

DISSERTATION

HOW DO LATINA PATIENTS EXPERIENCE INTEGRATED CARE

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Veronica Rivera

School of Education

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Doctoral Committee:

Advisor: Timothy G. Davies

Sharon Anderson  
Shelley Haddock  
Antoinette Aragon

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## ABSTRACT

### HOW DO LATINA PATIENTS EXPERIENCE INTEGRATED CARE

The underutilization of mental health services by Latinos and Latinas in the US is often attributed to factors such as cultural beliefs and perceptions about mental health; lack of awareness of the available services; and socio-economic matters. In order to improve the access to mental health services for Latinos, it is necessary to learn about their experience of these services. The purpose of this study was to gain understanding of patients from Latin-America making meaning of their experience as recipients of mental health services at two community health clinics that offer integrated care services. This is a phenomenological study that aims to understand the factors influencing Latina patients' decision about whether or not to follow up on subsequent mental health care appointments. Eighteen Latina women who had attended mental/ behavioral health services at the family health clinic were interviewed about their experiences. The first main theme to arise was patients' symptoms and the referral process. This included services requested by the patient or offered by the clinic, trust in the referring personnel, and familiarity with mental health services. The second theme was the behavioral health specialist's attitude and clinical approach, including personal qualities, clinical skills and knowledge. The third theme was the outcomes; these included improvement of symptoms and behavior, improved level of functioning, and better understanding of the situation. The essence of the findings was the overall feeling about their experience at the clinic, and the benefit to see the psychotherapist in the same health clinic in which they received medical services.

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## LIST OF KEY WORDS

Primary care, integrated care, Latino mental health, behavioral health, cultural competency, behavioral health consultant.

## CHAPTER ONE

### INTRODUCTION

*“We must feel comfortable before we can feel confident to trust and talk about our personal matters.” (“Maria,” personal communication, August 11, 2011)*

The need for an innovative model that formally integrates primary care and mental health services had been part of the health care conversation since the late 1970s (Coleman, Patrick, Eagle & Hermalin, 1979). However, it is only in the past few decades that mental and behavioral health care providers have started to work in closer collaboration with primary care providers (PCP). McDaniel, Campbell and Seaburn (1995) stressed the importance of primary care as a center point of services for various issues.

Primary care is usually the first contact that a patient has with the health care system, and it provides continues and comprehensive care. It often involves the management of multiple, undifferentiated health problems that are embedded in patients’ psychosocial context. (p. 283)

When primary care physicians work in concert with other health care providers, the services are what Alexander Blount referred to as “Integrated Primary Care,” or “Integrated Care” (Blount, 1998). According to Blount and Bayona (1994), “an integrated system is organized so that all primary care (meaning, the first response to almost any perceived problem of health or living a person can present) can be found in one place” (p. 174). Integrated care is useful in the identification and treatment of psychosomatic symptoms reported by patients during visits to their PCP; it is has also been shown to increase patient satisfaction, due to more cultural sensitivity and a non-hierarchical collaboration among

care providers. This also results in more effective care, management of care, and reduced health care costs (Grames 2006).

There is evidence that a large percentage of the visits to primary care providers directly or indirectly involve behavioral and emotional issues. According to Hunter, Goodie, Oordt and Dobmeyer (2009), up to 70% of primary care visits are related to behavioral health; in fact, the management of many of the chronic illnesses treated by PCPs, including chronic pain, obesity, cardiovascular disease and diabetes requires changes in behavior and habits. Moreover, many of the approximately 15% of Americans suffering from depression and anxiety often seek treatment from their family doctor (Murray & Lopez, 1996). This includes medication, as 80% of psychotropic medications are prescribed by primary care providers (Hunter et al., 2009).

Under an Integrated Care model, when a PCP, in the course of a medical assessment finds indications of emotional or behavioral issues, he or she consults with a mental health specialist located in the same facility. This type of mental health professional is also known as a Behavioral Health Specialists (BHS) (O'Donohue, Byrd, Cumming & Henderson, 2005). James and Follen (2005) use the term Behavioral Health Specialist (BHS) or Behavioral Health Consultant (BHC) to describe any mental or behavioral health provider who operates in a consultative role within a primary care setting. The BHS will commonly see patients for brief assessment and intervention. Occasionally the Behavioral Health Specialist will recommend a follow-up appointment for patients who may need additional intervention or to help patients maintain motivation for behavioral modification (James & Follen, 2005).

The concept of the integrated care model grew from research regarding the stigma around mental health challenges. Beginning in the early 1970s, studies revealed both a lack of mental health care providers, including psychiatrists, and especially in primary care settings (Coleman & Patrick, 1976). Moreover, primary care physicians noted a lack of follow-through with patients they referred to mental health professionals operating in a separate facility. Integrated care seeks to facilitate mental behavioral health treatment in the same medical setting and reduce the stigma many patients feel about seeking that treatment (Blount 1998; O'Donohue et al., 2005). Support for these types of health care services is grounded in the numerous studies showing that 70% of all patients diagnosed with a mental health disorder had never seen a mental health provider, and were only treated in primary care (McDaniel et al., 1995). Further studies revealed that more than 80% of the psychotropic medication was prescribed by non-psychiatric medical providers (Hunter et al., 2009).

In addition to the reduction of stigma, a body of research conducted over the past two decades further demonstrates the many other benefits of housing mental and psychosocial health services in the space where patients receive their primary care (Blount, 1998; Coleman et al., 1979; Grames, 2006; McDaniel et al., 1995). That said, while there is a large body of research regarding the need for the integrated care model, there is a notable lack of studies that discuss patients' personal experiences within an integrated care setting.

The research is especially limited when it comes to the experiences of Latina patients in behavioral and mental health care, and the ramifications of psychosomatic-mental health symptoms on physical health. Despite the high level of mental health concerns reported about Latinos and Latinas, there has been minimal participation of

Latinos and Latinas in formal mental health treatment (Grzywacz, Quandt, Chen, Ison, Kiang, Vallegos & Ascury, 2010).

Medical providers have long expressed concerns about their level of understanding around their patients' symptoms due to the potential inaccuracy of information provided by a third party – usually a child or other family member - accompanying the patient to doctor's appointments. Brooks (1990) reported that very few “interpreters” are truly bilingual; moreover, they lack medical training.

Some researchers have also reported that Latinos may refrain from asking questions or speaking openly about some health matters to an Anglo medical provider, even one who is bilingual. One possible reason for this could be cultural: Latinos and Latinas are often reluctant to “impose” by asking questions or reporting about mental or behavioral health-related needs (Brooks, 1990).

The data points to a need for greater cultural sensitivity, or *cultural competence*. According to Gallegos, Tindall, and Gallegos (2008),

The term cultural competence refers to the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each. (p. 53)

They further point out that, “Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system or agency or among professionals and enables the system, agency, or professionals to work effectively in cross-cultural situations” (Gallegos et al., 2008, p. 54).

Given the above, this study makes a significant contribution to the field of mental health care, specifically as it affects the Latino community. In gaining greater understanding of these linguistic and cultural nuances, as well as Latino patients' experiences, medical providers, including Behavioral Health Specialists would be able to modify their approach to such patients around health care. A new approach should include increased cultural sensitivity and possibly debunk culturally-based beliefs and stigmatization around mental health challenges. This would lead to greater patient satisfaction in that it will help them and their families feel better understood and supported by health care providers. This in turn could encourage patients to be more proactive around their health care, helping them to lead healthier lives and reduce health care costs.

### **Statement of the Problem**

The problem investigated in the study is how Latina patients experienced integrated care. It aimed to understand the perception and meaning of the experience; the impact of the services provided within the context of the integrated care model; and the motives influencing their decision to follow up with a behavioral health care appointment or not. While there is an existing body of literature about the incorporation of medical and mental health services under an integrated care model, those have relied primarily on the reports of the medical care providers, mental health providers and administrative personnel, with little to no input from the actual participants. There was also, as mentioned earlier, lack of research on the Latino community with regard to integrated health care. This study seeks to fill these gaps. First, it collected the personal narratives of 18 patients, which no other study has provided. This was accomplished through in-depth interviews, designed to elicit information about patients' feelings about integrated care and the motives that drove them

to either attend or refuse a follow up appointment with the Behavioral Health Specialist. Second, the study adds to existing research by specifically exploring the experiences of Spanish-speaking Latina women at two family health clinics in Northern Colorado.

### **Purpose Statement**

The purpose of this study is to gain greater understanding of Latina patients' making meaning of their experiences at two community health clinics that practice integrated care, and to understand the factors influencing their decision about whether to follow up on subsequent mental health care appointments.

The need for medical and mental-behavioral health collaboration has been well documented by research (Budman, Demby & Feldstein, 1984; Coleman & Patrick, 1976; Coleman et al. 1979; Feierabend & Bartee, 2004; Klinkman & Okkes, 1998; Mauksch & Leahy, 1993; McDaniel, Hepworth & Doherty, 1992; McDaniel et al., 1995; O'Donohue et al., 2005). With that being said, there has been a notable lack of studies exploring experiences from the patients' perspectives. The way in which the approach is implemented may vary, depending on the type of primary care setting; for example, the way integration is practiced may be different in rural and semirural clinics utilized by migrant workers than a facility in a big city that serves a different demographic. Regardless of the particular clinic, the primary benefit of the integrated care model is that medical professionals with different specializations are working collaboratively. In order to improve these services, health care providers must have in-depth, honest feedback from patients about their experiences. This is especially important for pediatric clinics, as they already provide a space for parents to discuss their children's physical, behavioral issues and family issues; therefore, an integrated approach could make it easier for parents to discuss mental health issues that

might otherwise go undetected. Again, in order to ensure patient satisfaction and cultivate the necessary level of trust, medical and mental health care providers must understand the beliefs held by patients around health care and how it can benefit their families (Finney, Riley & Cataldo, 1991).

The study provides information about the impact that integrated health care services have in the community health care clinics serving diverse populations. The patients seeking services in these clinics are predominantly Latin-American, Somalian, Caucasian, and African American, as well as other minority groups. They also, according to the health care providers there, commonly report their mental and behavioral challenges. The clinics provide services in English and Spanish; they also use a language line to better assist patients who may face difficulties expressing themselves in English. The selection of Latinos/Spanish-speaking patients as the participant group for this study was based on the fact that this is the largest minority group in the area. The population of the county is 28% Latino. The percentage of Latino/ Hispanic patients receiving services at these two clinics is 60%; of this, 42% are monolingual Spanish-speaking (US Census Bureau, 2000).

### **Research Questions**

1. How do Latinas experience integrated care?
2. What criteria do Latinas use to determine whether or not they will return for a follow-up visit as recommended by their medical provider or Behavioral Health Specialist?
3. What criteria do Latinas use to determine whether or not they decide to return for subsequent visits?

## **The significance of the study**

Currently there are no studies with in-depth responses and testimonials from patients about the integrated care program in their facility, and minimal literature has been found on Latinos experiencing mental health services. As a result, as the primary means of data collection this study relied on a qualitative inquiry in the form of individual interviews, including patients' appointments with their primary care provider, with a focus on their decision about whether or not to return for their follow-up appointment(s) with the BHS. Moreover, this study aimed to understand barriers for Latino and Latina patients to participate in mental health services and health services in general, and explored the culturally-based perception of integrated care services and how this impacts patients' decision to return for further counseling with the BHS.

Integrated care programs are expanding throughout the United States, the rationale being that, "Mental health disorders consume a large portion of patients' visits, with depression being the most common problem recorded by providers. Fifteen of the twenty most frequent multiple problem visits include mental health or health behavior problems" (Cameron & Mauksch, 2002, p. 343). In order for these programs to create a far-reaching impact, there must be studies highlighting different, typically underserved communities. This research informs medical and mental health professionals about the factors that influence patients' experiences, both positive and negative, with regard to health, mental and behavioral health services so that these professionals can more effectively meet the needs of diverse populations and cultures.

## **Delimitations**

There were several delimitations for this study. First, the study examined Latina patients who had attended appointments at one of the two community health clinics. Second, the participants were patients who receive medical and behavioral health services at one of the two clinics. Third, the study examined the unique phenomenon of having experienced integrated health care services offered at the clinics by one of the Behavioral Health Specialists. Fourth, the service of integrated care includes consultation between medical and behavioral health staff, and a referral to the BHS on either the same day of the medical appointment or another day. Finally, the integrated health care experience included patients who attended more than one follow-up appointment, as well an explanation from those who chose to not follow up.

## **Limitations**

Limitations of this study included the fact that there was just one primary researcher conducting it (in partial collaboration with one psychotherapist). The same researcher collected and transcribed the data in Spanish and translated it into English. Another limitation was that the study focuses on two community health clinics sharing similarities in care delivery, as well as the population they serve. Yet another possible limitation of the study was that most of the participants are from Mexico, as that population is the most represented at the clinic.

## **Researcher's Perspective**

During the initial part of the research, I had the presumption that Latino patients reporting positive comments about integrated care would be more likely to attend the follow-up appointment. The other presumption I had is that Caucasian patients may rely

more on medication, which may influence the likelihood of their returning to the clinic for a follow-up appointment.

The participants in the study are of Latin-American background, and the narratives hold strong similarities, which led to another assumption. I held the idea that while the patients sought help from the PCP, there was ambivalence about seeing the BHS. There were also similarities in treatment outcomes among participants.

### **The Research Bias**

The participants' positive experience with integrated health care could have been an influential factor in their decision to take part in the research study. Furthermore, their insightful, overwhelmingly positive narratives about said health care may have moderately biased analysis of the study.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

To better understand the phenomenon of how Latina patients experience integrated care, it is essential to examine the relevant literature. This chapter explores some of these studies, divided into the following areas: 1) documented studies of integrated care; 2) History of integrated care; 3) the Behavioral Health Specialist; 4) family therapy and integrated care; 5) Latinos' utilization of mental health services; 6) the benefits of integrated care services for Latinos with regard to mental health; 7) foundations of integrated care; 8) the benefits and impact and of integrated care; 9) patients' satisfaction with integrated care; and 10) outcomes and advantages of integrated care.

#### **Integrated Care: Documented Studies**

Various studies have documented the frequency with which mental health issues are identified during medical health care visits (Budman, Demby & Feldstein, 1984; Coleman & Patrick, 1976; Coleman et al., 1979; James & Folen, 2005; Mauksch & Leahy, 1993; McDaniel, Hepworth & Doherty, 1992). Researchers in this area commonly refer to the housing of mental health and behavioral care services in the medical care space, (i.e. the community clinics profiled in this study) as "integrated care." Alexander Blount, one of the primary researchers in the field, originally coined the phrase in 1998.

Integrated care is a relatively new model of service in which the mental health provider works within the primary care settings for the purpose of providing specialized services that more appropriately support patients and their families. It also frees up primary care providers to focus on their patients' physical health concerns. Research on the relationship between medical and mental health care dates back three decades, long

before Blount's characterization. The model of integrated health care has been adopted by small community health clinics since early 1970s; it also garnered the interest of researchers, resulting in an ever-growing body of literature on the benefits of such a health care model. This literature is founded on the high incidences of behavioral health problems reported by patients during their medical visits, which drew additional attention to the need for more holistic medical care.

Several studies explore themes and theories around integrated health care foundations, including patient satisfaction; psychosomatic symptoms reported by patients during the visit to the medical doctor; the decrease in stigma about mental health; cultural sensitivity around medical treatment, particularly mental health treatment; non-hierarchical collaboration among health care providers for a more effective management of patient care; and the reduced costs associated with an integrated health care model (Blount, 1998; Coleman & Patrick, 1976; Coleman et al., 1979; Goodie, Oordt & Dobmeyer, 2009; James & Folen, 2005; Mauksch & Leahy, 1993; McDaniel et al., 1992). All of these studies support the integration of medical and mental health services.

In 2006, Grames made a study of the Primary Mental Health Care Model, which is essentially the same as the Integrated Health Care Model. Like integrated care, the Primary Mental Health Care Model integrates mental and medical health services in the same location, with shared office space and patient exam rooms.

### **History of Integrated Care**

As mentioned previously, integrated health care originated in the mid-1970s, specifically at two clinics: one in New Haven, Connecticut, and the other in Rochester, New York (Blount & Bayona, 1994). These two clinics developed primary care teams in which

the responsibilities for patients' care were shared among physicians, nurse practitioners, physicians' assistants, and mental health providers. As one primary care provider had always led medical teams, this new concept, with collaborative conversations as a central feature, was a novel one (Blount & Bayona, 1994).

### **The Behavioral Health Consultant or Specialist (BHC or BHS)**

In the integrated care model, the mental health provider works as a member of the primary care team and is referred to as a Behavioral Health Consultant (BHC) or Behavioral Health Specialist (BHS) (Hunter et al., 2009). Typically, the BHS consults with the primary care provider (PCP), and then visits the patient in the exam room for approximately fifteen to twenty minutes in order to conduct a brief assessment. The BHS then provides feedback to the PCP about the patient's symptoms and details a treatment plan (Blount, 1998; Goodie et al., 2009; O'Donohue et al., 2005). After the first consultation with the BHS, the patient is typically scheduled for a follow-up appointment with the BHS and PCP, depending on the patient's needs and also taking into consideration his/her willingness to return. In some cases the consultation becomes an intervention, which may or may not require a follow-up.

### **Family Therapy and the Integrated Care Model**

According to the literature, family therapy is the mental health discipline most likely to be utilized under an integrated model. By its very nature it requires mental health providers to be sensitive and honor the patient. A goal in family therapy is to empower patients and clients to understand and confirm their life dilemmas as embedded in a social circumstance (Piercy, Sprenkle, Wetchler & Associates, 1996); moreover, family therapists

are specifically trained to collaborate with medical care providers. McDaniel et al. (1992) described by what is unique about family therapy:

It is distinguished by conscious attention to medical illness and its role in the personal life of the patient and the interpersonal life of the family. It combines biopsychosocial and family systems perspectives, and uses them to work simultaneously with patients, families, health care professionals, and community groups and agencies. (p. 4)

Integrated care is an ideal model for primary care clinics, as these clinics commonly serve community members of all ages and for a variety of reasons. Primary care is usually applied to acute cases of limited severity; however, basic symptom control methods are utilized as well (Gatchel & Oordt, 2003).

### **Latinos' Utilization of Mental Health Services**

It is well known that Latinos and Latinas prefer to share their difficult experiences with family members and trusted members of their community than with health care providers. This is supported by a substantial body of research indicating that Latinos underutilize mental health services (Kouyoumdjian, Zamboanga & Hansen, 2003).

Furthermore, Latina women have been found to be more open to talking about their mental or behavioral health problems than Latino men, and more likely than men to use medical and mental health services. (Cabassa, Zayas & Hansen, 2006).

Cabassa et al. (2006) compared information about Latino immigrants' use of mental health services. They found that Latinos experiencing mental health problems are more likely than non-Latino whites to underutilize mental health services. They also emphasized the fact that Latinos tend to rely more on the general medical services for their mental

health care rather than seeking out specialized services. One of the reasons for this is a lack of information about mental health services in Spanish; that said, studies have also shown that once patients become aware of culturally sensitive mental health services and experience them, they will most likely continue to use them (O'Sullivan & Lasso, 1992).

### **Benefits of Integrated Care Services for Latinos' Mental Health**

Integrated health care is based on consultation services, which can benefit populations that may not otherwise seek mental health services. These populations include Latinos, who despite a high level of mental health needs show minimal participation in formal mental health treatment (Grzywacz et al., 2010).

It has been reported that Latinos may abstain from asking questions openly or talking about health matters to Anglo providers, even when that provider is bilingual. This is because Latinos and Latinas do not want to "impose" themselves, but would rather be guided by a health care provider (Brooks, 1990).

Coleman and Patrick (1976), in one of the earliest publications in the field of integrated health care, suggested that the inclusion of mental health services was an important component of primary health care. This contention was based on a body of research demonstrating that the separation of mental health services from primary medicine had resulted in the exclusion of large sectors of the population that were at-risk and in need of mental health care. One of these was the Latino population, which had reported higher-than-average levels of depression and anxiety. Grzywacz et al. (2010) suggested that this is due to several stress factors faced by Latinos, including discrimination, poverty, poor living conditions and problems related to documentation, as well as the emotional distress of living in a different country than their families.

