets their guard down when they hear like, hey like I'm also a sexual minority so like I get you. I mean obviously not necessarily just because of that, I'll get them. But it's so nice to see that that they feel comfortable in a mental health setting which we know is super, does a super poor job for Latinx population." (28:36, page 6, lines 25-29, TEPL)*

Metaphors.

Seventy-two percent of participants, across 28 instances, endorsed utilizing sayings or stories from their clients' culture (e.g., cuentos, dichos), clients' own stories, and metaphors. Clinicians also explained that that they sometimes experience difficulty incorporating metaphors; some explained that they might not be particularly familiar with a clients' background and their stories and that when they attempt to explain a concept through a metaphor, their clients might not understand. Clinicians also explained translating metaphors proves difficult because meaning might get lost in translation.

> *"Yeah so. So for example, like how do you talk about radical acceptance. Like that's a really foreign concept, but if you really think about it, there's a couple of sayings in Spanish, which are spiritual and religious in a sense. You know this idea of like, si Dios quiere (God willing). All right then like you can that that's or using like the concept of like fatalismo to explain radical acceptance. Right, it's this idea that it is what it is. This is supposed to happen, so now how can you cope with it." Page 6, 22:04, Lines 23-28 WK95*

Goals.

Seventy-two of clinicians, across 20 instances, reported considering culture in the goal-setting process. Some participants explained that culture was sometimes salient, and a discussion of cultural values is often helpful in goal setting. Some participants explained that they purposefully have discussions about cultural values with their clients, while others explained they weaved cultural values into the therapeutic process as cultural values and themes emerged. Moreover, five percent of clinicians, across five

instances, brought up the concept of contextual functionalism in goal setting and that they place emphasis on the function of values when working on goals with their clients.

> *"Yeah. OK. So this is what it would look like for example. I have one client. She's in between ages of 25 and 30. And she's a professional woman. She has a great job and she's living at home. So she has panic attacks, and what she's been, what we've been using with her is the same thing. Like meditation, just sitting with self, taking a moment, deep breathing, all the wonderful good stuff just being mindful of also what she's feeling and eating too. […] And in the treatment plan, one of her goals is to have a better relationship with her family and have less panic attacks. And both are interrelated because of what her family has taught her or told her. So in the treatment plan, the goal is to increase positive experiences with family twice a week and decrease anxiety attacks to minimum at least just once a week. So get it down to once a week. So that would be implementing both by using strategies and just of awareness mindfulness, but also implementing when you get home what can you do first before you walk into the door. So you have a positive experience with your family vs. going at it and having conflict? So what she'll do now is she'll sit in her car for maybe like 15 minutes when she pulls up in the driveway and sit with herself. She'll meditate before she walks in." 22:03, page 8, lines 23-39 CGBX*

Context.

Seventy-two percent of participants, across 30 instances, explained that they consider their clients' context in their therapeutic approach. Participants described several

dimensions that might be considered in treatment (e.g., immigration history, generational trauma, sociopolitical context, family context, economic context).

> *"You know where they grew up, who they grew up with, who their primary caretakers were... If it wasn't a parent that was a primary caretaker, I guess like context around that. Or if it was just one primary caretaker context around that. Siblings. Like any time, they change school abruptly or you know just like move neighborhoods or cities or countries or anything like that. Losses, those are big ones. And connectedness to extended family, kind of gauging how much of that is there. But then also really just getting a snapshot of where their community is now. I mean a lot of people aren't from Austin. So usually there's some kind of migratory pattern here whether that's from like any other city in Texas or somewhere else in the States or Latin America." 89UC, 21:02, page 6, lines 37-45*

There were some differences on how clinicians learn about these dimensions. Some clinicians explained that learning about context should be a process that emerges along treatment. Others have an intentional conversation about cultural values with their clients even including it in the intake process (e.g., how does culture or your family's background impact you?).

> *" I just have that as the background knowledge, the history component. Like for example, just like this example of adapting mindfulness. I didn't really talk to them about it. I just, based on my other group who the majority of are Puerto Rican, and just hearing them and through their dialogue, I made those changes based on that other conversations that I've had with Puerto Rican clients and*

their belief systems. And a lot of them do identify as Pentecostal, a majority of them in our clinic. So therefore, I just opted to, based on what I already knew make those changes." Page 10, 39:23, Lines 29-37, WK95

Methods.

Fifty percent of clinicians, across 17 instances, explained that they have made adaptations that imply pragmatic aspects of providing services to their Hispanic/Latinx clients that was informed by their knowledge of client's culture or context. Many of these adaptations included aspects like paying for clients' parking, providing additional case management services (e.g., writing letters for immigration attorneys, flexibility with scheduling). This domain overlapped with the context and goals domains.

