Clinician's Experiences Implementing Multidimensional Family Therapy with Multilingual Families

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¡Arriba la Representación Michoacana!

Abstract

Multidimensional Family Therapy (MDFT) is an intervention that supports adolescents struggling with substance abuse, emphasizing improved family communication and restructuring of behavior problems. It provides a family-based approach to treating adolescent substance abuse and addressing mental/behavioral health problems. While most MDFT literature focuses on English-speaking populations, evaluating the therapy's effectiveness in Spanish-only, bilingual (Spanish and English), and trilingual (Mixtec, Spanish, and English) households is crucial. This study involves qualitative interviews with three *(N=3)* Licensed Marriage and Family Therapists that reveal key themes surrounding the practice of MDFT, including cultural competence, family dynamics, language in therapy, and interventions for parental reconnection. The prevalence of these themes became more apparent as data was collected, highlighting how often other therapists might come across such themes through their practicum and practice. Data collection included interviews that were qualitatively coded and analyzed using a grounded theory approach. Clinicians highlighted disparities between their formal training and the policies at their practicum sites, specifically regarding cultural awareness, power shifts in families, resource translation, lack of support for Spanish-speaking populations, and lack of trust towards Spanish-speaking clinicians. These findings call for further investigation to enhance treatment outcomes for bilingual and trilingual families.

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Introduction

Multidimensional Family Therapy (MDFT), a family-based intervention for adolescents struggling with substance abuse and behavioral issues, is a prominent example of a therapeutic approach that demands cultural sensitivity. Though MDFT is a standard approach and an evidence-based treatment based on research to date, evidence-based treatments are not evidenced for bi- or trilingual participants, which impacts MDFT's efficacy. Multidimensional Family Therapy (MDFT) is a guide to modifying treatment services for youth with a key goal of implementing a scientific, clinical, and practical approach toward therapeutic interventions. However, it is imperative to assess this treatment while implementing culturally and linguistically sensitive interventions (CLSI) toward minority groups, specifically toward the Latinx population (Rollins et al., 2023). Although Black families also receive these types of resources in the Central Coast, this paper will focus on the effectiveness of MDFT in Spanish/English bilingual families and Spanish/English/Mixtec trilingual families. These types of treatments are respectful and responsive towards the needs of all individuals wanting to receive services. When treating the needs of youth and their families, therapists go beyond family closeness and individualism alone to fully apply treatment services with maximum efficacy. MDFT is a comprehensive and developmental approach that is highly needed to create a better life for youth and their families.

While MDFT frameworks aim to help clients improve on de-escalating their criminal behavior, poor academic performance, self-esteem deficiencies, psychiatric symptoms, and later-in-life problems, it is crucial to start providing support to navigate these changes at all stages of

life, particularly within the Latinx population (Liddle et al., 2009). The Latino population is medically underserved in the US and needs culturally responsive care to address health disparities (Willerton et al., 2008). Therefore, culturally and linguistically sensitive interventions (CLSI) for Hispanic families with children struggling with addiction behaviors are crucial, especially within the "Mexican Indigenous community on California's Central Coast," a location that implements resources with this third language in mind (Bucholtz et al., 2023). MDFT literature has little to no research or information regarding exploring this intervention specifically within these areas of California, let alone in the U.S..

The field of psychology has witnessed a growing recognition of the importance of cultural competence in providing adequate mental health care. While MDFT has demonstrated efficacy in English-speaking populations, its effectiveness in Spanish-only, bilingual (Spanish and English), and trilingual (Mixtec, Spanish, and English) households requires further examination. This research paper delves into the critical role of cultural competence in MDFT, highlighting its significance in addressing the needs of diverse families and enhancing treatment outcomes.

Cultural competence is defined as "(a) directly addressing cultural and language differences, (b) inclusion of culturally based healing beliefs and practices, (c) acceptance and appreciation of traditions and relationship patterns that differ from the therapists', (d) awareness of the impact of immigration status, and (e) the influence of contextual factors such as poverty and limited access to resources," and is essential in the context of MDFT (Verdinelli et al., 2013). Adolescents and families seeking therapy often bring unique cultural perspectives, values, and communication styles to the therapeutic relationship. To achieve successful outcomes, clinicians must have the knowledge and skills to navigate these cultural nuances. Cultural

competence in MDFT involves understanding how culture influences family dynamics, communication patterns, and decision-making processes. For instance, in some cultures, hierarchical family structures may impact the willingness of adolescents to express their thoughts and feelings openly. Clinicians recognizing these dynamics can tailor their interventions to facilitate meaningful family discussions and promote healthier communication patterns (Verdinelli et al., 2013).