Guarnaccia, Martinez and Acosta (2005) made reference to a study suggesting that the longer immigrants from Mexico reside in the U.S., and the more acculturated they become, the more their mental health declines or they become more aware of their mental health-related issues.

They further point out that:

Immigrants are even less likely to use mental health services than U.S. born Latinos. When Latinos do seek help for mental health problems, they are more likely to do so in the general medical sector than in specialty mental health services. (Guarnaccia et al., 2005, p. 34).

According to Santiago-Rivera, Arredondo and Gallardo-Cooper (2002), Latinos can be educated about counseling; Latinos may also perceive counseling as similar to a medical visit, whether it be a onetime visit or part of an ongoing treatment plan. This supports the significance of integrated health care services, which begin with the patient's visit to a primary care provider and potentially lead to additional services for their mental health needs. Patients can return whenever they need additional support, or when they encounter a new stressor.

Latino and Latina patients typically prefer less formal encounters with a mental health provider; they also tend to view mental health services in a negative light (Cabassa et al., 2006) and are more comfortable with general health care providers. Documet and Sharma (2004) documented Latinos' preference for personal and warm relationships with providers; in fact, a provider's interest in and commitment to patients is reportedly as important, if not more so, than his/her medical knowledge. Latinos also place a high value on respect and view this as a necessary component to establishing an effective therapist-

client relationship (Guarnaccia et al., 2005). A study by Kouyoumdjian et al. (2003) demonstrated that the client's perception of a therapeutic alliance is a strong predictor of the effectiveness of the mental health service. They also contended that a relationship based on trust and support is crucial for therapeutic outcomes with Latinos.

There has also been considerable discussion about the underutilization of mental health services by Mexican-Americans (Guarnaccia et al., 2005). Some of the common barriers include low wages and a lack of health benefits; the stigma associated with mental illness; and the lack of information about services in Spanish and Spanish-speaking mental health providers. There is also the belief that one must be strong enough to cope with life's problems on one's own and with the help of family, without the involvement of outsiders (Orgeta & Alegria, 2002).

### **Foundations of Integrated Care**

The foundations of integrated care are teamwork, collaboration, co-location, coordination, and integration. Blount (2003) described this as a system whereby information is routinely exchanged between primary care and mental health providers in the same setting; they are located on the same premises and share the same waiting areas.

These co-located services follow a referral protocol that begins during a regular medical visit and leads to an assessment by a mental health professional. Studies show that the management of cases is smoother and more effective under these protocols, partly because service providers are able to frequently consult with one another. Coleman et al. (1979) found that when behavioral health providers were part of the primary care team for more than a year, more than 90% of consultations between medical providers and mental health providers were unscheduled and most took less than five minutes. Consultation

between medical providers and behavioral health providers most likely increases the effectiveness and skills of medical providers in addressing behavioral issues with patients (Coleman et al., 1979).

In integrated services, the treatment plan includes behavioral and medical components; and the diagnosis is built by both the medical and the mental health providers (Blount, 1998). When the field was in its infancy, behavioral health care services relied primarily on psychiatrists; there was also strong support for primary care providers becoming trained in the area of mental health care (Coleman & Patrick, 1976). Over the years, this research has evolved into support for the full-fledged integration of health care.

In 1979, Koch investigated the effect of behavior therapy on 30 patients referred to the clinical psychology service. This study revealed that patients with psychological problems consulted their general practitioners more frequently than other patients. He also concluded that patients with psychological dysfunction made more demands on general practitioners' time than others groups of patients. In evaluating behavior therapy intervention in the general practice Koch found that

Behavioral psychotherapy provided to patients suffering from anxiety, stress, psychosomatic disorders, obsessional states, habits disorder of eating, smoking, drinking, and problems of social, marital, or sexual dysfunction; by psychologists and mental health providers in the areas of systematic desensitization, modeling, response prevention, thought stopping, operant conditioning, social skills training, and marital therapy. (Koch, 1979, p. 337)

Furthermore, Koch noted that the frequency of doctor consultations was reduced by 40.5%, and the repeated prescriptions for psychotropic medication was reduced as well.

## **Benefits and Impact of Integrated Care Service**

The benefits of the inclusion of mental health services within the medical health field continued to be documented. Following up on the Coleman and Patrick study (1976), Coleman et al. (1979) studied the interaction and collaboration of primary care providers and mental health providers on the primary care floor. They found that “Collaboration occurred in the following themes: discussion, feedback, referral, medication, hospitalization, administration, and research...The primary care clinician gradually learns what to expect from the mental health clinician” (p.90). This study also referred to the importance and feasibility of delivering mental health services via an integrated care model and noted that it may reduce the barriers experienced by patients previously reluctant to utilize mental health services.

In the 1980s, research in the field of integrated health care focused on the measurable impact it could have on patients with mental health challenges. A controlled study measured the effects of mental health intervention and the medical services utilization. The small number of participants limited this study, and its results demonstrated that patients who had experienced mental health interventions appeared to seek medical services less frequently (Budman et al., 1984).

In 1984, Mumford, Schlesinger, Glass, Patrick and Cuerdon conducted a meta-analysis study of the outcomes of collaborative health care. They reviewed 58 controlled studies in which mental health interventions had been utilized to improve patients’ medical care. They found that in 85% of these studies the group with interventions experienced a decrease in utilization of medical services. In conclusion, this meta-analyses study found that while mental health treatment resulted in higher costs, due to the rise in ambulatory

and visits with mental health professionals; these visits also resulted in lower overall medical costs, primarily with regard to inpatient medical care.

Other researchers, including Kroenke and Mangelsdorff (1989), reported on the high costs of diagnosing several common physical complaints, including chest pain, fatigue, dizziness, headache, edema, back pain, dyspnea, insomnia, abdominal pain, numbness, impotence, weight loss, cough and constipation. They reported that of 567 patients, about 38% complained of at least one of those symptoms. According to the report, the cost of diagnosing these medical complaints was higher than \$7,000.

This is important because there is evidence that these and other symptoms reported by patients to their medical provider are primarily caused by environmental difficulties, stressors and other mental health issues. Furthermore, Byrd, Cummings and Henderson (2005) explained that patients who report psychological concerns to their primary care provider received profound benefits by getting the symptoms evaluated first by a medical doctor and then by a behavioral health provider.

In 2001, the US Department of Health and Human Services released a report on mental health based on culture, race and ethnicity, and it revealed that Latinos and Latinas showed higher rates of depression or distress than Caucasians. This report also addressed somatization as the expression of distress by Latinos and Latinas, which seemed to indicate that Latinos and Latinas feel it is less threatening to report physical complaints than psychological distress.

The literature published in the 1990s revealed a growing body of evidence about the utilization and focus of mental health services for different symptoms, as well as the benefits of integrated health care services (Campbell & Seaburn, 1995; Doherty, 1995;

Finney et al., 1991; Hemmings, 1997; Kates, Craven, Crustolo, Nikolau & Allen, 1997; Katon, 1995; Mauksch & Leahy, 1993; McDaniel et al., 1992; Miranda & Munoz, 1994; Peek & Heinrich, 1995; Regier, Narrow, Rae, Manderscheid, Locke & Goodwin, 1993; Sells & Smith, 1996; Scott & Freeman, 1992). All of these studies strongly support the integration of the mental health field with the medical field.

In 1995, Katon criticized some of the cost offset studies on the grounds that some of the groups in these studies were not matched, and that the effectiveness of psychotherapeutic intervention in decreasing distress to the patient or the family system had not been measured. He contended that

Many of the patients that primary care doctors are treating for psychological distress present with medical symptoms such as headache, backache, and abdominal pain, which are often quite related to distress they are feeling...the connecting between stress, psychological distress, and annoying physical symptoms, which can result in more cost-effective care for the patient. The over-utilization of medical services by psychologically distressed patients certainly puts the patient at risk of iatrogenic harm, that is, getting medications they don't need, unnecessary procedures, and even unnecessary surgeries. (p. 352)

In an effort to fill the research gap, Katon's 1995 study also measured the significance of patient satisfaction, including patients who were taking antidepressants for their severe depression.

Most of the research conducted on integrated primary care or integrated health care is based on descriptive studies. There is also a vast body of work on both the physical and

psychosocial issues symptoms, as well as psychosocial issues experienced by patients of community primary care clinics that operate under the integrated health care model.

The literature includes an exploration of the deterrents for patients in seeking mental health care. In a 2003 study discussing the ambivalence around mental health services, Blount reported that some patients will not accept a referral to a mental health provider in a separate location from their primary care provider.

Another barrier to seeking mental health care is the stigma around mental health challenges. As mentioned above, integration of services has been found to reduce such stigma; this is particularly true in a pediatric clinic. Pediatricians can be described as the gatekeeper of both medical and mental health care, the person to whom parents and other caregivers report their children's daily routines, development, and any behavioral health problems (Finney et al., 1990). Having a mental health provider on site can increase detection of and follow-up regarding these issues (Finney et al., 1991; Grames, 2006).

Primary care is viewed as the place for minority groups to seek help; and while Latinos and Latinas are generally resistant to discussing their psychological distress, they are reportedly more likely to open up to their medical provider. However, primary care providers are often under time constraints. They lack the time and/or the ability to recognize and diagnose mental health-related symptoms (US Department of Health and Human Services, 2001).

Integrated care services, as well as patients' perception of these services, have evolved in recent decades. A 2006 study by Todahl, Linville, Smith, Barnes and Miller showed that patients believed that collaboration increases therapists' awareness of medical issues and physicians' awareness of patients' emotional needs. Todahl et al.

(2006) also argued that the access to mental health services inherent in integrated care increased patient satisfaction with medical services and with the providers. This in turn improved patient compliance with treatment and clinical outcomes, as well as cost effectiveness in services delivery and offset of medical costs (Blount, 2003).

This was based on an earlier study by Blount (1998), which found that integrated services focused on the control of medical utilization and medical costs that come from psychosocial factors while improving health care outcomes, namely:

Improving the immediate clinical outcomes of primary care health and/ or behavioral health interventions for patients with mental health or medical outcomes. Producing better outcomes over time in patients with recurrent, chronic or progressive medical or mental health disorders; and limiting unnecessary medical utilization and costs in patients who have dramatic social support needs and/ or chronic and treatment resistant health or mental health problems. (Blount, 1998, p. 147).

Another significant benefit of integrated health care is the decrease in the utilization of medical services and hospitalization. The literature reveals that patients with high levels of stress, family issues, or various personality or behavioral issues visit the emergency room or outpatient clinics more frequently, resulting in higher health care costs. On the other hand, O'Donohue et al. (2005) reported that when integrated care services are available, more people receive appropriate services, which often results in a reduction in medical expenses.

There has been particular concern around patients who report mood disorders and behavior matters in the primary care setting. McLeod, Budd and McClelland (1997)

reported that lack of prompt treatment of these issues often results in health care costs:

Ineffective treatment of mood-related distress is costly to the health care system. It has been repeatedly demonstrated that high utilization of medical care is associated with symptoms of depression, anxiety, and somatic concerns. Patients with a high rate of medical utilization in the absence of disease tend to be distinguished by a somatizing style, rather than with major mental illness (p. 256).

O'Donohue et al. (2005) referred to the guiding mission of integrated care as population-based and with the following goals:

- To prevent the onset of illness through the management of health risk factors;
- To engage in early detection and management of illness;
- To provide stepped care for health-care problems in an attempt to manage most conditions within primary care;
- To provide palliative and chronic medical management for patients with chronic or progressive diseases; and
- To manage the total health care needs of patients through referrals to and coordination with medical subspecialists and conjunctive services such as behavioral health (p. 19).

### **Patients' Satisfaction of Integrated Care**

Literature about patients' experience, satisfaction and opinions around integrated care is scarce. However, there is a body of evidence demonstrating the many advantages of integrated health care, namely, the opportunity for patients to be treated for a multitude of

physical and mental issues in one location. The stigma of mental illness has traditionally served as a barrier against Latinos seeking mental health services (Guarnaccia et al., 2005). One of the advantages that integrated care has is the decrease of that stigma. Blount (1998) reported that “if the stigma played a role in keeping patients away from the mental health or substance abuse clinic, then providing access to behavioral health care at their doctor’s office would reduce the stigma and increase early access to care” (p. 121).

Currently, there are no known studies that examine patients’ opinions about the benefits or disadvantages of integrated care. However, numerous studies have shown that 70% of all patients who have been diagnosed with a mental health disorder have never seen a mental health provider, and are only treated in primary care (McDaniel et al., 1995). Moreover, more than 80% of the psychotropic medication is prescribed by non- psychiatric medical providers (Hunter et al., 2009). “Primary care is usually the first contact that a patient has with the health care system, and it provides continues and comprehensive care. It often involves the management of multiple, undifferentiated health problems that are embedded in patients’ psychosocial context” (McDaniel et al., 1995, p. 283).

Blount (1998) reported that 15 to 45% of the visits to a primary care provider were for medical symptoms caused by psychological factors. Others, such as Katon (1995), had found that about 50% of people with mental illness were treated solely by a primary care physician.

### **Outcomes and Advantages of Integrated Care**

Among the advantages of integrated care is that it is structured upon a collaborative team. Within this structure no one provider is expected to carry all the responsibility, and

the interaction in the consulting room is more likely to embody collaborative premises (Blount & Bayona, 1994).

Primary care patients with mental health problems visit their primary care providers more frequently, and have higher rates of illness, disability and mortality than other patients (McDaniel et al., 1995). These authors also referred to the outcome of integrated services as “The medical outcomes study demonstrated that depressed, primary care patients have the same degree of functional disability and morbidity as patients with serious, chronic medical disorder such as diabetes, heart disease, and cancer” (p. 284).

Blount (1998) also viewed primary care and behavioral health care fields as working in integrated manner to improve outcomes.

This integration would provide opportunities for cross training between primary care providers and behavioral health clinicians and that practicing together would ensure opportunities for providers to recognize what patients were already experiencing clinically: the joining of the mind and body in the course of their presenting complaints. The patients who returned to their primary care provider for somatic complaints with no known underlying physical disease would be provided a bridge to appropriate care through the presence of the behavioral health clinician in the physician’s office. We would provide the opportunity for the patient to improve his or her life while also making the primary care provider’s professional life easier in the process. (p.122)

Integrated care provides brief assessments that allow the Behavioral Health Specialists to intervene in a timely manner. The BHS tries to identify the solution and the exception to the problem, rather than assist in the processing of feelings through

empathizing and open-ended questions. Hunter et al. (2009) explain the need for close-ended questions during the brief assessment or intervention during the behavioral health consultation. Open-ended questions may draw lengthy and ambiguous answers that may require more than a brief consultation visit with a Behavioral Health Specialist. However, close-ended questions, or giving a list of options to the patient, allow the BHS to gather information needed to recognize the primary problem, causal factors, and create a diagnosis in a timely manner (Hunter et al, 2009). However, once the Behavioral Health Specialist has gathered all the necessary information, open-ended questions may provide further clarification. It should be noted that some mental health providers, who contend that longer meetings are needed in order to work an accurate mental health assessment and provided specific recommendations, perceive this method as a limitation.

As mentioned above, most of the research conducted on integrated primary care or integrated health care is based on descriptive studies, with a central focus on bringing mental health services into primary care. There is also vast research on the physical symptoms. Research has also focused on psychosocial issues, therefore patients from community primary care clinics that operate as an integrated health care can benefit.

Since the 1990s, Alexander Blount has continued to conduct research studies about the integration of mental health and primary care. As recently as 2003, he reviewed a study chronicling ambivalence around seeking mental health services and reported that some patients would not accept a referral to a mental health provider in a separate location from their primary care provider (Blount, 2003).

The understanding of patient's needs and beliefs is important when research is drawn upon impact of a behavioral health professional entering what patient's may feel is their territory and time with their primary care provider.

## **CHAPTER THREE**

### **METHODS**

This chapter discusses the methods used in collecting the data and the philosophy behind those methods. It also discusses the procedures used in obtaining the data. This chapter will include the research approach and rationale; the purpose of the study; the research site; participants; data collection; research journal; data analysis; and trustworthiness.

#### **Research Approach Rationale**

The method used in this research was qualitative, and the theoretical framework for this study was embedded in the constructionist epistemology. In this understanding of knowledge, it is clear that different people may construct meaning in different ways, even in relation to the same phenomenon (Moustakas, 1994).

The qualitative tradition of enquiry that I followed in this research study was phenomenology. I searched for the constructed meaning of the experience that patients who had received mental health support through and integrated health care service. The study centered its attention on a small number of subjects exposed to integrated care services offered at the community health clinic.

The conceptual framework explained the patients' experiences of integrated health care within the context of their lives, cultures, and environments. As noted by Moustakas (1994), "Phenomenology refers to knowledge as it appears to consciousness, the science of describing what one perceives, senses, and knows in one's immediate awareness and experience" (p.26).

## **Purpose of the Study**

This phenomenological research study was designed for the purpose of learning about how Latina patients experience the mental health service in an integrated health care setting; this includes the factors that may contribute or affect the patients' decision to follow up with a second or third visit for mental health services. The purpose of this research was to find evidence about the importance of the phenomenon (Latina patients' experience in integrated care).

Data on whether or not there is evidence about the benefits of integrated health care services, from the perspective of Latina members of the community, was generated, using evidence derived from patients' experiences with a behavioral health specialist during their visit to their primary care providers. Their construction of meaning about their experience enriches previous enquiry. In the study I searched for the phenomenological meaning of the experience and opinion about the impact of integrated care.

## **Research Site**

The study was based on two community health clinics that provide integrated services (medical and behavioral - mental health services) in Northern Colorado. Latinos comprise approximately 60% of their patients, and 42% of them are Spanish-speaking, first-generation Latinos. One of the clinics provides pediatric services, and the other clinic provides services to families, including children and adults. The pediatric clinic has four physicians on site from Monday through Friday and 1.5 Behavioral Health Specialists. The family clinic has a total of eight physicians and two Behavioral Health Specialists on a daily basis. Both clinics have a majority of bilingual-bicultural staff that includes physicians, medical staff, behavioral health care staff, administrative and support staff.

## **Participants**

There were eighteen participants in the study, all of whom were first-generation Latina women from Mexico and ranging in age from 18 to 65. Their medical provider had referred these patients to the Behavioral Health Specialist, and they had attended one initial visit with BHS, and a minimum of one follow-up appointment.

The two clinics were supportive during my recruitment of participants; in fact I was aided by the staff and the BHSs on-site. The Behavioral Health Specialist and I are both bilingual, and the contact was made in Spanish. I requested a list of male and female patients, including adult patients and parents of children who had followed up with one, two or more sessions with the BHS.

I chose patients with whom I had not had previous clinical contact; however, the contact was research-based. This decision was made to keep the data without bias built from previous clinical work. Their participants' diagnoses included depression, anxiety, and several psychosomatic problems that were affecting their medical health; behavioral problems were predominant among children. They had also had a BHS appointment within the past six months. The BHS informed them about the research and that I would be contacting them via phone. When I called to schedule the times and places for the interviews, I used a script so to facilitate communication.

The interview questions were formulated to draw information about participants' cultural experiences, as well as their opinions about health and health care, specifically their experiences with the behavioral health provider. Finally, they were asked their opinion about the impact of integrated care to the community. (See appendix A).

## **Data Collection**

The data collection methods used in this research followed the standards of a phenomenological study. Semi-structured interviews are a good form of data collection in a phenomenology study (Creswell, 1998). Semi-structured interviews guided the conversation with the participants, and participants were motivated to provide information that was important to them about the experience, although not necessarily reflected in the interview questions. During the individual interviews participants explored their meaning of the phenomenon in detail. They shared specific experiences, and their personal, family, and cultural beliefs as well as their perceptions in more depth (Smith, 1995).

The data from participants were collected using individual interviews in Spanish. Although participants were contacted over the phone, the interviews took place in person, in each participant's home. During the individual interviews participants provided an in-depth account of their experiences and perceptions around integrated health care.

The interviews were conducted in Spanish, and these were audio-recorded using a hand-held digital recorder with permission of the participants. These tapes were transcribed verbatim in Spanish then translated into English. Some notes were taken in order to assist in accuracy and transcriptions, and each participant was assigned a pseudonym in order to protect her identity. Written consent forms were stored in the participants' folders in my locked desk drawer.