"That's right. Yeah. And with him one of the adaptations I guess would just be that outside of the therapy, I did more case management with him than I'm inclined to do in my private practice with most clients. But he had an asylum case that was going, and on a volunteer basis without charging any extra for the services, I was coordinating with a volunteer attorney that he had found for his asylum case. And so, then there was a process of doing an assessment and writing a letter and coordinating with the lawyer around you know what are the pieces around, can a mental health need to be represented in this letter to strengthen this case? So, a part of adapting the treatment in that regard was really just about kind of my own willingness to do some work outside of the therapy hour to support the asylum case." 12:11, page 3, lines 14-24, PJX3

Content.

Seventy-seven percent of clinicians, across 13 instances, modified their intervention based on client-specific content. This often involved modifying exercises and scripts from different interventions; for example, one clinician explained that they have modified mindfulness for Latina clients so that they can incorporate this skill into their busy lives by mindfully doing dishes, or mindfully praying.

> *"So rather than doing that [doing safe space], I'll say like or you know imagine you and your family, you and your parents, you and your children, you and your loved ones. So little things like that that might not seem like a big deal often I think I make a good impact, a great impact. So, I try to really focus more kind of in like interpersonal stuff. Yeah. Yeah like like that's like. Yeah, I think that's a great example of what I do like instead of imagining just you, imagine you and your loved ones. 23:05, page 5, lines 36-45WC1L*

Some clinicians have also modified how they present certain constructs to their clients (e.g., mindfulness, compassion) in order to make them consonant with cultural knowledge (e.g., we're going to pay attention, we're going to be fair with ourselves).

> *" We were running this, you know, like a compassion, compassion exercise, like that was the topic with compassion. And this one guy, I will never forget. This one guy said to me, who was the college chick that wrote this? And he said, Yeah like compassion? Like who talks like this? [...] He's like no disrespect. I'm just asking. [...] but seriously compassion? Who talks like this? And I said OK how about are we being fair with ourselves? Does that sound better? So, then somebody said okay I can do that. And then they're like yeah, they were all like yeah OK. That's*

cool. And then everybody, and then everybody else was like OK. Well, That's cool man. Come on. And he was like OK. So then instead of being compassion was fair." – 31:38, page 8, lines 17-33; 6GBE

Concepts.

Seventy-seven percent of participants, across 38 instances, endorsed including cultural knowledge of their clients into case conceptualization. This often included a discussion of personal and cultural values that were relevant to the client and incorporating them into how clinicians thought about their clients and their presenting concerns.

"But talking about her well-being being important and also having her own family in the future so... And how, so she struggled a lot because she was […] negotiating what it meant for her to be a loving daughter for example how could that look different from what she was trying. And feeling that she was fulfilling that right now." Page 6, 18:49, Lines 27-32 (negotiating, how things could look different)

Research Question 3

What are some advantages of culturally adapting MBIs? What are some challenges of culturally adapting MBIs?

Advantages.

Clinicians identified several benefits to implementing MBIs with Hispanic/Latinx clients. Clinicians believed that MBIs are particularly helpful to Hispanic/Latinx clients because it teaches them to slow down. They reflected on the immediate effect of relaxation when applying mindfulness and how this might be effective. Clinicians also

explained that many Hispanic/Latinx clients respond well to the process of mindfulness and relaxation because it's concrete. One clinician also stated that this component was an alternative for medication for some clients who prefer to avoid pharmacological treatment.

> *"I think that mindfulness interventions, they have a great benefit when working with clients that is that the effect is immediate. So, for example, if you are teaching them about being here and now and focus, have them focus their attention on one specific aspect of what they're experiencing. Or if you're teaching them breathing relaxation exercises that are mindfulness based, the second, immediately they can experience that in the session with you. That is really easy for anyone, I think. To really get the point of why this is effective."*

Another benefit identified by clinicians was the opportunity to incorporate cultural values in treatment; this was the case for clinicians implementing ACT. For example, clinicians explained that by utilizing this model, they can incorporate religious values and family values into treatment and better engage their Hispanic/Latinx clients.

> *"The other component they talk about so much with other clients which is very good for Latino clients is the values component and the values clarification component. I do it with all my clients and I think in particular with Latino clients, their lives are centered around values and cultural ideas of what it means to be the person they are and their roles in their family and community. So, I think that in particular has very motivating for clients by thinking about why there is therapy, what the things they want to change. I think there has been a consistent*

theme of changing for the betterment of not necessarily themselves, but they can be of a better service for their children or for their, you know, for their family."