Language plays a pivotal role in cultural competence. In MDFT sessions, language barriers can impede effective communication and hinder the therapeutic process. Bilingual and trilingual therapists possess a unique advantage in bridging this gap. However, therapeutic alliance and human connection are not solely about speaking the language; it is about understanding the cultural nuances of communication, including idiomatic expressions, metaphors, and nonverbal cues. A skilled therapist can navigate these linguistic intricacies to foster a deeper connection with their clients. MDFT is a family-centered treatment program that aims to address mental/behavioral health problems and treat the ongoing problem of adolescent substance abuse. Therapists must be prepared to adapt therapeutic techniques to align with the cultural values and beliefs of the families they serve. This might involve integrating traditional practices, rituals, or symbols that hold significance within a particular cultural context (Hoskins & Platt et al., 2021). By doing so, clinicians demonstrate respect for the family's cultural identity and create a more inclusive therapeutic environment.

Literature Review

Intervention

The concept of including family therapy in substance abuse programs has emerged as one of the best integrative therapeutic approaches for adolescents struggling with substance abuse and exposure to substance abuse. As a result, the use of MDFT has rapidly increased over the past few years. Clinical and theoretical traditions of developmental psychopathology and psychology, the ecological perspective, and family therapy are also crucial components of the MDFT process (Liddle et al., 2016). MDFT aims to address different system levels that the adolescent might be struggling with and works with functioning domains such as the adolescent, parents, family members and community in the overall process. Some examples are therapists working with adolescent clients to improve cognition, intelligence, motivation, and lifespan development. Family is included in this process to help with the end of drug abuse and related problems, which develops inclusiveness and encourages struggling adolescents to imagine a more typical life trajectory when the adolescent and family are allowed to participate in the therapeutic process together. MDFT is similar to other therapeutic interventions like culturally informed group therapy for schizophrenia (CIGT-S), which also "represents a feasible, cost-effective approach that can be flexibly used with patients and family members of diverse racial and ethnic backgrounds" (Maura & Weisman de Mamani, 2013, pg. 27).

Multilingual Families

The Mixtec language is a dialect cluster for over 50 related languages spoken in Mexico. The "La Mixteca" area is based on the states of Oaxaca, Puebla, and Guerrero. Around 500,000 people are known to speak this Mixtec dialect, and California is home to around 170,000

indigenous migrants, who often face language barriers and challenges because they speak their native language and do not know English well. These populations are primarily employed in agricultural sectors, making the Mixtec language highly prevalent in the Central Coast region. Research has shown that studies amongst adolescents—a key component of MDFT—revolve around the WEIRD population, consisting of Western, Democratic, Industrialized, Rich, and Democratic people (Santiago-Rivera et al., 2009). Most of the MDFT literature concentrates on English-only populations, and has demonstrated a strong efficacy among those populations, but there are few resources for implementing this therapeutic approach with multilingual families. There is a high need for culturally responsive care to address these mental health disparities. This culturally responsive care can be demonstrated in practical applications. For example, bilingual teen clients discuss their trauma in English, while clinicians will respond in Spanish because parents tend to be monolingual Spanish speakers. This allows the adolescent clients to react differently to the original trauma experienced in Spanish, making it worthwhile to continue emphasizing Spanish speaking in therapy (Santiago-Rivera et al., 2009).

It is crucial to analyze this prevention therapy for underrepresented communities and consider the clinician's role in the approach. Clinicians play a significant role in MDFT, as there are few external resources aimed at helping monolingual Spanish-speaking and Mixtec-speaking clients who participate in this program. Bilingual mental health clinicians "have difficulty translating therapeutic terminology into Spanish [...] emphasizing a need for formal training in Spanish clinical terminology" (Estrada et al., 2018, pg. 1). Despite this difficulty, Spanish-speaking clinicians often go out of their way to translate and be culturally responsive to their clients without much support from their training and supervision experiences.