Participants were asked their age, sex, marital status and the number of children they have, and country of origin. As all of the participants were born outside the United States, they were asked how many years they had lived in this county.

After the interviews were transcribed and translated, each participant was contacted by phone to review the results. Participants appeared pleased to speak with me, and all agreed with the reported responses.

### **Data Analysis**

The analysis used in this study was the constant comparative analysis method, a process of collecting data and comparing the emerging categories (Creswell, 1998). This method of data analysis involved continuous comparison of units of data to derive concepts and elements of the phenomenon, although the full and complete structure of the phenomenon was just beginning to emerge. “Phenomenological data analysis proceeds through the methodology of reduction, the analysis of specific statements and themes, and a search for all possible meaning” (Creswell, 1998, p. 52).

I used this data analysis technique because it allowed me to compare the data I was receiving from each participant on a consistent basis, and to use descriptive analysis to arrive at the most important themes that emerged from that data. Merriam (1995) and Strauss and Corbin (1998) saw the importance of this approach to analyzing qualitative data, which can be used for other approaches than grounded theory.

As I conducted the interviews, I sought to find saturation of the data. After the first seven participants were interviewed, it was clear that I was starting to hear some commonalities in their experiences. That said, differences in different areas of the experiences were also emerging. I continued to interview participants until I reached saturation when I had interviewed eighteen participants.

I familiarized myself with the data, a process that was facilitated by the use of a researcher’s journal. I read each transcript numerous times, examining each for

statements and patterns associated to the phenomenon. I highlighted similar words and phrases to track repetition. I also tracked terms, phrases and sentences used by participants with a particular meaning: emotions, thoughts, beliefs, behaviors, opinion, and action.

The next phase of my data analysis included grouping the tracked words, terms, and sentences into open codes. I then followed the interconnection of these categories and formed axial codes and grouped these into a higher level of abstraction referred as select codes to form each participant's "story" (Strauss & Corbin, 1998).

Categories were derived, making sense of commonalities and repetitiveness among discrete ideas developed during coding. I compromised the high level of abstraction to achieve conceptual density. Strauss and Corbin (1998) referred to the identification of categories through higher level of abstraction as the constant comparative analysis approach that is utilized to form main structures that hold the central phenomenon in phenomenological enquiry. I utilized this analytical approach to make sense of the experience reported by the participants, from the moment they contacted the clinic following their referral to see a BHS to the actual visit with the BHS, including their opinion and beliefs about the service before, during and after the experience.

### **Researcher's Journal**

I kept a research journal throughout the data collection and data analysis process. Immediately after each interview or set of interviews, I made a journal entry. The journal entries included notes on my perceptions of the participants and recollections of how they behaved and spoke during the interviews. These notes aided my analysis in that they

allowed me to recall the meaning of what participants said in the interviews and identify any distractions or comments I felt were important to the findings (Lincoln & Guba, 1985).

Another role of my journal was the recording of ongoing thoughts about conducting the interviews. Finally, I listened for emerging patterns and themes during the process of conducting interviews. Thoughts on patterns and themes to be investigated during the analysis process were recorded. Because a constant comparative analysis approach was utilized when transcripts were completed, the notes from my researcher's journal formed the basis for beginning the procedures.

### **Trustworthiness**

Trustworthiness measures are an important component of a qualitative research study. Lincoln and Guba (1985) and Creswell (2003) employed numerous procedures to establish trustworthiness.

**Reliability procedures.** Creswell (2003) simple reliability practices were utilized in this study: I double-checked the transcripts to find errors. The significance of codes was continually checked against the transcriptions to ensure that the significance remained continual. I also looked for both "negative and discrepant information that runs counter to the themes" in the study (Creswell, 2003, p. 192). There were no obvious discrepancies noted. Also, all notes and transcriptions were given a pseudonym and maintained in the participant's file to ensure each participant's information remained confidential, together, and there was no confusion concerning data between participants.

**Validity strategies.** Lincoln and Guba (1985) have proposed four important aspects of validity: credibility, transferability, dependability, and confirmability. All four of these were utilized to ensure the truthfulness of this study.

**Credibility.** According to Lincoln and Cuba (1985), credibility deals with the question “How congruent are the findings with reality?” For example, did the research follow well-established research methods, as done in this study, using phenomenology qualitative enquiry. *Familiarity with the culture of participating organizations* guarantees understanding of the field; I had been exposed to the field of integrated health care, for more than two years. This conveyed a *relationship of trust between the clinic, the participants, and the study, including myself in the role of researcher. The eighteen participants were given the opportunity to refuse to participate in the study, and they were assured that future visits to the clinic would not be affected if they did so. Frequent debriefing conversations were held between my academic adviser and methodologist to discuss the progress and initial responses from interviews; receive feedback around maintaining fidelity to the research as designed; and to gauge whether the research questions are going to elicit the best information about participants’ experiences. The background qualifications and experience of the investigator* are instrumental in qualitative research; my qualifications as a family therapist and experience as a Behavioral Health Specialist increased the credibility of the study. The researcher was also aware of the various gaps from previous research addressed in the literature review.

**Transferability.** According to Merriam (1995) transferability in preference to external validity is the extent to which the findings of one study can be applied to other situations. The necessary information to consider any attempts to transference is made according to Morrow (2005) provided in the current study:

1. *The number of organizations taking part in the study and where they are based: the two health clinics where the study took place.*
2. *Any restrictions in the type of people who*

*contributed data:* the eighteen participants in the study were first- generation Latina patients. Second and third-generation Latin-Americans were also contacted. Participants were chosen because of their cultural background, and all were over eighteen years of age.

3. *The number of participants involved in the fieldwork:* there was one researcher - myself.

4. *The data collection methods that were employed:* in-depth interviews. 5. *The number and length of the data collection sessions:* in the study each participant was interviewed once for approximately one hour. 6. *The time period over which the data was collected:* the data in the study was collected over a period of six months. 7. *Researcher's information about the self (the researcher as instrument):* the information about my qualifications and experience in the field of integrated care.

***Dependability.*** To show dependability of the study, I utilized an audit trail (Lincoln & Guba 1985). An audit trail was kept in the study; detail chronology of research activities, and processes influenced the data collection, and analysis. This allowed a researcher to examine all aspects of the research.

***Confirmability.*** This ensures that the participants' stories are told with as little researcher bias as possible. The researcher is the instrument of the investigation, to achieve conformability. I provided a personal reflexivity "Reflexivity is an attitude of attending systematically to the context of knowledge construction, especially to the effect of the researcher, at every step of the research process" (Cohen & Crabtree, 2006, para. 1). I kept an audit trail in which I described the steps in the development of the research proposal, data collection and analysis and write-ups. This was done through journaling about the process.

## **CHAPTER FOUR**

### **RESULTS**

#### **Overview**

The purpose of the study was to explore the experience of Latina patients with integrated care, including the factors that may contribute or affect patients' decision to follow up with a second or third visit for mental health services. This chapter will report the findings of the research, and it is divided into six parts, namely, 1) The history of the clinic where the study took place; 2) The mental health needs of patients attending appointments in the health clinic; 3) Information about the participants in the study, including demographics, socio-economic background, type of housing and previous experience with mental health services; 4) The study's results, including an exploration of the three main phenomenology structures; 5) Summary the findings of the study; and 6) Discussion about the specific experiences of the participants.

#### **Part One: History of Health Clinic**

This study took place at two health clinics in Northern Colorado. These clinics originated from one mobile clinic, which in the 1970s had provided services to farm workers in the area. In 1980, the health care providers acquired offices in a building on the east side of the city and created two separate clinics, one specializing in pediatrics and the other serving both children and adults. Since 2006, the clinics have provided integrated services (medical and behavioral - mental health services).

The clinics serve locals- living and working in the area, approximately 60% of whom are Latinos, and 42% of them are Spanish-speaking, first generation Latinos. Among the

Latinos and Latinas who visit the clinic, 20% work in fields and farms, while another 30% work in a local meat plant.

The pediatric clinic has four physicians on site from Monday through Friday, as well as 1.5 Behavioral Health Specialists. The Family clinic has a total of eight physicians and two Behavioral Health Specialists on a daily basis. At both clinics, the majority of medical, behavioral and administrative staff is bilingual and bicultural.

### **Part Two: Mental-Behavioral Health Problems in Health Care**

Since the days of the mobile clinic, Primary Care Providers (PCPs) noted that patients often shared their current life circumstances, including feelings of distress and other emotions, with medical staff during their physical examinations. The usual procedure was for the PCP to refer such patients to the nearest mental health community agency. However, they found that often times the patients would not utilize the referral; instead, they would continue to share their mental health needs during their medical visits.

The PCPs brought to the attention of the clinic's directors and stakeholders the tendency of patients to discuss mental health challenges, as well as the existence of psychosomatic illnesses, and the frequency of such reports made by patients. In 2006, the clinics' directors and managers noted that the number of such reports had increased since the year 2000. This increase would serve as the impetus for integrated health and behavioral services offered by the clinic.

In October 2006 the executive directors of the Local Health Alliance and clinical directors of the Multicultural Services from the local mental health agency co-located in one of the health clinics to launch a pilot program. For the next two years, two psychotherapists worked collaboratively with the medical staff, with documented success.

Medical staff reported that a high number of patients reporting mental and behavioral health problems during their medical visit were responding to the visits with the Behavioral Health Specialist; many had shown improved symptoms from the problem originally presented. Based on these reports, the integrated health care services became a permanent model of care, and the Behavioral Health Specialist (BHS) an embedded full-time member of the primary care team.

The process is as follows: the PCP assesses the situation (i.e. the patient's complaints of mental health-related issues), and with patient's consent makes the appropriate referral for mental-behavioral health services. The BHS begins with his/her own assessment of the patient, and then determines a course of action that may include brief mental-behavioral treatment to address psychosomatic and psychosocial aspects of primary care.

The BHS can be a psychiatrist, psychologist, family therapist, psychiatric nurse, counselor, or clinical social worker. He or she should be focused on prevention and patient education, and knowledgeable of general mental health approaches, such as CBT, attachment and trauma work, and strong knowledge in family and systemic matters.

In addition, the clinic's BHS should be action-oriented, solution-oriented, creative, and able to work independently and as part of a team. It is also critical that he/she be cultural respectful and proficient; this includes the ability to understand and address resistance or ambivalence to mental health treatment due to cultural influences.

### **Part Three: Participants**

The participants in the study were eighteen Latina females ranging from 23 to 54 years of age (ten of them between ages 30 and 40) who shared their personal experience with the integrated care services offered by the clinics. They were among the 40 patients I

contacted after they received mental-behavioral health services through the clinics' integrated care program. Twelve of the 18 participants in the study agreed to participate during the initial contact, while the other six were contacted up to three times before agreeing so. Once they did consent to be part of the study, all 18 participants were responsive and made them available to meet with me as their schedules permitted.

Sixteen of the participants also included the experience of their children in their testimonials. Eight participants gave testimonials of their children who had experienced integrated care. Of these children, the girls ranged from four to 12 years of age, and the boys ranged from seven to 15 years of age.

The 18 adult participants were born in Mexico and had been living in the United States from three to 20 years; 12 of them reported living in the U.S. between ten and 16 years. All of the participants spoke Spanish and received the integrated care services from the BHS in Spanish. I am a bilingual Spanish-English researcher; I have also worked as a BHS in the clinic, two years before the study.

There was a wide variation in levels of education reported by the participants, ranging from no formal schooling to college graduation. One participant had a bachelor's degree, another had an associate degree; six participants had completed high school; four had completed ninth grade; four completed sixth grade and one completed fifth grade. One participant reported that she had never attended school.

All of the interviews were conducted in the participants' homes, 12 of which were located in the city where the health clinics are located. The other six lived in rural and semi-rural areas in Northern Colorado. The types of housing varied, with five private homes, two townhouses, six private apartments, two apartments paid for by the

government, one farm-worker apartment supported by the United States Department of Agriculture USDA and three trailers. Sixteen of the 18 homes visited were clean and tidy, while two were rather untidy.

The responses of the 18 participants were analyzed using constant comparative analysis, from which three main themes emerged: the symptoms identified by doctors or by patients; the personal qualities and clinical approaches of the BHS during the various encounters with patients; and the outcomes of the second, third and subsequent visits to the clinics.

The participants' experiences with integrated healthcare were conveyed in a manner best described as storytelling. These stories begin the moment the women contacted or visited the clinic seeking treatment for themselves and/or their children and continue through the courses of treatment for their various medical concerns.

These concerns included yearly checkups, seasonal allergies, minor illnesses such as colds and flu, thyroid issues, and pap examinations. They also came to the clinic for help with depression. Participants most commonly brought their children in for vaccinations, treatment of cold and flu; asthma; and dentist visits. However, they also visited the clinic to discuss their child's behavior or the fact that he/she was overweight. Eight of the participants stated that they paid for services through Medicaid, while five utilized their private insurance and three paid out of pocket.

The participants' trust in the medical staff, particularly in the PCPs, was evident in their responses to the interview questions. The women reported sharing their personal and family problems during their medical visits, as well as over the phone when they called

the clinic requesting assistance beyond their physical needs. The PCP would then offer to schedule an appointment with the Behavioral Health Specialist.

Thirteen of the 18 women reported that prior to this appointment they had never visited a mental or behavioral health professional. Furthermore, they admitted to feeling ambivalent and even fearful about seeing a psychotherapist.

These feelings were rooted largely in preconceived notions about mental health and its treatment, which according to participants had been communicated to them via their families and the culture in their country of origin. This includes labels like “insane” or “nuts” along with the ideas that a person needing mental health care is unable to “function” in life. These notions even caused some families to think that their child could be found mentally ill, or have something “wrong in the head.”

Participants also talked about their health practices. These were mainly related to healthy eating, exercise and regular visits to the doctor. As for mental health practices, patients mentioned “talking with someone” or even “venting to a psychotherapist”; they also acknowledged that it was important to “keep a positive mind” and a “positive attitude in life.” That said, it should be noted that these comments were made during the interview, which occurred after their treatment with BHS, when their situation and presenting problem had improved.

#### **Part Four: Results**

**Phenomenology Structure 1: Patients’ Symptoms.** The circumstances and symptoms that led to the receipt of mental-behavioral health services by the participants and their children were identified during their visit with the Primary Care Provider.

The mothers' symptoms were self-reported, and were also noted during a medical assessment. One of the women reported that the doctor had assessed her daughter's health, then suggested seeing the BHS so the two could improve their relationship.

***Symptoms of Adult Women.*** The 18 patients were diagnosed by PCP and BHS as having mild to severe anxiety. Eight patients also reported specific symptoms.

Maria (personal communication, August 11, 2011) noted that, "The doctor said to me that I look sad...I was constantly nervous and restless."

Another participant, known as Ana, said, "I felt some pressure, emotional pressure, and stress... I felt overwhelmed...I didn't know what to do." She also recalled, "I was feeling too much stress on me, I could not breathe and so many problems were on me... I was not feeling well" (Ana, personal communication, August 12, 2011)

Margarita (personal communication, September 10, 2011) reported, "I am afraid to take medications...I have suffered from panic and fear when I had to take medication, I become really nervous," while Brenda said, "I was going through difficult times with the father of my children, we were constantly fighting" (Brenda, personal communication, September 18, 2011)

Victoria was feeling overwhelmed by grief. "I had lost my dad; I was feeling worse than I had ever felt before" (Victoria, personal communication, October 1, 11)

Letitia "was going through some problems, I was sad and depressed" (Leticia, personal communication, October 10, 2011), and Jenny admitted, "I felt sad, I cried much. I was having episodes of anxiety, I was concerned about my son's situation" (Jenny, personal communication, October 12, 2011)

“I was struggling,” Lucia said, “and felt overwhelmed” (Lucia, personal communication, November 1, 2011)

These symptoms, as reported by the eight participants, informed the diagnoses, including depression, anxiety, stress, panic and general anxiety-related problems. They also formed the bases for the treatment plan constructed by the PCP and the BHS.

***Boys’ symptoms (as reported by their mothers).*** Eleven mothers shared with the researcher the symptoms exhibited by their young sons. These mothers went with them to their doctors’ appointments and were present throughout. Most of the boys’ symptoms, including those reported by the mothers and identified by the PCP, were behavioral in nature.

Leticia expressed concern about her son, who “had become aggressive and angry all the time. He had not been listening to me and is fairly restless and anxious” (Leticia, personal communication, October 10, 2011)

Vanessa had a similar concern, “My son sometimes struggled to listen to me” (Vanessa, personal communication, November 5, 2011)

Angela’s son “was restless and out of control. From a very young age he was not easy to handle, he used to fight and get angry; he used to scream and get out of control; he would throw himself on the floor and hit his head on the wall” (Angela, personal communication, August 21, 2011)

Brenda originally brought her oldest son to treatment because, “he was being aggressive towards me, and towards his siblings.” She was later terrified to hear him tell the doctor that “he wanted to die” (Brenda, personal communication, September 18, 2011)

Teresa (personal communication, September 25, 2011) “had problems with my son’s behavior” She also noted that, “My son couldn’t breathe well,”

Norma reported that her son was overweight, while Jenny was concerned because her son had tested positive for marijuana. Deisy’s three-year-old son was afraid to go to the bathroom, while Linda’s son had speech difficulties.

These symptoms were among the factors considered by the PCPs when referring families to the BHS. During the subsequent clinical assessments, the main diagnoses were Attention Deficit Hyperactivity Disorder (ADHD), Post-Traumatic Stress Disorder (PTSD), substance-related disorders and anxiety, depression and trauma-related disorders.

***Girls’ symptoms (as reported by their mothers).*** While the participants’ sons often displayed aggressive or rebellious behavior, their daughters’ challenges, six of them described below, manifested in different ways that were nonetheless very upsetting to their mothers.

My younger daughter seemed anxious and was wetting her pants. Her older sister had started school and was leaving the house every day. The little one felt alone without her sister. Doctor said this could be a little bit of depression. (Isabel, personal communication, August 25, 2011)

“Margarita’s daughter was told, “she needs to lose weight or her thyroid could be affected and her diabetes becomes more severe” (Margarita, September 10, 2011)

Maricela’s twelve-year-old daughter was referred to the BHS after going for her physical exam:

When the doctor tried to check her private parts, my daughter refused; she did not let the doctor touch her there. The doctor made her own conclusions, she thought that my

daughter may have experienced some type of abuse and that was why she was tense.

(Maricela, personal communication, September 14, 2011)

Daniela reported that her daughter “was making sounds with her teeth at nighttime”

(Daniela, personal communication, October 20, 2011)

Vanesa was concerned because her “daughter was misbehaving and not listening”

(Vanessa, personal communication, October 5, 2011)

After learning of these symptoms, whether reported by the girls or their mothers or through their own observations, the PCPs referred the girls and their families to the BHC. Despite the different behaviors exhibited by the boys and girls, the diagnoses were nearly identical, for example, Post-Traumatic Stress Disorder (PTSD) and, anxiety, depression and trauma-related disorders.

During their interviews with me, parents discussed the above symptoms at length and how they led them to either ask the PCP for help or accept the PCP’s suggestion that they go to a psychotherapist. Ten parents reported not knowing what to do about the behavior problem and symptoms presented by their children. Subsequent visits with the BHC yielded additional information about the symptoms and their origin. For the most part, they were rooted in the family dynamic, including trauma resulting from unhealthy early attachment, and adult attachment. These also reported traumas such as domestic violence, abandonment, unresolved losses, grief and loss, stress due to financial difficulty, immigration and lack of support.

To address these issues, the Integrated Health Program combined diagnosis-centered, child-centered and parenting-focused and Cognitive Behavioral Therapy treatments, including, medication and one-on-one therapy, as well as family therapy, with

either the entire group or specific members taking part in a session. The Program also offered specialized treatment mothers, mainly through individual work with the BHC.

***Services Offered By Doctor and Services Requested By Patients.*** The narrative of the participants' experience stressed a connection between the identified symptoms and the recommendation of BHC services. Thirteen of the eighteen participants in the study reported that the mental health services with the BHS had been offered by the doctor during their medical visit, without the participant having to request them. When asked about this, participants used various words to describe the way such services were offered to them by the clinic's medical staff. After reviewing the transcripts, the researcher decided it was prudent to group the services offered by PCP into three categories: offered, recommended, and referred.

