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A Phenomenological Study of Mental Health Providers' Cultural Sensitivity towards Latinx Clients

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Abstract

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Dissertation Submitted in Partial Fulfillment

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Abstract

This hermeneutic phenomenological study explored the lived professional experiences involving mental health providers' cultural sensitivity towards Latinx clients in the context of mental health service delivery. Pedersen and Essadoh's multiculturalism framework, known as the "fourth force" of psychology, was used as a guiding framework. Fifteen mental health providers were recruited. Data were collected using semi-structured interviews via Skype, in-person, or phone interviews with participants who had from two to over thirteen years of working experience with Latinx populations. Interviews were examined using an interpretive phenomenological analysis. Four themes emerged from participant responses. Findings revealed that cultural competence and cultural awareness were central to the delivery of mental health care to Latinx clients and approaches to developing cultural competence. Bilingualism and multilingualism were critical in terms of identifying and developing cultural competence among mental health providers, and Latinx clients sought mental health services due to depression, anxiety, PTSD, and suicidal ideation. Results may promote positive social change by increasing awareness of challenges experienced by minority communities and the value of cultural competence in addressing such challenges. This study may inform policymakers and educational stakeholders about policies and development of curricula that is relevant to cultural competence. Participants were a small sample of clinicians in Idaho whose responses may represent regional considerations. Further researchers can use mixed methods to reexamine connections between cultural competence and awareness and how use of language influences cultural competence.

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Dedication

To God, who guided me through this path and filled my soul with patience and preservance to continue this journey. Thank you for keeping my family healthy and alive through this difficult pandemic time. I also dedicate my work to my reasons to be. I love you all. Gracias mamá (thank you, mother), for my existence and your willingness to care for my children while I was out on residencies. My husband and soulmate Salvador for your presence during the long nights and for lifting my spirit when I was about to surrender. To my children for understanding and not complaining about my endless education commitments. You, too, can accomplish your goals! My sisters for questioning me, "When will you be done? That was helpful to reflect upon and continue moving forward. I hope this boosts others' motivation to know that anything is possible if you set your mind to it.

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Chapter 1: Introduction to the Study

Introduction

Cultural competency within the mental health framework has been studied for many years. In 1973, the Vail Conference of Graduate Educators in Psychology recommended integrating cultural diversity training in psychology graduate programs and endorsed it in 1976. In 1979, The American Psychiatric Association (APA) used volunteer interpreters in mental health evaluations with minority clients. Competence with English and Spanish and familiarity with patient cultures were major requirements in practice (Marcos, 1979). Sue et al. (1992) first proposed cross-cultural counseling competencies.

The American Psychological Association APA adopted guidelines on multicultural counseling competencies to provide standards for integrating cultural concerns into the work of psychologists. Cultural competence continues to be a core requirement for mental health professionals working with culturally diverse clients (APA, 2017). Clients who perceive their counselors as multiculturally competent report improved psychological wellbeing (Dillon et al., 2016). The topic of this study was lived experiences of mental health providers as they pertained to delivery of culturally competent services to Latinx clients. The intent of this study was to learn from providers who worked with Latinx populations in southern Idaho. This study needed to be conducted to understand more about what cultural competency entailed in this southern Idaho and uncover what was unknown about the phenomenon and its social implications.

Chapter 1 includes an introduction to this dissertation. I address issues of cultural competence, sensitivity, and multiculturalism as the theoretical framework for this study. I provide supporting information regarding the further study of cultural competence with a phenomenological approach to understand this topic from the perspective of the mental health service provider's lived professional experience with the Latinx populations. I provide the historical context involving research literature related to cultural competence, gaps in knowledge as reflected in current and relevant research, and why a qualitative study design was needed. Following this section, I discuss the purpose of the study, research questions, conceptual framework, nature of the study, definitions, assumptions, scope and delimitations, limitations, the significance of the study, and a conclusion.

Background

Latinx individuals are the most extensive and fastest-growing minority group in the USA; with a population of over fifty-five million, they account for 17% of the U.S. population (Siegel et al., 2015). This population has high depression, anxiety, and suicide rates (Silva et al., 2018). The National Alliance on Mental Illness (NAMI, 2018) reported that Idaho had one of the highest suicide rates, approximately 48% higher than the national average. Idaho had the fourth highest percentage of mental health illness in the nation. In Idaho, 12.5% of the population self-identified as Hispanics (U.S. Census Bureau, 2017).

Fawcett et al. (2018) described a qualitative case study approach using focus groups and structured interviews to enhance access to culturally competent health services for Latinx experiencing inequities. They identified challenges and strengths to

enable an environment of quality improvement in treatment and organizational change for cultural competence. The authors found that there were challenges to minimizing racial and ethnic disparities. Among them, was the lack of culturally competent health providers and leaders who created an organizational context that promoted cultural competence.

Olcoń et al. (2018) presented a qualitative study using thematic analysis during interviews with twenty-four service providers that worked with Latinx clients. This research yielded valuable information about the stressors Latinx clients experienced in their everyday lives which included dislocated social support systems, discrimination, poverty, and risks for developing depression and anxiety disorders. It focused on the providers who served them and gained a better understanding of how providers viewed clients. The study results support the importance of a cultural framework in guiding providers' experiences and practice decisions. The researchers suggested that focusing on individuals with their own unique stories to tell could be a first step toward reducing disparities and bias in terms of delivery of mental health services.

The literature contains several important studies which elaborate upon cultural competency from the perspectives of mental health service providers and service recipients. Benuto et al. (2018) conducted mixed-method research and interviewed several psychologists to ask how they conceptualized cultural competency. The study identifies the work of Sue (1998) as the pioneer in the arena of cultural competency. The authors proposed that the knowledge needed to work with diverse populations needs to be more sophisticated due to diversity of cultures and sub-cultures. Landesskog et al. (2015) utilized

a qualitative method to explore human service providers working with the Latinx community. According to the author's findings, they suggest that service delivery to Latinx individuals required that providers apply empathy and both language and cultural knowledge skills. The researchers promoted the practice of Latinx-serving workers having more meaningful participation in organizational decision-making around service for Latinx. Aggarwal et al. (2016) examined the meanings of cultural competence in mental health. This focus group study with patients, clinicians, and administrators defines the meanings and practices associated with cultural competence; themes were compared across groups and related to cultural competence policies in a hospital setting. The authors recommend qualitative research in other clinics to see if the findings of this study are upheld in other settings. They proposed that future work could examine perceptions of cultural competence across distinct types of clinicians at various stages of practice.

Rogers-Sirin et al. (2015) investigated the immigrant perceptions of therapists' cultural competence. After reviewing transcripts, researchers used the Consensual Qualitative Research (CQR) method to place information into two main themes related to multicultural or cultural competence. The research used the competencies identified by the Association of Multicultural Counseling and Development (AMCD; Sue et al., 1992). The participants shared how culture influenced their reasons for seeking therapy and their experiences in the session. The findings in this study endorsed that listening to the client's expertise can contribute to learning about cultural competence and what facilitates successful therapy and positive experiences. The authors recommended that

future studies examine therapist-level variables more closely, such as the therapist's level of training or multicultural experience.

Chu, J., Leino, et al. (2016) proposed a model for the theoretical basis of cultural competency as a guide to psychotherapy. This was a literature meta-analysis relevant to why cultural competency is adequate. The researchers reviewed several decades of cultural competency and psychotherapy literature to answer how and why cultural competency works. The authors explained cultural competency psychotherapy works because it creates a contextual match with clients' external realties, a fit in the microsystem of the therapeutic relationship or framework and an interpersonal feeling of being understood empowered by the client.

Delgado-Romero et al. (2018) article offered guidance and best practices for conducting qualitative research with Latinx (the term represents an all-inclusive identification that is not grounded in a gender binary model) populations. Qualitative research is increasingly significant for Latinx psychology. Delgado-Romero et al. (2018) emphasized that qualitative methodology purposely represents, involves, and benefits understudied populations. The researchers suggested that qualitative methods furthered accumulating a rich foundation of knowledge and information regarding Latinx people in the United States. They also found that culturally competent psychologists are better at building rapport and understanding the worldviews of clients and are thereby uniquely situated to work effectively with Latinx populations.

There has been extensive research identifying barriers to treatment and training that may improve quality of mental health care for ethnic groups. To gain a further in-

depth understanding of what cultural competency encompasses, it was essential to learn about lived experiences of mental health providers who work directly and specifically with Latinx clients. Optum Idaho (2020) recognized that "Those who have developed and advocated multicultural counseling competencies have repeatedly stressed that "cultural competence" is an aspirational goal, that no single individual can become completely competent, and that the journey toward cultural competence is a lifelong process."

Problem Statement

Latinx have a high prevalence of depression, a lower likelihood of diagnosis, and are less likely to receive follow-up appointments or treatment (Magaña, 2019). This population faces numerous documented health disparities. Access to care and lack of cultural perspectives in part due to language and cultural barriers directly impact their healthcare, contributing to these disparities (Magaña, 2019). Although the Latinx population has a high prevalence of mental health issues, many Latinx in Idaho are not seeking or receiving mental health treatment.

Based on Idaho's statewide mental health agency data, the total number of clients served in 2016 was 15,320, and 10.2% of clients identified themselves as Hispanics or Latinx (Substance Abuse and Mental Health Services [SAMHSA], 2016). Only 1,562 Latinx received mental health treatment in Idaho. Of this population, 539 were children with seriously emotionally disturbed (SED) challenges and adult clients with severe mental health problems (SAMHSA, 2016).

Purpose of the Study

Researchers have previously focused on barriers to services, provider training, and culturally relevant mental health outreach (Stickney, 2009). According to the APA Presidential Task Force (as cited in Torres et al., 2018), there is gap of services such as the number of bilingual providers, the limited practice of conducting culturally competent assessments, and limited integration of evidence-based practice with culturally competent treatment. The purpose of this phenomenological study was to obtain perspectives of Idaho-based mental health providers and managers of mental health agencies regarding provision of culturally sensitive services to the Latinx population based upon their lived professional experiences within their service settings. Challenges Latinx populations face include limited access to care and high incidence of mental health disorders, such as depression, anxiety, and difficulties in academic performance (Torres et al., 2018). However, less was known about local providers' experiences in their own words regarding provision of mental health care to Latinx populations within Idaho.

Benuto and O'Donohue observed through their review of several relevant studies that researchers focus on cultural sensitivity with Hispanics in several ways (2015). Cai (2016) suggested that response to culturally competent care and services involved "agencies" understanding cultural competence. The author described the process as a set of congruent attitudes of individual professionals inside a system that involved individual-level concerns or attitudes and behaviors that facilitate practical work in cross-cultural situations (Cai, 2016). Research and recommendations supported qualitative

research to fill the gap in understanding of experiences of those directly responsible for and involved in the delivery of mental health services by directly asking them about their experience involving delivery of culturally sensitive practices.

Research Question

In this phenomenological research study, the following research question was used:

RQ1: What are the participants' lived experiences regarding cultural competence in the delivery of mental health services to clients who are Latinx?

Theoretical Framework

The theoretical framework for this study was multiculturalism, also called the fourth force of psychology by Paul B. Pedersen and Pius K. Essandoh. Multicultural psychology is a major influence on multicultural competence and involve individual and intrapsychic factors. The cultural context is considered an essential aspect of the lives of individuals, groups, and psychological phenomena. To gain an understanding of perceptions and lived experiences of participants, it was necessary to incorporate the tripartite multicultural model by Derald Wing Sue, Arredondo, and McDavis According to this model, key components of multicultural counseling competency are knowledge of cultural minority groups, awareness of therapists' world view and cultural biases, and application of culturally appropriate skills to address concerns of clients and therapist biases (Derald et al., 1992). This model is used to address the development of cultural competence both at individual and organizational systems levels offering a better understanding of the factors affecting counseling. The authors suggest improving and

enriching services for an ethnically diverse population. Utilizing This framework was used to help understand study participants' perceptions of culturally competent mental health services delivery to Latinx clients in Idaho.

Nature of the Study

This study involved using a phenomenological qualitative research design to better understand a psychosocial situation. According to Creswell (2017), qualitative research involves occurring processes and product or outcomes. In this study, I was interested in understanding viewpoints of providers and management from different agencies about strategies they used to meet mental health needs demands of Latinx populations as they perceived those demands. It was helpful to use a phenomenological approach to describe what themes emerged as participants shared their experience the phenomenon of cultural competence when working with Latinx within their service settings. This approach was used to help understand what was not understood to date. Hearing from people who have directly experienced the phenomenon allowed me to obtain a deeper and richer understanding of the topic.

Definitions

Latinx or Hispanic: Latinx is an intersectional identity term meant to be used as a gender-neutral or nonbinary term that is inclusive of all genders (de Onís, 2017). Latino may refer to people originating from Latin America. However, the word Hispanic may be referred to those who speak Spanish, and not every group in Latin America speaks Spanish. Hispanic is not necessarily an all-encompassing term. The words Latino or Latina was not chosen because both terms are gendered. For this study, and based on the

literature review, the terms Latinx and Hispanic are used interchangeably and refer to Spanish speakers.

Culture: Values, beliefs, customs, traditions, patterns of thinking, norms, and mores of an individual or population (Young et al., 2020).

Cultural competence or cultural sensitivity: Cultural awareness and beliefs, included sensitivity to the impact of one's values and biases that might influence perceptions of clients, presenting problems, therapeutic relationships, knowledge of clients' cultural background, worldview, and therapy expectations, and cultural skills encompassing the ability to provide culturally appropriate and sensitive treatment (Sue et al., 1992). For this study, the two terms are equivalent and were used interchangeably.

Language: Culturally based explanations of development, health, and pathology that are linked with spoken or written language and affective experience. Use of native languages in psychotherapy facilitates clients' connections with early experiences. Individual meanings of language use emphasize the complex use and interpretation of words and phrases; therefore, it should be carefully considered (Tummala, 2015).

Minority group: Population subgroup with ethnic, racial, social, religious, or other characteristics that are different from the majority of the population (APA, 2015).

Assumptions

It was also assumed that mental health providers had experience working with Latinx populations I assumed that participants described their experiences with cultural sensitivity towards Latinx client as mental health providers accurately and honestly.

Another assumption was that participants had training and understanding involving cultural competence. I assumed that stakeholders who operate a mental health agency had basic knowledge of what the state of Idaho requires from them as owners of mental health businesses and what mental health providers need to use in practice. Another assumption was that the qualitative method of phenomenology was the best method for unfolding the experiences involving cultural competence in practice.

Scope and Delimitations

This study included phenomenological interviews with mental health managers, Latinx mental health providers, bilingual providers who spoke Spanish, and non-Latinx providers from different agencies in southern Idaho. Experiences involving provision of culturally competent services to Latinx populations were explored. Only participants in southern Idaho were included who worked in mental health fields. Semi-structured interviews were conducted initially via Skype and in person. I used a small sample of 15 participants for this study. Interviews included open-ended questions developed to elicit views and opinions of participants. Data were collected using Skype for Business, in-person contacts, and phone interviews.

Limitations

A qualitative study design is used to develop and enrich the initial understanding of a less explored or well-known topic (Levitt et al., 2018). Although a benefit of the qualitative approach is that it can be used to deepen understanding of a phenomenon that is not well understood, a potential limitation of this approach is that findings only apply

to the study participants. This study cannot be generalized to other individuals (Creswell, 2017).

Time, money, and sample size were also practical limitations. Potential barriers to recruitment included the limited number of participants that were available for recruitment and their motivation to participate. There were concerns about having enough participants. Therefore, this study involved a small sample size of community providers in the area who volunteered and had flexible time.

Yin (2009) reported that the qualitative research bias issue was the researcher's subjectivity. The human element, complete with assumptions and biases, can cause researchers to fail to observe present data. Therefore, in qualitative research, the researcher needs to understand their role and relationship in the study (Denzin & Lincoln, 2000). I recognized that being a Latina clinician in southern Idaho who works in the mental health field may influence the design of the study and review of literature. I kept a journal and audit trail to document and understand my role and challenges as a researcher. I intended to use qualitative data software programs such as NVivo, which can help reduce bias during handling of data. I found MAXQDA (QDA) a qualitative data analysis software 2020 user-friendly, financially suitable, and effective in terms of organizing data Rädike (2020).

Although the use of a qualitative design allowed me to better understand a complex phenomenon through narratives of study participants, this design did not support generalization of findings beyond study participants. This study was an essential first step to future research involving descriptions of experiences obtained using a qualitative

approach and subjecting such finding to study via quantitative or mixed methods design (Levitt et al., 2018).

Significance

There is limited literature on perceptions of mental health providers regarding their understanding of cultural competence (Lanesskog et al., 2015). Sue (1998) defined cultural competency as the belief that people should not only appreciate and recognize other cultural groups but can effectively collaborate with them. According to the APA (2020), approaches to developing culturally sensitive services can better proceed when exploring how practicing clinicians and mental health services managers conceptualize cultural competency.

The latest research study done by Stickney (2009) addressed mental health needs and the delivery of culturally appropriate care to Hispanics in Southern Idaho. The information compiled by Stickney 13 years ago was survey-based, gathered from non-Hispanic white specialists in the mental health field. Results from that study included the recommendation for interviews with Hispanic providers and mental health key informants, which supports qualitative research on this topic (Stickney, 2009). Chavira et al. (2017) proposed qualitative research in a specific region to provide valuable feedback regarding treatment consistent with that area. This study was a critical first step in terms of identifying mental health service providers' perspectives, attitudes, beliefs, and behaviors regarding providing culturally sensitive services to Latinx clients in Southern Idaho.

Summary

Cultural competence is understood to be an essential aspect of provision of services to Latinx populations. Providing culturally competent services has implications for overcoming barriers to treatment and promoting mental health and wellbeing. Based on previous studies and limited studies, it was possible to identify the gap in literature. My goal was to unfold the experiences of mental health providers and management regarding their understanding of cultural competence when working with the Latinx population in Idaho. I asked the following questions: (a) what are your beliefs and attitudes about cultural competence within mental health services? (b) how does cultural competence/cultural sensitivity related to providing mental health services for Latinx clients in their practice setting?