It is recommended that MDFT be more culturally sensitive towards other ethnicities. The effectiveness of this therapy should be evaluated within households with Spanish-only speaking, bilingual (Spanish and English), and trilingual (Mixtec et al.) family members. There are high rates of cognitive, psychological, emotional, and behavioral health issues amongst these households as well. Being more aware of culturally grounded therapy and family interventions is crucial in promoting mental health in Latinx communities. Targeting families can reduce conflict, promote Latinx mental health, and increase communication skills and psychoeducation. Culturally grounded interventions revolving around mental, emotional, and behavioral (MEB) health need to be developed, created, implemented, and tested to promote MEB health and encourage the Latinx community to be more open to receiving help. Research has also shown that immigration, cultural identity, poverty, discrimination, and lack of support for this community contributes to many mental health challenges (Cragun et al., 2009). A low number of Latinx youth are in progress or have received mental health services, even after searching for such support (Cragun et al., 2009).

Inadequate mental health utilization is not solely based on limited English proficiency. Anti-immigrant policies, transportation, healthcare, limited language providers, and the high cost of mental health services also contribute to the low number of mental health services received among the US Latinx population. Being able to fully target and explain the effectiveness of MDFT amongst bilingual and trilingual youth is essential to understanding how well-suited this process is for Latinx and Black families. This significance in the academic field adds to the gaps found in the literature regarding Mixtec-speaking populations and MDFT. It is highly recommended that more continuous research be conducted on populations not highly represented in academia, including Mixtec-speaking families. Scholarship must address research questions

surrounding Mixtec-speaking families, cultural values, resources, therapeutic interventions, and how the intersections of all these factors connect.

MDFT aims to explore the significant problem of adolescent substance abuse in the U.S., which is highly related to adolescent accidents, suicide, and crime, and its treatment through therapeutic approaches. The adverse effects of these substance abuse disorders increase problems in mental health, employment, and behavior and lead to a higher probability of the population being substance abuse adults. Considering these facts, it is vital to implement preventative and early-onset strategies for treatment and prevention.

Treatment

Long-term treatment is crucial to establish when an adolescent is first exposed to substance use. There is a significant gap between the resources that are given to participants versus the resources that are available to them. Establishing a long-term prognosis for these disorders and implementing the family unit into therapy is preferred. This type of implementation is the most validated for risk factors and substance abuse, which consists of poor academic performance and attendance.

MDFT includes principles of therapy focused on the individual, drug counseling, family therapy, and multisystemic intervention. This approach targets four domains: the adolescent, parents, family interactions, and extrafamilial relationships. MDFT helps adolescents with the engagement and alliance-building stage and also works to thoroughly integrate the family's role in the process. The significant gaps in the literature are based on insufficient research explaining how clinicians' perspectives highlight MDFT's efficacy with multilingual families, specifically bilingual (Spanish and English) and trilingual families (Spanish, English, and Mixtec).

Evaluating and assessing these perspectives is crucial in emphasizing how MDFT should be culturally sensitive towards other ethnicities and races, especially Latinx populations.

Graduate School Training

As MDFT begins to showcase its strategies thoroughly in different parts of the world, it is also vital to incorporate bilingual practices into graduate school curriculum.. Considering the prevalence of Latinx populations in the U.S., it is essential to integrate the resources necessary to assess this population. Ph.D. programs across the U.S. only have a small number of graduate school programs that implement bilingual training into their course curriculum. Most master's programs also face this issue, leading to very few healthcare workers and clinicians helping this population receive the needed resources.

MDFT's family-centered intervention approach integrates developmental psychopathology, ecology, and family therapy, catering to various adolescent life domains, and its effectiveness in diverse linguistic backgrounds, particularly among bilingual and trilingual families, is a critical area of exploration.

Spanish-speaking clients tend to discuss trauma in English, and the therapist receives responses in Spanish, leading to the client having nuanced reactions due to the linguistic shift. Clinicians must be trained in Spanish clinical terminology, and the lack of such training highlights a resource gap. Latinx populations are underserved and need culturally responsive care. The lack of Spanish and Mixtec resources hampers MDFT's applicability in these communities.

The effectiveness of MDFT among different linguistic backgrounds is pivotal. Limited research on Mixtec-speaking families and MDFT necessitates further investigation. The mental

health of Latinx and Black communities could greatly benefit from targeted research and interventions like MDFT.

