ORIGINAL RESEARCH

Latinx Community Health Workers: Meeting their Community's Emotional Needs in Intuitively Culturally Appropriate Ways

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ABSTRACT:

Background: Scarcity of trained mental health professionals who speak the language and understand Latinx cultures is a significant challenge in Oregon. Latinx, particularly immigrants, present to health settings with a variety of psychosomatic symptoms associated with emotional distress. Generalized fear in an anti-immigrant environment is an exacerbating problem that alienates Latinx, regardless of citizenship or immigration status, preventing them from accessing mental health services. The value of Community Health Workers (CHWs) in addressing the health disparities of marginalized groups is immeasurable, and has the potential to be expanded to also assist in meeting the mental health needs of Latinx communities.

Methods: This qualitative, participatory research study, co-designed and delivered by CHWs, reports on the experiences of CHWs working with Latinx in Oregon. Focus groups and a survey were used to gather data from CHWs about their experiences responding to the psycho-emotional needs of Latinx.

Objectives: The role of CHWs in providing help to Latinx who are not served by traditional mental health services is explored.

Results: CHWs significantly contribute to meeting the gap in provision of culturally relevant crisis intervention, in the language of Latinxs in need. Latinx in Oregon rarely make use of traditional mental health services and/or the services offered are linguistically and culturally inadequate.

Conclusions: Healthcare providers are encouraged to attend to both the mental health and physical needs of Latinx in culturally informed and sensitive ways. Given the shortage of adequately trained mental health providers, CHWs are key in accomplishing these goals.

KEYWORDS: Allied Health Occupations, Health Services Administration, Community health partnerships, Health disparities, Health promotion, Health Care Quality, Access, and Evaluation, Community Health Services, Mental Health Services, Medical Indigency, Refugees

Introduction

Latin Americans, and those of Latin American heritage regardless of citizen or immigration status, represent the largest growing ethnic group in the United States (US), estimated at 59 million (1). Latinos, or Latinx (the preferred term by the authors), experience various forms of emotional and psychological distress, often associated with the stress of discrimination and marginalization. Women and recent immigrants are reported to have depression in high numbers (2), and adolescents have noteworthy rates of suicidal ideation (3). Men are identified as having challenges with alcohol consumption (4); interpersonal family violence (5); and other expressions of mental anguish. For those who are immigrants, the migration experience, hostility caused by anti-immigrant sentiment, and challenges of daily living increase their mental health necessities (6,7). Government policies that lead to deportation and family separation, create a generalized increase in tension, anxiety, and depression across immigrant and non-immigrant Latinx communities (8), as even some US citizens are believed to be here illegally. For undocumented Latinx immigrants under real threat of deportation, survival becomes a daily task overshadowed by fear (7,9). These experiences are distressing in themselves, potentially serving as triggers to past trauma, leading to re-traumatizing effects and symptoms associated with chronic or complex trauma (10). These symptoms may have been previously mitigated by community and family (11) and in their absence, Latinx are left to manage them alone. There are not enough Spanish-speaking, culturally aware mental health professionals to assist with the emotional and social challenges of Latinx communities as a whole. This study tackles this disparity by exploring the contributions of Community Health Workers (CHWs) in addressing the mental health needs of Latinx in Oregon, where little distinction exists between immigrants and non-immigrants.

Latinx and mental health

Eight million Latinx in the US have a diagnosable mental illness (5). Latinxs suffer roughly the same levels as the broader population, but are overrepresented in depression, posttraumatic stress disorder (PTSD), anxiety, alcoholism and, for young Latinas, suicide (9). It is not possible to know how many of these are immigrants are part of mixed status families, with US citizens and members with various immigration statuses (12). Upon arrival, immigrants are healthier than the general population (13) but their mental health deteriorates the longer they are in the host country (13). An arduous migration trek, culture shock, economic hardship, and disappointment may contribute to this decline (11). Compounding stress and lack of supports can cause physical and emotional symptoms to manifest (8), exacerbating the prognosis for these communities.