Challenges/barriers.

Clinicians also identified several challenges and barriers to implementing MBIs with Hispanic/Latinx populations. Some clinicians explained that many of their Hispanic/Latinx clients tend to come to therapy hoping for immediate or fast relief to the symptoms and concerns that they present with. Many clinicians believe this is due to clients being used to a faster pace in life and due to having limited access to resources. This becomes a challenge in therapy, particularly when trying to implement mindfulness and asking clients to slow down.

"I would say that for the challenges in working with my monolingual English speakers um I think I've noticed the same issues such as wanting to find a "fix" I know or Oh so this might be a solution."

Additionally, many clinicians reported that their Hispanic/Latinx clients often have no previous experience with therapy. This can be challenging for clinicians because they may have to engage in more coaching or psychoeducation in order to engage their clients in treatment.

"Another challenge comes from adhering to treatment. They, some of them have never, ever received any type of psychological services, or they have even never heard about psychology. And so just providing psychoeducation about what the process is about, that they're actually the ones responsible of doing most of the work and the hard part of this work" WC1L

Most of the clinicians in this study explained that they are the only Spanish-speaking mental health provider in their clinics. This was especially challenging for some of the participants in the study who are still trainees because they typically don't have access to supervision in Spanish and their supervisors may struggle with the nuances of working with monolingual Spanish-speaking clients. Other clinicians pointed out that being the only Spanish-speaking clinician in their setting becomes an additional layer of case management and work that their peers might not be working with. Finally, clinicians stated that this role can be quite isolating as they may not get the most out of peer supervision opportunities.

> *"I'm the only Spanish speaker in my clinic, so it's very hard. It's very hard I. I receive supervision in English, as well. So even just translating back to my supervisors is super stressful. What I, what I do sometimes is I will talk to my mentor. So my mentor, my research mentor does speak Spanish. He's a native Spanish speaker and Latino man. And so when I.. When I have some issues with like, oh like is my translation of the metaphor making sense? Or like sometimes I make my own metaphors. So I'll sometimes like I'll talk to my research mentor, and he's open to that as well. But of course, I cannot talk to him about the actual clinical issues. So that's been a big challenge. Big, big challenge"*

Research Question 4

What type of resources or guidelines would make implementation of cultural adaptations of MBIs more feasible for clinicians?

Clinicians also reflected on resources that would make implementation of MBIs more feasible. The resources suggested by clinicians can be divided into two categories: physical and human resources.

Physical resources.

Clinicians explained that there is a great necessity for books (some available internationally, but not in the US), culturally adapted manuals (for specific populations, to incorporate specific values and practices of the Hispanic/Latinx community, to incorporate Latin American *refranes, dichos* and *fabulas*), worksheets, scripts, exercises, videos, infographics for psychoeducation, and metaphors. Many clinicians find themselves creating their own resources. Clinicians explained that it's important that these resources are available in colloquial Spanish or universal Spanish, as materials are often in formal Spanish which many clients have difficulty understanding. Finally, one clinician explained they would benefit from a list of existing available resources in Spanish.

> *"I think, you know, like manuals and hand outs and exercises and a lot of things you know like in a language friendly, in an average language friendly type of approach. Again, if you look at the DBT manual in Spanish, it is extremely complex. You know, my first language is Spanish so I can read it, I can say it, I can explain it. But I had the luxury to have a certain level of education in Spanish that a lot of my clients didn't have coming from a monolingual Spanish speaking background. So even if I'm explaining this concept, to me it's difficult using that language. So I think just kind of like being... Having client user friendly handouts, manuals, just actual materials will make it so much easier for the providers and*

for the clients. So things that may seem simple, I think will actually make a lot of difference..."- user friendly pamphlets in terms using language that is more appropriate 6GGBE

Human resources and sense of community.

Clinicians explained that they are often isolated in their clinics as the only Spanish-speaking clinician. They explained they would greatly benefit from a network of clinicians practicing MBIs for consultation or peer supervision (particularly ACT and DBT). Some explained they would benefit from being able to attend trainings in Spanish and from specialized graduate training in Spanish.