Our research question is based on clinicians' experiences implementing MDFT towards bilingual and trilingual families. Details to further assess this question are based on language and culture variables incorporated into the MDFT practice. Some reasonable strategies that help Spanish-speaking clients successfully transition into MDFT are bilingual/trilingual therapists using language switching in MDFT with their clients. For example, therapists often use *dichos*, a Spanish saying that can bring into perspective what a real-life situation means in the form of a metaphor. They often practice and use Spanish therapy terminology to refine the message and services for their Spanish or Mixtec monolingual-speaking clients and employ code-switching in their practice to better establish a connection with their clients, establishing trust and rapport.

Method

Participants

Participants were Licensed Marriage and Family Therapists working in an MDFT program, all from Latinx backgrounds. The interviews were conducted by myself, the lead researcher. As we continue to do more interviews in the future, the coding process will be done by myself and another graduate researcher to establish interprofessional reliability. This allows us to build a consensus on coding the transcripts while using inductive and deductive strategies to develop a codebook. We begin by following previous literature regarding other strategies for interviewing therapists/clinicians and gathering their codes to develop our own codebook. This process is called priori codes and involves describing the process of collecting data before actually analyzing the data. This analysis process is crucial to follow through with data other

studies have collected, and it pushes us to see whether or not our study contributes to the gaps found in the literature. We can also develop new codes to see if thematic differences exist between our research and other articles/data. Clinicians were asked about their language proficiency, graduate school training, and MDFT treatment engagement and success.

The participation incentive was $15. I was able to clean up the transcripts once recorded and transcribed. I recruited three participants by sending an email (see Appendix A) targeted to an entire MDFT team. Although my goal was to recruit more participants amongst this MDFT group, I reached saturation amongst emerging themes and ideas brought upon by the participants.

Procedures

I first submitted Institutional Review Board (IRB) approval to begin this process. As a new member of the Sharkey lab and a new researcher in general, I took the Human Subjects Committee (HSC) examination, which allowed me to interview clinicians. The examination aims to understand further how psychology has evolved and how research is conducted today. The IRB approval process explained details regarding location, procedures, compensation, confidentiality/privacy, data storage, autonomy, consent process, risks, benefits, and the creation of a consent form. I purchased a Zoom subscription that allowed me to transcribe interviews while I recorded them.

During the experimental portion of the research, I began interviewing my participants to learn more about their perspectives regarding how MDFT is applied towards multilingual families. I used Zoom for my transcription process and interviewed each participant using this video format. The project consisted of one-hour conversations exploring questions regarding graduate school training, supervision, differences in therapy amongst multilingual and

monolingual families, treatment engagement and success, and adapting MDFT towards multilingual families, specifically bilingual (Spanish and English) and trilingual families (Spanish, English, and Mixtec).

Measures

Appendix B provides an example of the interview protocol (see Appendix B) used to interview the participants for my research study.

By providing clinicians with these open-ended questions, we allowed them to express their ideas about general themes. These questions were reviewed with Dr. Jill Sharkey and the Sharkey School Psychology lab. Upon completing the recording and interview process, I became aware of the high need for culturally and linguistically sensitive resources that still need to be made available for families and children amongst this population.

Preliminary Results

As we began to analyze these results, the coding process was halted because more participants were needed to assess the saturation process. Common themes discovered through this interview were based on adapting MDFT towards the Latinx population and the MDFT program not having the necessary Spanish-speaking materials and culturally and linguistically sensitive interventions such as the Spanish language into practice. We aim to recruit and interview 10 Northern Californian and East Coast participants for future directions.

Quotes were taken from the interviews to highlight the main themes. One significant quote that stood out to me was: "So I feel like MDFT, even though it maybe was not developed specifically with Latinx families in mind, and even though we do not get [...] cultural

considerations [...] when you are working with people [...] I feel like the systems approach, like the systemic approach, makes much sense, specifically for like Latinx families." This quote emphasizes that therapeutic interventions such as MDFT are not culturally sensitive towards other cultures and populations that are Black, Indigenous, or People of Color.