Mental health services

Various factors limit the ability of Latinxs to receive adequate behavioral services. Forty-five percent of Latinx are uninsured (14,15), creating the first barrier to accessing treatment. Even if they have a form of payment, personal and programmatic considerations prevent them from seeking help. At the programmatic level, counseling based on a Eurocentric perspective that is "culture-bound," is inadequate (16). The client-therapist interaction is another factor, as stereotypes about Latinxs and therapist's own expectations affect therapeutic outcomes (17). Latinxs may prefer therapists of the same culture, but in some regions, there is low availability of mental health providers in general (18), and even less providers of the same ethnicity (18,19).

At the personal level, feelings of unease about using unknown systems, stigma surrounding mental illness, cultural interpretation of symptoms, and somatization prevent immigrants from reaching out for help. When they do seek specific support, Latinx individuals

have premature termination rates in therapy (20). Some report early dropout resulting from dissatisfaction with therapy, financial costs, lack of time, and transportation (20,21). Latinx describe that mainstream mental health providers do not understand them, and therefore cannot help them (19,21).

The blurring of physical, emotional, and mental dis-ease.

Immigrants tend to use the medical system for mental health needs, as there is a blurred line between physical and emotional symptoms (22,23). Medical practitioners often miss the underlying behavioral causes of physical symptoms, leaving immigrants to suffer with unresolved conditions (22). Loneliness, social isolation, forced separation, grief, a sense of failure (22), and fear affect their overall wellbeing (8,9).

The mainstream approach to mental illness may be inappropriate to capturing the multi-faceted factors influencing Latinxs wellbeing. Achetagui (22) proposes a culturally appropriate option, where building social support is emphasized and aimed at mitigating the loneliness and isolation of immigrants. Their basic concrete needs, such as food, shelter, and healthcare would be directly addressed, minimizing the already overwhelming stress of daily living. This approach, which emphasizes community development, would be preventative while promoting resilience and generalized support (22). To this goal, Buttaro (23) proposes the use of CHWs, as they are trusted members of the communities they serve and understand cultural nuances that interfere with seeking help when needed.

Community Health Workers (CHW) and socio-emotional support

CHWs are key to the goals of community health services (24,26), as they are the link between marginalized communities and health care systems. Patients listen to CHWs, as they are from the community they serve, making proximity possible (25); and patients are more likely to

follow through with treatment and make lifestyle improvements (27, 28). CHWs provide culturally and linguistically specific services for which other disciplines are not equally qualified (25). They provide education and socio-emotional support in the language of comfort and in a culturally appropriate manner (25, 30). They build trust, establish connection, and foster openness, which are key to the healing process and therapeutic relationships. In spite of CHWs' ability to create this unique bond, they have not been used specifically for this purpose.

Few evidenced based programs exist in the US that employ CHWs to improve the mental health of Latinx communities (26). Worldwide, increasing mental health issues in low-income countries have generated interest in community mental health and the use of CHWs (31,32). CHWs can provide auxiliary support and respond to immediate requests, while professional behavioral providers work with patients with higher-level need and symptomatology (28). Oregon providers affirm that there are not enough adequately trained mental health providers to serve Latinx in Oregon, and CHWs are already responding to emotional crises (19). Oregon providers recommend a multi-prong approach, with CHWs offering an immediate solution when practicing under the supervision of professionally trained behavioral providers (18,31).

Literature exists on service modalities and on barriers to provision of services to Latinx (20,21). What appears to be missing, however, is literature on effective culturally relevant models for meeting the mental health needs of Latinx, recognizing the cultural diversity within these communities. Further, CHWs are not represented amongst the professionals involved in the provision of these services, or the research.