"And I guess the last thing would be that um I just wish, too, that you know I could have more of a community of Spanish speakers who practice ACT so that there can be like informal peer supervision or consultation around issues that arise and I just haven't found that community. At ACBS there's a group in Spain but I think that's about all I know." Page 2, 5:58, Lines 29-32 (community of Spanish speakers) MC7E

Similarly, participants explained that there is a need in the field of mental health for more clinicians and researchers dedicated to culturally adapting treatments, particularly mindfulness-based treatments. Finally, one clinician explained it's important that those already in practice generate videos, blogs, podcasts, and other resources for the community at large.

"I think the biggest resource is just exposure. If we can get a lot more clinicians to just start making videos or blogs or writing about it even in Spanish, the native language. And be like hey you know what, therapists need therapists too. And on

Sundays and on Saturdays. This is what I use. I use mindfulness. I meditate and every chance I get I advocate for it and I share with it. But I think that it's still a growing movement within the practitioners that are Latinx"

CHAPTER 4

DISCUSSION

The present study investigated the intersection of culture and psychotherapy by understanding and contributing to the improvement of mindfulness-based interventions (MBIs) for Hispanic/Latino populations. It is based on the concept that to maximize treatment retention and outcomes when providing mental health services to Hispanic/Latino clients, it is important to provide culturally adapted treatment. This study focused on "real world" aspects of implementing psychotherapy practices by interviewing clinicians who have implemented MBIs with Hispanic/Latino populations in the practice field. To this end, this study explored how clinicians in the U.S. implement and adapt MBIs for Hispanic/Latino clients. This study also explored how clinicians implement Bernal et al.'s (1995) dimensions (e.g., language adaptations) to develop cultural adaptations, and the challenges and advantages of adapting MBIs for Hispanic/Latino populations. This study expanded upon Castellanos et al.'s (2019) systematic review of cultural adaptations and provides guidance for the development of more culturally adapted MBIs for use with Hispanic/Latino populations. As highlighted by our review (Castellanos et al., 2019) there are many gaps in our knowledge of culturally adapting MBIs for Hispanic/Latino clients. Currently, there is little evidence on how clinicians adapt MBIs when working with Hispanic/Latino clients, what type of adaptations are being utilized by clinicians working with Hispanic/Latino clients and utilizing MBIs, and the challenges clinicians face when adapting MBIs for

Hispanic/Latino clients. The current study offers evidence to address these gaps in the literature.

Eighteen clinicians who reported utilizing MBIs (e.g., ACT, MBSR, MBCT, Flow Meditation) with Hispanic/Latino clients completed interviews. Results demonstrated that clinicians utilize several strategies and theories to implement MBIs with Hispanic/Latino clients (e.g., functional contextualism, intersectionality, cultural humility). We also found that Bernal et al.'s (1995) domains are being widely utilized by clinicians in the U.S. Clinicians also reported on several challenges that they experience when implementing MBIs with Hispanic/Latino clients and ideas for resources that would aid in implementation, which could have implications for future research and practice.

Clinicians reported that they utilize a variety of strategies when adapting and implementing MBIs with Hispanic/Latino clients. These strategies fall under several models or theories. First, functional contextualism -a theory that looks at how people function within a specific context (Biglan & Hayes, 1996)- was cited by clinicians as an overarching framework that allows them to consider their clients' context when providing services for Hispanic/Latino clients. This is in line with Drossel et al.'s (2007) views which posit that the functional-contextual view of person-and-context relations provides therapists with the opportunity to be "genuinely curious and come to know aspects of the client's personal, political, and economic context" (p. 132). Similarly, clinicians participating in this study reported that they utilize intersectionality - the interconnected nature of social categorizations such as race, class, and gender as they apply to a given individual or group, regarded as creating overlapping and interdependent systems of discrimination or disadvantage (Howard & Renfrow, 2014)- and cultural humility - the

ability to maintain an interpersonal stance that is open to the other in relation to aspects of cultural identity that are most important to the person (Hook et al., 2017)- as tools of implementation for contextual functionalism. This approach of contextual functionalism also tied with themes of utilizing a family approach with Hispanic/Latinx clients, considering their religious beliefs and practices, and considering transgenerational trauma and individual differences. Briefly, findings suggest that when implementing MBIs with Hispanic/Latino clients, it is important to consider contextual functionalism, intersectionality and cultural humility.