Chapter 2 contains an introduction and information regarding search techniques used to find literature that was relevant to this capstone project. I describe definitions of cultural competence and sensitivity, a history of cultural competence in the mental health field and other fields, access to care, and disparities within Latinx populations. Chapter 2 includes an in-depth discussion of culturally competent practices and related studies. The qualitative approach design helped to explore the phenomenon further.

Chapter 2: Literature Review

Introduction

There is robust literature regarding culturally competent mental health services, including barriers to the provision of culturally competent services and needs of Latinx populations for culturally sensitive mental health services. The number of minority groups such as Latinx is rapidly increasing, which calls for further understanding of cultural competence as it is applied in psychology. This population has a high frequency of mental health problems, and treatment outreach is minimal (Rogers et al., 2015).

Cultural competence is a topic of continuous research in terms of delivering services to minorities. The APA (2017) reported that cultural competence does not refer to a process that ends simply because a provider is deemed competent. Instead, the APA recognized cultural competence incorporates the role of cultural humility whereby cultural competence is considered a lifelong process of reflection and commitment. Roberto Lewis-Fernandez et al. (2016) addressed in the DSM-5 Handbook on the Cultural Formulation Interview the necessity rather than an option for culturally competent in health care provision in practice. Lewis-Fernandez et al. (2016) emphasized that cultural competence operates at all levels of healthcare delivery involving patient-provider interactions to organizational, service systems, and society.

The following literature review includes research associated with Latinx or Hispanics, mental health services and disparities, cultural competence or cultural sensitivity practices, and the phenomenological research method. Literature findings are arranged in an inverted pyramid style, from the broadest literature about cultural

competence to relevant studies in Idaho. To begin, there is an explanation of literature search strategies. The next section is related to culturally competent/sensitive mental health services for Latinx recipients and status of research in this area. The sections after that contain a discussion of Latinx mental health diagnoses and services. The concluding section involves mental health services to Latinx in Idaho, followed by a summary.

Literature Search Strategy

In this study, I used the following key words: *Latinx or Hispanics*, *cultural competence, or cultural sensitivity*, *culturally competent*, *care barriers*, *rural*, *health services accessibility*, *mental health*, *barriers to treatment*, *qualitative study*, *health access*, *perspectives*, *culture*, *language*, *depression*, *suicide rates*, *underserved*, and *awareness*. I used Google Scholar as well as Thoreau multi-database search.

By using keywords, 60 peer-reviewed articles and journals were retrieved. Six published dissertations were found in an additional search related to keywords. To narrow down the search, articles that involved substance use treatment were discarded. Only those that applied to clinical psychology and mental practices were used. Most of the selected peer-reviewed articles and journals were qualitative studies. I also searched for quantitative and mixed methods studies to find gaps and recommendations for qualitative research. Mixed methods studies did not include lived experiences of the population. This literature review provides the most relevant support for this study regarding cultural competence and provision of services with Latinx populations.

Theoretical Foundation

The theoretical foundation for this study is multiculturalism, also called the "fourth force" of psychology by Paul B. Pedersen and Pius K. Essandoh. Multicultural psychology is a major influence on multicultural competence and involves individual and intrapsychic factors. The cultural context is considered an essential aspect of the lives of individuals, groups, and psychological phenomena. To gain an understanding of perceptions and lived experiences of participants, it was necessary to incorporate the tripartite multicultural model. Derald et al. (1992) delineates key components of multicultural counseling competency include knowledge of cultural minority groups, awareness of therapists' worldviews and cultural biases, and application of culturally appropriate skills to address concerns of clients and therapist biases. This model was used to address development of cultural competence both at individual and organizational systems levels, to understand factors affecting counseling. Using this framework helped me understand study participants' perceptions of culturally competent mental health services delivery to Latinx clients.

Literature Review Related to Key Variables

Cultural Competence or Cultural Sensitivity

The importance of cultural competence is derived from the Americans with Disabilities (ADA) Act of 1990. Federal regulations about cultural competence were established that prohibit discrimination. Rules-imposed translation services, language assistance, quality assurance, support for capacity, and appropriate range of services were required to serve the population. Historically, cultural competence or cultural sensitivity

has been defined in several ways. Literature from studies dating back to 1990 proposed multiple definitions of cultural competence. According to the US Department of Health and Human Services (HRSA, n.d.), cultural competence is critical in terms of providing relevant services to nations with growing culturally and ethnically diverse populations.

Hadwiger (1999), in the nursing field, defined cultural competence as a process of collaborating with patients from diverse cultural backgrounds as well as reflecting on beliefs and assumptions to negotiate a plan of care using problem-solving and writing competencies. Kondart et al. (1999) in social service defined cultural competence as a best practice approach that is pragmatic, practice-driven, and purposeful. Kim-Godwin et al. (2001), from an education management and educational psychology perspective, identified cultural competence included the key domains of caring, cultural sensitivity, cultural knowledge, and cultural skills. Stork et al. (2001) said "agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve" According to Stork et al. (2001), culturally competent professionals are those who have "the ability to serve individuals of diverse backgrounds."

Ferguson et al. (2003) noted that cultural competence is a dynamic continuum of seven stages: congruent behaviors, attitudes, skills, policies, and procedures enable the organization's caregivers to work effectively and efficiently in cross/multicultural situations. The cultural consultation models suggest a mechanism to address the impact of cultural diversity on mental health problems and diversity competence model assessment as an individual's ability to respect each person's uniqueness (Ferguson et al.,

2003). Benuto et al. (2015), defined "culturally sensitive" as any study that included a specific focus on the cultural group of interest.

However, cultural competence has been widely criticized by Olcoń et al. (2018) for its frameworks that underestimate the complexity diversity brings to the clinical encounter. Olcoń et al. (2018) agreed with Hook's (2012) point of view regarding the dismissal of the salience of structural barriers because of the emphasis on culture as a system of shared beliefs and values. Olcoń supported concerns about the consequence of emphasizing culture and cultural competence in mental health services. Olcoń and his colleagues argued about using outdated definitions of culture in the mental health service setting. In turn, Olcoń et al. (2018) emphasized their definition of "structural competency" that pays attention to forces that influence health outcomes at the level above individual interactions.

Despite the differences in viewpoints, for over 25 years, advocates for cultural competence in the psychology profession have stressed the importance of effective service delivery to racial/ethnic minority clients Sue et al. (1992) and the American Psychological Association (2003); Both entities proposed: (a) awareness of oneself as a racial/cultural being and of the biases, stereotypes, and assumptions that influence worldviews and (b) awareness of the worldviews of culturally diverse clients. To date, Flynn et al. (2019) endorsed that Sue et al. (1996) conceptualization is one of the most meaningful. The American Psychological Association (2003 & 2017) approved their Multicultural Guidelines for competencies based on the cultural domains of beliefs/attitudes, knowledge, and skills. The first domain consists of the awareness of the

professional's own values and biases that could potentially influence their view of the client. The following domain is about knowing the clients' beliefs, values, and worldviews. The third domain pertains to the cultural skills of the professional's ability to communicate and provide care in a culturally sensitive and relevant manner (Flynn et al., 2019).

The importance of understanding this phenomenon goes further than the definition of cultural competence and what is said. The impact of cultural competency in mental health services involves other factors such as the direct experiences of those providing mental health services in an understudied region and setting. Sue et al. (2016) proposed a framework for cultural competence that includes four levels of cultural competence involving the individual, professional practices, institutional practice and policies, and social policies. At each level lies the ability to integrate into care sensitivity to prejudice and knowledge of cultural aspects (Pedrero et al., 2020). Cultural competence has expanded beyond language to include understanding and factoring into services provision as the government requires states to offer culturally competent services (Stork et al., 2001).

Cultural Competence/Sensitivity Mental Health Services

Increased demand for culturally competent or sensitive mental health services has been identified in different health care settings. Govere et al. (2016) highlighted the need for greater culturally competent care when working with minority patients. The research results demonstrated that cultural competence training significantly increased the culturally competent level of healthcare providers and patient satisfaction. The U.S.

HRSA (2018) stressed the importance of culturally competent programs individually and organizationally. The HRSA reported that cultural competence in programs maintains a set of attitudes, perspectives, behaviors, and policies that promote positive and effective interactions with diverse cultures (HRSA, 2018).

Rogers et al. (2015) emphasized the need for effective and culturally sensitive mental health care for Latinx and identified the continued gaps in service and treatment. The study results proposed that culturally informed services can help address disparities. Rogers et al. (2015) determined that disparities may affect access to mental health care, engagement in service, and seeking health insurance. Moreover, noted the association of inequalities with the shortage of providers to deliver culturally and linguistically competent services to Latinx.

Cultural competency has been recognized internationally. Education Management and Education Psychology field researchers have applied cultural competency or proficiency in developing competent cultural scales pertaining to literacy. Çakir et al. (2016) used cultural proficiency to measure the cultural competencies of university students in Turkey. The skills that these researchers identified resemble the domains of cultural competency as defined in the U.S. The cultural competencies include cultural awareness, understanding, knowledge, interaction, and sensitivity.

Cultural competence is also increasingly becoming part of social services (Olcoń et al., 2018). Olcoń referenced the need to view cultural competence as a structural competency. She stressed the need to consider the importance of systemic structural barriers, such as poverty, legal status, and their impact on Latino's psychosocial well-

being. Results suggested that providers' worldviews do not exist in isolation of their own cultural and institutional influences but also include the lived experiences of their clients. Nevertheless, the researchers recognized the need to study this phenomenon, arguing that misconceptions about culture and illusionary cultural competence efforts can be found in any social service setting, contributing to inadequate mental health service provision to minority clients.

Flynn et. al. (2019) examined whether provider cultural competence reduces the emotional and behavioral consequences of adverse health care encounters among 112 Latina and 124 non-Latino White American women in the US. They suggested that cultural competence plays a vital role in health care encounters. Participants reported experiencing less shame and embarrassment to the negative encounter when they perceived their provider to be higher in cultural competence. Their study asserted that cultural competence (knowledge, awareness, and skills relevant to their cultural background) reduced the consequence of adverse health care encounters for both Latina and non-Latino White American women. Flynn and associates found less medical avoidance of medical care for Latinas when patients felt less shame. Results indicated that provider cultural competence could impact health behavior and improve patients' outcomes. Researchers recommended training health care providers in cultural competence could have beneficial effects on patients towards their provider and engagement (Flynn et al., 2019).

According to the American Psychiatric Association (2016), culture shapes every aspect of a patient's care, the experience of illness, the narrative of symptoms, and

distress. Cultural contexts frame the clinical encounter and understanding of psychiatric diagnosis for every patient, not only underserved minority groups. The APA (2016) highlighted that culturally competent service delivery is an important goal in any health care system and organization. Furthermore, organizations must integrate cultural competence practices to meet the needs of a continually diversifying population.

Cultural competence is incorporated into existing curricula and teaching approaches in the medical and adult psychiatric residency programs. It was formally introduced into professional education training programs in 1973. Training in cultural competence principles in knowledge, skills, and attitudes is required as part of standards for accreditation. In psychiatry, for example, the ability to understand how patient diversity affects patient care is a competency that needs development. The resident is trained to assess different ethnic minority groups and understand their own cultural background and beliefs and how they affect their patient interactions. The DSM-5 Cultural Formulation Interview (CFI) was developed to enhance an organizations or clinician's ability to integrate culturally competent assessment. The DSM-5 Handbook on the Cultural Formulation Interview (CFI) emphasized that "not only are there compelling reasons for developing cultural competence in the health care provision, but there are federal, state, and local government policies that support enhancement and integration of cultural competence" (American Psychiatric Association, 2016).

Phenomenological Research

A phenomenological study is an approach used to unfold the experience described by the person experiencing a phenomenon in their own words. For this study, the

phenomenon studied is mental health providers' shared experiences of their own cultural sensitivity and the role of cultural sensitivity in their mental health encounters with Latinx clients. Moustakas (1994) proposed phenomenological research as a conceptual framework to conduct human science research studies, leading to significant new knowledge of everyday human experience. Moustakas (1994) quoted phenomenology as "necessarily the path of universal self-knowledge" and pioneered new realms of philosophy and science. The phenomenology method was used to find a deeper understanding of the phenomenon studied.

Moustakas (1994) proposed phenomenology as the first method of knowledge that intends to set aside prejudgment regarding the phenomenon being investigated. He acknowledged that studies of human experiences are not approachable through quantitative approaches. Moustakas described phenomenology study as a step-by-step process of learning from the participants' description of their experience of a phenomenon. He urged the focus on the wholeness of the experience. This researcher intends to search for meaning and essences through this study rather than measurements and explanations. Therefore, gathering data of the experience was imperative in understanding human behavior and served as evidence for scientific investigation.

Moustakas addressed phenomenological psychology based on the findings of Knowles et al. (1979). They described it as the act of collecting protocols descriptive of the subject's experience and then systematically and rigorously interrogating these descriptions to arrive at the structure of the experience. He emphasized finding meaning to a subject from a person's perception and understanding of a phenomenon. Moustakas

(1990) argued for a separate way of knowing about a phenomenon of interest by obtaining narratives and descriptions of individuals with lived experiences in the topic of interest.

Latinx Mental Health Diagnosis

The Latinx population proliferates just as mental health disorders prevail. According to the U.S. Census Bureau (2017), by 2060, the number of Latinx/Hispanics in the U.S. is projected to grow to 129 million or 30 percent of the population. The last U.S. Census count in 2010 estimated the U.S. population of Latinx or Hispanics was 18.3%. SAMHSA (2018) revealed that 16% of the Latinx population reported having a mental illness. During that time, the amount was already over ten million people.

Latinx are at elevated risk for major depressive episodes, social phobia, posttraumatic stress, anxiety, and substance dependence and abuse (NAMI, 2020). From 2008 to 2018, severe mental illness (SMI) in the Latinx adult U.S. population rose to 4.1. In addition, there was an increase of 8% (age range 18-49) in major depressive episodes. In 2018, the National Survey on Drug Use and Health identified the annual prevalence of mental health illness among U.S. Hispanic or Latinx adults as 16.9%. The number of Latinx with a mental illness for this population is higher considering that other demographic factors were excluded, such as the percentage for the youth population.

In Latinx children and adolescents, psychiatric disorders continue into adulthood if not diagnosed or treated in time (Caqueo-Urizar et al., 2020). The mental health conditions of the Latinx population include those with major depressive episodes, schizophrenia, bipolar disorder, anxiety disorder, posttraumatic stress disorder, obsessive-

compulsive disorder, and borderline personality disorder (NAMI, 2020). Olcoń et al.(2018) research reflected on the importance of attending to the unique experiences of Latinx, particularly to immigrant youth. They pointed out different associated stressors, such as lack of social support and traumatic experiences, leading to a greater risk for depressive and anxiety disorders.

Consoli et al.(2020) researched that 15% of Latinx over the age of eighteen experienced or had a diagnosable mental illness in 2015. Latinx children, teens, and adults reported high rates of depression, anxiety, substance abuse, suicide, and other mental health problems in 2017. For example, more Latinx males died by suicide, and there were higher attempts to suicide for Latinx females age range between 9 to 12 years old. According to the U.S. Department of Health and Human Service Office of Minority Health (2017), suicide attempts were 50% higher compared to non-Hispanic white of the same age group.

As mentioned, Latinx with mental health diagnoses are at elevated risk for suicidality. The suicide rate among Hispanics has increased since 1999 by 30% in most states (Brenes et al., 2019). The National Center for Health Statistics (2020) the suicide rate for Hispanics in 2018 was 15% (per 100 000). The rate is lower than other non-Hispanics due to underreporting, lack of suicide screening, and culture issues (Brenes et al., 2019). Additionally, Consoli et al. (2020) research highlighted significant disparities in access and utilization of mental health treatment.

Mental Health Services to Latinx

With the rapid growth of the Latinx population, the literature highlights the continuous barrier in access to utilizing mental health services (Rogers, 2015). The lack of access is attributed to financial and linguistic barriers, which result in under-reporting and under-diagnosing (Al et al., 2020). About twenty percent of Latinx who experience symptoms of a psychological disorder discuss it with their physician. Only about ten percent reach out for mental health professional treatment (Al et al., 2020). Minorities such as Latinx encounter disparity in the use of mental health services.

Latinx are less likely to receive treatment when experiencing mental distress (Ragalin-Bignall et al., 2015). Moreover, their cultural beliefs can influence their understanding of mental illness, contributing to the disparity in services' utilization, creating an additional barrier to treatment choices. Raglan-Bignall opts to use a qualitative approach to assess mental health attributions regarding the etiology of mental illness. Individuals endorsed a variability of casual beliefs categorized into twelve themes: personal characteristic, family, environment, spiritual, normalization, biological, personal choice, just world, trauma, stress, diagnosis, and social other. The results indicated that ethnic minorities are more likely than Whites to favor the cause of a specific mental disorder to be a normal part of life or to have a spiritual etiology. The minority populations attributed mental health problems to normal behavior "normalization" such as "he is just getting old." Another example was, if a parent attributes their child's emotional problem to a biological cause, they might seek psychiatry. However, suppose the emotional problem is believed to be caused by a

spiritual force; in that case, parents may be inclined to seek help from a spiritual leader instead of seeking a mental health professional. The significance of the findings suggests that understanding ethnic minority mental health attribution is critical to promoting treatment-seeking behaviors and informing culturally responsive community-based mental health services. This study suggests mental health professionals should work towards understanding their clients' mental health attributions to provide more effective treatment to ethnic minorities (Ragalin-Bignall et al.2015).