Methodology

This participatory action study captures the experiences of CHWs as they navigate the mental health needs of the communities they serve. Participatory research integrates the lived

experience of the participants, using these experiences as the primary focus. The study consists of focus groups, a typical form of gathering information from this population (33). Focus groups replicate a natural environment, maximize self-reflection, and promote social interaction (34). We sought to learn from the experience of CHWs, both as a process of inquiry and of seeking solutions to an identified community need. With the goal of discovering whether CHWs could be part of meeting a gap in mental health services, the research questions explored:

1. What role do Community Health Workers play in meeting the mental health needs of Latinx communities in Oregon?

2. How do CHWs respond to challenging situations?

3. What training and support do they need to be effective?

Co-investigators include CHW, from *Nuestra Comunidad Sana* of The Next Door, Inc, a former CHW social worker, and a Latinx immigrant academic. *Nuestra*, as it is known, employs CHWs to promote health in north-central Oregon. The research team has no history of previous collaboration, but were introduced by a retired medical practitioner who saw this potential. Researchers engaged as equals to give voice to Latinx, a marginalized group (35). They are trained in and have experience leading groups, are fluent in Spanish, and four of five identify as Latinx. This cultural similarity and professional diversity offered both proximity and familiarity to put participants at ease, while requiring attention to potential bias. The literature indicates that researchers must maintain awareness about their position in relation to the participants (36). Debriefing throughout the study allowed for integration of diverse perspectives (37). Further, a pilot focus group, conducted prior to data collection to aid in question development, discussed how participants view a mixed research team, and agreed that this was beneficial. CHWs from *Nuestra* co-designed and co-facilitated the study and provided feedback throughout analysis.

Our findings are derived from five focus groups with CHWs in Oregon: two held in Portland, two in Hood River, and one in Corvallis. A total of 92 CHWs participated. Participant recruitment strategies relied on the Oregon Community Health Workers Association (ORCHWA)(33) and the Northwest Regional Primary Care Association, which sponsors the Western Forum for Migrant and Community Health (WFMCH) conference. *Nuestra's* membership in ORCHWA provided an opportunity to conduct chain criterion sampling. ORCHWA members statewide were invited, via email, to participate in the focus groups, with a follow up contact from *Nuestra's* CHWs, lending credibility to the study. The WFMCH Conference in Portland Oregon offered an opportunity for CHWs throughout the state to participate. Inclusion criterium for participation were to be:

1. A certified CHW working with Latinx communities,
2. 18-65 years old,
3. Affiliated with a community health center, hospital or community organization,
4. Latinx.

In Oregon, there are four geographic communities where Latinx live: Portland, Lane & Benton counties, the Mid-Columbia Gorge, and the Klamath Falls Region. The goal of conducting a focus group in each region was partially realized as the Klamath Falls group was cancelled. However, CHWs from this region did participate in the study, as they were present at the conference where two focus groups took place.

Two teams of co-facilitators conducted the focus groups, each consisting of a social worker and a CHW. A third member observed and documented the deliberations. The teams extensively discussed process and structure in relation to group's facilitation skills, bias, and ease of participant integration. Focus groups were conducted in Spanish. Questions were drafted in

Spanish and translated to English. The pilot focus group helped to clarify questions making them more focused on learning from the experiences of CHWs, following inductive reasoning. Respecting varying levels of comfort with either language, facilitators accommodated and translated if necessary. The groups in Portland exceeded recommended numbers, with 24 and 25 participants each. The team decided to proceed, as it was not possible to add additional focus groups at the conference. This challenge was surpassed by ensuring every participant had the opportunity to speak. Each group lasted 75 to 90 minutes.

Data analysis

Thematic and content analyses guided the analytic process (36,37). Audio recordings were transcribed in Spanish, and analysis was conducted in that language. The team used an iterative process of revisiting data through inductive codes. Data was analyzed across and within groups, using thematic content analysis, to gain a deeper understanding of common themes and differences. The primary investigator conducted the analysis, and the team discussed findings at each phase. Six phases occurred: creation of a codebook from emerging themes; application of codebook to data; identification of additional themes as coding was applied; analysis of each theme within itself; discussion with partners of theme and latent content; observer comment integration; and member-checking at the following WFMCH Conference. The team presented results at a workshop where CHWs commented and confirmed the findings.