***PCP Offered BHS Services.*** Participants who stated that the doctor "offered" the BHS services felt that the doctor was informing them that the services were available and accessible to them. They also said that it was an optional service.

As Maria (personal communication, August 11, 2011) stated:

The doctor said to me that I looked sad. She told me about some people who could help me [BHS staff]. She said that they have helped others and could advise me according to my need. She said if I wanted she would call one of them to come into the exam room and we could talk.

When Cecilia stated that she was worried about her son, "they [the doctors] offered counseling services to me. I wanted to get help for him... I didn't know what else to do" (Cecilia, personal communication, August 8, 2011)

“The doctor said that she [my daughter] needed to lose weight, and she needed to see a counselor for that. The doctor asked me if I wanted to see her [counselor]. They gave me the option” (Margarita, personal communication, September 9, 2011)

As mentioned earlier, the physicians at the Integrated Healthcare Program showed concern about the individual patient’s situation and feelings, and offered specialized support without imposing such service upon them.

These statements demonstrate the fact that mental health services were offered, but optional. In doing so, they allowed the participant to think and consider the offer, under no obligation to accept.

***PCP Recommended BHS Services.*** In some cases, the primary care provider went beyond simply informing participants about BHS services and “suggested” that they utilize them, for themselves and/or their children. That said, these services were still presented as “optional.” Similarly, four participants reported that BHS service was “recommended” as a specialized support for issues noted during the medical exam.

Ana noted, “The doctor suggested to me seeing the therapist in the clinic, because my son was restless through the visit. They asked me if I wanted to talk with a therapist” (Ana, personal communication, August 12, 2011)

Maricela recalled that, “She [the doctor] recommended the psychologist to visit us. The doctor said that she wanted for my daughter to speak with a counselor” (Maricela, personal communication, September 14, 2011)

For other participants, the recommendation was a bit vaguer.

Deisy said, “The doctor said that we needed to see the psychologist,”

While Lucia stated simply, “The doctor gave me the option of seeing a psychologist” (Deisy, October 24, 2011)

In Vanesa’s case, the physician felt that it would be prudent to get a second opinion.

“Doctor said that for a more accurate advice she recommended us to see a psychologist” (Vanessa, personal communication, October 5, 2011)

These statements demonstrate the fact that mental health services were advised, but optional. In doing so, they allowed the participant to remain in control of her health care.

***PCP Referred Patients to BHS Services.*** Four participants reported that their doctor “referred” them to BHS after learning about their situation. Furthermore, these participants reported that that they appreciated the option to follow up with the BHC.

“I spoke with the doctor,” Brenda said, “and the doctor told me that she would refer me to the therapist” (Brenda, personal communication, September 18, 2011)

Victoria recalled, “I went to see the doctor to be checked up and he determined that I was physically fine, but the issue was depression. He referred me to a therapist” (Victoria, personal communication, October 10, 2011)

Norma said, “The doctor referred me to the psychologist. I was told that he [son] had problems with weight and that I needed to see a psychologist, to see, in case he had a problem like depression or something of that type” (Norma, personal communication October 5, 2011)

Linda was also concerned about her child and, “The doctor at the pediatrics” clinic referred us to the psychologist” (Linda, personal communication, October 26, 2011)

***Patients' Seeking Services.*** While the majority of the participants in the study reported that the PCP made the recommendation of BHS services during their medical examination, others reported that they contacted the health clinic to support their mental or behavioral issues. This supports the researcher's observation regarding the trust that patients have in the clinic and its medical staff.

In fact, seventeen of the eighteen participants reported that they decided to ask for their advice and guidance. Of these, five participants contacted the clinic to ask for help with their children's behavior.

Isabel recalled:

I rushed to the clinic because someone told me that she probably presented symptoms of abuse. The doctor said there was no abuse and said there was nothing physically wrong, but she was depressed and felt alone without her sister. That was the counselor to whom we were referred to by the doctor. (Isabel, personal communication, August 25, 2011)

Teresa had different but similarly supportive experience. "I confided with my friend who is the event organizer, I told her that I had problems with my son's behavior. The health event organizer introduced therapist" (Teresa, personal communication, September 25, 2011)

Leticia first sought help for herself, then her child. "Second time experiencing seeing a therapist, I asked for help and asked for the counselor to help my son" (Leticia, personal communication, October 10, 2011)

Like the others Jenny decided to engage BHS services on behalf of her child. "I had been introduced to the counselor earlier, and I was told that she helped children and

adolescents with problems. I decided to seek for the help from the counselor” (Jenny, personal communication, October 12, 2011)

Daniela was guided to the right person for her family.

I called the clinic, or well, I was not sure if I should call the clinic or call the dentist. I did not know if I should call her doctor or her dentist, because it was about her teeth. But I thought that the doctor will know if I needed to be referred to the dentist or what to do, and from there they referred me with the psychologist.

(Daniela, personal communication, October 20, 2011)

The above statements illustrate the level of trust participants had for the medical staff at the clinic, even to the extent that they sought care for their children. Some patients were not sure what kind of help they needed, but they clearly believed the staff would advise them properly.

One participant, Angela, reported feelings of despair about her son’s uncontrollable behavior. In fact, she had received notice from his school threatening to expel him if things did not improve.

“I was desperate...for an appointment with the doctor,” she said. “I explained the situation over the phone and was given the number of the psychologist. The doctor suggested over the phone that I needed to take my son to see this counselor” (Angela, personal communication, August 21, 2011)

***Patient’s Trust in PCP.*** They shared their personal and family matters during their visit to the PCP and reported that medical staff supported them around parental concerns and overall family dysfunction.

Three participants reported a variety of problems to the doctor during their appointment.

Brenda brought her daughter to the clinic and was surprised by how perceptive the doctor was.

I spoke with the doctor, who was checking my daughter about family matters, and I reported that my oldest son was acting aggressive. I reported with the doctor because she noticed that I was not behaving and responding the same ways I usually respond and behave when I go to the clinic. She asked me if I had any problems.

(Brenda, personal communication, September 18, 2011)

Jenny developed trust with the clinic staff over a long period of time.

I have been taking my children to the clinic for about eleven years; I have always taken my children there, to the doctor. I feel that he is like a friend. I had already met the counselor and we greeted (each other) at the clinic when we saw each other... I felt that there I could find the manner, the advice from someone, someone to tell me what steps to take, what needs to follow now that (my son) had already given a positive drug test, now we needed to know... what to do. (Jenny, personal communication, October 12, 2011)

Linda also expressed great trust in the staff.

Doctors make us feel comfortable and we trust them... they take care of us not only in the physical part but also about feelings, behavior, and our children...our concerns. The doctor has helped me much and she seemed pleased to be helping me, as well as truly caring about my wellbeing and the wellbeing of the children.

(Linda, personal communication, October 26, 2011)

Perhaps the greatest evidence of the patients' trust in the clinical staff was their willingness to follow their doctors' recommendation and accept the BHS services.

"If the doctor is the one making the recommendation," Leticia said, "and says, 'You need help, ask for help, and we have the help here,' ... sometimes we listen to the doctor more than to others... We listen to our doctor" (Leticia, personal communication, October 10, 2011)

Maria (Maria, personal communication, August 11, 2011) stated that she: initially accepted to talk with a therapist because the doctor suggested so. [The doctor] told me about some people who could help me. She said that this person could advise me according to my need, and if I wanted she [doctor] could call this person to come into the exam room and we could talk, if I wished so... I said yes and the doctor called her [BHC-Psychotherapist].

Ana recalled:

I've taken my son to that clinic since he was a baby, I trust them there. Due to my son's behavior the doctor suggested to see the therapist, they asked me if I wanted to talk with a therapist; I made the decision and said yes. (Ana, personal communication, August 12, 2011)

Maricela was undecided about receiving BHS services, but was willing to try it based on her doctor's recommendation. "I thought, well let's see what comes out of this... Let's see how she can help us" (Maricela, personal communication, September 14, 2011)

Victoria recalled:

"[I] had lost my father and needed support when I met with the therapist during my pediatric visit with my daughter. I felt as if nobody cared about what happened to me. The

doctor suggested getting help from counselor” (Victoria, personal communication, October 10, 2011)

It is clear from these testimonials that the participants accepted the doctor’s recommendation, even if they had not initially sought out mental health services. Some, like Maricela, expressed doubt about whether these services could improve their situation. One participant had had a negative experience in therapy more than a year earlier. Others were ambivalent because of the stigma around mental health in their home countries.

“When the doctor told me that we needed to see a counselor, I thought it was going to be the same thing I had heard when I was in Mexico,” Maricela said, “At the beginning I was afraid and after a while I said: I need to do this and not think much about it. I used to be afraid of them [psychologists], but when I started to get to know this psychologist I stopped being afraid of them” (Maricela, personal communication, September 14, 2011)

Teresa expressed similar reservations. “I felt strange, well the fact of going to see a psychologist. We are not used to going to see a psychologist, but if the doctor sent us it was for a reason” (Teresa, personal communication, September 25, 2011)

Despite their concerns, the participants’ statements reveal that their trust in the medical doctors exceeded their fear, ambivalence, and misconceptions about mental health.

An even greater indication of the trust participants had for their physician was that they requested mental health services for their children.

Ana “mentioned to the doctor if I could also get help for my feelings and for me. The doctor said yes, and also said that I could open up with therapist.” She stated how easy it was to talk to her doctors, and then added, “I thought that if they gave me the option it

(psychiatric services) was going to be something good. The doctor said that it should be ok and also said to not be afraid” (Ana, [personal communication, August 12, 2011])

“We went there [the clinic] to see the doctor with a problem,” Isabel said, “I trust them” (Isabel, personal communication, August 25, 2011)

Cecilia recalled that “I wanted help for my child, he needed help... I didn’t know what else to do” (Cecilia, personal communications, August 8, 2011)

Norma approached the topic of mental health services during her child’s wellness visit. “I told the doctor about my son’s behavior. I asked for an appointment with BHS” (Norma, personal communication, October 5, 2011) “I already knew about the program and that made me feel that I could trust...” Deisy said, “...I talked to the doctor about my children, and she helped me talk with the counselor...and when I met the [psychotherapist] I liked [her]. It made me think that she was an excellent person to work with my son” (Deisy, personal communication, October 24, 2011)

These statements reveal a relationship with the medical staff based on trust and reliance that empowered them to ask about mental health services. Some requested services with BHS because they had heard about the program, while others felt comfortable asking their doctors for additional assistance.

***Building Trust with BHS.*** As mentioned above, the trust participants had in their primary care provider was a key factor in their decision to accept the recommended mental health services. That said, these women still had to build a new relationship with the BHS, independent of the one they had with the PCP.

The doctor asked if I wanted to get someone for me to talk with she can get someone for me to talk with, and I said yes. It only takes a couple of minutes to

listen to the counselor to decide whether we want to talk or not. We must feel comfortable before we can feel confident to talk and trust our personal matters.

(Maria, personal communication, August 11, 2011)

Ana (personal communication, August 12, 2011) had this to say of her meeting with the BHS:

I wanted to listen to her and to get to know her, and see what that was about. I felt emotionally pressured and stressed out. I felt overwhelmed. I didn't know what to do. I talked with her because I felt comfortable and I trusted her.

Angela (personal communication, August 21, 2011) described her experience with both the BHS and a psychiatrist:

When I called the clinic they got me an appointment with this person [BHS]. I thought that if they gave me the option it was going to be something good.... (On seeking the psychiatrist) The therapist explained things really well, and she told me all the pros and the cons, she said that I could try and see and if this did not work or you did not feel okay things could stop.

Maricela (personal communication, September 14, 2011) also felt positive anticipation about her appointment with the BHS:

When the counselor called me to make the appointment I was already feeling more relieved, and I trusted in the process, I was ok, and I was in the disposition to receive any type of help, and yes, there was nothing found to do with any abuse.

I was hoping that someone helped my son, I was concerned about my son doing something really bad...(pause) I was concerned about the situation with him

getting worse if he did not get treated or if he is not given the right help in that moment. (Brenda, personal communication, September 18, 2011)

Norma viewed her mental health treatment in the context of the overall care she received at the clinic. “Depending our level of trust in the doctor is our confidence in the therapist” (Norma, personal communication, October 5, 2011)

“During earlier visit with baby for doctor’s checkup” Leticia (personal communication, October 10, 2011) recalled, “I was introduced to psychotherapist, and I talked with her. This time, I requested services with psychotherapist,” while Daniela noted, “I felt strange, well the fact of going to see a psychologist; we are not used to go to see a psychologist” (Daniela, personal communication, October 20, 2011)

For Deisy, the idea of mental health care was not new. “The doctor said that we needed to see a psychotherapist in the clinic, I already had experience in therapy, it helped” (Deisy, personal communication, October 24, 2011)

The same was true for Linda, “I felt good about that idea because in the past I had already taken my son to see a psychologist when he was younger” (Linda, personal communication, October 26, 2011)

Lucia was also amenable to mental health treatment. “Doctor made the recommendation to see psychologist, and gave us the option; I thought it was a good idea” (Lucia, personal communication, November 1, 2011)

The common theme among the accounts in this section was acceptance of BHS services. Some patients reported feeling good about the idea, other said that she felt hopeful. The opposite effect was also reported here: one patient reported to have felt strange before the idea of seeing a psychotherapist. It was also reported in one statement

that the doctor presented it as an optional decision. Participant ten, reported to have lost her father and the psychotherapist became an appropriate support, therefore the acceptance of specialized service offered by the medical provider.

The initial experience with mental healthcare took various forms. In some cases, the BHS staff came to the examination room as part of the medical visit and did an assessment to their situation and possibly determines their need for additional appointments. These appointments either took place that day in the therapy room or were scheduled for a different days. In other cases, the participants, after being referred by medical staff, called back and made an appointment with BHS staff over the phone.

Some participants reported that their PCP had called BHS into the exam room, during a medical appointment. As noted earlier, some participants reported their situation to their doctor who then mentioned BHS; others were referred to services after the doctor noticed their discomfort, anxiety around their situation or that of their children.

Maria (personal communication, August 11, 2011) stated that, “The psychologist came to the room. She introduced herself to me in a nice manner, she was nice, she asked me questions and I vented with her all my distress” while Margarita’s doctor saw a connection between her physical condition and possible underlying emotional causes.

“The doctor reported concern about the illnesses that come with overweight,” she said. They [medical staff] sent me to see her [therapist]. The same day I met with the counselor in the exam room” (Margarita, personal communication, September 10, 2011)

For others, like Brenda, the clinic provided immediate services for children experiencing symptoms of emotional distress:

I spoke with the doctor, who was checking my daughter, about family matters, and I reported that my oldest son was acting aggressive. That service was immediate, they called the therapist and she... visited us the same day. The doctor told me to wait in the exam room while she spoke with the therapist, and that's when the therapist came to see us... The therapist took my son with her for a while. (Brenda, personal communication, September 18, 2011)

Leticia recounted a similar initial experience with BHS:

The first time, the doctor told me that she will talk with the counselor...the counselor arrived to the exam-room and we talked. The second time, she [the BHC] took me to another room when she spoke with me. I felt more confident because I already knew her [therapist], I had already spoken with her; that made me feel good. (Leticia, personal communication, October 10, 2011)

The BHS also made Jenny (personal communication, October 12, 2011) feel more comfortable about receiving services. "The counselor came to the exam room...she introduced herself and she told me that she was there to help and support me if I ever needed support with the behavior or feeling of any of my children, or myself."

These testimonials demonstrate the efficiency and immediacy with which primary care providers and BHS delivered initial mental health services. In each case, the participant visited the clinic for a medical clinic, then either told the PCP about their non-medical symptoms (or those of their children), or exhibited symptoms that prompted the PCP to offer BHS services. The BHS then came to the exam room to conduct the first clinical assessment. One participant reported that the PCP asked her to wait for BHS in exam

room, while others stated that they were asked whether they wanted to see the BHS before calling the BHS into the exam room.

Several participants reported that after talking with PCP about their problem, they or their child were transferred to BHS office, where they further talked about their difficulties.

Ana recalls, "The same day I met with the therapist we talked about my needs, my matters, and she then gave me a follow up appointment" (Ana, personal communication, August 12, 2011)

Isabel stated that, "We went to see the doctor with a problem, I trusted them. The doctor said there was nothing physically wrong but she was depressed and referred us to doctor" (Isabel, personal communication, August 25, 2011)

Maricela had a similar experience regarding her daughter:

Doctor said that she wanted my daughter to speak with a counselor, that is why they sent us to see the counselor to check things out and the counselor said that everything was okay, but we are still going to see her to talk about the fights that she has with her sister. (Maricela, personal communication, September 14, 2011)

Other participants reported that, pursuant to a referral, they made an appointment with the BHS for a later date, usually because the therapist was booked for that particular day. The point is that the primary care provider created the initial connection with BHS after he/she determined that this was the appropriate treatment for that particular participant and/or her children. The only exception was Teresa, who as mentioned earlier was introduced to a therapist by a friend who worked as the event organizer for the Health Department.

“I told her that I had problems with my son’s behavior. My friend introduced the therapist and me. Then we made the appointment for the following week” (Teresa, personal communication, September 25, 2011)

Whether the appointment with BHS took place the same day as the medical exam or on another date, the participants revealed a desire on the part of the PCP and BHS to provide support. In several cases the primary care provider suggested that the therapist would be able to help; the caring demeanor of the BHS reinforced this.

***Participants’ Experience with BHS.*** Thirteen of the 18 participants in the study said that attending services with BHC exposed them to seeing a therapist for the first time.

Nine participants reported to had never experienced seeing a psychotherapist before this experience. Maria, Ana, Angela, Isabel, Cecilia, Maricela. Norma, Linda, and Vanesa said that they I had heard about psychotherapy, but they had never seeing a counselor before.

Four participants – Margarita, Brenda, Daniela and Lucia – stated that their experience with the BHS was their first time “in therapy” or “first time seeing a psychotherapist.” However, they did not say they had never heard of a psychotherapist before.

These two similar statements reported by participants differed in the wording used by them, on what they responded about their experience seeing the BHS being the first seeing a psychotherapist or not. Nine of them conveyed that this had been their first time seeing a therapist, however they had heard about psychotherapy before. Four participants stated that this was their first time in therapy, and they had never seen a therapist.

Some, like Theresa, had had one appointment with a therapist in the past, while others, like Leticia, had had at least one follow-up visit with the same therapist.

When asked about previous experiences, participants' responses seemed to indicate that they were not particularly helpful.

I had been in counseling with my seven-year-old daughter. She used to cry much... She is getting speech therapy; I went with her since she was little... the counselor worked with her and a few other people. She gave me advice to help my daughter, and it did help much, I went once to counseling, my daughter was four when I took her there. My daughter had fear, she was afraid of staying alone. (Jenny, personal communication, October 12, 2001)

Another participant, Victoria, simply stated that the "first experience with therapist was not positive; second experience (with different BHS therapist) was a really positive experience" (Victoria, personal communication, October 10, 2011)

Regardless of the quality of the experience, all the participants who reported their visit with BHS as their first time seeing a psychotherapist expressed initial fear, doubt and guilt around taking their children for mental health services. However, some participants stated that they felt more comfortable after meeting with the BHS.

I felt nervous when I was told about the counselor...I thought that the counselor might... have doubts about me abusing my daughter. I was afraid at the beginning! I know people, who make some mistakes with the care of their children, and even their intention is not bad, they are just so busy working so they can provide for their family and give the best to their children, but they end up getting in trouble. (Isabel, personal communication, August 25, 2011)

Margarita's apprehension had more to do with what she had heard from others. "I used to be afraid of them. Because of the bad reputation, the negative things that are said about psychologists, I was so afraid of going to see a psychologist." However, she was able to overcome these fears based on her trust of the primary care provider. "When the doctor told me that we needed to see a counselor, at the beginning I was afraid and after a while I said, I need to do this and not think much about it" (Margarita, personal communication, September 10, 2011)

Others were worried on the effect seeing a therapist would have on their children.