Further assessment reveals how much change is needed when working in the therapeutic and mental health realms. The lack of training to support Spanish-speaking clients emphasizes the need for more Spanish-speaking clinicians and therapists to help these families in the MDFT process, which can be challenging to navigate for underrepresented individuals. However, change can happen. One quote addresses this: "I have noticed that people react differently when you say the same thing, but it is in Spanish. […] Like once you switch to Spanish, because that is part of their connection, right? So, you can see, 'Oh, like something more happens' than just talking in English. So yeah, you see a different reaction with people when you are talking their language, and you are using [...]what they know." Paying attention to the need to speak to people in their native language is vital to the improvement and success of MDFT. If these resources are not a part of the progress, it hinders therapy improvement. Therefore, by establishing the connection these families and individuals require for success, we pay attention to their needs. Lastly, another theme in this analysis is that the MDFT program lacks the necessary Spanish-speaking materials to better guide its clients. One quote paints this picture: "And they have refresher trainings that we attend, [...] and then those refresher trainings, like all of us have asked, 'Is any of this material in Spanish?'"

Moreover, the reply is always 'no.' The interviewee further states, "I do not understand how a big entity like this has not translated any of their material into Spanish; most of the most significant population they serve are Spanish-speaking families." These materials are more a

requirement than a suggestion, and the need to have them is long overdue. Change must happen now. Clinicians have desperately needed these materials since the beginning, so their advocacy is also desperately needed.

Discussion

The process of MDFT can become problematic when clinicians are not provided with the right resources to work with bilingual and multilingual families. Although language switching may be implemented to establish trust, bond with clients, and promote disclosure through specific phrases, it is crucial to implement techniques that foster natural Spanish language and Mixtec language interventions in MDFT, particularly with families seeking these resources (Cragun et al., 2009). Evidence highlights how clients use language switching from English to Spanish when discussing specific experiences revolving around improving family connections and relationships, allowing clients to experience certain positive and negative emotions that are represented differently depending on their language. Thus, bilingual and trilingual-speaking clinicians should improve communication and connect with Spanish-speaking and Mixtec-speaking patients (Cragun et al., 2009). More information is needed about what it is like for a bilingual and multilingual therapist working with solely monolingual Spanish and Mixtec populations.

This draws even more attention to therapists working with Mixtec populations, as very little information is available regarding therapists with this language expertise. There is evidence that suggests that the urge to work with this population and share Latinx cultural values and ethics strengthened the connections between clinicians and their clients; however, that does not dismiss the need to have more bilingual (Spanish/English) therapists and clinicians, as well as

multilingual (Mixtec/Spanish/English) therapists and clinicians (Verdinelli et al., 2013). The Latino population continues to grow at high rates, and "as a medically underserved population, Latinos experience many health disparities, including those related to mental health." (Willerton et al., 2008, p. 196). There is a desperate need to assess how MDFT works for populations that are not English-speaking. Although the literature suggests much improvement is needed to successfully work with Spanish-speaking clients and populations, there is also a desperate need to analyze these interventions toward Mixtec-speaking families.

Limitations

While this study provides valuable insights into clinicians' experiences implementing MDFT with bilingual and trilingual families, it is essential to acknowledge its limitations. The sample size was relatively small, consisting of only three participants from a specific county in California. As such, the findings need to be more generalizable to other regions or populations with diverse linguistic and cultural backgrounds. To address this limitation, future research should aim to interview a more extensive and diverse pool of clinicians from various MDFT sites across different geographic locations.

Additionally, the study focused primarily on clinicians' experiences. While their perspectives offer valuable insights, it is equally important to include the viewpoints of the families and adolescents participating in MDFT. Including their voices could provide a more comprehensive understanding of the challenges and successes of the therapy process from the client's perspective.

Furthermore, while the study emphasized the need for Spanish-speaking resources and cultural adaptations within MDFT, future research could explore the development and

effectiveness of such resources. Investigating how integrating culturally sensitive materials and interventions impacts therapy outcomes for multilingual families could offer practical insights for enhancing the MDFT approach.

Future Directions

Graduate programs are pivotal in preparing clinicians for culturally competent practice, especially when working with linguistically diverse populations. Future studies could delve into graduate programs' curriculum and training approaches to assess how well they address the needs of bilingual and trilingual therapists. This could involve examining the extent to which bilingual proficiency, cultural competence, and specific interventions for diverse populations are incorporated into training programs.