Institutional Review Board approval was granted. Participants provided verbal and written consent for participating and audiotaping, and were informed of the potential risk of re-traumatization as they describe their experiences as well as the possibility of feeling relief after sharing.

The study is guided by constructivist (38) and critical theories (39). Constructivist theory acknowledges multiple ways of viewing the world beyond mainstream culture and dominant ideology. Critical theory aims to give voice to traditionally oppressed groups.

RESULTS

CHWs that participated in the study (N=92) have been in the field between 2-19 years, primarily working in community-based organizations, healthcare centers, and hospitals. Their stated role is to provide health education, and to encourage treatment adherence and compliance. Of these, 29 were male and 63 female, ranging in age from 18-65, with the majority between 30-52 years old. Most were from the state of Oregon (N=86), one from Nevada, two from Idaho, and three from Washington. When researchers realized that some participants were not from Oregon, they decided to proceed and determine the impact of this during analysis. Demographics reflect the diversity of the Latinx communities CHWs work with, as they originate from various countries: Mexico (N=64), Guatemala (N=5), Colombia (N=3), Honduras (N=2), and the Philippines (N=1). Seventeen identified as Mexican American.

The richness of the focus groups provides unexpected and confirmatory information. As one participant stated, "*We are finally being asked about our work.*" The focus groups provide information about circumstances the Latinx communities in Oregon are enduring. CHWs in the Pacific Northwest report similarly. CHWs describe challenges in performing their work, both with clients and their colleagues and supervisors. CHWs offer programmatic, administrative, and policy recommendations to address these challenges. The results will be presented accordingly, addressing: the difficulties confronted by the community; what CHWs do to assist them; creative solutions outside the scope of their work; and what they need to be able to do this work.

Difficulties in the communities

CHWs work with Latinx who face a range of individual and social issues that affect their mental health. They respond to individuals diagnosed with various mental health conditions as well as undiagnosed psychotic symptoms that they feel unprepared to address. Depression, alcoholism, suicidal ideation, interpersonal family violence and other family conflicts are interwoven into people's lives. Stress is seen as a pervasive determining factor in the state of being of those served. As one CHW put it, "*This stress is enough to put anyone over the edge.*" Social and environmental stressors that exacerbate Latinxs' physical and psycho-emotional state include financial concerns; multiple social determinants; scarce and low-quality helping resources; culture shock; assimilation and acculturation; family difficulties resulting from cultural differences; specific problems experienced by women; racism including discrimination; and the influence of a white supremacist, anti-immigrant socio-political climate. Loneliness, fear, grief, and guilt are feelings consistently expressed by community members. CHWs believe that fear causes hyper-vigilance, anxiety, and an unwillingness to leave one's home, leading to isolation. CHWs associate strain resulting from this stress with family tensions, increased use of alcohol by males, sometimes leading to domestic violence, ultimately leading to mental illness.

When the need for professional help is recognized, CHWs highlight the lack of resources. Treatment was often stymied by a lack of Spanish speaking providers, long waiting lists, or the patient feeling misunderstood by professionals. If able to connect patients to mental health agencies, these referrals often proved unsatisfactory. When CHWs inquired about the experience, clients reported *"it wasn't helping, or the worker didn't like them, made a racist comment, or just didn't seem to care."*

How CHWs assist

CHWs are going beyond their job of providing health information and access to services. They provide more than language interpretation, extending to being "*cultural brokers.*" That is, they explain cultural nuances to medical practitioners, and help patients understand the cultural context from which the practitioner communicates. They feel they are left to mend medical professionals' neglect, insensitivity, even ignorance. Inadvertently, they are often the ones to speak with patients after receiving a serious diagnosis, often with unanswered questions. As CHWs they feel unequipped to do this; still, they want to create a space where the patient can make sense of what they just heard. A woman defined this as "*the trauma of a serious diagnosis."*

CHWs offer emotional support, advice, and encouragement. They assist with problem solving through offering alternative perspectives and options. They attempt to link individuals to resources, however limited they are. In some situations, even if services exist, the patient might not be able to access them. CHWs describe the limits of helping those who are undocumented, as federal policies make it impossible for funds to be used to serve those with unclear legal status. "*Agencies and hospitals have accepted this and have not sought funding alternatives that would enable them to service these communities*".