"I was afraid to be talking to a counselor," Maricela said, "it was talking with someone I don't know, not knowing the counselor, and also not knowing about how my daughter thinks" (Maricela, personal communication, September 14, 2011)

The core theme amongst participants was fear of the unknown. As Daniela said, "I was very nervous because I did not know what we were going to do" (Daniela, personal communicator, October 20, 2011)

These statements reveal the underlying and pervasive fear experienced by the participants after being referred to a mental health specialist. This fear was largely based on negative stereotypes about psychotherapy; participants also appeared worried about being judged and how their children would feel about seeing a therapist.

Brenda summed up these feelings:

When we were told that my son had to see a psychiatrist, I remembered I had a cousin who had psychiatric problems... her nerves...she was seeing a psychiatrist, She ended in a psychiatric inpatient institution...She was a nun, she did not want to be a nun, her parents forced her into that, and I thought no, my son will be put in a

hospital! My mom used to tell us about the treatment that my cousin was going through in the psychiatric hospital... and all of that came to my mind, and I thought that my son was going to, I thought of my cousin and what she went through and I prayed to God because I imagined that he will be treated in a similar manner as my cousin, and I thought to myself: oh no they will do things to my son and no I don't want that... And I then thought, well, I will take my son to see this doctor and we will see what he makes us feel... (Brenda, September 18, 2011)

This statement illustrates the extreme anxiety based on things they had heard about mental-behavioral health services, namely, that the person had severe problems or was “crazy” and would be at the mercy of institutions. Others admitted to a lack of confidence about interacting with the therapist.

Ana said, ““In the beginning she asked me many questions... I was not sure what to think. This was new to me” (personal communication, August 12, 2011)

Angela had similar concerns:

At the beginning I felt bad because I thought what if I am bringing my son here and maybe this is for children who are mentally ill or insane... I thought that my son had issues and problematic behavior, but he was not mentally ill. Before seeing a psychiatrist: I thought that a psychiatrist doctor did not seem a good idea, I was not happy and was not sure. (Angela, personal communication, August 21, 2011)

Maricela (personal communication, September 14, 2001) “first started to feel doubtful, thinking that there was something wrong,” while Daniela (personal communication, October 20, 2011) “felt strange. Well, the fact of going to see a psychologist; we are not used to [it]...”

Vanessa also had concerns at first, stating:

Negative stigma about seeing a mental health clinician gives doubts, but it was good. My daughter said that she was not mentally ill...I was concerned because I had never seen a counselor, I felt unsure, I was not sure how things would be at the beginning, I was a little puzzled. (Vanessa, personal communication, September 25, 2011)

This uncertainty was also experienced by Cecilia, "I had no idea, I did not know anything, I didn't know if it was good or bad. I used to think that they did not help. Maybe some doubts were there" (Cecilia, personal communication, August 8, 2011)

Margarita admitted to feeling "sad" when the doctor told her to see a counselor because he was concerned about the behavioral health of her daughter" (Margarita, personal communication, September 10, 2011)

These reports show a lack of knowledge about what mental-behavioral health services entail and worry and sadness about the possibility that something is wrong with their children.

On the other hand, six participants reported no initial misgivings when referred to the BHS by their medical provider.

Brenda stated, "I had no fear or doubt about seeing BHS;" in fact, she had requested the services" (Brenda, personal communication, September 18, 2011)

Teresa said, "I was not nervous because she was introduced to psychologist by a friend whom I trust" (Teresa, personal communication, September 25, 2011)

Leticia (personal communication, October 20, 2011) "requested services directly with the psychotherapist" and "had already been greeted by psychotherapist during previous clinic visits. I think this helped me, I knew more or less what to expect," and Deisy

said, “had seen another therapist three years ago, this help making it easier” (Deisy, October 24, 2011)

The above statements show that when participants knew what to expect or trusted the doctor or friends’ recommendation, they felt less fear about receiving mental health service. Most of all, participants felt more comfortable about seeing the BHS when they had sought out the services themselves.

***Barriers to Access Health and Mental Health Services.*** During the course of this study several the researcher perceived several barriers to mental-behavioral health services with regard to Latinas, including fear, lack of knowledge, previous experience, stigma and preconceived notions about seeing a psychologist. A lack of means to pay for such services was also a problem for ten participants.

Isabel (personal communication, August 25, 2011) stated, “It is hard for most people to pay for appointment, for therapy session or therapist... And for medication” while Brenda (personal communication, September 18, 2011) cited “not having Medicaid or national health care insurance” as a reason for not seeking services. Similarly, Teresa was concerned with “not being able to pay, not having Medicaid, too expensive” (Teresa, personal communication, September 25, 2011)

Other participants indicated that they were unaware that psychotherapy was offered at the health clinic. They also stated that they found it difficult to place trust in a stranger, that being the mental health provider.

According to Maria, “Some people will not want to talk or listen to someone they don’t know. Many people say that they don’t want to talk to a stranger about their

problems. We sometimes feel afraid about making appointments” (Maria, personal communication, August 11, 2011),

Similarly, Ana felt that, “People do not commonly ask for help when they feel that their emotions or the way they feel is not okay... I did not believe in mental health as the help for me or for what I needed. I did not think I could visit a therapist or psychologist” (Ana, personal communication, August 12, 2011)

Two of these testimonials reflect the lack of trust in therapy. The therapist is a stranger and some people find hard to open up about their personal matters. The third testimonial demonstrates the lack of awareness that therapy is even available in the health clinic.

Participants mentioned a predisposition, negative opinion or misunderstanding about mental health as the barriers to access this service.

Angela said, “I think it would be difficult for them [people] to call for help” (Angela, personal communication, August 21, 2011), also “It may not be easy because of predisposition to mental health”

Isabel voiced even graver concerns:

I originally did not think okay about them [psychotherapists], I thought that they instead of helping they will try to take our children away. In many occasions I have known about the same counselors trying to take children away from their parents. (Isabel, personal communication, August 25, 2011)

Margarita (personal communication, September 10, 2011) stated that “the negative things that are said about psychologists” were the reason for her fear, while Norma cited,

“Not having an understanding about mental health” (Norma, personal communication, October 5, 2011)

“People don’t know. I never knew about psychological health” (Leticia, personal communication, October 10, 2011)

Lucia noted the negative opinion about psychotherapy, while Victoria said, “I knew that psychology existed, but that was all, and about mental health I knew nothing” (Victoria, personal communication, October 10, 2011)

These testimonials portray the negative opinion that many people hold about mental health and mental health services engulfed by parents and their own culture. The negative reputation, and the misunderstanding about mental health providers trying to take children away from parents; are the portrayed barriers to access mental health services.

Two participants referred to fear, and not knowing how to start a conversation about personal matters as the barriers to accessing services.

“It is difficult to contact services on our on... It is difficult how to say things... (pause) how to make sense of what is happening” (Cecilia, personal communication, August 8, 2011)

“It’s not common for me to make appointments with psychotherapists or psychologists. I don’t think I would have ever made an appointment by myself, without the doctor’s guidance” (Daniela, personal communication, October 20, 2011)

Both of these testimonials mentioned the element of difficulty, making an appointment to see a BHS (psychotherapist or psychologist), and also the beginning of a conversation with a BHS as the main barriers to access the services.

**Health, and Being Healthy.** As part of the study, participants were asked to share their definition about what it means to be healthy, as what as one can do to enhance one's health. Their responses were quite varied and usually involved a combination of physical, mental and emotional components.

Ana, for example, defined health as, "Not to be ill. To be strong and with energy." (Ana, personal communication, August 12, 2011) Angela (personal communication, August 21, 2011) described health as, "When the child is healthy, active, attending school, makes friends and is nice to the teachers" Also, "Being active and illness-free. It is about not being sick. People refer to health when they are healthy and with energy. When people are not visiting the doctor and they are content"

Isabel also noted the connection between physical wellness and emotional state:

To be content, to have energy... because if we are not well... Like with a headache and we feel that the whole day is dark or the whole day is sad... But if we feel well, the days go fast and in a good way... It is not to be in pain or not to be chronically ill of anything... So they can go to work...If they can move they feel that they are healthy. There are people who may be sad, depressed... But because they can move, their feet don't hurt, their hand does not hurt, they feel they are healthy now... If people are still able to move...They are okay (Isabel, personal communication, August 25, 2011)

Similarly, Margarita (personal communication, September 10, 2011) stated that, "Health is being well, at peace and relaxed. I feel well, relaxed content...at peace and comfortable with myself... Nothing worries me."

Maricela (personal communication, September 14, 2001) focused on the physical  
“To have energy, no pain, good hearing, good vision, and strong bones”

“Not to be sick,” Teresa said, smiling, “...in general, mind and body, to be healthy”  
(Teresa, personal communication, August 25, 2011)

To Victoria (personal communication, October 10, 2011), health means, “To be well,  
and to be healthy was to feel well. When there is no pain, when the person is active and has  
a positive mind and positive thoughts”

Jenny (personal communication, October 12, 2011) stated health is, “To have no  
pain and no problem. To feel well. To be able to do house chores. When we are well we  
are happy, we engage in different activities, we can play music, we can eat”

Vanessa’s definition of health was simple: “Feeling good about oneself” (Vanessa,  
personal communication, October 5, 2011)

Other participants referred to their own role in maintaining health. Ana (personal  
communication, August 12, 2011) spoke about the need “to take care of yourself. We do  
not fall sick; we can work and be functional”

On the other hand, two participants stated that they prefer not to speak about  
health. This, they said was an attitude learned through their families and cultural  
backgrounds.

Cecilia (personal communication, August 8, 2011) stated that, “Where I come from  
they don’t want to see a doctor, they want to take care of their issues by themselves” while  
Margarita recalled, “My mom did not talk about illness. I recently found out that neither my  
siblings nor I have been vaccinated. My parents did not like to see us cry when vaccinated.  
Thank God that we did not get sick” (Margarita, personal communication, August 8, 2011)

She also went on to say that Latinos when are ill and go to the doctor they expected to be medicated. If they are not, they feel it was a waste. ‘They will get a big bill and the doctor did not even give an aspirin’ (Margarita, personal communication, September 10, 2011)

***Healthcare Practices and Prevention.*** In order to fully understand Latinos’ experience with integrated healthcare, it was necessary to determine their overall approach to healthcare; this includes the periods of time *between* visits to the clinic. When asked what practices they follow in order to prevent health problems, several participants said they frequently went to the doctor for checkups, while others said they usually went to the doctor only when they were not feeling well.

One participant, Victoria, stated that she became proactive about healthcare after losing her parents. She attributed their premature deaths in part due to their irregular doctor visits.

I don’t want to suffer what my dad and my mom suffered. To go and see the doctor when I am not feeling well is important because we are not exempt from getting sick or suffering an illness... in case there is something that is happening to me I would not like to not treat it on time because I am not seeing the doctor. My mom was too young... and my dad was sixty-four years of age, and I think that he was also taken away too early, but this was because he did not get treated for colon cancer on time. (Victoria, personal communication, October 10, 2011)

The testimonials include the element of visiting the doctor, whether it is to check their blood sugar levels, when they are ill or feeling unwell, to get their children vaccinations, or for physical examinations.

**Nutrition.** Several participants also discussed other behaviors around maintaining good health, including being mindful about what they eat and what they feed their children. For example, Maria (personal communication, August 11, 2011) mentioned, “Eating vegetables, drink boiled water” while Isabel (personal communication, August 25, 2011) stated that “I am trying not to eat much junk food”

To Jenny, “eating homemade meals” was important, “as well as not eating much pork or beef, using whole meal products, using olive oil” (Jenny, personal communication, October 12, 2011)

Others, like Ana, acknowledged that lowering stress is also important to health. “Eating well, doing exercise, sleep good, eat vegetables and also... To feel relaxed and at peace” (Ana, personal communication, August 12, 2011)

**Exercising.** In addition to eating healthy and getting enough sleep, several participants also stated that they stayed active in order to prevent health problems. This included a combination of cardiovascular and other kinds of exercise, as well as joining a sport.

“Exercising every morning,” Angela said while showing the interviewer an exercise DVD (Angela, personal communication, August 21, 2011) Isabel also indicated that she made exercise a priority despite her busy schedule, “I walk! I walk indoors; I have to take care of my child and cannot take her out... It is half hour every morning” (Isabel, personal communication, August 25, 2011)

Margarita’s regime included “exercising, taking medication and vitamins. Vitamins are good nutrition” (personal communication, September 10, 2011), while Victoria

(personal communication, October 10, 2011) acknowledged that “feeling positive” was also important to staying healthy.

Two participants stated that maintaining their health was not a part of their regular routine. They do not visit a doctor for checkups; nor do they exercise. Instead, they visit the clinic as a last resort and when they are experiencing symptoms. Some of their responses also seemed to indicate that they were continuing learned family and/or cultural behaviors.

Maria stated that:

Many people don't like to go to the clinic. They bear not feeling well. They take home remedies.” She went on to say that, “One of my grandparents did not accept to see a doctor until he was really ill... His children used to beg him... [but] he was afraid of the needles for vaccination, he was afraid of the drip. (Maria, personal communication, August 11, 2011)

Angela gave a very candid, much more detailed explanation about her attitude and fears around healthcare:

I do not think I do anything to take care of my health (laughing). I just take care of my children. [In her mother's country] we wait to go to the doctor until we are actually really ill... I am afraid that the doctor will find illnesses interfering in my life, something severe....I think that I may lose my interest in life and the children may lose a happy mom and will have to endure a mom that is always worrying... So if I don't see a doctor I don't know what is wrong with me... When I think about going to see the doctor I think that I will get sicker. (Angela, personal communication, August 21, 2011)

***Hygiene and cleanliness.*** Three participants stated that they believed that being diligent about personal hygiene and keeping their homes clean are ways to prevent illness and live healthier.

“I take care of the house,” Angela (personal communication, August 21, 2011) said, “wash dishes, and help the children when they are at school,” while Vanessa (personal communication, October 10, 2011) discussed “Using hygienic techniques, good health is reflected in good appearance.” She went on to say that, “Back at home there were health educators who talked about good health, as well as practices, vaccination for children at schools.”

***Views on Mental Health.*** Opinions around mental health varied among the participants, with some referring to those with mental health challenges as “crazy” or “insane” and others taking a more positive stance on mental health is about. As in their previous responses, some participants referred to the collective or learned beliefs.

According to Maria, “Many people think that when a child is born with illness, the child is mentally insane” (Maria, personal communication, August 11, 2011)

Others echoed this statement. “Being mentally ill, I think that being nervous; not having control of the mind, also the mood” as Ana (personal communication, August 12, 2001) said, while Angela “thought it was about being mentally ill and insane” (Angela, personal communication, August 21, 2011)

Leticia thought that “Therapists and counselors are for people who are mentally ill, people who are sick in the head and need help” (Leticia, personal communication, October 10, 2011)

Linda, on the other hand, indicated that her views on the topic had changed. “Most people think, including myself a few years ago, think that mental health is being mentally ill and not okay in the mind” (Linda, personal communication, October 26, 2011)

Other participants stated that mental health was severe, yet did not refer to such illness in terms of insanity.

Maricela referred to someone with mental health challenges as “a person who is not conscious of his or her acts. Someone who is not well in the mind and does not think right.” She went on to say that, “Mental health services is only for critical issues, something severe” (Maricela, personal communication, September 14, 2011)

Brenda pointed to her head as she said, “Mental health is when they say to us that we are in a bad condition” (Brenda, personal communication, September 18, 2011)

Jenny described a personal with mental health challenges as “someone who does not have the ability to function appropriately, who is not able to understand anything. Don’t pay attention if we talk to them. They cannot grasp anything because their way of thinking is not okay.” She added, “This is for people who need special treatments for they are not functional” (Jenny, personal communication, August 12, 2011)

Some described mental health challenges in terms of behavioral expression.

“Behavioral health is when a person losses the temper and gets really angry, the person screams” Maria (personal communication, August 11, 2011) said.

Teresa described a mental illness as:

Feeling nervous, irritable, suddenly sad, suddenly normal, like a mental disorder.

Being emotionally unwell, and behaving in negative ways like anger or rage, we

don't think what we say or do. We affect others, my life, we can affect our children, second and third people. (Teresa, September 25, 2011)

When asked about her thoughts on mental health, Maricela linked it to one's overall wellness. "There is connection between mental health and health, because everything comes to the head and the mind, mental is mind, and we have everything connected to the mind and to the brain" (Maricela, personal communication, September 14, 2011)

Still other participants discussed mental health from a positive perspective. "We have to be emotionally well" Maria (personal communication, August 11, 2011) said.

Margarita (personal communication, September 10, 2011) stated that "Mental health or health in the mind is being happy"

Victoria (personal communication, October 10, 2011) felt like, "A better attitude, to me it is being more patient... to be more tolerant, to be a good listener, to be able to, to have a good attitude, good approach toward others"

Lucia and Vanessa also felt one's behavior toward people was a good indicator of his or her mental health. "To behave in a good manner" Lucia said, "not to use violence or mistreatment, to treat each other well, to treat each other with respect, and to feel comfortable with one another" (Lucia, personal communication, November 1, 2011)

Vanessa described mental health as "To feel content and to do everything the way is meant to be. Think positive, do good to others" Vanessa also took a positive view of mental healthcare providers, adding that, "Psychologists are to help people who face difficulties in life and need help, and space to talk" (Vanessa, personal communication, October 5, 2011)

On the other hand, three participants indicated that they at first did not believe in counseling, or that a therapist could understand their problems. Instead, they felt they were better trying to deal with their symptoms on their own.

Celilia (personal communication, August 8, 2011) said, "I used to think that counselors did not help" She also said.

My doctor referred me to another counselor in previous visits, but I stood firm, not wanting to see a counselor. I thought about fighting my fear and anxiety on my own, I planned to get better by myself... (Smiled) I was aware about my situation and wanted to get better. I was afraid of getting worse, however I did not want to allow a psychologist or therapist in my healing, I did not believe in that myself. (Celilia, personal communication, August 8, 2011)

Similarly, Brenda stated that, "I did not believe in therapists before that experience... I thought, how could they understand and help me about something they are not experiencing" (Brenda, personal communication, September 18, 2011)

These three testimonials referred to their original lack of confidence in the help that a therapist could provide. These accounts refer to the lack of reliance on therapist.

***Opinion about Mental Health in Participants' Culture/ Country of Origin.*** Ten participants said that in their culture, it is commonly believed that the term mental health equals mental illness and insanity. They believe one's mental health is directly related to the way he or she was parented. One participant said that people in her country do not think there is cure for mental health challenges. Furthermore, there statements also reveal the deep shame and stigma associated with mental illness and its treatment in their home countries.

“Many people say that someone is mentally insane because his or her mom was a heavy drinker, or because he or she was abandoned” Maria said, she added, “They are taken in an inpatient facility...they get medications” (Maria, personal communication, August 11, 2011)

Ana (personal communication, August 12, 2011) said those in her culture equated mental health with “being mentally insane. When someone cannot think right, and someone who does things out of the normal being. Looks as if acting out”

Isabel and Cecilia made similar statements. Isabel (personal communication, August 25, 2011) described the prevailing belief that mental health was, “Something not physical, but something in the head... They don’t think it is emotional or something, but it is something physically noticeable” while Cecilia said that, “They think that [mental health] is when there is something in the head like mentally ill or insane.” She added, “They think that it does not cure with medication” (Cecilia, personal communication, August 8, 2011)

Margarita also referred to her culture’s lack of belief around counseling:

Counselors were only for mentally ill and mentally insane people. Counselors and psychologists are only for crazy, insane people. Where I come from, mental health is only for mentally ill people, people who are not doing well, these people who break the law. In Mexico people generally think of someone who has a mental illness, a mental problem some cannot control psychomotor movements, someone dropping saliva, someone who is stupid and unable to process thoughts. (Margarita, personal communication, September 10, 2011)

Victoria (personal communication, October 10, 2011) took a similarly pessimistic view of treatment. “Some think that psychologists are to treat mentally ill people only...

The person cannot think by himself” Norma, Leticia and Jenny made statements that it was very uncommon to see a psychologist in her home country; it was seen as a last resort for someone who was severely mentally ill.

At the time she was interviewed, Angela was taking her son to BHS. She said that in her culture, people think that her son is mentally ill for visiting a psychologist. The fear of being seen as “crazy” often keeps people suffering in silence around mental health issues.