Mental health practitioners are encouraged to go out and interact with Latinx from varying racial backgrounds. Adames et al. (2016) identified little attention to within-group differences among Latinx regarding skin color and racial features. They considered this factor can negatively affect mental health treatment. Their document concludes with a model to assist mental health practitioners, and clinical supervisors in gaining the knowledge, awareness, sensitivity, and clinical skills to competently learn, understand, and address the complexities of skin color and physiognomy when working with Latinx. They offered a variety of scholarly, cultural resources, illustrations, and recommendations, to deepen the understanding of this topic.

Adames et al. (2016) indicated that extant literature reviewed suggests that individuals with darker skin experience more racial stigma, discrimination, less educational attainment, lower income (wages), and consequent psychological distress. Therefore, mental health providers must be knowledgeable regarding how skin color and colorism may impact Latinx and how to integrate such knowledge into clinical practice. The authors discussed the mix of three predominant racial groups, including Indigenous,

Black, and White, referred to the historical socialization of Latinx that continues to maintain the denial, deflection, and minimization of skin color hierarchy as Mestizaje Racial Ideologies (MRIs). They argued that individual of Latin American descent was socialized not to identify themselves racially, and the MRI instilled in Latinx have impacted their racial self-identification in complex ways such as when asked to identify their race, and over half continue to identify as "some other race" or Latino/Hispanic." These researchers argued that many Latinx might not see themselves as victims of racial discrimination because they do not classify themselves as black despite being phenotypically black. Consequently, the researchers reported higher levels of depressive and stressed symptoms among Latinx decedents of mixed race, such as Afro-Latinas. They urged mental health providers should be adequately prepared to meet the needs and the complexities of within-group differences. The researchers proposed that considering factors such as skin color and physiognomy in the general well-being and mental health treatment of Latinx may foster rapport building in therapy and better treatment outcomes across the color gradient. Furthermore, integrating these factors may contribute to the provision of culturally responsive and racially conscious services to the individuals from the community studied (Adames et al., 2016).

Lanesskog et al. (2015) revealed a complex set of service barriers related to language skills, cultural competence, empathy towards clients, and the will to act. Twenty-five human service professionals working with Latinx immigrants in one new-growth community found that service delivery to this Latinx requires not just language ability and cultural knowledge but the convergence of the four distinct skill sets.

Researchers reported that as the rapidly growing Latinx populations continue, highly educated professionals Latinx leave as unskilled Latinx arrive, leaving behind the lack of the bilingual, bicultural human service workforce needed to provide linguistically and culturally accessible services.

The participants had a range of views regarding what aspects of language proficiency were more impactful. Degree of fluency and their own or colleagues' proficiency was among their considerations. Lanesskog et al. (2015) argued that some providers only have conversational language skills, but their colleagues and supervisors assume they possess the technical proficiency required to conduct therapy in Spanish. Bilingual mental health providers reported that clients with limited ability to read, speak, write, or understand English (LEP) required additional time and effort to address challenges. Moreover, feeling obligated to assist clients in communicating with other staff outside their job responsibilities.

Participants highlighted the importance of cultural knowledge in multiple contexts, such as understanding norms and values from both Latinx and American cultures well enough to negotiate tension. Empathy and the will to act emerged separately. Some participants proposed, "if their colleagues only knew about the hardships Latinx face in this community, they would feel for the clients and act on their behalf." Recommendations such as helping workers with less language and cultural skills strengthen their skills as they collaborate closely with more knowledgeable peers may improve service delivery while leveraging the capacity of workers willing to share responsibility for Latinx clients (Lanesskog et al., 2015). The findings suggested that

Latinx clients need help identifying and accessing services, navigating the referral process, and negotiating cultural differences. Institutions were encouraged to provide Latinx-serving workers with more meaningful participation in organizational decision-making around services for Latinx.

Consoli et al. (2020) indicated that fewer Latinx received mental health treatment than whites and other racial and ethnic groups in 2017. They reported that 1 in 10 Latinx with mental health received a mental health professional service. They also pointed out that language and communication differences resulted in misdiagnosis or undertreatment. They referred to barriers found in similar studies associated with seeking treatment, limitations in English and Spanish language availability, and shortage of culturally responsive service from culturally competent humble providers. Consoli et al. (2020) identified the scarcity of mental health providers in the US and referenced 5.5% of mental health professionals provide services in Spanish. Further, they expressed that only 5% or about 5,000 identified as Latinx psychologists in 2018. Villalobos et al. (2016) highlighted that the Latinx felt discomfort sharing information when translators were available and more significant benefits of privacy, trust, and accuracy of interpretation from bilingual providers. Consoli et al. (2020) urged the implementation of bilingual English/Spanish mental health training of providers due to the significantly limited services being offered in Spanish.

Mental Health Services to Latinx in Idaho

Community partners in southern Idaho continue improving access to affordable health insurance for the most affected population, Hispanic/Latinx. In 2018, Idaho passed

a proposition to expand Medicaid. Despite the efforts, the Community Health Needs Assessment (CHNA, 2019) reported that the percentage of people ages eighteen or older having any mental illness in Idaho was 21.62% making it the fourth-highest percentage in the nation. Mental Health, according to CHNA, includes our emotions, psychological, and social well-being. Outcomes of the report highlight mental illness as a common condition in the US.

According to this report, community mental health status can help explain suicide rates and the need for mental health professionals in our service area. The information disclosed the need to lower suicide rates and improve mental health. Idaho is on the top ten states for its rate of suicide, with suicide being the eighth leading cause of death. The suicide rate for males is about four times higher than the rate for females.

The Hispanic population represents 20% of the defined serviced area in southern Idaho. This number indicated that 21,162 people identified themselves as Hispanic. There was an increase of 30% in population from 2000 to 2016. In 2016 Idaho adults with lower incomes were three and a half times more likely to have a depressive disorder, and women more likely than men to be diagnosed with a depressive disorder. Still, the authors reported a shortage of mental health professionals in 2017. Moreover, uninsured individuals experience a higher mortality rate, more adverse outcomes mentally, and are less likely to receive preventive, diagnostic health care and treatment. Hispanics are twice as likely not to have health insurance coverage as non-Hispanics. In 2018, The State of Mental Health in America reported that people in Idaho with a mental illness reported not

receiving the treatment they needed due to a lack of adequate insurance, treatment providers, and treatment types (Community Health Needs Assessment, 2019).

This report indicated high-priority community needs to address mental illness programs and the availability of mental health professionals. The researchers noted effective programs in lowering suicide rates and improving mental health. However, there are current challenges with getting corresponding treatment for mental illness and stigma around receiving it for the Latinx population. The Community Health Needs Assessment is done every three years. In 2016, one of the goals was to improve mental health and reduce suicide. Since then, depression screening was established to provide more effective screening, assess risk, and provide proper discharge and follow-up care. Unfortunately, according to the research, barriers to education, stigma, lack of services, uninsured, culturally competent treatment, and access to care prevail.

The NAMI (2019) pointed out that while there may be a preference for finding Latinx mental health professionals, there is a small percentage of providers. Moreover, that many providers still lack cultural competence to treat Latinx effectively. The report underlined essential questions that could be asked when providing mental health services. They proposed the following:

1. Have you treated other Latinx?
2. Have you received training in cultural competence or on Latinx mental health?
3. How do you see our cultural backgrounds influencing our communication and my treatment?
4. How do you plan to integrate my beliefs and practices in my treatment?

These questions could be integrated into research to understand the lived experiences of providers in Idaho related to cultural competence provision of services to Latinx.

Vega et al. (2016) identified Latinx as the majority minority in the US. They focused on community-based programs offered in Southwest Idaho and other regions. Results suggest that additional research needs to develop culturally relevant approaches to engage unserved, underserved, and disenfranchised audiences. The study indicated that having bilingual and bicultural staff gives the organization credibility and commitment to serving Latinx families and is viewed as mentors and role models.

Vega used a systematic literature review and multiple online databases to retrieve sixty-six articles published within the last 20 years. Twelve key components were identified as best practices when developing and implementing programs for Latinx. The result from the literature review suggested the following: bilingual & bicultural personnel, caring and trustworthy staff, trust and relationship building, culturally appropriate programming, family-centered, valuing relationships, time & effort, community partnerships, connecting families with resources and referrals, research, and program evaluation, and cultural competence. Vega and colleagues remarked that having providers with (heart) to serve truly, care, and find effective ways to communicate when working with the Latinx community is valuable because it builds a safe place and stronger relationships/trust. The findings suggest that having a “heart” contributes to the success of the programs. They proposed that community programs are a method for program delivery leading to successful outcomes in reaching the Latinx audience,

including out of school. In these safe environments, the families can participate in direct programs.

Summary and Conclusions

Chapter 2 contained a review of the current conceptual understanding of cultural competence. I addressed cultural competence/sensitivity, culturally competent/sensitive mental health services to Latinx, Latinx mental health diagnoses, mental health services to Latinx, mental health services to Latinx in Idaho, and use of the phenomenological methodology to address experiences of mental health providers and management.

This study helped address answers to questions: about beliefs and attitudes about cultural competence within mental health services as well as how cultural competence/cultural sensitivity relates to the provision of mental health services for Latinx clients in their practice setting. While the literature reveals what is understood about culturally competent practices, requirements, meanings, barriers, and benefits, understanding lived experience involving the phenomenon as perceived by mental health and management working with the Latinx population in southern Idaho.

A better understanding of the importance of culture competence was obtained by reviewing the relevant literature regarding beliefs and attitudes about cultural competence within mental health services and how relates to service with Latinx clients.. Chapter 3 includes the study's research design and rationale. The purpose of Chapter 3 is to present detailed discussions of the qualitative methodology. A discussion of the role of research is presented. It is followed by a description of the target population as well as ethical considerations for this research.

Chapter 3: Research Method

Introduction

The purpose of this qualitative phenomenological study was to obtain perspectives and experiences of Idaho-based mental health providers and managers of mental health agencies regarding provision of culturally sensitive services to Latinx populations through their service settings. In this chapter, there is an in-depth discussion about the chosen methodology. I explain the research design and rationale for its use. I then address the methodology process of the study. This is followed by issues of trustworthiness and ethical procedures related to the study. Finally, there is an overall summary of main points of Chapter 3, followed by a transition to Chapter 4.

Research Design and Rationale

The central phenomenon that I explored is the lived experiences of Idaho-based mental health providers and managers of mental health agencies regarding provision of culturally sensitive services to the Latinx population. Research has indicated significant racial and ethnic disparities in mental health care. However, less was known about local providers' experiences in their own words regarding their provision of mental health care to racial/ethnic minority groups such as Latinx in Idaho. Based on the problem identified and purpose of this study, the research question of interest was:

RQ1: What are the participants' lived experiences regarding cultural competence in the delivery of mental health services to clients who are Latinx?

I used a qualitative research approach to explore the central phenomenon. A qualitative approach helps gain an in-depth understanding of participants' lived

experience as they describe them (Vagle, 2018). Creswell (2017) explained that researchers use the qualitative approach to guide studies involving emerging questions, collecting in-depth data, subjectivity, data analysis, building from particulars to general themes, and interpreting meaning of data. Given this unique approach to understanding each participant's experiences, although themes and content is reviewed for patterns among participants, the study's findings cannot be generalized to other individuals (Creswell, 2017). A qualitative research approach was appropriate for exploring and understanding meanings individuals ascribe to the phenomenon in this study.

I considered using a quantitative approach; however, quantitative methods would lead to numerical data regarding provision of services offered to Latinx in Idaho rather than perspectives of this phenomenon. Researchers had not captured lived experiences involving mental health providers' provision of culturally competent services to the Latinx population in southern Idaho. Previous research had also recommended interviews with Hispanic providers and mental health key informants (Stickney, 2009). Quantitative and mixed methods were not appropriate for this study because the research question did not focus on causes and effects of providing culturally competent services but rather phenomenological experiences of mental health providers working with Latinx clients.

I selected a phenomenological research design and found it appropriate to explore participants' lived experiences in their own words. The phenomenological design provided an opportunity to explore human experiences, rich data, and the phenomenon. The benefit of a phenomenological design over other qualitative designs is that it is most suited to capture unique experiences through participants' verbal narratives. This design

addressed experiences of mental health providers' provision of culturally competent services to the Latinx population. The description culminated in the essence of the lived experience of several individuals who experienced this phenomenon (Creswell, 2017).

Using the phenomenological research design helped raise awareness and increase insights regarding this phenomenon. Results contributed to existing research to better understand how culture influences treatment choices and the population served based on participants' perspectives. A qualitative phenomenological design allowed a deepened understanding and explore how mental health providers experienced this phenomenon. Other qualitative research designs such as grounded theory or ethnography were not appropriate because they did not align with the study's purpose. I was not interested in developing theories about this phenomenon; therefore, the grounded theory was inappropriate. The ethnographic design was not suitable since I did not intend to study patterns of behaviors, language, or cultural actions over a prolonged period.

Role of the Researcher

I was the primary instrument in this qualitative study to capture participants' narratives. As the study's primary instrument, I recruited participants, collecting data, analyzing results, and disseminating findings. It was essential to monitor and reduce bias. I addressed bias by remaining conscious about my previous knowledge and dispositions about the topic. I explained the study without biasing potential participants.

Conducting interviews properly according to the design was essential. I developed questions that were clear, consistent, and easy to understand for participants . I collected and ensured data accuracy based on participants' perspectives. I prepped before

interviewing and evaluated the technology that I used. I made appropriate observations to identify factors that may have influenced the study throughout the process. I self-assessed to be alert for any potential influence involving power over participants to address and set aside my biases. Yin (2009) explained self-assessment is done to understand the researcher's experience and beliefs on the topic and bias issues that can cause researchers not to observe data as presented.

My role as the researcher involved recognizing that being a Latina clinician in southern Idaho who works in the mental health field may influence the study's design or conduct as well as review of study findings. I kept a journal and audit trail to document and understand my role and challenges as a researcher. I also intended to use NVivo, which helps reduce bias during incoming data handling. However, I decided to use MAXQDA software which worked appropriately for this study.

Further, I had no prior personal or professional relationships with participants, including supervisory or instructional relationships. Researcher bias and power relationships was managed by recruiting participants from south Idaho who did not work directly with me. This study was conducted in a private and confidential room setting without possible distractions. There were no incentives promoted for participation, which was voluntary.

Methodology

This section includes an outline of methodological procedures for this study. The section consists of participant selection logic, instrumentation, recruitment procedures, participation, data collection, and the data analysis plan.

Participant Selection Logic

This study included volunteer participants, including mental health managers, Latinx mental health providers, bilingual providers who speak Spanish, and non-Latinx providers from different southern Idaho agencies. Chavira et al. (2017) considers that qualitative research in a specific region provides valuable feedback regarding treatment consistent with that area. Participants only included providers or management from southern Idaho in the mental health field who had worked with the Latinx population.

The entire population for this study included all mental health providers and managers in the state of Idaho. However, I used purposeful nonprobability sampling to select a part of the population for a comprehensive analysis. Therefore, findings cannot be generalized to the entire population. Also, the participants needed to meet the criteria to be eligible to participate in the research. I used snowball sampling if the sample size was not reached through the recruitment process. Participants were asked to refer people that meet the criteria to participate.

All participants in this study were mental health providers or managers who identified as Latinx and bilingual providers who speak Spanish, or were non-Latinx providers who provided services to Latinx clients in southern Idaho. Confirmation about eligibility was disclosed during recruitment with each participant that met full criteria. I recruited fifteen participants who met the criteria required for this research. Samples for qualitative studies are generally smaller than those used in quantitative studies, allowing me to focus more in-depth on narrative descriptions' meaning and richness.

Participants were identified, contacted, and recruited via email. The email addresses were obtained from the internet and community resources. The recruiting process involved using flyers and e-mail invites, including informed consent delivered and received by email and or in person to local Idaho-based mental health providers and managers of mental health agencies involved in services with Latinx clients. Participants were recruited through various public websites such as Psychology Today, public directories, Facebook, LinkedIn, my professional network, and snowballing sampling. The purpose of the study and criteria for participation was explained to assure that the providers met the requirements to participate in the research. The participants of the study were determined by using the criterion sampling method. The main objective was to focus on the participants who met the criteria of being a mental health provider or in a management position within mental health services in southern Idaho who had worked with Latinx clients. All participants must have experienced the same phenomenon for consistency in phenomenological research.

Saturation was used as a guiding principle in this study during the data collection process. The rationale for the size was based on data saturation when collecting new data did not shed any further light on the issue under investigational. Saturation was reached at any point when sufficient participants and data enabled the development of meaningful themes and valuable interpretations. I continued recruiting participants if there was no evidence of data saturation. Creswell (2017) suggested 10-15 participants is the optimal range for a sample because of saturation. He indicated that a small study with “modest claims” might achieve saturation quicker.

Instrumentation

I was the primary instrument in this study. As the researcher, I was a fundamental component of this study during the entire process and was responsible for sharing each participants' lived experience's accuracy. I recruited, collected data, analyzed the data, provided results, and disseminated the findings.

I prepared an interview guide for the interview process that included the most relevant questions to ask each participant to establish sufficiency in responding to the research question. I followed the interview protocol, starting with explaining the process and using semi-structured, open-ended questions for the participants to answer the interview questions. Most of the data collection was via Skype for the Business interview, in-person contact, and less by phone due to the COVID pandemic and travel restrictions. However, in-person contact was not as limited as I thought it would be. Technology was an essential instrument in this study; therefore, preparing to ensure the equipment worked appropriately took place. Phone interviews were available as an option for the participants.

All participants were interviewed and recorded to gain a deeper understanding and better understand their lived experiences. I used the interview guide and set it aside if the client needed clarification or a follow-up question. I prepared the setting and tested the essential technical equipment to avoid technical issues during the interviews. Following the interviews, I used MAXQDA, a qualitative data analysis computer software, to store and organize the incoming data.