They advocate on behalf of clients. One woman described an example of advocacy within her own institution, where she attempted to educate the staff in the birthing room of the cultural differences of indigenous Mexican and Central American women. The women's childbirth customs were ignored or ridiculed by staff, including requests for a warm drink, rather than crunching on ice, or a warm room. In their culture, babies are welcomed into the world by passing through a warm body and into a warm and re-assuring physical space, a stark contrast from the sterile hospital environment.

Creative strategies

CHWs are creative, resourceful, and deeply committed to earning the trust from the communities they serve. All the groups discussed the importance of trust, and how long it takes to accomplish it: "*It is easier said than done".* An early aspect of trust-building was providing concrete needs such as transportation, which "*meets two goals:ensure people get to where they need to be and get the message that I care and keep my promise*." CHWs describe going out of their way to communicate understanding of cultural norms and values of the community.

In every focus group, there is awareness of how strong and resilient people can be. As a strategy, CHWs emphasize the power of bringing people together to find common solutions. They highlighted examples of small self-help or mutual support groups they have created, to encourage sharing a common problem and solution seeking by their clients. They noted the importance of breaking isolation, as well as getting people to see that "*they are not alone in the problem, or in the solution.*" Instances of great generosity were named, "*if I could, I would build on this and create circles of support."* One participant emphasized interconnectedness: "*Knowing what it feels like makes me want to do more. When I get what I'm after, I feel strong and useful.*"

When a mental health provider is the next recourse, they are challenged as there are limited options for appropriate referrals. One CHW acknowledged the advantage she has: *"It is easier when we have a counselor in house, people are more willing to trust*." Much effort is required to get the patient ready to accept the referral, and when it fails, the outcome may be insurmountable. CHWs exert time and energy following up on referrals to ensure success. When the client does not return as a result of an adverse experience some CHWs are discouraged, while others are propelled to advocate for culturally responsive clinicians.

Professional challenges

The example of helping patients with a serious diagnosis exemplifies the challenge of limited resources. CHWs must find adequate referrals despite limited resources and structural barriers resulting from federal policies that make it impossible to serve those with unclear immigration status.

CHWs report that some co-workers who are not of Latinx heritage fail to support their work. "*It is hard enough that we do so much. When our co-workers are not supportive, we have to do double the work.*" They also cited "*lack of understanding from administration and supervisors"* who "*think our job is simply providing information. They do not understand*." All of the groups expressed this concern and explicitly requested training for administrators, and support through supervision to help "*figure out how to handle difficult situations.*"

Professional stress affects CHWs on a personal level. In regards to proximity to the population they serve, one CHW explains, "*we are only a step away from being where they are."* Some have shared experiences: "*I've been where they are, I know what it feels like to be so scared and alone."* This emotional closeness leaves them feeling responsible, worrying they will not be able to meet the expectations of the people they aim to help. Two groups discussed vicarious trauma and compassion fatigue in great depth, and acknowledge that their efforts to make a difference led them to feel depleted, powerless, frustrated, and exhausted.

The exhaustion is often the least of their concerns, as some CHWs have been directly challenged and attacked by community members that identify them as helpers of immigrants, leaving them to feel '*singled out'* and unsafe. One CHW talked about threats and insults he has received by Anglo members in his town for being perceived as being an ally of "*illegal aliens*". CHWs state that in the current climate they are afraid for themselves and for their families.