The second aim of this study was to explore how clinicians in the U.S. are adapting MBIs for Hispanic/Latino with a specific focus on Bernal et al.'s suggested dimensions of cultural adaptations. Bernal et al. (1995) proposed eight dimensions necessary to develop and implement cultural adaptations with Hispanic/Latino populations. Although clinicians were not generally familiar with Bernal's (1995) model of cultural adaptations, they did report utilizing many practices that fell under the eight dimensions. The most frequently used adaptations reported by clinicians are what Bernal et al. (1995) classified as language adaptations. In this study, we found that clinicians actively check in with their Hispanic/Latino clients to ascertain whether they are delivering their interventions as they intend. Additionally, clinicians reported on the challenges they experience when making language adaptations, which included being the only Spanish-speaking provider in their clinic, being trained in English and having to deliver the intervention in Spanish and translating specific terms such as mindfulness. This shows that, despite language being the most common way of adapting an intervention, it is still important to dedicate resources for clinicians to be able to make

these adaptations possible. This was in line with Castellanos et al.'s (2019) findings around language being the most commonly used form of cultural adaptations. Moreover, these findings add to the literature on these type of adaptations by providing specific examples of *how* clinicians adapt MBIs to consider language.

Clinicians believed that people or cultural match adaptations were important to the therapeutic relationship with seventy-seven percent of clinicians endorsing having experience with cultural match. This is in line with evidence to date that suggests that pairing ethnic minority clients seeking mental health treatment with therapists that share the same ethnic background has been demonstrated to increase treatment utilization and lower rates of drop out (Ibaraki & Hall, 2014; Griner & Smith, 2006). For example, Ibaraki and Hall (2014) found that when culturally matched, Latino/a clients were more likely to discuss sexual identity and had longer treatment stays. This finding is important given the lack of bilingual or Hispanic/Latino mental health providers (American Psychiatric Association, 2014). The dearth of Hispanic/Latino providers posits a difficulty for Hispanic/Latino clients to receive treatment from mental health professionals in their cultural group and which in turn may put them at risk of dropping out of treatment (Hall, 2001; Sue, 1998; Sue & Sue, 2012; Cheng & Sue, 2014).

Metaphors adaptations, while challenging to implement, were also widely utilized by clinicians (72% of the sample endorsed utilizing metaphors). Clinicians shared creative instances of adapting metaphors by incorporating *cuentos, dichos* or their client's own stories and adapting concepts such as fatalism into metaphor adaptations. Findings in our current study are in contrast to Castellanos et al.'s previous findings – where only 38% of studies had utilized metaphors. It's possible that this discrepancy is due to

difficulties with operationalization in Castellanos et al.'s (2019) previous findings, where metaphors – defined as utilizing metaphors that were culturally and/or relevant to the treatment population – might not have been reported in studies included in the review. Similarly, goal adaptations, which involved framing goals within values relevant to the client, were widely reported by clinicians (72%) in contrast to Castellanos et al.'s 2019 where only 9% of studies reported on goal adaptations. This is also likely to studies refraining from reporting on goal adaptations.

For clinicians in this study, learning about context was an important part of adapting MBIs for their Hispanic/Latino clients. Findings from this study suggest that learning about context is relevant to fitting treatment to client needs but *how* clinicians go about learning about this context is yet unresolved – learning about context purposefully (e.g., asking specific questions about important cultural values, customs or habits) vs. embedding it in treatment (e.g., letting cultural values come up during the therapy process) – and it is not clear whether one approach is more effective than the other. Further evidence is needed regarding the impact that different modalities of learning about context (purposeful vs. embedded in treatment) have on therapy outcomes and on the therapeutic relationship.

Methods adaptations, that is pragmatic aspects of adapting MBIs, were the least utilized by clinicians in this study (50%). Clinicians who endorsed making methods adaptations explained that these are often related to reducing barriers to access services (e.g., parking, scheduling) and that these may involve more case management. This is also relevant to some of the challenges that clinicians face when working with Hispanic/Latino clients, as they might be dealing with added layers of work, such as case

management, that goes unrecognized. It is interesting that two clinicians talked about *willingness* when it came to these pragmatic aspects of implementation; that is, they explained that in order to provide services, they had to be willing to make these adaptations even if they might go unrecognized. It is important to consider that these adaptations might be less frequently applied because they entail time and resources for clinicians. This could also help to explain why many Hispanic/Latino clients are less likely to receive services or fall out of care at higher rates than other groups (Ibaraki & Hall, 2014).

Content adaptations were also widely used by clinicians (77%); this was also in contrast to our previous findings where only 19% of studies reported utilizing these adaptations. Content entailed familiarity with cultural values, customs and traditions, in a way that displayed appreciation for culture and a commitment to clinical change. For example, one participant utilized her knowledge about traditional gender roles to adapt the idea of compassion to fairness for a group of Hispanic/Latino veterans going through a DBT program.