Procedures for Recruitment, Participation, and Data Collection

I recruited participants and collecting the data for this study. Flyers, in-person, and online contact, and through referrals to recruit participants (see Appendix B). As the main instrument of this study, I provided details of data collection for each data collection instrument and research question on the interview guide (see Appendix C). Mental health managers, Latinx mental health providers, bilingual providers who speak Spanish, and non-Latinx providers from different agencies in southern Idaho notified via email and in-person about an opportunity to participate in the study. Participants who met the full criteria that included providing culturally competent services to the Latinx population were asked to participate. Informed consent was completed before collecting data (see Appendix D). There were no professional or personal contacts that presented an ethical concern in this study.

The primary data source was the responses to interviews with the participants using semi-structured, open-ended questions developed to elicit participants' views and opinions. I built rapport with the participants to provide a safe environment in a comfortable, confidential setting. I collected the data using Skype for Business, in-person contact, and phone interviews. I coordinated with each participant to determine their preferred appropriate location and method. The frequency of the data collection was limited to one interview per participant. The duration of each interview was about forty-five minutes to one hour. The interviews were recorded using Skype for Business and phone voice recording as a backup (password protected) and transcribed to gain a richer understanding of the participants' description of their experience about the phenomenon

of the provision of cultural competence services to Latinx clients. I transcribed the narratives using verbatim transcription to capture every verbal sound in the recordings into text using Skype for Business without editing or changing anything. I also listened and hand transcribed the voice recording to verify the responses from each participant. The participants were part of the second interview as part of the member check process to clarify their answers. The data collection ended at the point of data saturation when no new information was forthcoming from the interviews.

Data Analysis Plan

Once the transcription process concluded, I used MAXQDA to organize incoming data from interviews into open-ended responses. MAXQDA is a world-leading software used for qualitative research, including qualitative text analyses and mixed methods approaches. The software allows researchers to collect, transcribe, organize, analyze, visualize, and publish data. The data can be scoped, interpreted, interrogated, and saturation can be reached using this innovative qualitative research software. The query search provides ways to view the data, reflecting on the study in new ways. MAXQDA can help store, organize, and analyze data. However, to conduct research, ethical responsibility and cultural sensitivity are required to ensure valid results.

After collecting data through phenomenological interviews, the data was transcribed and followed by the member check procedure. I was responsible for the phenomenological analysis process to transform the data collected from concrete data to categories. I followed the steps utilized by Heidegger's Hermeneutic Circle basis for phenomenology. The procedure involved describing the process of understanding and

connecting the philosophy of what was understood and interpreted, embracing how people made sense of the world while uncovering Heidegger's Hermeneutic Circle, the essence of the experience (Peoples, 2021).

Heidegger proposed that there was no way for the process of Epoché bracketing to occur because, in our experiences, we are "always existing in the world with others" (People's, 2020). Instead, the idea is to be present in the world "Dasein," which involved making my own biases and judgment explicit. Knowingly, I brought preconceived knowledge "fore-sight or fore-conception" into the research. For validity purposes, I recognized my preconceived knowledge about this phenomenon of cultural competence in the framework of Multiculturalism. I wrote the information in the literature review about my pre-understanding and journaled about my personal biases before analyzing the data. As an understanding or interpretation set off, my biases, knowledge, and judgments were revised.

The focus was to enable the participants in this phenomenological research to answer the research question based on their experience and narrative. The phenomenological analysis steps I followed were:

1. horizontalizing, or listing all relevant expressions,
2. reduction of experiences to the invariant constituents,
3. thematic clustering to create core themes,
4. comparison of multiple data sources to validate the invariant constituents,
5. constructing of individual textural descriptions of participants,
6. construction of individual structural descriptions,

7. construction of composite structural descriptions, and
8. synthesizing the texture and structure into an expression.

First, horizontalizing was part of the phenomenological reduction. All the statements (the whole) were considered equal value, and irrelevant data outside the study's scope was discarded (Yüksel et al., 2015). I cleaned the data by eliminating overlapping, repetitive, and vague expressions. A list was created from the participants' verbatim transcripts, and irrelevant expressions were deleted. The interviews were cleaned to keep only the statements directly related to the lived experiences regarding cultural competence in delivering mental health services to clients who identified as Latinx. For instance, the statement was eliminated if a participant spoke about culture and were not related to cultural competence in delivering mental health services with Latinx. After the cleaning of data and the meanings or horizons were kept.

Step two was the reduction of experiences to the invariant constituents where this researcher clustered horizons (textural meanings) into themes (Yüksel et al., 2015). This process involves assigning labels to the codes found in the previous analysis stage. The data was split into meaning units so that each of the themes had only one meaning.

The third step was thematic clustering to create core themes from the experience of the phenomenon (Yüksel et al., 2015). I clustered and thematized the horizons Moustakas (1994) defined as the experience's core themes. I organized the data into clusters of themes based on similarities, similar concepts, or patterns in the narrative. I developed several categories that represent the core themes of the lived experiences

regarding cultural competence in delivering mental health services to clients who are Latinx.

Step four involved comparing the multiple data sources to validate the invariant constituents (components of the experience) from the themes formed by the data collected, including the participants' interview, observation, and literature to verify accuracy (Yüksel et al., 2015). Creswell (2017) highlighted those different perspectives do not always unite; therefore, discrepant cases were addressed by discussing contrary information. I accomplished this by discussing evidence about a theme or summarizing each participant's lived experience to ensure a clear representation of data within the resources.

Step five entailed the construction of individual textural descriptions of participants. I described the participants' experiences using verbatim extracted from their interview and explained the meaning in a narrative format. This helped explain the participant's awareness of the phenomenon and understand their experiences.

Step six is the construction of individual structural descriptions. This step involved textural descriptions. The researcher used eidetic reduction, a form of imaginative variation, to imagine how the experience occurred and create the structures. I used eidetic reduction to identify the essential components of the phenomena to draw out the phenomena’ absolute necessary essences.

Step seven is the construction of composite structural descriptions where I wrote the textual description for each participant and added the textural description into a structure at the end of each paragraph to explain how their experienced happened and to

gain an understanding of the participants' experiences about the phenomena (Yüksel et al., 2015).

Step eight involved synthesizing the texture and structure into an expression where two narratives were created for each participant, a textural describing what happened and a structural of how it happened. I listed the meaning units for each participant, created meaning units common to all participants, created a composite textural and structural description based on the shared meaning units. I integrated the hermeneutic circle and went back to the beginning of these steps. I analyzed the data as "a whole" in a spiral movement multiple times to reach the elimination process and create the essence of the phenomena.

A composite narrative was written from the third-person viewpoint representing the synthesis of all narratives for the group as a whole. The composite structural and textural descriptions were combined to create a universal description of the phenomenon to reach the essence of the experience (Yüksel et al., 2015).

Issues of Trustworthiness

Credibility

To maintain credibility (internal validity) in this study, I conducted member checks with the participants, who were a means to increase validity and a method essential to the credibility and accuracy of the ideas presented in this study. I verified that their narrative transcription accurately described their experience via email to determine whether a correction was needed. Triangulation in this study was applied using multiple data resources to verify themes.

Transferability

The essential criterion for selecting participants is their having experienced the phenomenon of interest. In this phenomenological research, this was addressed by establishing transferability (external validity). Furthermore, an adequate thick description of the phenomenon under study was given to allow the audience to understand it properly. The sample size was 10-15 mental health care providers or management from southern Idaho who voluntarily participated in this study. Only providers or management from southern Idaho and in a mental health field who had experience providing culturally competent services to the Latinx population were included.

Dependability

I addressed dependability by maintaining an audit and log trail through the research process for tracking decisions and assumptions. This strategy allowed outsiders to see how such decisions and assumptions evolved over the process. Audit trails are one strategy to ensure greater consistency between the result and the data collection (Candela, 2019). Using an audit trail, I placed a date and time stamp on all documents and entries created and edited in MAXQDA. This step allowed for monitoring how the research process unfolds throughout the study.

Confirmability

Confirmability was established by keeping a methodological log to document all decisions related primarily to research methodology. While coding in MAXQDA, a spiral notebook was used to write why specific categories were chosen and add a self-reflection journal. The handwritten notes were transferred into the MAXQDA coding journal memo

to reflect coding strategies further. Creswell (2017) indicated that inquiries identify reflexively their biases, values, and personal background that shape interpretation in a study. I acknowledged that being a Latina clinician in southern Idaho who works in the mental health field may influence the study's design or conduct and review of the study. Subjectivity was kept in check by creating flow-up memos after each interview and after receiving and reading each specific piece of data for the first time. The memos helped as a trail map to the thoughts, questions, and ethical concerns that could emerge about the information gathered and reflection.

Ethical Procedures

Obtaining Consent

Before recruiting participants via email or in person, I requested consent to conduct research from Walden's Institutional Review Board (IRB; see Appendix A). Once the research approval was received, I started the recruitment process. I submitted a copy of the recruitment flyer and e-mail for voluntary participation in this study (see Appendix B). The participants were asked to reply to the email, and their electronic signature signified consent for participation and the recording of the interview process. The consent form was also available to participants in person and completed before participating in the study. All consent forms and research data are kept in an electronic file or a locked file cabinet for five years.

Summary

Chapter 3 included the methodology and phenomenological approach, where I found meaning from perceptions and understanding of a phenomenon (Moustakas,

1994). Data collection method, data analysis, role of the researcher, and ethical consideration were discussed. Chapter 4 includes a brief review of the purpose and research questions followed by an in-depth discussion of data analysis, including instrumentation and data analysis strategies. Descriptions of personal or organizational conditions that may have influenced participants were also discussed. Demographic characteristics relevant to participants in this study were presented. Furthermore, data collection, data analysis, evidence of trustworthiness, and research supported by data to support findings were explained. A concise summary of answers to the research question and a transition to Chapter 5 is provided.

Chapter 4: Results

Introduction

Cultural competence has been defined in mental health as having awareness and understanding and being sensitive to clients' cultural identification, which includes cultural beliefs and norms of behavior (DeAngelis, 2015). Application of cultural competence is a requirement in practice when providing services in the mental health field and is a feasible way to minimize barriers (Fawcett et al., 2018). The purpose of this study was to understand aspects of cultural competency and mental health service delivery that have received less attention from researchers involving experiences of mental health providers and managers in their own words regarding provision of culturally sensitive services to Latinx populations within the state of Idaho. The research question was:

RQ1: What are the participant's lived experiences regarding cultural competence in the delivery of mental health services to clients who are Latinx?

This chapter includes an overview of the context for conducting this hermeneutic phenomenological qualitative study as well as findings from the study. A description of the setting and demographics is provided, followed by a description of data collection procedures, data analysis, evidence of trustworthiness, and findings.

Setting

The research started after receiving approval from Walden University's IRB (#09-10-21-0613864) to initiate recruitment of participants. I conducted all interviews in a private office to minimize distractions. Participants had the choice between in-person

contact or remote interviews through the online videoconference application Zoom. Of the fifteen participants, ten chose in-person interviews, and five opted for Zoom interviews.

Interviews and follow-up member checks took place in a private office, a safe environment that was both comfortable and confidential. For in-person participants, COVID-19 safety protocols were followed by wearing masks, social distancing, and ensuring that all involved had no recent or present symptoms related to COVID-19. Participants did not disclose any concerns and complied with safety procedures. Five interviews took place via Zoom because of issues and limitations involving their travel ability. Information was stored in a password-protected electronic file in a locked room. Information will be discarded after 5 years.

Self-Reflection

During interviews, participants described their lived experiences involving the phenomenon. I knew that my preexisting knowledge and any possible biases could influence my approach to this study. I initiated the study using a multiculturalism lens pertaining to cultural diversity and valuing cultural differences. I understood my own experiences as a researcher could impact this study.

Understanding who I am, including my cultural background, was essential for this study. I identify as a Latina and bilingual mental health provider. I knew that being a Latinx provider in the mental health field and interviewing participants who were similarly identified could have influenced results. However, my focus was on participants' lived experience to grasp the very nature of what providing cultural

competence services to Latinx clients looked like for them. I allowed participants to describe their experiences without influencing or sharing anything about my background. I kept a journal about my beliefs, knowledge, and experiences as a researcher in order to account for any possible biases. I used reflective journaling to become aware of potential biases and preconceptions in order to be as transparent as possible in terms of acknowledging them and their possible influence on my data and findings.

I wanted to hear about participants' experiences involving working with Latinx clients. I was eager to understand how they felt about challenges they experienced and what they did about them. My goal was to determine if their views were different from mine and why, and I was prepared to respect and accurately document and analyze participant views that differed from mine. I also monitored my own demeanor during interviews to ensure my reactions did not influence participants' responses, such as by causing them to moderate their opinions or perceptions that disagreed with mine.

Before conducting the study, I understood that learning about cultural competency is a lifelong process. I have seen difficulties involved with providing services, which include barriers such as lack of providers, insurance, language, stigma, and difficulty navigating the system. I also wanted to learn about participants' experiences with Latinx clients regardless of many challenges. I also wanted to know what has worked with Latinx clients in southern Idaho, what could process could be better, and what needs to change to suit the needs of clients. Interviewees were eager to share their voices, as well as be listened and understood.

Demographics

Creswell (2017) recommended a sample consisting of 10-15 participants for a qualitative study. This phenomenological study involved experiences regarding cultural competency services for Latinx populations in southern Idaho. Fifteen volunteer participants completed the first interview and the follow-up member check process. At the time of this study, all participants were college graduates working in a mental health setting as providers or in management positions. At the same time, some were also owners of private practices. Participants were either bilingual Spanish and English speakers or non-Latinx providers who had worked with Latinx clients.

Participants were eager to share information. This led to obtaining more background information than I had anticipated, primarily about their cultural background. They shared information about their age, socio-economic status, education, gender, language, and professional roles. Due to the nature of this study, all participants were required to be older than eighteen. Therefore, it was relevant that they shared information pertaining to their age. All participants were required to be mental health providers or in a management position in mental health in Idaho who had worked with the Latinx population. Participants also discussed their professional role and whether they were a therapist, in a management position, or private practice. Further information included types of degrees they had obtained and professional licenses. Participants also shared information regarding languages in which they were fluent.

Twelve participants were female and three were male. The average age of participants was forty-two. Of the fifteen participants, all had a bachelor's degree or

beyond, and/or were licensed to practice in the state of Idaho. Participants described their socioeconomic status in the following socioeconomic categories: low/middle, medium, average, middle-, and high-income bracket. Most participants fell in the middle-income range. Eight indicated that they were in private practice, five worked for an agency, and two worked for an agency and in private practice. Gathering information about their cultural background was relevant to this study in order to identify whether they were bilingual English/Spanish providers or not. Of the fifteen participants who were interviewed, twelve were bilingual English/Spanish speaking providers, while three spoke English only. Participants self-identified their cultural background for privacy, and not all details were included (see Table 1).

Table 1

Demographics

Participant	Cultural Background	Bilingual Provider	Private Practice	Age Range	SES	Degree or License
1	Native	N	N	55-64+	Middle	BA
2	Hispanic	Y	Y	25-34	Middle	LMSW
3	CA	Y	Y	55-64+	Average	LCSW
4	White	N	Y	35-44	Middle	LPCC
5	Half Hispanic	Y	N	45-54	High	BA
6	Mexican	Y	N	25-34	Middle	BA
7	MA	Y	Y	35-44	Middle	LMSW
8	MA	Y	Y	45-54	Average	LCSW
9	White	Y	N	25-34	Middle	LPC
10	Caucasian	Y	Y	55-64+	Middle	LCPC
11	Caucasian	N	Y	55-64+	Average	LCPC
12	Latina	Y	Y	25-34	Middle	LMSW

13	SA	Y	Y	45-54	Medium	LPC
14	Born in Idaho	Y	N	25-34	Middle	MS
15	MA	Y	Y	25-34	Low/Middle	LCSW

Note. *Abbreviation for Mexican American (MA), from Central America (CA), and South America (SA). License: (LCPC) Licensed Clinical Professional Counselor, (LPC) Licensed Professional Counselor, (LCSW) Licensed Clinical Social Worker, (LMSW) Licensed Master Social Worker.

Data Collection

Data collection started after IRB approval was obtained at Walden University. Forty-two total potential mental health providers in southern Idaho were invited to participate in this study. I used public access websites that provided e-mail addresses to reach the potential participants. Flyers and electronic invite emails were sent starting in the middle of the month during September 2021 to all forty-two potential local participants. The snowballing sampling method was also used through several participants who offered to invite their mental health collaborators to participate in the study. Fifteen participants accepted to participate in this study. Participants were contacted by e-mail and or phone, placed on the schedule, and all the consent forms were obtained before each interview via encrypted e-mail or in-person contact.

There were fifteen participants in the study who were de-identified and provided with number codes for the purpose of data collection and tracking. I had three interviews scheduled per week and all interviews were completed by the end of October 2021. All fifteen participants agreed to the follow-up member check interviews designed to clarify in-depth the details of their cultural competency experience in working with the Latinx population. The location for the ten in-person interviews was in a private office setting.

The five remote Zoom interviews were conducted in a private office at home in which no distraction took place.

The sample size of fifteen participants was consistent with the recommendation of Creswell that 10 to 15 participants be included, and it was determined by data saturation. Data saturation occurs when additional collection and analysis of data ceases to yield new themes and insights (Fusch & Ness, 2015). In this study, data saturation was assessed as achieved when analysis of the interviews from the last two consecutive participants (P14 and P15) yielded no new codes or themes.

The initial interview was scheduled to last for 45 minutes, but the actual length varied based upon the length of the respondent's answers. All the interviews were recorded using Skype for Business and backed up by voice recording using the researcher's password protected device. The interviews were transcribed verbatim via Skype for Business in Microsoft 365. I verified the transcripts by reading and rereading them while listening to the recordings, making corrections, and removing personal identifiable information as needed. The second meeting with each participant took place after transcription was completed. The members were provided with a summary of their transcript, including my preliminary interpretations of their responses, and member checks took place as participants reviewed my interpretations and either verified them or recommended corrections. The shortest interview transcript was three pages in length, while some of the longest interviews were from P15, P12, P11, P9, P8, P6, P4, P3, and P1 and ranged from six to eight pages.