Recommendations

CHWs offered many suggestions to improve services to their clients, relations between community and healthcare providers, and the community at large. They urge administrators to understand the value of CHWs contributions to health promotion, and request that they be given adequate supervision and support. Most participants had clear and precise ideas for how to potentialize the possibility of meeting the mental health needs of their communities (Table 1). Training is a request all CHWs make, both for themselves and for clinicians. For themselves, they want more training on specific mental illnesses, on family dynamics, and on counseling skills. They want to become better equipped to handle psychotic episodes. They recognize the limits of their profession, but acknowledge that the nature of their work places them in immediate crisis situations. They recommend training to mental health professionals to make them more culturally aware and responsive to the diversity of and the specific needs of Latinxs.

Table 1. Community Health Worker (CHW) Suggestions to Health Professionals and Administrators

Sphere of Impact		**Recommendations**	**Who is Involved**
Program Development		1. Create self help and support groups 2. Family counseling and support 3. On line or phone program to provide resources, answers, referrals, options counseling, and community support. 4. Hotline in Spanish 5. Counselor/social worker on staff in the health facility	Individuals, families, and communities
Training for CHWs		1.General knowledge of mental health and counseling	Community Health

		2.Specific to: depression, post-partum depression, suicide, alcoholism, domestic violence, dealing with a hallucinating person 3.Special needs of children: autism, mental health, learning issues 4.Family dynamics 5. Assistance with vicarious trauma and compassion fatigue	Workers and supervisors
Organizational Accountability & Support		1. Educate medical personnel on cultural issues and sensitivity 2. Educate mental health providers on cultures and cultural humility 3. Make Supervisors of CHWs aware of the depth of work and challenges as to "*what our work really is.*" 4. Provide CHWs with supervision and support	Professionals, clinicians, and administrators
Community Development		1. Address anti-immigrant sentiment 2. Offer resources and services regardless of immigration status 3. Create a network of support and idea exchange across state lines for CHWs in the Western region of the US	Community leaders, organizations, and politicians

DISCUSSION

CHWs recognize that the communities they serve are targeted by hatred and persecution, and besieged by substandard social conditions, further complicating their emotional and psychological well-being (7,9). The study confirms the literature regarding the types of conditions and the problems Latinx have accessing mental health services. CHWs have a nuanced understanding of how socio-political factors increase fear and stress, intertwining in

ways often missed by healthcare and mental health professionals (8,20). The study's findings concur with Achetagui (22) in that the psycho-emotional needs of Latinx must be addressed in a comprehensive way, at the prevention, intervention, advocacy and community building levels. CHWs are already breaking isolation through building community, and creating holistic culturally appropriate behavioral responses (23). Their proximity to the community and the trust they have earned place them in a position of identifying behavioral issues, responding in crisis, and of being a bridge to specialized resources.

The study reveals that CHWs are often the ones to lend immediate assistance, potentially mitigating the effects of fear, isolation, and stress. In the absence of mental health professionals equipped to respond to the needs of Latinx, CHWs are offering emotional support, and providing case management and informal counseling. In Oregon, CHWs are highly trained and prepared to work in marginalized communities. CHWs ask for more training and supervision. If capacitation were expanded (i.e. on anxiety and depression, crisis intervention, and the basics of abnormal psychology) they could be better equipped to respond. Under the supervision of mental health professionals, they could be the link that helps ensure that Latinx remain in treatment when referred to psychotherapists and substance abuse treatment facilities.

CHWs' ability to conduct outreach and education provide opportunities for them to raise awareness of mental health and to reduce stigma. Further, they can initiate community building strategies, including their own programming recommendations, such as developing formal support groups and creating communities of support. Study participants spoke of the effectiveness of connecting people to others who have experienced similar issues. This is consistent with Buttaro, who asserts that community-building is at the core of ameliorating isolation, despair, and guilt often common in immigrants (23). CHWs concur, if their employers

offered them more support, they would be better able to serve as an efficacious bridge to existing mental health services. Simultaneously, offering culturally appropriate training to behavioral professionals would maximize the possibility of successful interventions and outcomes for Latinx in Oregon.

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