Margarita (personal communication, September 10, 2011) said that, “People did not talk about mental health in Mexico”

Maricela (personal communication, September 14, 2011) felt the same way, stating that, “The majority don’t talk about it, don’t say anything, they suffer it silently and alone”

These testimonies reinforce the previously mentioned stigma around mental health. In the participants’ countries and cultures of origin, anything related to mental health problems and their treatment are a source of shame, often forcing people to not seek help until the problem is severe enough to require hospitalization.

As Cecilia said, “They think that people need to control that [the mental health] by themselves” (Cecilia, personal communication, August 8, 2011)

Participants often revealed a general lack of understanding and knowledge about mental health issues:

Cecilia said that “the majority does not have an understanding,” while Victoria referred to a “lack of knowledge and information. People don’t know”

Victoria also mentioned that she had little guidance around health matters in her home country, both at home and at school.

“When I attended secondary school they never talked about our development and about getting our period, and when I got my period and I did not know anything. Not even my mom had told me anything, can you imagine?” (Victoria, personal communication, October 10, 2011). She went on to explain that her parents were so busy working to support the family that they did not have time to spend with their children.

Victoria described it as, “Feeling nervous, irritable, suddenly sad, suddenly normal, like a mental disorder” She also said, “Being emotionally unwell, and behave in negative ways like anger or rage, we don’t think what we say or do. We affect others, my life, we can affect our children” (Victoria, personal communication, October 10, 2011)

Given the stigma and lack and belief in its validity, participants did not express much faith that people from their culture would open up to mental health services, especially to someone they do not know.

There are people who can be referred to this service, [but] they may think like I did, I used to think that I did not need that service because it will not help me in any way. I used to think that they (the therapist) only want to know what is happening to me and what is wrong with me, that is what I used to think. (Brenda, personal communication, September 18, 2011)

As mentioned earlier, some participants defined mental health as doing right by others, participants. Some also indicated that this was a pervasive belief in their culture. For example, when Brenda asked about the opinion those in her culture had about mental health, she replied that it means, “To do the right thing, to be good and do well to others” (Brenda, personal communication, September 18, 2011)

***Patients' Mental Health Care Practices and Prevention.*** While some expressed doubt about mental health services, nine participants did state that they had seen a psychotherapist. They gave importance to the benefit of venting and receiving support from a professional.

Sometimes we get so overwhelmed with life and we do not even know how to handle things, we feel that doors close before us and our mind goes blank. The advice that we receive makes us think and we realize that often there is a way out, we can think clearer. (Maria, personal communication, August 11, 2011)

Margarita also emphasized the importance of discussing life stressors and receiving advice as it encourages reflection, and thinking of a way out. It is a helpful way to cope, "Visit a psychologist when experiencing estress" (Margarita, personal communication, September 10, 2011)

Maricela (personal communication, September 14, 2011) also admitted to seeking help. "I am attending counseling sessions because it is not just necessarily just about being okay in the physical health, but also the mental, and emotional health, that is also health, and that is what I did not really have"

Norma (personal communication, October 5, 2011) stated that by, "Going to talk with someone, we vent. So we feel good, we feel better"

These participants acknowledged a benefit in going to see a therapist so that they could air their various problems and receive guidance and support.

The women also stressed that a positive attitude was key to maintaining mental health. This could be achieved, they said, by doing things one enjoys and by nurturing their close relationships.

Ana said, “Talk with friends or neighbors about life,” also, “go to dance or to parties. Get support from the family” (Ana, personal communication, August 12, 2011)

Jenny (personal communication, October 12, 2011) mentioned that, “Supporting each other at home. Guidance is important”

Of the 18 participants, only one, Angela, said that she and her family do not think about how to treat and prevent mental health matters. This is reflective of the idea that people should take care of their own emotions, and that if one ignores such problems they will simply go away.

**Phenomenology Structure 2: Behavioral Health Specialist’s Attitude and Clinical Approach.** As mentioned earlier, there is a prevalent belief among Latinos that therapy does not work, largely because they do not feel a therapist can understand what they are going through. It stands to reason, therefore, that the personal qualities and clinical approach of the Behavioral Health Specialist was critical to successfully treating them. Indeed, all eighteen participants highlighted the Behavioral Health Consultant’s personal qualities as important in building rapport, comfort, and trust. Furthermore, the personal qualities and approach of BHS were reported by patients as critical to their decision to stay in the first session to discuss their presenting problem and the negative feelings they had been experiencing.

***BHS Personal Qualities.*** When assessing the personal qualities and the approach of the BHS, participants consistently mentioned the greeting, personal approach, good listening skills, and the ability to make others feel understood. Also important was her willing to include family members, and her ability to instill hope and respond with empathy.

**Greeting.** Participants repeatedly referred to psychotherapist's way of welcoming them into the session. Their responses seem to indicate that this went a long way to building trust in the therapist and reinforcing the trust they already have in the primary care provider that referred them to BHS services. Participants made statements such as:

"We were first greeted with a smile" (Maria, personal communication, August 11, 2011)

"She introduced herself to me in a nice manner" (Isabel, personal communication, August 25, 2011)

"The way the therapist talked to me made me feel okay" (Brenda, personal communication, September 18, 2011)

"She had a soft and caring voice" (Jenny, personal communication, October 12, 2011)

"She spoke genuinely to me from the first moment" (Victoria, personal communication, October 01, 2011)

As shown in the above testimonials, the body language, tone of voice and warm manner of the BHC were just as important, if not more so, than the words used, in making participants feel comfortable.

**Personal Approach.** Sixteen of the 18 participants reported a positive opinion regarding the BHS's approach; in fact, ten of the participants described this approach as critical to their feelings of comfort around receiving mental health services. Again, participants mentioned the body language and tone of voice, as well as the warm attitude of the BHS as a factor in their decision to talk and share their personal experience. She

reported the need to feel comfortable with BHS, before they could trust, and confide their difficulties. This was also highlighted as influencing follow up appointments.

As Maria stated, “It only takes a couple of minutes to listen to the counselor to decide whether we want to talk or not. We must feel comfortable before we can feel confident to talk and trust our personal matters” (Maria, personal communication, August 11, 2011)

Other participants echoed these sentiments when they discussed their experiences with BHS, during the first and follow-up sessions. Their statements included:

“She presents herself in a kind and friendly manner” (Maria, personal communication, August 11, 2011)

“She had a soft and approachable personality” (Maria, personal communication, August 11, 2011)

“She spoke with me as if she already knew me” (Maria, personal communication, August 11, 2011)

“She has a friendly and positive approach” (Cecilia, personal communication, August 28, 2011)

“It was as if she was my friend of mine who cares” (Maricela, personal communication, September 14, 2011)

“She added a positive component to the therapy sessions” (Teresa, personal communication, September 25, 2011)

“She is like a friend” (Victoria, personal communication, October 01, 2011)

“She is good with children” (Linda, personal communication, October 26, 2011)

“She patiently worked with me” (Victoria, personal communication, October 01, 2011)

***Good listening Skills.*** Several participants specifically referred to the BHC’s listening skills as a key factor in making them feel heard, cared for and understood.

“She paid attention when I talked” (Ana, personal communication, August 12, 2011)

“She listened to us with much patience” (Isabel, personal communication, August 25, 2011)

“She was showing interest, showing patience and listened to me” (Brenda, personal communication, September 18, 2011)

“She listens to our feelings” (Victoria, personal communication, October 01, 2011)

***Ability to Make Others Feel Understood.*** Participants referred to the BHS’ ability to make them feel understood during their visits with her.

“She said that it was okay not to feel comfortable” (Ana, personal communication, August 12, 2011)

“She paid much attention to the children and to me, and that made me feel Accepted and understood” (Margarita, personal communication, September 10, 2011)

“She is easy to understand” (Leticia, personal communication, October 10, 2011)

***Showed Interest and Included other Family Members.*** Participants indicated that they found it very important that BHS included all members of the family present in the clinic. It contributed to their feeling of feeling heard, included, and cared for, as illustrated by these general statements:

“She paid attention to me and to my son” (Angela, personal communication, August 21, 2011)

“She allowed my daughter to talk and express herself” (Maria, personal communication, August 11, 2011)

“She always makes eye contact; she is giving full attention to us. She is not on the computer, she is always looking at us, giving us attention, observing us... what we say matters” (Brenda, personal communication, September 18, 2011)

She appeared interested in what was happening with my son / daughter” (Leticia, personal communication, October 10, 2011)

“She is interested about us; she calls, and she checks on my son” (Daniela, personal communication, October 20, 2011)

“She included me in the therapy session of my child” (Linda, personal communication, October 26, 2011)

These testimonials describe BHS’s interest in the totality of the patient’s life, including her family, which went a long way to establishing trust.

***Instills Hope.*** Participants felt that BHS provided hope and wanted them to feel optimistic and hopeful in order to work on their situation and look for solutions. After learning what they were going through, the therapist made them feel that their situation would improve, thereby decreasing their stress and providing them with some peace of mind.

“She teaches to see the positive things that we cannot see when we feel sad and concerned” (Victoria, personal communication, October 01, 2011)

“She said that he showed some problems, his behavior, and we needed to work together... She said that this had a solution” (Angela, personal communication, August 21, 2011)

“She gave me hope right there“ (Angela, personal communication, August 21, 2011)

“The therapist had many positive words to make me believe that everything was going to be okay” (Norma, personal communication, October 05, 2011)

**Good Helper.** Participants talked about the BHC as being eager to provide support.

“She encouraged me; she said positive words, good things” (Cecilia, personal communication, August 28, 2011)

“She made me think that I needed to get out of my house and take fresh air and helped me understand the power of sunlight” (Victoria, personal communication, October 01, 2011)

“She guided me in a way that was easy to understand and follow” (Brenda, personal communication, September 18, 2011)

**Promotes Confidence.** Two participants reported to feel that BHS made them feel confident, by the attitude she presented.

“She spoke to me with confidence, an attitude that seemed willing to help” (Maria, personal communication, August 11, 2011)

“She made me feel comfortable and also promoted confidence” (Victoria, personal communication, October 01, 2011)

These two statements describe an increase of confidence and a relaxing atmosphere that transfers from BHS to patients during the sessions in the clinic.

**Empathy.** Four participants reportedly felt the BHS had empathy for what they were going through.

“I felt compassion from her” (Maria, personal communication, August 11, 2011)

“It seems as if she feels, as if it hurts, as if she is hurting about what is happening to us” (Victoria, personal communication, October 01, 2011)

“She was listening to us with her heart, she really wanted for everything to be okay” (Victoria, personal communication, October 01, 2011)

“It looked as if she was into our problem; she looked sad, almost feeling my pain” (Teresa, personal communication, September 25, 2011)

These four testimonies describe BHS’s approach as understanding and connecting with the feelings they were experiencing. These depict BHS as feeling patient’s pain.

Two of the 18 participants referred to therapist’s personal approach and interaction with them, as like a family member.

“She made me feel as a family member, as if she was family.” (Victoria, personal communication, October 01, 2011)

“It was like talking with our own mother” (Maria, personal communication, August 11, 2011)

**Responsiveness.** One participant said that BHS responds rapidly to calls and other contacts, which for her was extremely important.

**BHS Clinical Approach.** The 18 interviewed patients in the study highlighted the Behavioral Health Specialist’s clinical approach and skills. These made them believe and trust in her ability to help. These skills were a deciding factor in their return for second and third follow-up appointments; some attended as many as six follow-up sessions. The clinical approach and skills are grouped in the following themes: assessment; support and motivation; support and validation; guidance to support their children; guidance to better parenting and to rebuild attachment; overall guidance for the family (family therapy

model); liaising with other professionals; and guided exploration of feelings and expressing feelings. Participants also noted that the BHS promoted hope, used practical and useful exercises, kept the information confidential, and exhibited cultural competency.

**Assessment.** Patients reported that the BHS asked appropriate questions designed to elicit understanding about the situation. They felt these methods were extremely important and demonstrated the BHS's knowledge and good clinical skills while evaluating each individual and their family. Such responses included:

“She asked me questions and I vented with her all my distress” (Maria, personal communication, August 11, 2011)

“She invited me to open up and vent” (Maria, personal communication, August 11, 2011)

“She asked me about things I was already doing [to find out] which were working and which were not working” (Ana, personal communication, August 12, 2011)

“The counselor asked me to describe the problem, then asked me some specific questions about it” (Angela, personal communication, August 21, 2011)

“She took a sheet of paper out, and she asked me to write down the way I thought my daughter felt at home, and at school” (Maricela, personal communication, September 14, 2011)

“She asked me about my son, and also about his behavior change” (Teresa, personal communication, September 25, 2011)

“The psychologist asked me if the other children were acting or responding the same way” (Leticia, personal communication, October 10, 2011)

“She spent time talking with my son, she talked with him and asked me questions”  
(Angela, personal communication, August 21, 2011)

“We talked about my sons’ behavior at home” (Linda, personal communication,  
October 26, 2011)

“She did a test to see how much I knew about my daughter, about what she thought  
and what I knew” (Maricela, personal communication, September 14, 2011)

“She asked about our lives, our difficulties, and she also asked about  
how she could help us” (Leticia, personal communication, October 10, 2011)

***Support and Motivation.*** Participants reported feeling supported and guided by  
the BHS while working with her. Some participants felt motivated and encouraged to  
engage and change their attitudes, as well as to change their parental practices.

“I received positive advice from her” (Maria, personal communication, August 11,  
2011)

“The counselor has helped us much, for a while she was our main support” (Maria,  
personal communication, August 11, 2011)

“She guided us and helped me see things differently” (Victoria, personal  
communication, October 01, 2011)

“She gave us some tips in that moment to practice before our first  
appointment” (Teresa, personal communication, September 25, 2011)

“Gives us feedback as well as tips” (Leticia, personal communication, October 10,  
2011)

Victoria gave this lengthy description the services she received from the BHS:

The way of processing things, the way in which she worked with me helped me to get through and cope, now I see things from a different perspective, and ... (pause-thoughtful for a few seconds) she helped me get out of the whole I was digging myself into, and I did not want to live anymore, she told me that life was beautiful, that life was important, and that there were people who depended from me, and who missed me. She made me think and process about life in the sessions that I experienced with her were totally different from my experience with the previous counselor. (Victoria, personal communication, October 10, 2011)

These statements indicate ways in which BHS supported patients, and motivated them to cope, continue trying, and also guided them with feedback and advice.

***Support and Validation.*** When asked about their experiences with the BHS, participants stated that they received guidance on their issues, as well as validation that normalized their fear, negative thoughts, concerns and sadness. The BHS also explained things in a clear and positive way that normalized their ambivalence around seeking such services.

There are many lovely things, and beautiful things that she reminded me of, which I could not think about when I was concerned and distress. She teaches to see the positive things that we cannot see when we feel sad and concerned. (Victoria, personal communication, October 10, 2011)

“The therapist explained things really well,” Maria said, “and she told me all the pros and cons, she said that I could try, and see if this did not work or didn’t feel ok, things could stop” (Maria, personal communication, August 11, 2011)

“She also helped me decrease my fear, and all the negative thoughts that I had”  
(Jenny, personal communication, October 12, 2011)

“She opened up the conversation about good and potentially not good things related to the medication,” Isabel explained, “She helped me understand the benefits of the medication” (Isabel, personal communication August 25, 2011)

“She validates and confirms things that I felt” (Brenda, personal communication, September 18, 2011).

***Guidance to support their children.*** Ten participants felt that BHS had supported and guided their child in therapeutic ways.

“She invited my daughter to play some games, therapeutic games” (Maria, personal communication, August 11, 2011)

“She got him to draw things that he thought about, and they processed the drawings. She guided my daughter and I into playing together, she helped us through playing” (Isabel, personal communication, August 25, 2011)

“She helped her [daughter] through playing games, these were supposed to stimulate her brain” (Margarita, personal communication, September 10, 2011)

“They talked about going to the bathroom, also about wetting her pants, this was my daughter learned to go to the bathroom again” (Deisy, personal communication, October 24, 2011)

Daisy also reported:

The counselor helped her [daughter] to express herself and talk, and she validated her, she seemed to try to understand and connect with her, as well as encouraged her to talk, asking her questions about specific places, things that had happened and

also about feelings. (Deisy, personal communication, October 24, 2011)

“The counselor, she ordered it (urinalysis), and since that day he has done three tests for drugs, he does the test every three weeks” (Jenny, personal communication, October 12, 2011)

“The counselor suggested my son join a sport” (Jenny, personal communication, October 12, 2011)

“She showed him about his feelings, his fears; she spoke with him and advised us about how to improve their behavior and their feelings” (Angela, personal communication, August 21, 2011)

These statements describe ways in which BHS supported and help the children during the sessions. The ways in which BHS is reported to support children were in methods used in the sessions, including drawing, therapeutic games, as well as guiding the child, starting with a conversation about the presenting problem, and looking for ways to help child relax and cope.

***Guidance to better parenting, and to rebuild attachment.*** Participants said that they were guided and advised on their parenting approaches, as well as in ways to improve their relationship with their child.

“Every time I went, I received different words and themes. It sounded like magic to me, because of the practical and helpful things she said” (Maria, personal communication, August 11, 2011)

“The counselor advised me about the attention that my daughter needed” (Maria, personal communication, August 11, 2011)

“She told me to try to give attention to my daughter for a few minutes, invest yourself on her and give her some of your time” (Ana, personal communication, August 12, 2011)

“She gave us some parenting skills, guidance” (Angela, personal communication, August 21, 2011)

“She thought me how to manage things at home” (Cecilia, personal communication, August 28, 2011)

“She has given tips how to make things easier for my child, about helping children be happy... creating activities and giving them attention... also about talking with children about what they are going through, and their feelings” (Brenda, personal communication, September 18, 2011)

“She gave tips about how to feed him better, what to eat, and how to help my child spend more time with us, among us, and be calmed. We were guided about how to play and share activities, interacting with him” (Leticia, personal communication, October 10, 2011)

“She talked about how we needed to approach our children, and she talked with us about how to talk with children” (Maricela, personal communication, September 14, 2011)

“Encouraged us to play a game and with this I have learned about who is the one who screams, who demands, and who does things” (Daniela, personal communication, October 20, 2011)

“She would tell us what we had to do and we did it, she used to tell me to take the children for a walk to the park and to let them run and do things like this” (Lucia, personal communication, November 01, 2011)

“There were activities that she helped me and guided me do with my son” (Angela, personal communication, August 21, 2011)

“She also guided me about ways in which I could interact with my son in the session, and mainly at home” (Angela, personal communication, August 21, 2011)

“She has helped me to be a better mother, for example if I had a doubt about guiding him, showing discipline, and also to redirect him, help him, and provide him with what he needed” (Brenda, personal communication, September 18, 2011)

“She guided me about how to support him according to his needs. She guided me in a way that was easy to understand and to follow” (Brenda, personal communication, September 18, 2011)

“She guided me about parenting and how to respond to him. How to treat him and all, all the parenting matters that I needed to pay attention to” (Deisy, personal communication, October 24, 2011)

These testimonials described techniques used by BHS to guide them in their parenting, responding to their children, and connecting with their children. The techniques mentioned aim to enhance and re-build the attachment. These will ultimately help parents decrease the presenting anxiety and distress caused by their lack of full ability to help their children’s symptoms and behavior.

***Guidance to Family togetherness and Quality Time (Family Therapy model).***

Parents mentioned the guidance and support from BHS in a family approach, having the children with them in session, or during home visits.

Maria talked about guidance received from BHS:

She helped us to play together; she encouraged us to learn from one another, she

used to make us draw together... we drew our family, then she used to get us to eat together and she made suggestions about what to eat, she used to give us certain details. (Maria, personal communication, August 11, 2011)

Maricela said, "She encouraged us to play, my daughters changed their roles, acted each other's attitudes, they then talked about what they liked and what they did not like, they also talked about themselves" (Maricela, personal communication, September 14, 2011)

"We exercised as part of the treatment. I did it together with my son, he liked that very much, the psychologist encouraged us to play and exercise together" (Leticia, personal communication, October 10, 2011)

"She made us play as a family, this way helped him understand why he became angry, she helped him decrease and helped us control" (Angela, personal communication, August 21, 2011)

"She talked with the children, advised us and, and invited them to try and be patient with me and to also try and talk about their needs, she explained to them that I was not feeling well" (Teresa, personal communication, September 25, 2011)

"She also engaged the other children in the session, I was able to pay better attention to the way in which he interacted with them and these responded to him" (Teresa, personal communication, September 25, 2011)

"It became a family treatment to help one family member, my son. She has taught me, guided me, and helped me to guide my children with their well-being and their emotional being" (Brenda, personal communication, September 18, 2011)

“She guided us and taught us things to do on the spot” (Vanessa, personal communication, November 05, 2011)

“She encouraged us to draw a picture that reflected the way we would like our family to look like, the way we would like to live our lives” (Lucia, personal communication, November 01, 2011)

“We played and we really got into the roles we were playing” (Norma, personal communication, October 05, 2011)

These statements describe BHS techniques to guide parents to interact better with their children, during their family therapy sessions. These included playing, drawing pictures, doing exercises together, and also acknowledging errors and apologizing with their children.