Table 2

Interview Data

Participant	Interview Time in Minutes	Pages Transcribed
1	60+	6
2	45-60	3
3	60+	7
4	60+	6.5
5	45-60	5
6	60+	7
7	60	8
8	60+	7
9	60+	7
10	45-60	4
11	60+	6.5
12	60+	7
13	45-60	4
14	45-60	4.5
15	60+	7

Data Analysis

Once the interviews were recorded and transcribed, I employed Heidegger's hermeneutic phenomenological analysis. These three steps were followed: (a) Dasein-"being there" (b) Foresight/fore-conception-preconceived knowledge about the phenomenon" (c) Hermeneutic circle-interpretation as revision, a description of the process of understanding (Peoples, 2021). The initial step (Dasein) involved confronting and acknowledging my own existence as a subject with a specific relationship to my environment that determines my experiences, in contrast to the unbiased perspective

allegedly attained through *epoche,* or bracketing, by a researcher using a transcendental phenomenological design. The nature of my individual relationship to my environment was determined by my experiences and constituted my fore-conception, which incorporates my training as a mental health provider, my lived experiences as a Latina, and my review of the academic literature related to the topic of this study. I maintained a journal to record my biases and judgements and made my personal biases explicit through self-reflection, revising my reflective journal after every interview and analysis of an interview to unfold new meaning.

I kept an audit and log trail while engaging in the data analysis of hermeneutic circle. I used the hermeneutic circle to analyze the data and find the profound meaning of the individual parts (codes and themes), and the whole (entire transcript). The hermeneutic circle works as a spiral that, in several turns, deepens to achieve a more pertinent interpretation of the pattern of meanings while focusing on certain themes. The data was analyzed from the object to be understood to comprehension as a researcher and then back to the object. I moved back and forth in thinking of my lived experience of the phenomenon. I reflected on how I understood in new ways as I learned new things throughout this study. Heidegger proposed constant revision to make sense of the phenomenon (Peoples, 2021). I was being present (Dasein) between what I knew (foresight) and learned from what each participant shared with me to synthesize both into a new meaning about the phenomenon. The hermeneutic circle gave sense to understanding of the phenomenon as a "whole" by using continuous spiral movements by

analyzing the incoming data, interviews, literature review, and the parts to interpret the phenomenon studied.

I first started by analyzing the transcripts that provided data relevant to the interview questions. I prepared, organized, and explored the data by doing intensive reading of the interviews and used the interview guide to develop my initial analysis of the whole. In thematic analysis the whole is considered of equal value in which all data were considered. I investigated the constituents of the phenomenon while keeping the context as a whole as proposed by Peoples (2021). Horizontalizing took place by identifying patterns, meaning, and exclusion of data to list the relevant expression. I looked at what was not directly pertinent to answering the research question, and to understand anything interesting within the data while discarding the irrelevant data. As I followed the hermeneutic circle process, I systematically moved from basic coding, to polish the data, and categories were systematically analyzed into parts consisting of units of meaning. I used color coding each time I circled back to analyze the data and selected the words or phrases (horizons) most pertinent to the study. In the hermeneutic process, the whole is the sum of its part, and the meaning is not determined just by the frequency of the appearance of a component. There is a meaning that is derived from interconnection of the parts and the whole in which comprehension of words, paragraphs, and concepts is reached. To seek full understanding there was a need to go back and incorporate the parts that were previously not considered and analyzed the whole data again until a new understanding emerged. It required a consistent spiral analysis until this researcher had the ability to explain meaning and the significance of the findings.

The data was manually reviewed and broken into parts to identify codes for input to the MAXQDA 2020 software system. Next, I assigned textural meanings (labels) to codes, and the data was reviewed to generate clustered horizons or common patterns, which led to the creation of themes. The spiral concept previously described in my review of the Heideggerian hermeneutic circle was used to return my attention to the entire transcript where it was analyzed it as it was read. As new information emerged, the whole of the data was reviewed and analyzed once more. An understanding of the parts, the codes, and themes, was found. When analyzing the data, the information was broken down into parts and then synthesized. Once that was done, the entire transcript was reviewed as a whole, which became the new understanding. The parts helped to make sense of the whole, and the whole in turn helped to make additional sense made sense of the parts. As this cycle teased out additional data from the parts and the whole, new knowledge emerged and formed themes that described the participants' lived experience.

I took the participants' description of their lived experiences to inductively identify words and phrases pertinent to the study. I used MAXQDA to conduct rounds of coding and summarized the codes to be more concise. After several rounds of coding, I broke down the codes and reviewed the data to keep the most meaningful and accurate representation of the participants experience. There were seventy-seven codes that emerged in the data (see Figure 1).

Figure 1

Word Cloud

After reviewing the data, codes were placed into categories. It took several rounds of coding to identify eight categories and thirteen subcategories. Once the categories were identified, the themes could be more fully developed. The themes represented a condensed description of the essential information contained within the respondents' narrative which deepened my understanding of each participant's lived professional experience. Four themes emerged during the analysis: (1) The connection between cultural competence and cultural awareness (2) Approaches to developing cultural competence; (3) The role of language and communication in service delivery; (4) Latinx clients' reasons for seeking mental health services. All fifteen participants endorsed each of the themes mentioned above. There were some discrepant cases where participants

described their experience based on their work setting. These responses were factored into the analysis and explained later in the results. These themes and categories emerged from the participant's responses to the interview questions:

- The connection between cultural competence and cultural awareness
    - Awareness
    - Differences
        - Belief system
        - Family dynamics
        - Build trust
        - Support
        - Challenges
- Approaches to developing cultural competence.
    - Learn
        - Ask questions
        - Train
- The role of language and communication in service delivery
    - Language and communication
        - Spanish
        - Bilingual
        - Translate
        - Communicate
    - Consult

- Referrals
- Latinx clients' reasons for seeking mental health services
  - Mood disturbances
    - Depression
    - Anxiety
  - Resources

Evidence of Trustworthiness

Credibility

Credibility involved increasing the validity and accuracy of the ideas presented in this study. It was essential to acknowledge and account for researcher bias in the research and to recognize the discrepant cases in order to provide evidence of credibility in the research findings. The participants described their actual life experience, and the discrepant cases were noted that contained contradicting data to the identified themes; this process of identifying data that diverged from the main themes helped this study be credible and valid. The discrepant cases are discussed further in the presentation of results in this chapter.

I engaged in the study by interviewing participants without influencing their responses and noted my biases by journaling about my individual experiences during the conduct of the study. I did individual interviews with the participants in a comfortable and confidential setting for 45 minutes or more. I built trust with each participant. As the participants felt more relaxed, they were more willing to share. There were moments in which it became a challenge not to disagree with participants who expressed views that in

some cases sharply diverged from mine, but I reflected on my emotional reactions to avoid having them get in the way and accounted for this in the study results. I conducted member checks with the participants to increase validity and credibility. I verified that their narrative transcription accurately described their experience via email to determine whether a correction was needed.

Credibility was enhanced through the process of member checking. Member checking was conducted during a second meeting with each participant, in which I asked them to review the transcript of their interview and my preliminary interpretations of their responses. All participants verified my initial interpretations, indicating that my interpretations were not products of my own error.

Using as the major findings in this study themes that incorporated the experiences of all or most participants further enhanced credibility by minimizing the potential for individual participants' errors or biases to influence the findings. When finding are based on the views of multiple participants, then responses that diverge from the majority view, possibly due to an individual participant's bias or error, are identified as discrepant data. The themes used as the major finding indicate where participants' perspectives converged reducing the influence of individual bias or error.

Transferability

Candela (2019) proposed transferability needs to be addressed in phenomenological research. Qualitative findings typically cannot be generalized, but their transferability to other samples and settings may be assessed by a reader of the study on a case-by-case basis (Peoples, 2021). To assist the reader in assessing transferability,

the inclusion criteria for the sample have been presented, as have the sample demographics. Thick descriptions of the finding, in the form of direct quotations from the data, are provided in the Results section of this chapter to preserve participants' individual perspectives through the use of their own words.

Dependability

Dependability in qualitative research refers to the consistency between the results and the data collection. Peoples (2021) suggested the dependability of a study is its ability to be replicated. I explained in detail and followed the research process to maintain the study's dependability. I addressed this element of the study by keeping an audit and log trail throughout my research to track my decision-making and assumptions. When I used an audit trail, I placed date and time stamps on all the documents and entries in MAXQDA. This step allowed me to monitor how the research process unfolded during the study. I used journaling to track my experience and progress when collecting the data. I summarized the responses from each participant and did member checks to clarify the data. I included quotes from the participants and an overview of the codes, categories and themes that derived from the participants lived experience.

Confirmability

Creswell (2017) defined confirmability as the extent to which study findings reflect participants' opinions rather than researcher bias. Creswell recommended that researchers reflexively identify their biases, values, and personal background as potential influences on the interpretation in a study. I acknowledged that being a Latina clinician in southern Idaho who works in the mental health field may influence the study's design or

conduct in this research. I used journaling to make my biases explicit and anticipate projection of my personal beliefs and attitudes in the pursuit of understanding. Through journaling, I reexamined my personal biases, and every revision exposed a new meaning, and until the meaning was clear.

Subjectivity was kept in check by creating follow-up memos after each interview and after receiving and reading each specific piece of data for the first time and continuously. These memos helped as a trail map to the thoughts, questions, and ethical concerns that emerged about the information gathered and reflection. Confirmability was established by keeping a methodological log to document all decisions related primarily to research methodology. While coding in MAXQDA, I concentrated on the lived experience of participants through the constant emergence of incoming data. The memos were transferred into the MAXQDA to reflect coding strategies further.

Results

Research Question

This study consisted of one research question and fifteen semi-structured interview questions supporting the research question. The research question was: What were participants' lived experiences regarding cultural competence in the delivery of mental health services to clients who are Latinx? The research question was answered through interviews with mental health care providers or managers' descriptions of their lived experiences. The interviews were reviewed numerous times to ensure appropriate coding and categorizing. The following four themes developed from the experiences described by the participants: (1) The connection between cultural competence and

cultural awareness (2) Approaches to developing cultural competence; (3) The role of language and communication in service delivery; (4) Latinx clients' reasons for seeking mental health services. Sections of the interviews were described, along with quotes obtained from the responses of the participants' transcriptions. The themes that emerged were analyzed and illustrated on the following tables. These four themes provided understanding into the experiences regarding cultural competence in delivering mental health services to Latinx clients.

Theme 1: Connection Between Cultural Competence and Cultural Awareness

A theme that emerged from the data collected was how the participants' related cultural competence to cultural awareness (see Table 3). The participants responded to the first interview question (see Appendix C) regarding what culturally competent or culturally sensitive mental health services looked like. There were two categories: Awareness and differences about their experience working with the Latinx population.

Table 3

Theme 1

Categories	Themes	Participants	Quotes
Awareness	The connection between cultural competence and cultural awareness	14	"We need to increase awareness of other cultures because we're not always going to serve clients like ourselves."
		11	"I think it's important to sparks cultural competence being at least aware that there is culture as much as you can."
			"Aware of our own background so to not be bias or prejudice."
		4	"For me and my experience, what that looks like is being aware of my own kind of cultural experience and curious about my clients cultural experience."
			"Earlier, if I don't, if I'm not aware of my own biases."
			"Less awareness is something that strikes me."
		5	"Aware and sympathetic to what their needs are."
		9	"I am very aware that I don't come from the same cultural background and neither do Latina clients."
		8	"That's why they come look for you, because I felt you would probably have those

		dynamics or be aware of that.”
	6	“We don't assume that they know about mental health. I think it's more lack of awareness of what these issues are.”
	1	“I am well aware in the Hispanic or Latinx culture is different from other ethnic groups. There's a lot of difference in the disparity.”
	10	“Having that awareness of their culture. Also helps me understand or be sensitive.”
	7	It is important for mental health professionals to recognize that they are not experts regarding the Latin X/Hispanic populations. It is important that the mental health professionals model vulnerability in the sense that they can be open/honest with clients about not knowing about their culture.
Differences	7	“Clients are dealing with having to conform to two different cultures, two different traditions, languages, and expectations.”
		“There are many different people/countries who comprise the Latin X/Hispanic populations and although they may share

	commonalities, they are also distinct in their own ways.”
2	“What makes them different is that they take longer to come to you because they let things accumulate.”
15	“What are the different ways that you would grief in you grieve in your own culture?”
12	“I don't think that happens that you’re completely competent of culture and understand everything that has to do with that culture, especially if your own culture differs from theirs.”
5	“And it goes to different cultures and expectations and how to be.”
1	“They have close ties to their culture.” “Assist the child without interfering with the family culture.”
	“When we untangle relationships, we have to make sure we understand there’s a lot of trust issues.”
11	“Just using some basic trust building and really understanding somebody.”
9	“Cultural stigma that has been passed down through generations and generations

	only for you know crazy people.”
4	“And culture informs who we are and how we understand the world and my culture is different from theirs, so just in terms of values in terms of kind of the relational dynamics within the clients.
6	“What their culture looked like where their barriers challenges what's the family dynamic.”
	“That stigma is also a challenge within the culture because they feel like they're crazy, or they may be labeled as something else.”

Awareness

Participants indicated that their cultural awareness and sensitivity included awareness of their own cultural experiences and of how these might differ from those of their Latinx clients. Participants contemplated their experience of providing culturally competent services to the Latinx population. All the participants viewed their experiences in similar ways. Participants responded to key components of the tripartite multicultural model by Sue et al. (1992). For example, the participants recognized their knowledge regarding cultural competence based on their experience working with cultural minority groups, in this case, the Latinx population. Participants communicated their worldview as providers including their self-awareness, and cultural biases in treatment. The participants emphasized the factors that support the need for awareness skills in practice.

Differences

Participants shared their experiences as they provide cultural competence services. They shared the differences they perceived with the Latinx population. There were five subcategories: belief system, family dynamics, build trust, support, and challenges. Recognizing the differences helped gain insight into the population they serve and may help increase cultural competence.

Belief system

Participants described the differences within the Latinx population belief system that shape their culturally competent services experiences. Several participants acknowledge that the Latinx have specific belief systems that need consideration for providing mental health services. Participant #2 said, “Latinos have different beliefs and specially with counseling and mental health services. She strongly pointed out “They may call themselves crazy, or be shamed.” Participant #8 described some of the differences, and related, “Just different beliefs like music, religious, cultural beliefs, their family dynamics.” P2 said, “It’s about where the client is at and what the client believes rather than mine.”

Participant #3 stated: “The ability to know traditions, their religious beliefs” and “Beliefs from the religion, I tried to use the strengths from that culture.” Participant #10 highlighted the importance to, “Demonstrate a respect to their belief system and whatever worked for them.” She gave an example of a Latinx cultural tradition, and said, “Talking

about *Day of the Dead*[1]." Participant #8 also shared a similar view, and said, "Talking about like *la Llorona*[2], trying to respect where they are coming from."

Meanwhile, Participant #13 voiced her experience and said, "I related to their beliefs, and if they need guidance." The Participant #11 also indicated how she integrated this in practice and shared, "I had done is really listened to their beliefs and what they really wanted, and I support it." Participant #7 expressed, "I respect the individual beliefs. Accept them where they are at." Whereas participant #9 concerns were to "Acknowledge the Latinx cultural beliefs need or effectiveness of mental health counseling."

Family Dynamics

Family dynamics played a significant role when providing culturally competent services to the Latinx population. Participants had similar thoughts regarding the importance of family dynamics and noted the differences within in the Latinx family culture through their encounters with clients. Participant #7 observed the family dynamics and shared, "Many times they're creating a cycle of mental illness within the family unit as it is not discussed and they in general attempt to forget about whatever the issue is." Participant #8 had a lot to say about the family dynamics. She shared, "They are parents, and they know their own beliefs; Traditional beliefs, parents who immigrated from Mexico and kids being raised in the United States; Some of the dynamics that I see

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[1] A holiday typically held on November 1 and 2 to remember and celebrate deceased friends and family.

[2] "The Weeping Woman," a mythical figure who drowned her children after seeing her husband with another woman and wanders the world as a vengeful ghost.

within a lot of the family systems as far as let's say; The family dynamics, the parents and how that works out; Assist the child without interfering with the family culture we don't try and isolate the child from the family that seems to be very detrimental to the therapeutic; With parents being very traditional and the teens taking on a lot of the American belief systems and just that dynamic with the traditional culture and then having some of the American; Uhm culture, so there was kind of clashes in that and parents not understanding, you know, clothing things like that."

Participant #1 suggested, "More about the family and the family cultures and the issues that they're dealing with, because, uh, gosh, I I'm very aware that it's family and protection of family when I'm dealing with." She added, "What their culture looked like where their barriers challenges what's the family dynamic." The client, so my cultural competency is I'm always learning so that I, you know, I talked to them and make sure I understand what their family dynamics are." While Participant #7 asserted, "I recognize the importance of the family unit." Participant #1 identified strength in the Latinx family dynamic and shared, "They stay forever but the family because there's strength in the family that way, and I think that that's something that's really necessary for people to understand because we talk about a lot." Participant #3 underlined providers need to look at when rendering culturally competent services. She stated, "You know the historical background of the traditions and what people do, what people eat, and how people are raised, how families and systems of families function within the Hispanic culture."

Participant #4 voiced her concerns about, "Parent child kind of understanding of the relationship culturally in terms of especially kind of gender roles in the relationship.

She shared that she questions the client and asks, “Do you think this might be some machismo like?” The Participant #5 described his experience regarding factors that are considered important in the Latinx family dynamics, “And Hispanic families often have a huge family gathering around them a lot, and you have more people to address, and in dealing, With cultural sensitivity, and then when they do pass, they’re grieving, even looks different, I still go back to typically what I see is a stronger family support system, Even if there are bed bound and they have needs, you know you can see the family being 100% attentive to whatever that was needs.” Participant #11 described his experience around “Working on relationship issues and things, And the family component of culture.”