While cultural competence is recognized as a crucial aspect of effective therapy, its integration into MDFT practice is challenging. One significant challenge is the lack of standardized training and resources that specifically address cultural competence within the context of MDFT. Clinicians often rely on personal experiences and informal strategies to navigate cultural dynamics. To address this gap, training programs, and clinical settings should prioritize cultural competence education as an integral part of therapist development.

Moreover, cultural competence requires an ongoing commitment to self-reflection and continuous learning. Each cultural group brings its unique history and context, and clinicians must remain open to learning about and adapting to new cultural perspectives. This necessitates an attitude of humility and a willingness to acknowledge mistakes and shortcomings, all in service of providing the best possible care to diverse populations.

As the mental health field evolves, researchers, practitioners, and training programs must collaborate to address these gaps. By striving for cultural humility, linguistic proficiency, and culturally grounded interventions, the mental health community can work towards more inclusive and effective therapeutic approaches for all individuals and families, regardless of their linguistic and cultural backgrounds. This study serves as a starting point, highlighting the need for further research and advocacy to promote equitable access to quality mental health care for diverse populations.

Cultural competence stands as a cornerstone of effective Multidimensional Family Therapy. As the therapy landscape diversifies, mental health professionals must equip themselves with the tools necessary to navigate cultural complexities and provide equitable care to all clients. By recognizing the influence of culture on family dynamics, adapting interventions to align with cultural values, and effectively addressing language barriers, therapists can create a therapeutic environment that fosters understanding, growth, and healing.

In conclusion, this study's findings shed light on clinicians’ experiences and challenges in implementing MDFT with bilingual and trilingual families. The insights provided by the participants underscored the importance of linguistic and cultural considerations in effective therapeutic practice. The lack of Spanish-speaking resources and formal training in culturally sensitive therapy approaches presents significant barriers that must be addressed to better serve Latinx and other underserved populations.

Moving forward, integrating cultural competence into MDFT should be a collaborative effort involving researchers, clinicians, educators, and policymakers. Standardized training programs, culturally tailored resources, and ongoing professional development opportunities ensure that MDFT effectively meets the needs of bilingual, trilingual, and culturally diverse

families. By championing cultural competence, the field of MDFT can contribute to more inclusive, responsive, and impactful mental health care for adolescents and their families.

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Appendix A

Recruitment Email

"Hello, I hope this email finds you well. I am a third-year Psychological and Brain Sciences Major with two minors in Applied Psychology and Spanish. I am a McNair Scholar working under Dr. Sharkey's School Psychology lab. I am conducting a qualitative study to understand further clinicians' experiences implementing MDFT with bilingual [Spanish/English] and trilingual [Spanish/English/Mixtec] families. For this study, I am recruiting multilingual clinicians. You would be asked to participate in a 30-minute interview during work hours to answer questions about bilingual/trilingual therapy practices and how MDFT works for monolingual and multilingual families. These interviews would be done in the summer. Compensation would be $15 gift cards; you have no direct benefit if you participate. However, you would be adding to the gaps found in the literature regarding MDFT, multilingual therapy, and further graduate school training for multilingual therapy practices. Please feel free to reach out to me for any questions: jacqueline_lopez@ucsb.edu. I look forward to working with whoever decides to participate!"

Appendix B

Sample of Interview Questions

1. Tell me about your language proficiency. [Ask a, b, or c only if needed]
    a. What languages do you speak well?
    b. How did you become multilingual/bilingual?
    c. What is your comfort in speaking each language in your therapeutic practice?
2. In what ways did your graduate school training prepare you for bilingual/trilingual therapy practice?
    a. Did you receive supervision in Spanish or Mixtec?
3. In what ways did MDFT training provide support for non-English speakers or clients that prefer Spanish or Mixtec?
4. In what ways have you noticed a difference between how MDFT works for monolingual vs. multilingual families?
    a. What does MDFT do well to support clients who prefer languages other than English?
    b. What could MDFT do to improve support for clients who speak another language other than English?
5. What have you done on your own to best support people who prefer Spanish or Mixtec?
    a. Switching languages (code-switching), dichos…
6. How have your strategies to support people who prefer Spanish or Mixtec impacted treatment engagement and success?

7. In what ways has adapting MDFT to the needs of these populations impacted you as a clinician? [exciting, energizing, exhausting, feel burnt out if training is not provided to help these specific populations.., etc.]