Finally, concepts adaptations were also commonly used by clinicians. These adaptations entailed utilizing cultural knowledge for case conceptualization. This was also in contrast with the Castellanos et al. (2019) review where none of the studies implemented concept adaptations. This could also be due to challenges with operationalization in Castellanos et al.'s (2019) review where concept adaptations were not reported by authors.

It is important to note that many of these dimensions overlapped, particularly context, concepts, content, and method adaptations. For example, clinicians often stated

that in order to implement a method adaptation (e.g., validating parking), they had to first learn about their client's context (e.g., ask problems with transportation). While these dimensions sometimes overlapped, findings from our study suggest that they are discrete in that there were instances where each dimension was coded separately. Such is the example of clinicians who may be purposeful about learning about context but are unable to carry method adaptations due to limited resources in their practice settings. While Bernal et al. (1995) stated that their framework was a preliminary one and their dimensions might overlap, our study builds on their proposal by demonstrating which dimensions are likely to overlap.

Another aim of the current study was to understand the advantages and challenges of adapting MBIs for Hispanic/Latino clients. One clear advantage of mindfulness treatments is that clinicians are teaching their clients to "slow down" and that they find this particularly beneficial for clients who are immersed in very busy and complicated lives due to factors such as socioeconomic status, immigration concerns, and language barriers. Mindfulness also offers a concrete solution to physical manifestations of psychological disorders which clinicians find to be very helpful for their Hispanic/Latino clients who are often seeking concrete and immediate relief from symptoms. One clinician reflected on how this might be helpful to engage clients. Another clear advantage of MBIs, particularly ACT, is that they offer the opportunity to incorporate personal and cultural values into treatment. This was also identified as a tool for engaging and retaining clients.

It is critical to also acknowledge the challenges that clinicians working with Hispanic/Latino clients experience. Perhaps the most difficult challenge for clinicians is

that they are often the only providers working with Spanish-speaking clients in their clinics. This can be isolating for clinicians and can also lead to them not receiving adequate supervision for the challenges posed by working with this population. Additionally, these clinicians might be tasked with added layers of case management, such as assisting clients with finding stable housing or transportation to sessions. In line with the literature of reducing barriers to treatment with Hispanic/Latino population, it is important to recognize the challenges that clinicians face when providing services to this population. Thus, findings from our study suggest that in order to reduce barriers to treatment for the Hispanic/Latino population, it is essential to dedicate resources for clinicians such as increasing the bilingual mental health work force this is an essential task in our field and a particularly challenging one. Evidence suggests that there was a modest increase in the percentage of ethnic minorities receiving PhD degrees from 1989 (8%) to 1999 (15.1%) but there has been no growth since then, additionally, the representation of ethnic minority students entering PsyD programs was less than two-thirds of population representation (Cheng & Sue, 2014). This lack of diversity among psychologists, particularly at doctoral and faculty levels, hinders the development of mindfulness-based treatments for different cultural groups.

Finally, we asked clinicians to reflect on resources that would be helpful for implementing MBIs with Hispanic/Latino clients. These were aimed at addressing the challenges these clinicians face when working with their Hispanic/Latino clients. Clinicians suggested a number of physical resources that are needed for implementation, such as books, manuals, worksheets, scripts, exercises, and videos. They also expressed the need for more mental health providers in their clinics and in the field. This is in line

with Cheng and Sue's (2014) critical tasks for developing culturally competent MBIs where they propose that in order to create more MBIs, it is necessary to increase the number of ethnic minority psychologists and develop culturally adapted interventions and in line with other implications of this study.

This study had multiple strengths. First, our sample included participants from all areas of the U.S. and at different levels of training which allowed for multiple perspectives. Moreover, it focuses on clinician perspectives to address the lack of literature regarding cultural adaptations of MBIs for Hispanic/Latino populations. It utilized a well-established theoretical framework for developing research and interventions with Hispanic/Latino populations (Bernal et al., 1995). Findings from our study could serve as stepping-stones for efforts aimed at systematically implementing adaptations among Hispanic/Latino populations. To our knowledge, this is the only study available that explores how clinicians in the U.S. are adapting MBIs with Hispanic/Latino populations. Additionally, the qualitative nature of our study adds to the results from quantitative studies included in Castellanos et al.'s (2019) review by demonstrating *how* clinicians implement Bernal et al.'s (1995) framework.