Building Trust

Participants echoed their experience regarding building trust with the Latinx client and what it meant for them. Participant #1 argued, “There’s no trust among any type of law enforcement authority, so a lot of times they come to us thinking were authority, when we’re not they turn around and that’s the closed they trust law enforcement and they’re told they must call the crisis. There’s a lot of trust issues and I think that needs to be out there to understand that you just must know.”

Participant #6 said, “I think this when you can be culturally competent, especially within the Latinx community I mean, there's such a commodity. A family of trust, and when you can, really you know, they really are bonded by spirituality and religion, and so I've come to respect all those things because I think it enhances their healing and it enhances the trust that I have with them.” Participant #10 described her concerns and

said, “Even though I said on one way that they trusted me uh, there was still more of a disconnect and a more of a distrust. I am a Caucasian, I think that there’s always a feeling of disconnect and I can’t think of the word, lack of complete understanding and with some of them, a little lack of trust.”

Participant #11, who is Caucasian as well, expressed a contrary view, and said, “the biggest benefit is that if you can't be confident in that your you will not be able to make a connection with your clients 'cause they won't trust you, wow, so it definitely is a core of being able to build trust. It just shows understanding and uh, and get to know what their culture is. Just using some basic trust building and really understanding somebody. I think it's part of building trust is getting to know. Understand your clients and getting to know them. It's that building of trust at the beginning, I think that's pretty important. Actually, some basic trust building listening stuff.” Participant #7 said, “It has been my experience that the Latinx community in general tends to keep mental health struggles within the family and find it extremely difficult to trust anyone outside the family.”

Participant #12 also shared how it can be a benefit to build trust, she commented, Oh “hablas Espanol? Si te puedo ayudar en Espanol.[3] And so the benefit is that they tend to open up a little bit more and that trust is there a little bit more easily obtained because they see, oh, you speak my language. Of that would be definitely the trust sometimes, open up about trauma from what they have experienced before Mexico or even here.”

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[3] “Do you speak Spanish? Yes, I can help you in Spanish.”

Another benefit shared by Participant #14 was, “It is much easier going into their homes and spark conversations with the family. We can relate to each other’s experiences and can create a more positive and trusting bond. With Latinx clients, they fear for the safety of their children and are less trusting when I begin.” Participant #15 said, “You have to work with him a little bit and build that trust and be like OK, I'm gonna do counseling and we really work on my trauma.”

Support

Participants’ responses were associated with questions thirteen and fourteen of the interview guide. Participants described their experience about the skills they utilized to address the issues unique to Latinx clients. They elaborated on their “willingness to act.” Participant #1 stated, “About how we can help these kids and pull him away from the gangs and the support that that’s giving them a lot of financial support for them otherwise they didn’t have any.” Participant #4 commented, “Helping to kind of support the primary culture and bridge that.” Participant #8 identified the lack of support and suggested, “And really not having support in school system, have him try to seek another resource.”

Participant #9 shared, “Offer services in their native language, preferably form their cultural backgrounds and other support and services they may additionally need, A different approach, or different interventions or different even like environmental supports to make sure that they can get the full benefit of counsel, Take account extended family structures or supports, When I was in the schools there was all this grant money to help with coronavirus to help kids trying to help families get that help, I’ve also help

parents navigate the school systems." Participant #12 described, "It's trying to help them and provided resources and then just processing to you know different difficulties that they face in this country and different, that when they have somebody that is Latinx, or they ask and seek support and that's when I come in."

Participant #13 shared, "In taking the extra time to explain something to the client. What is counseling, what to expect, the boundaries, psychoeducation, and answer all the question as many times that person need to understand." Participant #14 stated, "I help the parents address their fears and establish a good communication. I create opportunities for the parents to be involved with the intervention in two languages, so they don't have to worry about not understanding how to help their children, that happens a lot actually, where I stay longer than the intended time to interpret or just talk to the parents about their struggles, wants and needs, I often find myself helping parents with translating paperwork or answering questions for things they do not understand. Many a times, it is not related to my work with their children, but they feel comfortable enough to ask me to help."

Challenges

Participants described their experience of delivering culturally competent services to the Latinx clients by responding to question three of the interview guide. They all identified challenges in diverse ways when working with this population in Idaho. Participant #1 said, "And my biggest challenge is I have kids that come in hungry and with mental health needs. The problem is they peel like onions. They don't disclose that there's an issue. I have several of them that are self-harm. Sexual abuse that nobody

wants to report because they're scared to death of being put into child protection or foster care, I have parents that protect the other parent even though there's domestic violence in the home. There's its' a big challenge."

Participant #2 was concerned and said, "How we can deal with the mental health issues without the client being shamed and looked down. It's already pretty severe before they coming in." Participant #3 stated the client, "Say the insurance company is not paying. I could understand that they're having an issue paying. You know, I know that they're hard workers and they pay, but at the moment they, didn't have the full amount." Participant #4 said, "A lot of relational distress. There's also a lot of like situational kind of economic needs that feed into them." Participant #5 stated, "Barriers in cultural in general. Socioeconomic status again, that's a wide range. You could have completely impoverished families. Did they serve in the military because that has another layer of mental health needs? Multi layered as far as our mental health needs." Participant #6 underlined, "I think lack of education. Lack of education is not in terms of like degrees or anything like that. You know they're not just because they have barriers. They're very competent folks, you know, and they have the drive. They have the willingness if they just know how to. If they know what's available, they will get it done. You know some folks are more privileged than other marginalized communities." Participant #15 pointed out, "Well, if Latinx if they have to put in their money and if it's going to be a stressor and with transportation, they won't do it. They won't engage in it. It has to make sense and like, OK, I can come here, and we'll have to spend as much money in gas or whatnot, especially if it's on a weekly basis so."

Several participants focused-on language as a significant challenge and overlap in some of the ways they defined their experience. Language also emerged as a major theme and is further discussed in this study. Participant #15 shared, “I would say the biggest challenge is yes, the language barrier. Participant #11 described her client, “Who struggles with the English language, and I get frustrated that I can't fix.” Participant #9 reiterated, “Once again struggles with the language and cultural barriers.” Participant #8 shared a concern, “I felt that there was a major barrier even though there was an interpreter online. Participant #5 highlighted a similar perspective, “I still go back to language barrier.” Participant #7 elaborated, “Some of the commonalities that I have observed in the Latinx clients are that they in general find it extremely difficult to seek treatment, they have a difficult time navigating the mental health system, and sometimes have difficulty with language barriers.”

Theme 2: Approaches to Developing Cultural Competence

Participants expressed their eagerness and the importance of learning what cultural competence entails. Most of the participants shared common practices. They described their lived experience and need to learn whether it was individually in and out of the community. They identified two types of learning: asking their clients questions and obtaining training. There was one major category: Learn in which multiple verbatims are displayed in the following (see Table 4).

Table 4

Theme 2

Categories	Themes	Participants	Quotes
	Approaches to	14	“I love learning about other

developing cultural competence		cultures." "Even if a belief or something is different than my own, I take it as a learning experience."

Learning as an Approach to Developing Cultural Competence

11	"I think just being willing to be there and learn people's cultures."
10	"Desire to learn, I've taken the time to learn, and I think that really takes down the barriers."
6	"Be with people of color to learn how the culture works." "Representation matters and to have people of color train others."
13	"I learned about cultures to understand and not to make assumptions."
12	"When you're willing to learn about it. "We're supposed to use more of a cultural humility approach to learn about the clients cultural. "Open to long learning about other people."
8	"I've learned from my clients, and I've probably learned the most from my clients."

1	“So my cultural competency is I’m always learning so that I, you know, I talked to them and make sure I understand what their family dynamics are.”
7	“Sometimes this may be letting them know that I don’t have all the answers and that I am learning from them.”
	“I’ve learned that Latinx clients are just like everyone else, they are individual that benefit from empathy, understanding and compassion.
	“I’ve learned that at times they need a little more education regarding the mental health field."
	“I’ve learned that they benefit from case management services as there are a lot of systems that they don’t know how to navigate.”
2	“I’ve learned that this is a population that definitely needs to be educated on mental health.”
	“I learned that it's difficult for them to come in and receive the help that they are needing.”
4	“I think I'm continuing to grow and continuing to kind of learn and in terms of cultural values and again.”

3	"You know some words in the mental health field are complicated, you know, so it's hard for us to learn the language in Spanish. And it's even harder for clients to understand what that means."

Learning as an Approach to Developing Cultural Competence

The participants shared their experience regarding learning as it relates to cultural competence. Many of the participants reflected upon what they learned from their clients. Participants revealed their desire to continue learning as a way of focusing on the needs of the Latinx population. There were two subcategories related to this theme: the participants learned, informally, when they asked their clients questions, and they learned formally through training.

Learning by Asking Questions. Participants felt they gained knowledge by asking questions while providing services to their Latinx clients. They discussed the types of questions they ask to gain insight into what the Latinx culture involves. Participant #10, I ask them the question and they answer what their beliefs are. Participant #13 stated, "Well, I ask them the question." Participant #3 , "If they say that, say, for example, that they're from the United States, I ask, well, do you have a Spanish surname." Participant #6 explained, "I invited them, and you know, I really just asked them what do you need from me what like this is what I do? This is what my role is. This is what the agency could do, but what do you need from us?"

Participant #4 suggested, "So I try to really ask and encourage them to share." Participant #2 thoughts about learning went with encouraging her clients and shared, "It

is OK to reach out and ask for that help." Participant #1 asserted, "I'm smart enough to ask the questions to find out what the cultural the dynamics of that family is." Participant #14 communicated her means of inquiring, "I appreciate their feedback and encourage them to tell me how I can better serve them despite our differences." Participant #12 shared, "I also ask them like what language do they prefer to be talked in? That in language and understanding the values or asking and asking."

Learning Through Training. Participants voiced their thoughts and had similarities regarding the ability to seek training, training experience, training needs, and research in their determination to learn. Participant #14 said, "I wish there were more training available across mental health providers here in Idaho specifically so that we would have a better understanding of how to work with Latinx." Participant #11 highlighted, "Yeah, I think it's important to train about the actual culture, so you learn about it." Participant #6 indicated, "It's about doing research so that you can provide the proper services." Participant #13 said, "Trainings that are more specific for the Latino population."

Participant #12 acknowledged, "I could definitely use more training in problems they face." Participant #8 seemed enthusiastic, and said, "You know I would like to compare what they are saying in training to what I do know and so what I've learned from my experience of working with them." Participant #7 described his experience, and mentioned, "Some of the trainings have been required and some I have taken voluntarily to better understand potential populations that I could serve."

Participant #4 shared, “As much research as I can do in the back end.” Participant #5 suggested, “Training in how to work with Latinx populations and multicultural in general.” Participant #3 reported, “I think cultural competency training will be good, specifically on LGTBQIA Latinos. Offering training on the different gender and sexual orientation issues unique to Latinx communities and the discrimination and mistreatment they still receive from their families and their communities. I’ve taken a cultural competence class not specifically to Latinx.” Participant #9 said, “Doing prior research and making sure you’re informed on different ways to approach or to offer services to clients who fit to different demographics.” She added, “We typically have a trainer come in once a year and provide that type of training. Sometimes our training is virtual.” She expressed her concern, and said, “I don’t feel that’s enough, honestly. Most agencies only require one culturally sensitive training a year or sometimes every so many years.”

Theme 3: Role of Language and Communication in Service Delivery

The third theme that emerged from participant interview is the importance of language and communication in service delivery (see Table 5) and the role they play in providing culturally competent treatment to the Latinx clients. The three categories were language, consult and referrals, all of which are forms of communication within the mental health field. Participants describe the relevance of language and disclosed the similarities they experienced in several ways. They highlighted how they apply their competency in practice through consulting and referring clients to services that meet their needs.

Table 5

Theme 3

Categories	Themes	Participants	Quotes
	The role of language and communication in the service in service delivery		
		7	"Clients are dealing with different languages."
			"Sometimes have difficulty with language barriers."
		8	"I really listen to their cultural beliefs like language, English and Spanish."
			"Because of the language area, I really feel like people just kind of dismiss them."
		14	"So when I'm working with Latinx clients, their parents appreciate my relatability to their cultures. they appreciate that I speak Spanish and assist in both languages."
			"I'm able to help them more than another person that does not speak their native language would."
			"I allow the client to feel comfortable speaking to them in their language so they can have a safe space."
			"I create opportunities for the parents to be involved with the intervention in two

languages, so they don't have to worry about not understanding how to help their children."

"I understand the relief someone feels to be helped in a language they know."

15 "I would say the biggest challenge is yes, the language barrier."

12 "Is that they tend to open up a little bit more and that trust is there a little bit more easily obtained because they see, oh, you speak my language."

"I also ask them like what language do they prefer to be talked in?"

"Just learning the language and being able to speak the language."

9 "Be best practice for them to be able to work with the provider who not only can speak to them in their native language."

6 "They're barely hearing this for the first time, so I think we have to be prepared at utilizing materials that are culturally appropriate in their language."

5 "And being culturally sensitive because there's always been, I think barriers in language."

	3	“I have to use a language that is neutral, something that everybody can understand.”
Language and Communication in Consultation		
	9	“There's a phone number where someone who speaks Spanish will answer.” she is Latinx, and she does speak Spanish as a native language and I been able to consult with her on things a lot.”
	7	“There aren't many Latinx Hispanic counselors in my office, so whenever there's a question related to that population of individuals, I tend to be a person that's asked.”
	1	“One of the things that I've done is brought them in with a Hispanic speaking counselor.”
	3	“Whenever somebody gets stuck because they don't have an interpreter, they usually tend to call me to help them out.”
	5	“As far as my staff. Uh, they always come and ask. I’m relied heavily on cultural competency.”
	12	“The other staff come to me

	when they need some assistance in a case."
Language and Communication as Referrals	
9	"I create my referrals in my resources very carefully to make sure that there's someone who speaks Spanish there."
	"In my area who speak Spanish and are from a Latinx cultural background, they tend to be full, but I do refer if they're just feeling like we can't understand each other."
	"I try to serve as a referral source to clients to help them find you know culturally competent care or find a provider that can work with them in their own language and from their same cultural background."
	"If your client isn't getting what they need from you, making sure you have other people who can offer services in their native language, and preferably from their cultural background and other supports and services that they may additionally need."
	"If you feel like this isn't a good fit or we're having trouble understanding each

other, I do have a list of three providers."

And I'm just aware of that I and I always tell them, you know, Spanish is not my native language and if you feel like this isn't a good fit or we're having trouble understanding each other, I do have a list of three providers.

Participants reflected on their experience at the time of working with Latinx clients in Idaho. There were four subcategories: Spanish, bilingual, translate, and communicate. Participants identified the benefits of rendering services in the client's native language. They also disclosed the difficulties that came alone with the language barriers.

Communication in Spanish

Participants shared commonalities about Spanish and how the language influenced their experience in practice. For example, Participant #15 stated, "sometimes I'm the only one that speaks Spanish, so it's I get booked up pretty fast and sometimes I can't always meet everybody." Participant #14 shared how she used her skill in practice. She stated, "When I go into a home and provide services in Spanish, the parents can incorporate the same interventions in a way they understand. Our agency is always looking to bring in more people that speak Spanish so we can increase our range of people that we can help." Her concern was that "Their issues are often dismissed or handed off to the only person that speaks Spanish and then that person becomes overwhelmed because they have so many people and so little time to work with all of

them.” Participant #12, shared a common experience and said, “Well, what I see, so I'm the only Spanish speaking counselor that we have in my agency and what I've noticed is we're very need.” Participant #11 recognized and agreed, that “Maybe the client might understand English, but the parent is Spanish speaking only. I struggle as I don't know the Spanish language. That's why we need more Spanish speaking therapist.”

Participant #9 noticed, “When I work with Spanish speaking or Latino clients sometimes extended family members are more involved with in treatment.” She explained, “And Spanish is not my native language and sometimes I make mistakes in Spanish.” Participant #3 described, “I think that's the thing that I've learned that not everybody speaks Spanish. She highlighted, “In the mental health field are complicated, you know, so it's hard for us to learn the language in Spanish.” Participant #2 spoke about her willingness to help, and said, “So with the Latinx population I know those appointments can take a little bit longer just because sometimes it takes a little bit longer to explain things in Spanish and you know trying to find the correct words or you know just depending on the client but you know we do have to take those extra steps.”

Participant #10 asserted, “I may not understand everything they say in Spanish especially “si hablan rapidamente” they speak fast, they always respond positively that I have taken the time to learn, and I think that really takes down the barriers and that I have better luck, at least with you with most Hispanics.” Participant #4 identified “Some acculturation and, and especially when I was working with children, the parents who are primarily like monolingual Spanish. Parents, grandparents, adults that are monolingual kids are bilingual. That disconnect is magnified.” Participant #5 clarified, “We have

consent forms that are all in Spanish and then it's going through all those consent forms with the translator to make sure that they have our patient or client has a clear understanding of the services that are going to be provided. Participant #6 said working with Latinx clients was “That the verbiage is understandable, if not, we have to be willing tender to explain what that is. Because there's formal Spanish and there's very informal Spanish, and we have to be familiar with that as well.”

Bilingual Communication

Participants had different ways to talk about providing bilingual services in Spanish to the Latinx clients. They shared about the complexities of not being bilingual, and lack of bilingual providers. Participant #9 commented, “provide more bilingual providers and interpreters.” Participant #6 mentioned, about having, “Staff available, teach and provide services in those languages and that in their culture, in their needs and wants.” Participants #3 shared, that she is “Bilingual, I explain everything in Spanish. You know I don't need to interpret anymore.”

Communication through Translation

Participants had common concerns regarding interpreting needs and services. Participant #8 disclosed, “I felt that there was a major barrier even though there was an interpreter online.” Participant #14 observed, “Sometimes information is missed in translation” during her experience of when providing services.” Participant #3 asserted, “I've heard from clients that tell me that when they have to talk through an interpreter. It's really hard for them to express what they want to get and too much time is spent in translating and interpreting that they don't get benefit from their sessions.” She added, “I

used to work at a clinic and even the doctors and the nurses would call me sometimes to interpret for them. That's always happened to me even if my position is not that of an interpreter, and at times I have to say I am not the interpreter, but at times you know just because I'm kind and I like to help the person I do it, and I talk to them." She claimed, "If we want to get over a diagnostic interview in an hour, we don't have the extra 20 minutes to do interpretation."