***Support as Liaison With Other Professionals.*** The BHS clinical approached was acknowledged by some participants, for the help referring the children with specialists to support particular needs. Also supported parents with their children’s schools.

“She made a referral appointment with the appropriate doctor. She got us an appointment with a psychiatrist” (Angela, personal communication, August 21, 2011)

“The therapist helped me out getting a referral for an appointment for an evaluation, a speech proficiency evaluation” (Linda, personal communication, October 26, 2011)

“She gave me a letter for the school principal and yes, it did help me with the difficulty” (Angela, personal communication, August 21, 2011)

“She helped me with the report to the school principal” (Angela, personal communication, August 21, 2011)

“The pediatrician and also the psychologist advocated for my son before the school

district and he was admitted into school at an early age, and he received additional help” (Cecilia, personal communication, August 28, 2011)

These testimonials described actions taken by BHS, to refer children with further specialists. These needs had risen after assessment carried with BHS, and she has served as liaison with other services. BHS also issued letters to school, in support of child’s behavior and parental needs.

***Guided Exploration of Feelings and Expressing Feelings.*** Participants acknowledged BHS help to explore feelings and the ways in which parents expressed these, such as:

“Learning how to say I love you” (Maria, personal communication, August 11, 2011)

“Express what we feel and how we feel” (Ana, personal communication, August 12, 2011)

“In the session we used to talk about feelings to one another, we said to each other I love you, we also said things that we liked from one another and things we did not like from one another” (Maricela, personal communication, September 14, 2011)

These statements described BHS’s support to parents during sessions while guiding them to express feelings, including how to say I love you. One of the participants explained that in the sessions with BHS they used talk about feelings and practiced saying I love you to, and positive things about the other, in the session with BHS.

***Practical and Useful Exercises.*** Two participants described guidance to relax, and the use of natural things in the treatment with BHS.

“She made us do breathing exercises and other things that helped us relax.

With the exercises I learned to relax myself.” (Margarita, personal communication,

September 10, 2011)

“She showed me natural things like roses to smell, and these relaxed me, she had bottles of essence, and when I was trying to relax in the session, she helped me letting smell the essences” (Victoria, personal communication, October 01, 2011)

These two testimonials describe exercises such as breathing, to help parents, and children relax. One of the testimonials also reports the guidance on use of natural resources also useful to decrease anxiety.

**Confidentiality.** One participant said that had appreciated BHS explaining about confidentiality.

*She explained to me that everything was confidential and she said that it was her job to offer help, and she won't tell anyone about what we say.* This testimonial describes BHS explaining about her duty to keep everything confidential. This was important to this patient, and made her feel more comfortable to open up with BHS about her situation, knowing she will keep everything private.

**Professionalism and Care.** Four participants made reference to BHS managing the situations presented to her, and also showing care even when needing to do things that may be out of her duty.

“She is managing the situation very well. She is interested about us, she calls. She checks on my son” (Jenny, personal communication, October 12, 2011)

“She follows up with what we did in the previous visit” (Daniela, personal communication, October 20, 2011)

“She does things that may not be required for her job but can still benefit us” (Linda, personal communication, October 26, 2011)

These three testimonials describe experiences from participants that showed BHS professionalism, knowledge, in combination with a caring attitude.

***Cultural Competency.*** Two participants referred to the approach of BHS displaying cultural awareness for the context they were living. They described the BHS as a non-Latina, Spanish-speaking therapist that helped ease their doubts about receiving mental health services. In one case, the BHS went to the participant's house to explain the primary care's concern about the child's reluctance to being examined. BHS took the lead in a highly culturally competent manner, which led to positive resolution of the situation.

**Phenomenology Structure 3: Outcomes.** The participants' accounts regarding the outcomes from the visits with the Behavioral Health Specialist are presented in this section of the study. These are grouped into themes, each describing the effect of the visits with the BHS. These outcomes demonstrate an increased level of awareness about their own needs as well as those of their children's needs.

These results also show improvement participants' abilities to manage challenging situations. Adults improved their emotional state, and were able to manage their emotions in such a way that improved their level of functioning, both on a personal level and as parents.

The outcomes also describe children showing improved behaviors. Families are described as interacting better. Parents reported receiving referrals and appointments with speech specialists and psychiatrists, and having benefitted from the BHS liaising with their children's schools.

**Awareness.** Participants reported that as a result of their experience with Integrated Healthcare Services they had a better awareness about the situation they were experiencing and tools to cope and get better.

In the visits with BHS, they also received information and advice that enhanced their understanding of their children's behavior. They were also more informed about medications their children were taking and how as parents they could more appropriately respond to their children's needs.

"The advice we receive makes us think and then realize that often there is a way out, we can think clearer" (Maria, personal communication, August 11, 2011).

"She helped me understand the benefits of the medication" (Angela, personal communication, August 21, 2001)

"The therapist guided me. With the advice of the counselor I became more aware about what my daughter was going through and I became more interested about what I needed to do" (Isabel, personal communication, 2011)

"As the sessions continued I felt better because I was learning to get to know my daughter, I understood her more" (Maricela, personal communication, September 14, 2011)

**Improved Ability To Manage Challenging Situations.** Two participants described that the support from integrated health care services had enhanced their ability to respond to their children in a healthier way. These moments including in the moments of family distress and tension, as well as helping their children regulate their emotions.

“When I saw my daughters fighting, I got angry every time, and I could not monitor my emotions, I could not understand the problem. Now I can, and I can manage my emotions” (Maricela, personal communication, September 14)

“She helped me to guide my children, which helped with their well-being and their emotions” (Brenda, personal communication, September 18, 2011)

These two statements portray parental ability to respond to their children, and the improvements, through awareness, and through action, change of managing emotions. These will promote healthier ways to respond to children, and influence children.

***Child Improved Behavior.*** Ten participants reported that as a result of the guidance and information they had received in the visits with BHS and family therapy sessions, they had observed improved behavior in their children. This includes the behaviors they had identified during the session with the primary care provider.

“His [son] behavior was slowly improving just with the therapy” (Angela, personal communication, August 24, 2011)

“It helped my daughter; she stopped wetting herself” (Isabel, personal communication, August 25, 2011)

Cecilia had this to say about the her son’s behavior after seeing the BHS, “I noticed that my son was changing; he was behaving in a better way... he was improving his behavior, I know that he will always make some mistakes he is a child, but he did change and improve his behavior” (Cecilia, personal communication, August 8, 2011)

Brenda and Teresa also shared their positive experiences with family therapy:

He [son] is more relaxed, more calm. He still fights with his siblings but a lot less than he used to. I noticed progress and improvement in the behavior of my son. Yes

still aggressive, but not like he used to be. (Brenda, personal communication, September 18, 2011)

Teresa said:

I have noticed a change in my son, now even if he does something that is not okay, when I tell him off even if he makes a little drama, he later comes to me and talks with me about his feelings and apologizes. (Teresa personal communication, September 25, 2011).

“My oldest son has learned, she helped him decrease and control his anger” (Norma, personal communication, October 5, 2011)

“My son engages and listens” (Leticia, personal communication, October 10, 2011)

For Jenny, the BHS helped her child channel his energy into something positive.

He [son] is now more involved in sports, he is practicing football; he plays and has a game on Wednesdays and comes home at seven thirty. He calls his dad to go and pick him up. He [son] is getting more organized. He is doing well and he is attending school. (Jenny, personal communication, October 12, 2011).

“She [daughter] is able to relax with the activities practiced. She is not making sounds” (Daniela, personal communication, October 20, 2011).

“My daughter felt calm and relaxed. Communicates better, also she was able to think about things she needed to improve” (Lucia, personal communication, November 1, 2011)

The statements present improved symptoms, and healthier behaviors of children, after the visits with BHS. These progresses and improved behaviors were described to be a

result of the improved parenting responses and approaches after sessions with BHS in the health clinic.

***Family Interacting Better.*** Five participants in the study explained how the guidance and support from BHS led to improved interaction with their children, which in turn created an overall improvement in the family dynamic.

Isabel had this to say about the family therapy at the clinic:

It helped us not be distant from one another anymore. We became closer; it helped me so that I could guide my younger daughter to be apart from the company of her sister. She now plays with me, now she seems comfortable to look for me, talk with me, and play with me. (Isabel, personal communication, August 25, 2011)

Cecilia had a similar experience with regard to her home life, “It helped me improve things at home, issues with myself, my partner, my children. I felt it helped me to have a better family and better environment at home. Things have worked out because we [family] get along better” (Cecilia, personal communication, August 8, 2011)

“I am sharing more quality time with my daughters at home. And I feel more harmony at home. Also, I can now talk in better ways with my daughters” (Maricela, personal communication, September 14, 2001)

“We learned to express feelings to one another” (Lucia, personal communication, November 1, 2011)

“We [family] have become closer” (Brenda, personal communication, September 18, 2011)

These testimonials describe improved parent-child interactions, and also better relationships, parents and children being closer and getting to know children better. These

improved family interactions had been described as a result to the guidance and support from BHS in the sessions attended.

***Improved Emotional Being/ Feeling.*** Nine participants reported that the visits and support from BHS had helped them feel better and happier, less fearful and less stressed.

“After a while I felt better, I come home with a more clear mind and feeling better, even my daughter could tell. I felt confident... And I felt in company and supported. I am happier” (Maria, personal communication, August 11, 2011)

Ana reported that, “It made me feel stress free. It helped me decrease the burden and the weight I carried in my mind and in my heart” (Ana, personal communication, August 12, 2001).

Angela (personal communication, August 21, 2001) said of the BHS, she “made me feel better. She helped me decrease my fear, and all the negative thoughts that I had”

Other participants indicated that they were more relaxed and less anxious; they also felt supported in a way they had not experienced before, and they had a more positive outlook in general.

Victoria offered a more detailed assessment:

I felt supported, and helped me leave the house and take fresh air. It helped me clear my mind, see things different, and explore more positive things and feelings in my life. She helped me process things in a positive way. (Victoria, personal communication, October 10, 2011)

“I vented was I was carrying inside, and I felt comfortable and confident” (Daniela, personal communication, October 20, 2011)

**Improved Level of Functioning.** Two parents reported that they were better able to guide and support their children. One of them also reported that her daughter had also learned to take care of herself.

“I was able to interact better with others” Maria said, “do my job better, I felt better in many ways.” (Maria, personal communication, August 11, 2011)

“I learned to take care of myself and my daughter learned to take care of herself” (Margarita, personal communication, September 10, 2011)

These statements described improved levels of functioning as parents and also in life. These participants said that they had achieved an improved level of functioning after their visits and treatment with BHS.

**Got Appointment With Specialist Services.** Two patients reported that in addition to the support and guidance provided during the session, the BHS also aided them in getting referrals and/or appointments with mental health professionals that met the specific need of their children:

“She made the referral appointment with the appropriate doctor” Angela (personal communication, August 24, 2011) noted, “Got us an appointment with a psychiatrist”

Linda was also pleased with the assistance in this regard. “She [BHC] also connected me with further help in Fort Collins. It was a program of social skills, which was appropriate for my son” (Linda, October 26, 2011)

**The Whole Experience/ Sharing the Experience.** Three main structures in this phenomenological study were formed by the various themes. After grouping these themes, there were many other testimonials that captured the overall experience of receiving

integrated mental health services. This last part of chapter four covers that holistic experience as described by participants. That said, the data was divided into sub-themes.

These sub-themes refer to the therapy sessions with BHS, this was described as a good place to open up and “vent.” Some participants indicated that their situation was normalized and hope was instilled by the BHS. A group of participants described an initial ambivalence to attend services with BHS, which in the follow-up sessions became a positive experience. The eighteen participants reported that BHS made them feel welcome, comfortable, and confident. Some participants described an appreciation of the guidance received, and others reported that the services from BHS had been offered to the family together, this they thought was beneficial.

Participants also described positive results reflected in their children’s behaviors, their improved capacity to manage feelings, as well as their level of functioning. Last, participants talked about the benefit to have medical and mental health services co-located, and the invaluable help of the services, especially not having to worry about a large fee to see a therapist (BHS).

***Place to Open Up and Vent feelings and Fears.*** Five participants said their whole experience in integrated health care, as the benefit to have a space to outlet their feelings and fears.

“Once you are already there and talking with them it is so different. It helped me much, I vented with her all my distress, and I felt good, I felt safe, I felt positive. I felt comfortable, I felt relaxed, at peace. It was perfect for me” (Maria, personal communication, August 11, 2011)

“Knowing that what we share is confidential, that builds more trust, and we vent in a more confident manner” (Jenny, personal communication, October 12, 2011)

Brenda, Victoria, and Deisy provided more detailed accounts of their experience:

I opened up, I told her that I was going through difficulties with the father of my children, I told her what was happening with him and I also said that my son seemed to be affected the most out of all the children about our family matters. (Brenda, personal communication, September 18, 2011)

“Therapist helped me to process things in a positive way. I was able to tell her everything that was happening in my life, everything, everything, from the time I was born until today, she made me believe” (Victoria, personal communication, October 10, 2011)

We have learned that this is good, for things and issues that we may not be able to talk with the family, things that are difficult, a person that would be good listener and guide us can help to vent. (Deisy, personal communication, October 24, 2011)

These five statements described the benefits found in their experience, having the integrated health care space to open about their stressors and fears, in the professional company and support of the BHS.

***Normalized the Situation and Instilled Hope.*** Four participants shared a positive response from BHS, and her appropriate initial feedback during the initial stage of their sessions with her. They said that she had normalized their situation, and she had also appropriately installed hope, while problem solving about their current situation.

“I felt I was given hope. After talking with the therapist she said that he showed some problems with his behavior and we need to work together...She said that this had a solution” (Cecilia, personal communication, August 8, 2011)

I was hoping that someone helped my son. I hoped that they might be able to help him there. I was concerned about my son doing something really bad. I was concerned about the situation with him getting worse if he did not get treated.

When I was told that I needed to see a counselor and that my son will be referred to see one... (pause) let me tell you, part of me felt a relief... (pause) Part of me felt that maybe they could help me, but I did not fully believe in counselors or therapists.

(Brenda, personal communication, September 18, 2011)

“She made me feel comfortable, she was professional and made me feel that I could talk with her....She was positive and cheered me up, gave me hope right there and then”

(Teresa, personal communication, September 25)

“Therapist made me feel that what I was feeling about school was normal and that my son was ok and not a bad thing... she is, how do you say; she validates and affirms things that I felt” (Deisy, personal communication, October 24, 2011)

“The psychologist said to me that she believed my son was doing well, she thought it was a normal stage of my son’s development. She helped me overcome my fears and doubts; she helped me see things different” (Vanessa, personal communication, October 5, 2011)

These statements described the experience of six participants, in relation to their situation normalized by the BHS. They also conveyed the BHS instilling hope and confidence, while supported them in their problem solving.

***Initial Fear – Ambivalence to See the BHS and Positive Follow Up Experience.***

Participants shared their initial feeling about attending a session with a BHS; they felt

ambivalent. Four participants explained that they felt initially afraid. They described their experience in follow up sessions as easier and more enjoyable.

“At the beginning I did not feel too confident and did not feel like talking, however the way the therapist talked to me made me feel ok, and I with time started to vent, with time... In each follow up appointment I slowly opened up more and more” (Maria, personal communication, August 11, 2011)

I was not sure in the beginning, but it was not a bad experience. I wanted to listen to her, to know her, and see what that was about... (pause) But I was not one hundred percent sure... (pause) this was new to me. (Ana, personal communication, August 12, 2011)

I felt nervous when I was told about the counselor because I thought that the counselor might come and have doubts about me being the one abusing my daughter... When I spoke with her, I felt comfortable, and after a while I felt better, more relaxed... (pause) Umm... (pause) How can I say this? She made me feel comfortable and also promoted confidence. (Isabel, personal communication, August 25, 2011)

At the beginning I was afraid and after a while I said, I need to do this and not think much about it...(pause) When we met the counselor at the clinic I liked her, and the second time we met I liked her more, and after that I really liked going to see her. (Margarita, personal communication, September 10, 2011)

“It was something I had never experienced... (pause) well, but as sessions go by we feel better, and these may get even better” (Maricela, personal communication, September 14, 2011)

These statements conveyed initial fear, ambivalence, and anxiety when they were first advised to see a BHS. One of the testimonials reports being afraid of mental health professionals. The statements also carry a shift in the early experience, and the follow up sessions. These last are described as helpful, enjoyable, feeling relaxed and comfortable.

***The BHS Effect.*** Participants said that the BHS had made them feel comfortable, relaxed, and confident in the various sessions they had with her. They also said they had felt supported by BHS's help and approach.

"I felt welcomed, and that made me feel confidence. I continued attending the services, for me and also for my daughter" (Maria, personal communication, August 11, 2011)

The therapist made me feel comfortable. I liked talking with the counselor. I felt good, she made me feel that getting help was good, some type of support was good, and I enjoyed having that support... (pause) It helped me. (Ana, personal communication, August 12, 2011)

"The therapist explained things really well, and she told me all the pros and the cons, she said that I could try and see and if this did not work or I did not feel okay things could stop" (Angela, personal communication, August 21, 2011)

"The approach is good, I liked the counselor, and I also liked the approach as well as when the doctor made the referral, it was all good" (Cecilia, personal communication, August 8, 2011)

The therapist treated me so well that made me feel comfortable.... (pause) Made me feel confident and I became relaxed. She's always made me feel comfortable, content and relax and this is something I only experience when I am with family and

close relatives. I do not feel anxious anymore; also my children are doing better.

(Margarita, personal communication, September 10, 2011)

My son used to enjoy talking with therapist. He loved going to see the therapist. I would say to him that we had appointment with the psychologist and he responded: oh yes, I like that, I like going there... I noticed progress and improvement in the behavior of my son. My son would remind me about when the next appointment was going to be and he would tell me on the day, then I asked him if he liked going there and he said that he liked going there... (pause) He liked the way she treating him. (Brenda, personal communication, September 18, 2011)

When I met her I felt as if she was someone showing interest in me, she was someone with the patience to listen to me, and that was not showing desperation or feeling overwhelmed; that made me trust again. The therapist made me believe again in counseling and that someone in counseling could help me. (Victoria, personal communication, October 10, 2011)

“The therapist treated us, the way in which she spoke to us, and also the way in which she explained things to my daughter, and to myself; she talked to us in a good and clear way” (Lucia, November 1, 2011)

The participants’ testimonials described positive responses from BHS; they described her as helpful and responsive. Some of the testimonials described her approach as pleasant. Participants’ accounts report them feeling understood and supported. The accounts described BHS’s approach and attitude as positive, helpful, clear, and caring.

Under the theme of BHS effect, one participant said that once one trusts therapists, it is difficult to go to someone else, and start again.

“I don’t think it’s easy to change counselors when we have already vented deep feelings and things” (Angela, personal communication, August 21, 2011)

**Guidance Received.** Three participants said that they felt supported and guided as part of the experience with the BHS. They also received advice about ways of responding to their children.

“She guided me about how to support him according to his needs. She guided me in a way that was easy to understand and to follow” (Brenda, personal communication, September 18, 2011)

“Therapist explained things. We receive advices and guidance, they give opinions, and these are good” (Norma, personal communication, October 5, 2011)

“The counselor guides us about how to treat our children, for example in the adolescence it is quite challenging” (Jenny, personal communication, October 12, 2011)

The three participants’ statements described that the BHS had guided, and advised them. One statement says that BHS had also explained things well, which made it easy to practice.

**Family Therapy Approach.** Four participants said that having experienced the services with BHS using the family therapy context had been favorable for their families.