There are some limitations to this study. First, the sample was limited to clinicians practicing in the U.S.; the study could have benefited from perspectives from clinicians working with Hispanic/Latino populations outside the U.S. This study was also limited to clinician perspectives; it would be beneficial for future studies to explore client perspectives on how they receive adapted MBIs. The majority of our sample also identified as Hispanic/Latino and while we know this offers some advantages for treatment with Hispanic/Latino populations, it could be advantageous to gather

perspectives from a broader ethnic sample. Moreover, while qualitative methodology allowed for a better understanding of the ways in which cultural adaptations are applied, it is limited in providing and understanding outcomes associated with MBIs for Hispanic/Latino clients. Quantitative methodology, alone or in conjunction with qualitative research, would be valuable for understanding outcomes associated with MBIs for Hispanic/Latino clients. Moreover, to further develop Bernal et al.'s (1995) framework studies similar to this could be enhanced by implementing a grounded theory approach. Finally, while we have provided evidence to answer the question of *how* MBIs are being adapted, further research is needed to best understand *what* works best when adapting them, and for *which* outcomes they are most effective.

Taken together, the findings in this study suggest recommendations for clinical practice as well as directions for future research. Clinicians implementing MBIs with Hispanic/Latino populations would benefit from utilizing Bernal et al.'s (1995) framework to guide their interventions; our study shows this is a particularly good fit for MBIs. Indeed, feedback from our participants suggests that answering our questions allowed them to reflect on their own practice. It is imperative to develop resources for clinicians working with Hispanic/Latino populations, particularly books, handouts, and media. To this end, research around cultural adaptations for MBIs for Hispanic/Latino populations needs to be further developed. Research in this area would be improved by developing measures and frameworks to systematically implement and assess cultural adaptations. Conceivably, Bernal et al.'s (1995) framework could be implemented with other ethnic and racial groups. Moreover, replication of studies similar to this is warranted to determine the reliability of findings and for theory development purposes.

As suggested by Castellanos et al.'s (2019) review, research efforts targeted at improving this area should include rigorous methodological procedures such as sample randomization, treatment comparisons, and large and diverse samples. Finally, findings in this study confirm two essential tasks for the development of culturally adapted MBIs. First, it is imperative to dedicate resources to increase the bilingual/bicultural mental health workforce at all levels of training. It is also important that efforts dedicated to developing culturally adapted MBIs ensure that treatments consist of effective and affordable models to address the mental health services needs of Hispanic/Latino populations, and these are made widely available to clinicians.

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APPENDIX A

SEMI-STRUCTURED INTERVIEW GUIDE

Mindfulness and Latinos/Hispanics

- In the survey you completed before this call you stated that you use xyz mindfulness interventions, what has been your experience in utilizing mindfulness interventions with Hispanic/Latino populations? Can you tell me about a time when you did this?
- What are the most challenging aspects of adapting MBIs for Hispanics/Latinos?
- What are some benefits that you've identified when using MBIs vs other types of interventions with Hispanic/Latino clients?
- What resources would you like to have available to make implementing mindfulness with Hispanics/Latinos easier?

Dimensions

- **Language:** How do you ensure that you adapt language for your Hispanic/Latino clients – how do you make sure that the language you are using is culturally appropriate for your client? Can you tell me about a time when you did this? What are some challenges that come up for you with this?
- **Persons:** What has your experience been like with cultural match –for example, have you ever worked with a client whose identities match yours in any way? How have you utilized that for the therapy process when implementing MBIs with Hispanic/Latino clients?

- **Metaphors:** Have you ever utilized sayings or stories from your Latino/Hispanic clients' culture to explain something to them when implementing MBIs? How? Do you have any examples?
- **Content:** How do you adapt the content of MBIs- so for example, if you're aware that family is very important to a client do you bring the family in or include them in treatment in any way?
- **Concepts:** Do you/ How do you include cultural considerations in case conceptualization of MBIs? For example, dependence is a negative feature in some cultures, but cultures that value collectivism may not perceive dependence as negative. How do you incorporate this type of cultural aspects into case conceptualization?
- **Goals:** How do you incorporate cultural considerations in treatment goals when utilizing MBIs with Hispanic/Latino clients? How do you discuss cultural values when approaching goals?
- **Methods:** What are some practical considerations you take to incorporate culture into treatment when utilizing MBIs with Hispanic/Latino clients? An example could be if a Hispanic client had problems with transportation.
- **Context:** Do you discuss relevant context with clients when utilizing MBIs with Hispanic/Latino clients? How? (e.g. acculturative stress, immigration history?)

Additional probing questions: Can you tell me about a time when you did this? Can you give me an example for that? Are you thinking of any particular client? Can you tell me about your experience working with them? How do you think that generalizes to other Hispanic clients?