Participant #1 reported, "The assessments are culturally biased, such as we use the term bully in the assessment, and that's not found in the Latino language, and so we have an interpreter that we work with side by side." Participant #9 said, "I just kind of leave a stream of translated Spanish paperwork behind me everywhere I go." Participant #5, stated, "So when we go to put a patient on the Hospice, services are part of the Latinx community and let's say they're not bilingual, we automatically know that we need to slow down and use interpretive services we have."

Communication

Communication emerged as a sub-category of interest. Participants felt that communicating with clients is imperative to provide culturally competent services to the Latinx community. Participant #9 related her experience and acknowledged, "Honestly is kind of a challenge and it's like I understand the words that they're saying, but sometimes I don't know what they're talking about." Participant #11 confirmed, "I struggle as I don't know the Spanish language." Participant #2 explained her experience by saying, "Communication is a big thing I think that a lot of times when I've had Hispanic population come in they do not feel comfortable using a translator and so me being able

to speak their language has made a big difference in the translation because they feel a lot more comfortable and they almost feel like you get them you understand them."

Participant #3 said, "The parents who select me because they want to communicate with someone who speaks their language. Well, I think clients feel comfortable with someone who looks like them and speaks like them and they are more willing to open up or more freely share what's going on with them. You know, even though their children don't necessarily speak Spanish, but I communicate with their parents, and I explain to the parents what's going on with their children." Participant #14 said, "I am able to communicate in Spanish and for families, it's really important that they're understood correctly." Participant #2 reiterated, "Communication is a big thing. I had to change a client with somebody that couldn't speak her language and I notice she didn't follow through anymore with counseling she tried, I think if was just that barrier in that she didn't feel they were going to understand her she felt judged when (you know) going to another provider."

Language and Communication as Consultation

Participants described their lived experience of providing culturally competent services to the Latinx. They shared about their interpretation skills and how they are brought into that different role when it comes to counseling. They acknowledged they are relied on for consulting cases when it comes to Latinx clients, and consulting is a form of communication within the mental health field. Participants shared their lack of staff they can go for assistance. P#8 said she uses phone interpretation support. This theme was used to address needs of providers delivering culturally competent services.

Language and Communication as Referrals

Referrals are also a form of communication in which mental health providers engage. Participants shared their experience regarding referral for service with the Latinx clients. Some participants shared they create their own list of referrals. Other participants become a referral source to other providers. Participants suggested providers should have other contacts who can provide services in their native language, for additional needs or other resources. Several participants recommended to refer out when a client is not a good fit or if there is a communication problem.

Theme 4: Latinx Clients' Reasons for Seeking Mental Health Services

For the fourth theme, participants identified in their experience with the Latinx population mood disturbances (see Table 6), which were associated with PTSD. Participants described this issue as a prevalent indicator for the Latinx population seeking culturally competent services. Participants also discussed the resources they attempt to utilize to accommodate clients with mental health needs. Two categories emerged from this theme. The categories were mood disturbances and resources.

Table 6

Theme 4

Categories	Themes	Participants	Quotes
	Latinx clients' reasons for seeking mental health services		
		12	"I see a lot of anxiety."

Mood Disturbances as Reasons for Seeking Mental Health Services

13	“Uh, mostly anxiety.”
11	“The most common would be depression and anxiety.”
9	“A lot of anxiety and depression.”
8	“It was mostly anxiety, depression, and some issues with parents not understanding, being raised in the United States.”
6	“Anxiety or from even more intense mental issues, suicidal thoughts.”
3	“Adolescence is usually identity or problems with social anxiety, anxiety, self-esteem issues, depression, suicidality.”
7	“The clients are dealing with the anxiety of having to conform to two different cultures, two different traditions, languages, and expectations.”
	“In addition to these complex mental

		health struggles clients typically are dealing with anxiety, depression, substance use, anger, and psychosis."
	2	"I see a lot of people with PTSD depression, anxiety and I've seen some you know with borderline personalities."
	15	"Depending you know there's people who come in for seasonal depression. There's individuals who come in a lot of stress related in the Hispanic."
	1	"Drugs, that's really the biggest issue that we have right now is we have a strong influence in our particular area. Non-reported abuse, and on probation."
Resources Needs as Reasons for Seeking Mental Health Services		
	4	"That's not really a resource that's been given to me, so I kind of use a relative to interpret."
	8	"I would say that resources compared to what I have in English

	are probably not as many you know."
	" I send them to other resources and things like that."
	"Getting people to psychologist."
	"They're referred to me at that point by their PCP's most of them am after being scored like for depression or anxiety and so then they would be referred to."
13	"They have limited services this is a different limitation."

Mood Disturbances as Reasons for Seeking Mental Health Services

Participants identified a variety of mood disturbances. According to participants, Latinx clients seek services for various mental health reasons. Participants identified the most common mental health concerns for which the Latinx clients seek services. Several participants cited PTSD and trauma exposure which may be a factor in their needing services. There were two subcategories under the category of mood disturbances.

Depression as a Reason for Seeking Mental Health Services. Participants described similar reasons for why Latinx clients seek services and how they struggle with depression. Participant #2 shared her experiences and approach, "They come in with

there's different treatments to each to each diagnosis so for example if you know somebody comes in with depression you know we use you know a lot of like CBT. I see a lot of people with PTSD depression. Where they're crying all the time almost suicidal thoughts." Participant #3 explained, "I see a lot of adults for mental health evaluations from immigration cases. I see adults that suffer from depression, anxiety, PTSD." Participant #4 described, "I've treated individuals with mood disorders with psychotic disorders." Participant #6 asserted, "many of our clients have suffered at some point in their life from depression." Participant #7 stated, "In addition to these complex mental health struggles clients typically are dealing with anxiety, depression, substance use, anger, and psychosis." Participant #8 claimed "I would see teenagers and there was depression and PTSD. The PTSD was usually around more violent issues." Participant #9 explained, "And they come with a variety of issues. My profile is kind of tailored. To depression, anxiety, past trauma abuse in or divergent clients, and so often they'll come with another one of those issues as well." Participant #10 shared she provided services to "Hispanic females who suffered from depression and grief. I think that depression is a really big one." Participant #11 mentioned, "The most common would be depression and anxiety." Participant #12 stated, "I see a lot of depression or trauma for sure. I mean like acculturation issues trying to fit into this culture, or trying to even just understand it." Participant #15 described, "Depending you know there's people who come in for seasonal depression."

Anxiety as a Reason for Seeking Mental Health Services. Participants had common views regarding their experiences providing culturally competent services to

Latinx client that suffer from anxiety. Participant #2 stated “Latino clients that come have a lot of anxiety it's hard for them to sleep.” Participant #3 agreed with Participant #2 and said, “They have a lot of issues with anxiety and depression and suicidality.” Participant #4 mentioned her clients come in with “A lot of relational distress. There's also a lot of like situational kind of economic.” Participant #6 stated, “they suffer from anxiety or from even more intense mental health issues, suicidal thoughts.” Participant #7 said, “The clients are dealing with the anxiety of having to conform to two different cultures, two different traditions, languages, and expectations.” Participant #8 recognized “A lot of the majority would come in for older and teenagers would come in for anxiety. One of the things I will say I feel like there's a lot of anxiety that is transmitted from parents to the kids.” Participant #9 shared “They come with a lot of anxiety and depression.” Participant #12 questioned, “This is Latinx community, right? I see a lot of anxiety.” Participant #13 expressed her concern, “Uh, mostly anxiety with issues of immigration many children were affected because their parent was deported.”

Resources Needs as Reasons for Seeking Mental Health Services

Participants described needs for resources. Some identified barriers involving obtaining resources to accommodate Latinx clients. They explained how they refer clients to other resources and why. An example provided was getting the client a to higher level of care for additional resources such as with a psychologist.

Discrepant Cases

There were a few discrepant cases found during the coding process. The cases disclosed contrary information to the theme. The description of the phenomenon clearly

indicated that some participants' reported experiences differed from those of the majority of participants. The discrepant cases were factored in data analysis. It was important to discuss unique experience of participants in reporting results to demonstrate rigor and develop ideas about the phenomenon. Recognizing the discrepant cases added credibility to the study (Creswell, 2017).

For example, participants shared common experiences about the Latinx cultural belief systems and traditions. Most of them described their experience from what they have learned from the client directly. However, Participant #15 shifted her view to, "School system have different beliefs and rules." She linked her thought to cultural setting and to what her understanding was about parents' views. She suggested, "so be able to understand the parents' perspective, but also you know kiddos who don't always align with their parents' views." This discrepant case will be further discussed in Chapter 5 because not only did it align with the recommendation found in the literature review but is also related to a new finding in this study.

Most of the participants shared similar thoughts about having or gaining awareness into the Latinx culture when providing culturally competent treatment to this minority group. Participant #1 was the only one who provided an additional response that differed from the rest and focused her answer to the present moment. Other participants shared about what they had experienced with the client directly. She instead, shared about her awareness of what she experienced at the time of responding to the interview and P1 said, "I just realized how incompetent I am."

Participants shared their view about family dynamics. Most of them described their experience about the family relationship and unit. Participant #9 had a distinct perspective and said, “When I work with Spanish speaking or Latino clients sometimes extended family members are more involved with in treatment than would be expected in like a mainstream white American household.” She was the only person who highlighted the topic of extended family. The participant further elaborated on P9 said, “And other cultural barriers like HIPAA is just not written to take into account extended family structures or supports.”

Summary

Interview questions were used to address the study’s research question and provide participants with opportunities to explain their lived experiences regarding cultural competence in terms of delivery of mental health services to clients who are Latinx. Participants responded promptly to invitations to participate in the study and appeared willing to share their ideas. A description of the research approach was provided. Four themes emerged from data: connection between cultural competence and cultural awareness, approaches to developing cultural competence, the role of language and communication in service delivery, and Latinx clients’ reasons for seeking mental health services.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to explore professional experiences of Idaho-based mental health providers and managers of mental health agencies regarding provision of culturally sensitive services to the Latinx population through their service settings. I used a hermeneutic phenomenological qualitative approach to describe what participants had in common as they experienced the phenomenon and "grasp of the very nature" of involving cultural competence when working with Latinx. To achieve this, I interviewed mental health providers and management regarding their experiences providing culturally sensitive services to Latinx clients. Additionally, I sought to uncover the strategies and behaviors that emerged from experiences working with Latinx populations in southern Idaho. The object of this phenomenological study was to determine participants' experiences involving provision of mental health services to Latinx clients. A hermeneutic or interpretive phenomenological approach allowed me to consider foreknowledge in terms of my own lived experience and relevant multicultural theory as lenses with which to view the participants' experiences as they provided in semi-structured interview.

There is existing research regarding the topic of cultural competence in mental health. Cultural competence has been recognized as a key factor in the mental health field by Optum Idaho, the managed care contractor for the Idaho Behavioral Health Plan through Medicaid. In addition, there was current data from the Idaho Mental Health NOMS and survey-based research focused on mental health illness rates and issues of the

Latinx population. However, there is a gap in relevant literature regarding providers who have lived professional experiences involving mental health and management working directly with this minority group in southern Idaho. My intent was to learn how these providers engage with culture during the process of providing mental health services to Latinx clients. I addressed that gap in the literature through this study by describing the experiences of those providers and by identifying the themes that emerged from the responses regarding how the participants give meaning to their lived professional experiences of cultural sensitivity within their mental health settings.

Summary of Findings

Participants provided detailed account of lived professional experiences regarding culture in terms of services to Latinx and providing culturally sensitive services to Latinx clients. Themes that emerged were connection between cultural competence and cultural awareness, approaches to developing cultural competence, role of language and communication in service delivery, and Latinx clients' reasons for seeking mental health services.

Finding suggested that participants had commonalities in their experience of providing culturally competent services to Latinx clients although, different participants may have given emphasis to different aspects of their experiences. Some participants reflected about the importance of becoming aware of differences between their cultures and their clients. A few participants said developing cultural awareness helped them deal with their own beliefs in terms of how they perceived the Latinx community as well as preconceived conclusions they might have had about Latinx populations prior to meeting

and servicing them. For instance, two Caucasian participants talked about experiencing language barriers; they were not bilingual, and had to work hard and consistently to earn their clients' confidence and trust despite sharing cultures. Experiences involving bilingualism and language related to the research question. Cultural competence is based on their ability to effectively converse with and understand their Latinx clients.

Interpretations of the Findings

Results were discussed in terms of identified themes and their connection to existing literature. From analysis of collected data, four categories were determined: connection between cultural competence and cultural awareness, approaches to developing cultural competence role of language and communication in service delivery, and Latinx clients' reasons for seeking mental health services.

Theme 1: Centrality of Cultural Awareness on Cultural Competency

Cultural competency is a multifactorial/multidimensional phenomenon. Within my sample, study participants emphasized the importance of cultural awareness.

When analyzing data collected from fifteen participants, research presented a need for culturally sensitive and competent care providers working with Latinx communities in Idaho. Govere et al. (2016) reiterated these observations and highlighted a need for greater culturally competent care to serve the minority group. Similar responses were reiterated by the report posed by the U.S Department of Health and Human Services the HRSA (2018) said cultural competence was important because it helped in terms of maintaining attitudes, behaviors, policies, and perspectives that were critical when promoting effective interactions in diverse cultures. Rogers et al. (2015)

emphasized that the Latinx community were entitled to adequate and culturally competent mental health care. Rogers et al. further noted that the disparities in culture and inequalities influenced quality of mental health services accessed by the Latinx as well as health insurance.

There were some differences in responses from participants. The participants who were familiar with culturally competent terms responded readily, whereas those who did not question more. Participants who showed cultural understanding and understood their clients' culture showed enhanced awareness of individual cultures. With further data analysis, two subthemes emerged: awareness and differences. Differences were categorized into belief systems, family dynamics, support, trust, and experienced challenges, which were the most significant categories.

Cakir et al. (2016) supported multi-dimensionality of cultural competence and established that cultural competence included cultural awareness, knowledge, interaction, cultural sensitivity, and understanding. Like current findings, Cultural competence improved quality of services that participants offered to their clients. Flynn et al. (2019) asserted cultural knowledge, skills, and awareness improved health outcomes of Latino-African women.

All participants reported that being culturally competent providers required that they become aware and appreciative of distinct cultures confirming the conclusions arrived at by Adames et al. (2016). Adames et al. (2016) established it was important for mental health practitioners to interact with clientele, including Latinx clients from diverse backgrounds to gain cultural competence. Adames et al. (2016) illustrated that being

culturally competent meant enhanced cultural knowledge, sensitivity, and awareness. In addition, participants realized that being culturally aware and appreciating diversity helped them build confidence and trust not only with Latinx clients but from other diverse communities.

Participants who mentioned keeping an open mind about culture and diversity improved their service delivery. These were supported by Flynn et al. (2019), who found that cultural competence increased an individual's professional development in values and biased. In addition, Sue et al. (1992) noted, being culturally competent helped reduce cases of prejudices and stereotypes by encouraging diversity. Finally, these conclusions were supported by Ragalin-Bignall et al. (2015), who demonstrated that understanding ethnic minorities was critical in terms of promoting individual clients' health-seeking behaviors. While health practitioners are trained to serve and administer care to different clients, discussions involving cultural diversity improved their delivery of healthcare services. It is arguable that being culturally diverse equipped one with the skills to understand the cultural beliefs of people from a particular community and developing conversations from this point helped build trust or connection between the healthcare provider and their clients. Developing trust with clients helps care providers ask them how well they could be served, thus improving health outcomes.

Theme 2: Phenomenology of Developing Cultural Competence

In a closer analysis of the participants' responses regarding learning cultural competence through asking questions, the participants noted that by asking open questions, they developed an understanding of the kinds of services the target population needed and

what language to use. For instance, a few of the participants who responded to this prompt noted that it was easier to know what kind of services were needed by asking questions. Additionally, asking questions about the Latinx beliefs, what their culture described as quality services and questions on how the Latinx culture influenced the decision to seek medical help especially for mental health illnesses allowed the participants to learn about the Latinx culture. Besides encouraging the target population to share their experiences, asking questions to set a base for open interaction between the participant and their clients.

Apart from the developing cultural competence by asking questions, learning about Latinx culture through training improved their cultural competence. For example, the participants identified areas that needed specialized training, including training more Latinx mental health professionals. Most of the participants emphasized cultural sensitivity training and research as the only way to learning how to approach and treat clients. However, there were arguments that despite cultural sensitivity being important, having the training once a year was not sufficient to develop competence to serve the Latinx community. These responses confirmed the findings by Lanesskog et al. (2015) that training individuals with minimal cultural skills improved their competence in serving and working with Latinx clients. Vega et al. (2016) explained that the Latinx was the majority minority in the U.S. Therefore, there was a need to train more professionals to ensure the development of culturally relevant approaches to engage unserved, and marginalized audiences. Overall, while the participants who questioned their clients about their culture saw it as an effective means of achieving cultural competence, the majority of the

participants endorsed formal cultural competence training as a means of achieving cultural diversity.

Theme 3: Importance of Bilingualism to Mental Health Service Delivery to Latinx Clients

When analyzing participant responses for the first theme, the participants responded that part of their lived experiences involved experiencing language problems in becoming culturally competent in the offered cultural services. For this theme, the participants explained it was necessary for them to speak Spanish, be bilingual, or have a translator, and communicate clearly. The majority of the participants explained that their ability to speak Spanish resulted in them having more clients compared to participants who did not speak Spanish. Overall, the participants responded that their experience of serving the Latinx population revolved around the language they used. Consoli et al. (2020) said although accounting for only 5.5% of U.S. professionally trained mental health care providers, Latinx preferred someone who spoke Spanish. The NAMI (2019) illustrated, despite the preference, the number of professional Latinx was small and culturally incompetent.

Illustrating the significance of language in promoting the delivery of mental health services to Latinx patients, Lanesskog et al. (2015) discussed that there was more than just sharing a similar language but the relevance of language to cultural knowledge, cultural sensitivity, understanding and awareness, which facilitated the delivery of quality mental health services. Consoli et al. (2020) discussed that language barrier between service providers and recipients resulted in misdiagnosis and undertreatment, and

discouraging clients from seeking mental health services. In addition, to speaking Spanish, the theme related to language identified bilingualism as a key factor and that the use of the native language improved delivery of mental health services.

Consoli et al. (2020) discussed that implementing bilingual and multicultural training would favor delivering mental health services to the Latinx community in Idaho. Vega et al. (2016) also established that having bilingual and bicultural staff gives the organization credibility and commitment to serving Latinx families and is viewed as mentors and role models. However, they argued that the lack of bilingual providers and interpreters in the Latinx community-made work challenging for participants that did not speak English or Spanish. Villalobos et al. (2016) illustrated that more significant benefits of privacy, trust, and accuracy of interpretation were obtained from bilingual providers. With regards to the present findings, bilingualism or having the ability to converse in more than one language is an added advantage to individual working with people of color and a cultural preference identified by the Latinx clientele. As illustrated, lack of bilingual skills hindered the participants from serving member of the Latinx community as they relied on an interpreter. However, in this context, being bilingual was of value as participants did not need the services of an interpreter to understand the mental health needs of the members of the Latinx communities and diagnosed in a way that is understood by the target population.

Participants had varied responses to the use of translation services. The participants noted that using translation distorted the accuracy and meaning of the information shared with clients. Moreover, contradictory interpretations of clients'

communications made it difficult to meet the clients' needs, especially when the clients found it difficult to explain and describe their feelings. These assertions were similar to Villalobos et al. (2016), who wrote that the Latinx felt discomfort sharing information when translators were available. However, according to Lanesskog et al. (2015), lower levels of education among the Latinx communities meant that the community lacked professionals with bilingual and multicultural understanding to enhance the provision of mental health services. As a result, Lanesskog et al. (2015) proposed the need to train and improve the skills of Latinx workers with limited cultural skills by pairing them with more experienced peers to enhance the quality of services offered and enhance their ability to work with Latinx clients.

This theme proved important in advancing understanding within the current study even though it did not directly address the developed research question. The responses of the participants relevant to this theme enhanced an understanding of why language competency is considered essential to becoming culturally competent and highly effective in the delivery of mental health services.

Theme 4: Predominance of Mood Disorders among Latinx Clients (and its relevance to culturally competent mental health service delivery

Analyzing the responses from participants for this fourth theme, the participants identified mood disturbances as the main reason Latinx clients sought mental help. The responses relevant to mood disturbances indicated depression and anxiety as key reasons for Latinx clients seeking services. On depression, the participants responded that most clients presented with signs of suicidal thoughts, PTSD, abuse, anger psychosis and

substance use. Similarly, the participants responded to their anxiety experiences, noting that most of their clients had difficulties sleeping, intense mental health issues, and presented with suicidal thoughts.

The evidence that many Latinx in Idaho presented themselves to the participants with extensive mental health problems confirms the statistics and findings presented by previous scholars, as discussed in the literature review section. In particular, the fifteen participants interviewed mentioned that many of their clients presented themselves with indicators of depression and anxiety companied by suicidal thoughts, anger, and substance abuse. It is therefore worth noting that increased experiences and prevalence of mood swings and anxiety hindered the participants' development of cultural competence. The urgency to respond clinically to crises interfered with the opportunity to ask questions concerning cultural competence. Confirming these findings, the reports by NAMI of 2020 revealed that Latinx were at elevated risk of developing major depressive episodes, posttraumatic stress, anxiety, substance abuse and social phobia. Concurring with the NAMI (2020) reports, Caqueo-Urizar et al. (2020) asserted schizophrenia, bipolar disorder, anxiety, disorder, PTSD, and obsessive-compulsive disorder as major mental health problems that Latinx face.

In their responses, most of the participants, including participants #4 and #6 reported that most of their clients presented with PTSD, anxiety, depression, substance use, psychosis, and suicidal thoughts. The findings by Caqueo-Uriazar et al. (2020) align with the responses by participants #8, #9, and #10 who said that the majority of individuals who presented with severe mental health symptoms were teenagers. Similar

findings were presented by Consoli et al. (2020) who reported that 15% of the Latinx population 18 years and older were reported to experience high rates of anxiety, depression, substance use, and suicidal ideas.

While the current participants did not mention the frequency of suicide rates among their clients, their responses aligned with the findings of Brenes et al (2019) and the reports published by the National Center for Health Statistics (2020) that the number of Latinx at risk for completing suicide due to mental health problems had increased by almost 30% (Brenes et al. 2019; NCHS, 2020). In their responses, the participants noted that they had to deal with and help clients presenting symptoms of PTSD, depression, anxiety, and suicidal ideation first-hand.

Multicultural Competencies

Sue et al. (1992) established that multicultural competence enhances knowledge of minority groups, increases individual awareness of world view and cultural biases, and applying culturally appropriate skills to address clients' concerns and biases. The results obtained in the phenomenological research concurred with the critical attributes of multiculturalism, indicating that essential to serving the Latinx population, the participants first had to learn and develop an awareness of their culture in terms of language and belief for diversity. Additionally, individual understanding of culture helped raise awareness of the cultural diversity between the participant and therapist critical in addressing issues with bias. These findings are critical in that they support the use of multiculturalism in understanding the development of cultural competence in minority groups within the United States. In addition, the results identify that adopting a

reflective approach when learning the points of convergence and divergence between clients' and provider' cultures and cultural understanding in important.

Phenomenology

Conducting a phenomenological study to understand the lived experience of participants regarding cultural competence resulted in diverse areas of interest that are worth examining. Prior to highlighting these areas, it was evident from the presented findings and previous research that though achieving multicultural competencies was commendable, its application in the delivery of quality services was the pinnacle of multicultural competence. From the preceding finding it was evident that cultural competence promoted the understanding and appreciation of diversity. The participants discussed that being culturally competent influenced their delivery of mental services to clients. However, the point of understanding and reflection on multicultural competence from the phenomenological study is that despite finding multicultural competence to be important, language competence was key in developing cultural competence. Despite language not being the point of concern for this research, I learned that with language competence, service providers understood their clients and their needs and in turn gave them proper diagnosis. Therefore, the significance of language in describing perceived cultural competency along multi-dimensional lines is worth further investigation.

Limitations of the Study

The hermeneutic qualitative approach allows for critical, in-depth analyses of the data from a population. Participant accounts from the current study speak only to the subjects included in this piece of research and does not generalize beyond the participants

of this study. However, through in-depth analysis, original information has been accessed, which may be relevant informing practice and policy about a relatively under-researched population. A secondary reflection on the hermeneutic phenomenological approach concerns the researcher and interviewer's role. It is essential to recognize the subjective stance of all individuals and how this may have impacted the development of the research project itself, for example, the construction of the interview protocol and the facilitation of the interview itself. Therefore, the process of conducting qualitative research was a significant challenge.

The second limitation was my implicit bias. The human element, characterized by personal assumptions and biases, can result in failing to critically interrogate the data and the likeliness to lean on one side. Therefore, being a Latina clinician in southern Idaho who worked in the mental health field could have influences the design or conduct of the study and review of study findings. Another limitation was associated with time, money, and sample. At the end of the study, the researcher found that the sample selected yielded the required data. Qualitative research was not expensive. The allocated time was enough to complete the study from start to finish.

Recommendations

From the review of the relevant current literature to the obtained results of this study, it is evident that the research on cultural competence and its impact on mental health service delivery is limited, and as such, there is still room for more empirical research to improve our understanding of cultural competence and provision of culturally competent mental health services to Latinx clients. It is recommended that future scholars

replicate the current study but widen its reach geographically to incorporate participants from other areas to facilitate the generalizability of the findings. The current results are only applicable to the study participants who deliver services to Latinx clients in southern Idaho. Based on the conclusions presented, future researchers should re-examine the connection between cultural competence and awareness and how the use of language influences cultural competence utilizing mixed-methods research with Latinx clients in other regions of the country.

Implications

The current study underscores the challenges experienced by minority communities and the value of cultural competence in addressing such challenges within mental health service delivery. This study described the participants' experiences with cultural competency in mental health service delivery to Latinx client in southern Idaho and has implications for positive social change within the service system in that region and potentially within other regions in which Latinx clients receive mental health services. First, being culturally competent as a mental health provider will help address the challenges faced by the Latinx population and promote cultural diversity. Second, the current results can be used as a blueprint by policymakers and educational stakeholders in formulating policies and curriculum on cultural competence. Having a well-designed and culturally competent curriculum will encourage teachers to teaching and focus their student training on culture and the need for diversity.

The theoretical implication is the current qualitative phenomenological research is essential to the literature. While research on cultural competence and provision of mental

health services exist, the studies are few, and as such, this study is an important addition to the field of research. The study addresses some of the gaps in the literature regarding the lack of participants' or mental health' professions own experiences with serving minority communities. As per their responses, cultural competence is important in provision of mental health services to the Latinx population. Language is a barrier that will limit how well members of the minority groups are treated unless sorted. As per the responses given by the participants, the Latinx population, especially the elderly population or individuals advanced in years preferred mental health providers who were Latinx, understood Spanish, or could converse in Spanish. The participants described that it was challenging to those who were not bilingual to explain their diagnosis or understand what members of the community described as aiding them without the help of an interpreter. The results on cultural competence and its application in the current study validates the significance of the theory of multiculturalism and its application in studies with minorities as population of interest.

Practical implications and recommendations for practice are that healthcare providers will use the current findings to prepare themselves when going out to serve a minority community. The participants reported that members of the Latinx community were more drawn and receptive to care providers that were either Latinx, spoke Latinx or understood their Latino culture compared to those that did not. Therefore, with this knowledge, mental health providers can prepare for what to expect in the field and what would influence their work while in the field. During the preparation, the mental health provider will learn about their culture, which affects how they respond to medication,

their religious beliefs, and their language, which will determine whether the service provider will need a competent interpreter with whom the local population will be frees to share without feeling intimidated. Second, educational stakeholders can use the current findings as a drive to begin teaching cultural competence especially language diversity in schools and advocate for bilingualism and multicultural learning in schools and not only in health services.

Conclusion

This qualitative hermeneutic phenomenological study involved understanding experiences of Idaho-based mental health providers and managers of mental health agencies regarding provision of culturally sensitive services to the Latinx population within southern Idaho. Providers participated in semi-structured interviews and had the opportunity to describe their professional experiences in their own words. Their accounts of professional experiences supported the importance of culture in terms of provision of mental health services to Latinx clients. Results from findings demonstrated that most mental healthcare providers in Idaho practiced cultural competence when providing services involving mental health problems. Practicing cultural competence was used to encourage and build understanding of Latinx culture. Participants endorsed the value of cultural awareness, appreciation for diversity, and understanding of culture influences access to mental health services. According to study participants, clients are more likely to engage in mental health treatment when their providers share a common culture and language with them. Language is key in terms of developing trust between service providers and service recipients. A unique finding that addressed the gaps in the relevant

research is that participants identified knowledge of Spanish and viewed it as a key component of cultural competence. Language was understood in the broadest sense to reflect the cultural perspective and values of the Latinx population. Language was key to engagement of Latinx clients in mental health services.

Participants in the current study identified the Latinx population as a population with many reported cases of mental health problems in the United States. Among the reasons given were limited number of professionally trained mental health service providers who are bilingual and culturally aware. Therefore, the current research was used to provide an understanding of how culture influences individual access to mental health care and how cultural competence affects interaction and quality of services offered by mental health care providers by describing how participants equate quality of care to providers' culture, as they tend to trust care providers who share a similar culture. Overall, starting the practice and training of students on cultural competence earlier may help undo current challenges experienced by healthcare providers serving minority communities.

This study can serve as the foundation for future mixed-method studies that identifies the key components of cultural sensitivity within the context of mental health service delivery to minority populations. This study has potential significance in deepening our understanding of engagement of Latinx clients in mental health treatment and potentially improving outcomes for a minority population that is underserved within mental health.

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Appendix A: IRB Approval

This email is to notify you that the Institutional Review Board (IRB) has approved your application for the study entitled, " A Phenomenological Study of Mental Health Providers' Cultural Sensitivity towards Latinx Clients."

Your approval # is 09-10-21-0613864. You will need to reference this number in your dissertation and in any future funding or publication submissions. Also attached to this e-mail is the IRB approved consent form. Please note, if this is already in an on-line format, you will need to update that consent document to include the IRB approval number and expiration date.

Your IRB approval expires on September 9, 2022 (or when your student status ends, whichever occurs first). One month before this expiration date, you will be sent a Continuing Review Form, which must be submitted if you wish to collect data beyond the approval expiration date.

Your IRB approval is contingent upon your adherence to the exact procedures described in the final version of the IRB application document that has been submitted as of this date. This includes maintaining your current status with the university. Your IRB approval is only valid while you are an actively enrolled student at Walden University. If you need to take a leave of absence or are otherwise unable to remain actively enrolled, your IRB approval is suspended. Absolutely NO participant recruitment or data collection may occur while a student is not actively enrolled.

If you need to make any changes to your research staff or procedures, you must obtain IRB approval by submitting the IRB Request for Change in Procedures Form. You will receive confirmation with a status update of the request within 10 business days of submitting the change request form and are not permitted to implement changes prior to receiving approval. Please note that Walden University does not accept responsibility or liability for research activities conducted without the IRB's approval, and the University will not accept or grant credit for student work that fails to comply with the policies and procedures related to ethical standards in research.

When you submitted your IRB application, you made a commitment to communicate both discrete adverse events and general problems to the IRB within 1 week of their occurrence/realization. Failure to do so may result in invalidation of data, loss of academic credit, and/or loss of legal protections otherwise available to the researcher.

Appendix B: Flyer and Email

Invite for Research Participants

This is an invite to participate in a Phenomenological Study of Mental Health Providers' Cultural Sensitivity towards Latinx Clients. To evaluate this phenomenon, you are invited to describe your lived experience when working with the Latinx population. This research is being conducted in partial fulfillment for a doctorate in Clinical Psychology.

About the study:

- Semi-structured interview (approximately 45 minutes or longer depending upon the level of detail provided by participants in their responses) via Skype or in-person contact (COVID restrictions may apply).
- Member check via Zoom (approximately 30 minutes or more depending on the level of detail provided by the participant) to verify the narrative transcription.

Qualifications:

- Latinx and non-Latinx Mental health provider or in a
- Mental health Management position
- In southern Idaho
- Worked with Latinx clients
- 18 years or older
- Speak English, or bilingual providers that speak Spanish.

To confidentially volunteer to participate, please contact:

* To protect your privacy, no names will be exposed in the findings.

Good morning,

I am a student in the Ph.D. Clinical Psychology Program at Walden University, Georgia.

This is an email to invite you to participate in a research study.

It is a Phenomenological Study of Mental Health Providers' Cultural Sensitivity towards Latinx Clients. In this study, you will describe your experience working with the Latinx population. This email is specifically for Latinx and non-Latinx mental health providers or in mental health management positions in southern Idaho that speak English or bilingual providers that speak Spanish and that works with Latinx clients. If you are interested in participating, please reply to this e-mail. You will then receive an encrypted e-mail that includes the consent form for your participation. This researcher will contact you for the next step in this study, which involves a involves a Skype or in-person interview.

You must be at least 18 years old to participate.
To protect your privacy, no names will be exposed in the findings.

This study has been approved by the Institutional Review Board (IRB). The IRB is a university committee established by Federal law responsible for protecting research participants' rights and welfare. If you have concerns or questions about your rights as a research participant, you may contact the IRB Administrator at or irb@mail.waldenu.edu.

Respectfully,

Appendix C: Interview Questions

1. I am sure that you have often heard the term culturally competent or culturally sensitive mental health services. What in your experience does that look like? Could you give me some examples?

2. What do you think, in your experience, are the benefits (if any) of delivering culturally competent services to your Latinx clients?

3. What is your experience in treating Latinx client? Can you characterize the type of clients that come to your setting? How are they referred to you? What are their ages and or socioeconomic status? Overall, what are the range of mental health needs by which they are challenged? How does this compare, in your experience, with clients from other ethnic groups or cultural backgrounds to whom you have delivered services?

4. Have you received training in cultural competence? Can you describe, to date, any training you have receiving relevant to cultural competence?

5. Have you received training specifically about the cultural issues related to Latinx mental health?

6.Can you describe, to date, any training you have receiving relevant to Latinx mental health?

7. What is your cultural background?

8. What are your thoughts about how your own background may influence your communication with clients in treatment?

9. What is your experience in acknowledging clients' beliefs and practices in treatment? Walk me through how you experience this?

10. In thinking about the mental health services you provide, what role, if any, does your cultural competence play? What have you observed about your colleagues or staff?

11. Do you think that there are any biases that influences your understanding of culturally competent services to Latinx? If so, how might these biases influence your mental health service delivery? Could you give me an example of a time that you thought that cultural issues may have influence your service delivery to a Latinx client?

12. What in your experience are the particular issues that come up in the treatment of Latinx clients?

13. What culturally appropriate skills have you utilized to address the issues unique to Latinx clients?

14. In a recent article, the researchers used the term "willingness to act" and referred to attitude as important to the provision of treatment to Latinx clients. By that they meant how much clinicians care to go the extra steps of interpreting, making sure the client understands which may extend the time for service delivery. What are you experiences with this? Can you give me a recent example? Walk me through how you handle these issues.

15. What have you learned from your experience of working with Latinx clients? What could you do different or needs to change if anything? Any recommendations, based upon your experiences, for training other mental health providers?