APPENDIX B

DEDUCTIVE CODING SCHEME BASED ON BERNAL ET AL.'S CULTURAL ADAPTATIONS DIMENSIONS.

Type of Adaptation	Definition	Examples
Language	Culturally appropriate language for the client. Specific statements stating that intervention had been delivered in Spanish.	Statement that intervention delivered was done by bilingual therapist.
Persons	Cultural "match" between clients and therapists. Interventions that mentioned a match in terms of ethnicity or other characteristic (e.g., member of the community) between intervention provider and client.	Statement that therapist was also Hispanic/community member.
Metaphors	Clinicians talk about using sayings or stories from the culture, used clients' own stories and metaphors; or materials are intentionally adapted to fit the intended culture.	Books or DVDs with Hispanic characters. Sayings from clients culture.
Content	Clinician interventions are informed explicitly by knowledge of the participants' culture.	Including relevant cultural content in session (e.g., reviewing issues related to parenting when working with mothers).
Concepts	Explicit integration of cultural aspects into conceptualization of the psychological model and the theorized process of change will be coded as concept-related adaptations for the current study.	Dependence (e.g. fusion, attachment) is a negative feature in some cultures, but cultures that value collectivism may not perceive dependence as negative.
Goals	Discussion of treatment goals included cultural considerations in regards to the clients' values, customs, or traditions.	Therapist meets with clients and discuss client's cultural values in regards to therapy goals.

Deductive coding scheme based on Bernal et al.'s cultural adaptations dimensions, cntd.

Type of Adaptation	Definition	Examples
Methods	Pragmatic and practical aspects informed by knowledge of the culture and context and not directly related to the therapeutic process.	Providing childcare and transportation for low-income communities.
Context	Discussions of potentially relevant contextual aspects that were not targeted directly in the intervention.	Mentioning how acculturative stress may be relevant to clients.

APPENDIX C

CONSENT FORM FOR INTERVIEWS

Study Title: Mindfulness, Culture, and Clinical Practice: Utilizing Mindfulness and Acceptance with Hispanics/Latinos

Investigators: Rebeca Castellanos, University of South Carolina
Dr. Kate Flory, University of South Carolina

INFORMED CONSENT FOR INTERVIEWS

Purpose: A research team from the University of South Carolina is doing a study called "Mindfulness, Culture, and Clinical Practice: Utilizing Mindfulness and Acceptance with Hispanics/Latinos."

You have been invited to participate in an interview to tell us about your experiences working with or serving Hispanic/Latinx clients/patients and your experiences implementing Mindfulness Based Interventions (MBIs) with them. We are hoping to learn more about the different ways in which clinicians in the field are applying cultural adaptations of Mindfulness Based Interventions (MBIs) with Hispanic/Latinx populations. Cultural adaptations are systemic modifications of evidence-based treatments or intervention protocols that consider language, culture, and context in a way that is compatible with the client's cultural patterns, meanings, and values.

What is asked of you: First of all, you will be asked to answer some short questions about yourself but you will not be asked to include your name on the form. Next, you will be asked some questions regarding your experiences implementing Mindfulness Based Interventions (MBIs) with the Hispanic/Latinx community. The interview will last anywhere between 45 minutes to an hour. Someone from the research team will ask the questions and record your answers for future analysis.

Privacy: What you say during the interview will be recorded and kept private. The team doing the study will type up what was said but will not put your name on the form. Your name will never be used on any forms or reports. No one other than the people doing the study can ever look at the forms unless you give them permission

Your rights: Participation in this study is voluntary. You may ask questions about the study at any time. Your answers are important, but you can choose not to answer any question and to stop taking part in the study at any time.

Payment: You will not be paid for being a part of this study, but your participation will most likely be used to create guidelines and recommendations for implementing MBIs with Hispanic/Latinx clients.

Potential risks or discomforts: What you say will not be matched to your name. The questions we ask about what you think or have experienced in working with the Hispanic/Latinx community can be personal and you may feel uneasy with some of the questions but you may choose not to answer any question(s) at any time.

Potential benefits: What we learn from the interview will tell us a lot about how clinicians in the field are adapting MBIs to serve the Hispanic/Latinx community. This could help us in making services better for the Hispanic/Latinx community.

If you agree to participate in the study, we will proceed by asking you a few questions, the interview will last about 60 minutes. If you do NOT agree to be in the study, you can STOP now. You may also stop at any point during the interview.

If you have any questions or concerns, please contact Rebeca Castellanos, M.A. (rebeca@email.sc.edu). You will be given a copy of this form for your records.

Thank you for your participation in this study,

Rebeca Castellanos, M.A.