“I liked the way therapist treated both of us, and my son asked me about his appointments happy and willingly to go” (Angela, personal communication, August 24, 2011)

We attended sessions together. She got us to play together my two daughters attended sessions a few times. I learned much and also felt relaxed every time I

went. My daughter enjoyed her time there, and she constantly asked about going to see the psychologist. (Margarita, personal communication, September 10, 2011)

It became a family treatment to help one family member, my son. She also engaged the other children in the session; I was able to pay better attention to the way in which he interacted with them and these responded to him. (Brenda, personal communication, September 18, 2011)

“We liked the session because we exercised as part of the treatment. I did it together with my son, he liked that very much, the psychologist encouraged us to play and exercise together” (Norma, personal communication, October 5, 2011) said.

The four statements describe the experience with BHS in a family therapy approach. They described to have liked the inclusion of children with the adult in the sessions, the treatment conducted in family, playing and completing exercises together.

**Home Visits.** One participant said that she used to occasionally experience the sessions with the BHS in her home. The BHS visited the patient at her home to carry out sessions, when patient could not get to the clinic.

“Sometimes I had no transportation to get to the session, she used to come and helped me at home. I noticed that after about five sessions things were getting better” (Margarita, personal communication, September 10, 2011)

This participant’s statement describes the experience accommodating and responsive to her needs, when she does not have access to transport to attend sessions.

**Positive Results.** Twelve participants said that they had felt good during the sessions with BHS, and more importantly, experienced positive results from each session. These results included improved parenting skills, reduction of fear and anxiety (initially

presented as a reason for seeing the BHS support), and improved responses to daily matters, especially concerning their children.

It helped me much because we got therapy together with my daughter, first myself and after wards with my daughter. My daughter and I, the two of us used to leave the session feeling good and content, and the same when the psychologist used to come to our place.

(Maria, personal communication, August 11, 2011)

“The advice that we receive makes us think and we realize that often there is a way out, we can think clearer” (Jenny, personal communication, October 12, 2011)

“The learning was little by little... (pause) Therapy sessions help us think and react in different manners” (Margarita, personal communication, September 10, 2011)

“What I was feeling when I started attending services, I did not feel it anymore during the second and third visit” (Ana, personal communication, August 12, 2011)

“After that first visits things got better. Therapist helped me decreased my fear, and all the negative thoughts that I had. She helped me understand the benefits of the medication” (Angela, personal communication, August 21, 2011)

“It helped me improve things at home, issues with myself, my partner, my children... (pause) I felt that it helped me to have a better family and better environment at home” (Cecilia, personal communication, August 8, 2011)

Brenda said that her son showed positive results:

My son left the room more, a little more calmed... (pause) Yes still fairly aggressive, but not like he used to be. Brenda reported. I also learned more about the way in which he engaged with games and activities, the way he interacted with the

psychologist, and how he responded to me when guiding him. (Brenda, personal communication, September 18, 2011)

“It promoted emotional closeness. It promoted trust” (Teresa, personal communication, September 25, 2011)

“My son was able to control his temper and anger” (Norma, personal communication, October 5, 2011)

“It made me calmed, relaxed and content” (Lucia, personal communication, November 1, 2011)

These testimonials described improved parenting skills and parent-child relationships, decreased feeling of fear and thinking negative thoughts, improved child’s behavior, feeling calm, relaxed, and content. These improved behaviors relate to a positive experience with BHS.

***Benefits of Medical and Mental Health Services in one Location.*** Three participants stated the benefit of health and mental health services being co-located; they mentioned the benefit of not having to leave the medical clinic to see a therapist.

The service has many benefits like we do not have to leave the medical clinic for the service, in the same clinic we get the referral to this person, we do not need to go from one place to another. In the same clinic we get the referral to the therapist, the referral is from within and this is more practical for us. (Isabel, personal communication August 25, 2011)

There is communication when referring, like they say to one another the reason for the person to be coming, they ask each other for help, there is communication between counseling and the doctor, and talk about what has helped, in this way I think that our health and our mood both improve. It is really good that they work in coordination,

medical doctor, psychologist, and also dentist. I think feel that they make a team, a very good team. (Victoria, personal communication, October 10, 2011).

These statements described the benefits of having the medical health and mental health services together. The statements refer to the communication between medical staff, mental health staff, and dentistry staff, as beneficial, and easy.

**Concern about Payment.** As with any health care treatment, people worry about their ability to pay. More than one of the participants in this study expressed relief that this program runs at no charge to clients.

When I spoke with the doctor at the children's clinic, and she called the counselor there from the clinic I became worried again thinking about how much they would charge me for that visit, until they told me it would be free of charge for me because it is covered by the clinic. The counselor said that this would be free. (Margarita, personal communication, September 10, 2011)

"Now I am so happy because someone is listening to me, helping my family and me, and I do not have difficulties of payments" (Maricela, personal communication, September 14, 2011)

These two statements described the benefit of not having to pay for the session with the BHS. It is something that is beneficial because it provides a space for them to be supported by a professional.

**Experience before first visit with BHS & following the first visit.** The participants mentioned the initial experience in integrated health services with the BHS, and the follow up sessions experienced, expressing differences in both experiences.

At the beginning I did not feel too confident and did not feel like talking, however the way the therapist talked to me made me feel ok, and I then with time started to vent with time. Also in each follow up appointment I slowly opened up more and more. (Maria, personal communication, August 11, 2011)

What I was feeling when I started attending services, I did not feel it anymore during the second and third visit. I felt some pressure, emotionally pressured and stressed out; I felt overwhelmed, I did not know what to do. Follow up sessions I felt good, comfortable, and more confident, made me feel better. (Ana, personal communication, August 12, 2011)

Pressure made me accept the (psychiatric) doctor at the beginning. But after the first visit things got better. (Initial) fear and hesitation, I felt bad about my son, but then I said to myself that this should be a good thing. Therapist helped me a lot with the process, she also helped decrease my fear and all the negative thoughts that I had, she talked so well with me. After the first time, the next time when I saw him he seemed more normal. After meeting this counselor at the clinic... Now I know what a counselor is and what it is like. (Angela, personal communication, August 21, 2011)

“At the beginning I was afraid,” Margarita said, “and when I met with the therapist I liked her, and the second time I liked her more. I felt comfortable since the first visit” (Margarita, personal communication, September 10)

In the initial visit I thought: well let’s see what comes out of this. Let’s see how she can help us out... But as sessions continued, I felt better because I was getting to know my daughter, I was understanding her more, and following the advice that she (psychotherapist) gave me. (Maricela, personal communication, September 14, 2011)

My son needed someone to make him feel comfortable, for him to be able to vent and get everything out. When I returned to the follow up sessions I noticed progress and improvement in the behavior of my son... (pause) that time is when she said that I needed to provide a more relaxing and more peaceful environment. (Brenda, personal communication, September 18, 2011)

“We thought the first visit was good, and after the second visit we thought it was helping” (Norma, personal communication, October 5, 2011)

“Each visit is more helpful, for me and for my son” (Jenny, personal communication, October 12, 2011)

“I felt nervous at the beginning, however helpful from the beginning, and each session positive and better” (Vanessa, personal communication, October 5, 2011)

The personal statements described feelings ambivalence, doubt, and some resistance to attending sessions with a BHS. The statements also described the follow up visits with the BHS as positive; patients were more willing to talk during their second and subsequent follow-up sessions.

***Cultural Awareness.*** Spanish speaking Latino and Latina patients feel more comfortable and open to a mental health provider in their own language, and even more, to someone who shows understanding of their beliefs and practices (as stated by participants).

Participants made reference to the Spanish proficiency of BHS in their experience, and expressed how this had made it easier for them to open up about their personal issues in the sessions.

“She spoke Spanish with me. I spoke openly with her because she spoke my language, she also showed understanding of my culture and my beliefs” (Cecilia, personal communication, August 8, 2011)

We feel skeptical to talk about our personal things and our family matters with a person we don't know (like the psychologist), now having a third person in the room would make the interaction more difficult...(pause) We even have problems of communication in our own language and sometimes the interpretation of what we actually say may not be accurate. (Deisy, personal communication, October 24, 2001)

“It is so important to understand what they say in my own language, especially some medical and psychological terms I will not understand in English” (Linda, personal communication, October 26, 2011)

These statements described the Spanish proficiency of psychotherapist as beneficial and also motivating them to utilize the BHS service offered. These also described the understanding about their culture and beliefs being something important in their experience with the BHS.

The following participant described in detail the incident with which she and her daughter had been referred to the integrated health services, to see BHS. Patient explained that her daughter had not allowed the medical provider and the nurse to examine her private parts during the year checkup. The initial response from the PCP was potential child abuse: sexual abuse. The BHS intervention and high level of cultural competency allowed her to do a detailed assessment, she included every member of the family, and mainly the girl.

“I have taught my daughter that nobody should look at, touch, or grab her private parts” Maricela said after her daughter refused to let the doctor and nurse examine her, “None of her parts at all” (Maricela, personal communication, September 10, 2011)

This statement described the presence of the BHS in the clinic, and more importantly, the strong cultural understanding she has in the Latino culture, including their beliefs and parental influence on children, to keep them safe. This case could have ended on a child protection department, however, the thorough assessment conducted by the BHS and the medical team, and the inclusion of each family member as part of the service, provided clarification about the parental values to protect her daughters by not letting anyone touch their private parts, this causing anxiety on the young girl when exposed to the medical-physical examination.

***Patients' Accounts and Reflections.*** Three participants offered their personal opinions, as well as the general opinion that Latinos and Latinas have about mental health, requesting or not services for mental health, and what they may need to feel and see in a therapist, to decide whether or not to follow up with the service.

“We must feel comfortable before we can feel confident to talk and trust our matters” (Maria, personal communication, August 11, 2011)

Ana and Isabel offered these insights into mental health treatment:

People may be surprised at the beginning to receive mental help, but when they get to know this, they may feel better....They will like the experience... People need this service, they just don't know. We hesitate, get scared, and lack confidence, and we think what if something happens... Our wrong way of viewing mental health, but once we are there and we see how well they treat us, we then feel content and

comfortable about being there. It's like... (pause) they care about you because they want to help you to get through life. I now feel confident to call the therapist, she gave me a business card and said that I can call if I am not feeling well...(pause) She gives the option to terminate services when we feel better and also she makes herself available for future contact if needed. Ana (personal communication, August 12, 2011)

I think it is better that the counselor or therapist comes to us, even if we do not ask for it, because we often don't want help, or we can be resistant to this help... (pause) We may not easily accept that something is happening to us.... (pause) However, once you are there and you see the approach of the therapist you feel better. (Isabel, personal communication, August 25, 2011)

These statements describe the transformation of their views of mental health services from fear and distrust to relief and an increased sense of wellness.

Two participants described in detail that patients are more likely to accept and follow up with the suggestions made by their PCP, including appointments with the BHS. The participant also said that most people are in need of guidance and support, and this integrated care services, make things more accessible to people.

When we go to the clinic and they suggest something, these suggestions are more acceptable than to do it alone and contacting other services.... (pause) I don't think this may have happened.... (Pause) I think that we may not feel comfortable to do this [make an appointment with mental health professional] alone, when we have serious problems we may not do something about things like stress or behavioral issues, we don't. We often lack trust, and others may not understand this ... (pause)

When we are going through emotional pain, the pain in our heart is so strong, that makes us lack trust and may not want to talk about our problems to someone...

(pause) Sometimes I think about that, this is what happened to me, I was not sure, and after a while I felt better, I came home with a more clear mind and feeling better, even my daughter could tell. (Cecilia, personal communication, August 8, 2011)

Teresa pointed out the financial concerns associated with such services:

I think that people are in much need for guidance and support, this is a good type of service that is available and we can make use of it in an easy manner... (pause)

Many of us may need help but we may not be able to afford it because it is too expensive, or they do not accept Medicaid, or any other monetary barrier... (pause).

These are barriers for us to try and ask for help right. In this manner, the way this program works is available for everybody. (Theresa, personal communication, September 25, 2011)

These participants' testimonials describes the experience of patients in integrated care services with the BHS. She described the emotional needs, including distress experienced by people, the lack of trust to confide our emotions to someone else; the suggestion made by the PCP to see the BHS serves as a motivator for patients to accept the services they need.

**God.** Three participants mentioned God when they were talking about their experience in integrated care at the health clinic.

"People have to trust in God. I had faith in God" (Cecilia, personal communication, August 8, 2011)

Victoria made several statements about her faith, such as, “God says that each day will bring something different... If today I had a difficult time, tomorrow may be different”; “For me and for my daughter the service is a blessing from heaven” and, “She [BHC] allowed me to talk about God. God is always with me” (Victoria, personal communication, October 10, 2011)

Brenda prayed that the negative outcome she worried about would not happen:  
I prayed to God because I imagined that he [son] would be treated in a similar manner as my cousin, and I thought to myself: oh no they will do things to my son and no I do not want that... (pause)... And I then thought: well, I will take my son to see this doctor and we will see what he makes us feel, but no, nothing, nothing, nothing... (pause) I had a different expectation and no nothing. (Brenda, personal communication, September 18, 2011)

These statements describe the faith in God as a strong value, faith in positive days, and that being in company of God is meaningful to them. In this context, it was important that the BHS supported their beliefs.

***Patients Trust in Interviewer – Confided Personal Accounts During Interview.***

Some participants in the study shared personal experiences with researcher while interviewing them.

One of the participants shared her personal mental health crisis when she lived back in her home country. Her depression was compounded by a lack of support from her family.

When I was seventeen I was in Mexico. I was unhappy and sad, I was told there that I was a bitter person, they called me bitter, not body told me

that I was depressed or that I had a type of depression... (pause) I locked myself in my own world... (pause) I used to talk with my sister sometimes, but not all the time, so they used to say: look at this one she is so bitter these days, she does not want to talk with us... (pause) I did not talk and they did not ask me. (Isabel, personal communication, August 25, 2011)

Another participant named Margarita described her mother, who on the one hand was overprotective and on the other neglected basic needs such as health care, education and socialization.

My mom did not talk about illness, she was reserved. I also did not talk much with other people, I was always at home, my mom did not even let us go to school. She would not let us go on the streets (pause). None of my siblings or I attended school because my mom did not let us go. I recently found out that neither my siblings or [sic] I have been vaccinated (pause) because my mom and dad did not like to see us crying. (Margarita, personal communication, September 10, 2011)

Teresa revealed to the interviewer a sad experience her family was currently going through and expressed the need for emotional assistance and support.

My family has recently experienced something sad (pause). We lost my brother...my parents lost a son (crying). That has been so difficult, that also brought much irritability and anger...much emotional discomfort. Sometimes we are okay, sometimes we are not, sometimes there is much pressure, we sometimes don't understand the reason why something happens, and this makes us respond in a violent and angry manner. We can suddenly become depressed, lack understanding(pause) but this affects much.... My parents, for example, they are

currently going through a very difficult time, that I think, I think that they are needing much psychological support to be able to assimilate what has happened(pause). We are three children in my family, and we have always been close with one another (crying). So really this is (pause), God had his plan for my brother, take him from here when he did, so (pause). And it is so hard to be okay (crying). (Teresa, personal communication, September 29, 2011)

One participant reported to the interviewer that she had a bad experience with a therapist she had seen a year earlier, and compared that experience to her most recent experience with the BHS.

My experienced with her was totally different from my experience with the previous counselor [said the name of the counselor]. It was like as if she was doing her job because she had to do it, not because she really wanted to help me feel better and get out of the problems that I was experiencing, and improve the symptoms...(pause) I did not like when...(pause) I felt the environment negative and hostile, much indifference form her toward me, and when I went to the second appointment with her it was when she said to myself, what I told you earlier, I said to her that I was trying to do my best to feel better but I couldn't, I couldn't because there was something inside of me that was much stronger than my own will. I was feeling as if I was making my family feel overwhelmed, she [therapist] responded: you are making me feel overwhelmed because I was not doing anything different. (Victoria, personal communication, October 10, 2011)

This testimonial describes the interaction between the participant and her previous mental health provider. It describes words and body language displayed by psychologist,

which made the participant feel uncomfortable, and influence her discontinuing the service.

### **Part Five: Summary**

This chapter discusses the history of the clinic where the study took place, the population served since the origin of the clinic, the participants in the study, including their background information, and the main phenomenological structures, formed through grouping common impressions described by the participants in the study. This chapter also presents the participants' testimonials of their experience in Integrated Health, including their perspectives about health and mental health, as well as the practices they engaged to achieve wellbeing for themselves and their families. The final part presented testimonials that describe participants' feelings throughout the process, from the visit to the primary care physician through the evaluation and treatment by the BHS for mental and behavioral challenges.

The results of the study presented in chapter four were understood and organized into three main structures, which hold the central phenomenology. The first structure included the *patients' symptoms*, or the circumstances and presenting situation that led to the receipt of mental health care. These symptoms were then further divided into those experienced by adults, boys, and girls. The participants discussed the factors that influenced their decision to see the BHS for a follow-up visit. This included trust in the primary care provider (the referrer and pathway to mental health services) to whom patients had initially confided their problems, and the Behavioral Health Specialist. In evaluating the BHS they focused on her attitude, which also included appropriate skills and personal qualities, as well as an understanding of the participants' culture and country of

origin. Also critical to a positive Integrated Care experience was the strong connection between the primary care provider and the BHS. Oftentimes, a participant's ambivalence and initial resistance to see a BHS was decreased because of this connection.

The second structure holding the central phenomenon was the *Behavioral Health Specialist attitude and clinical approach*. The kind and humane approach from the BHS, with whom the majority of the participants were meeting for the first time, was also key in promoting a relaxing and confidence-building experience. The clinical skills and guidance from the BHS were used to tackle the presenting problem while normalizing the participant's initial feelings.

The third structure supporting the central phenomenon was *outcomes*. This structure from the phenomenon built up from participants' successful experience with BHS. When participants started to see positive outcomes after applying the guidance and tools provided by BHS, they decided to follow up with a third, fourth, and up to six sessions with BHS. These three structures hold the central phenomenon: the experiences that the eighteen participants had in integrated care services.

## CHAPTER FIVE

### DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

This chapter is organized into the following five parts: discussion of the research questions; the assumptions, biases and the researcher's experience throughout the study; the relevance of the study's findings to existing literature; conclusions and implications of the study; recommendations for future research around the integration of medical and mental health care; and my final reflections regarding the study and its findings.

#### **Discussion of Research Questions**

The answers to the three research questions were found in the participants' responses. The participants' presented common views and similarities about their experience. These were organized and analyzed. The responses from the participants formed themes, and these themes interconnected from the beginning of their experience they have related.

*Research Question 1: How do Latinas experience health care based on a model that integrates medical and mental/behavior services?*

The eighteen participants reported that their experience in Integrated Care began with trust in the clinic and the health care providers, particularly the physicians. This trust served as the primary motivating factor in their decision to confide in their primary care provider (PCP) about their present situation, either while in the exam room, or by calling the clinic to ask for help.

As mentioned in chapter four, chronicling the participants' experiences at the health care clinics was an ongoing process that began the moment that the adult participant, on behalf of herself or her children, visited or contacted the clinic and reported a non-physical,

health-related problem. It continued when they were offered the services of a Behavioral Health Specialist.

Participants reported a myriad of reasons for contacting the clinic, including their children's checkups, vaccination, illness, asthma, weight problems (overweight), dental issues, and behavior. They also visited the clinic for their own health concerns, including a wellness exam or checkup, thyroid problems and pap exam. Some adult participants reported going to the clinic because they were not feeling well in general or because they were depressed.

The common thread among the participants was that from their first visit or phone contact with the PCP, a foundation of trust was established. This trust would become the foundation for their overall integrated care experience as they shared their personal and family problems and requested help beyond their medical needs.

The connection from the PCP to the BHS was also a significant part of the experience. Having already established trust with the PCP, participants were reportedly more amenable to a referral visit with a BHS, and at the end of the first meeting with the BHS, they opened the discussion for possible subsequent visits to the mental-behavioral health services provided at the clinic.

Thirteen of the eighteen patients reportedly never visited a mental or behavioral health professional prior to their experience with the BHS. These patients admitted to feeling hesitation, ambivalence, and even fear when they initially considered seeing a psychotherapist. This anxiety was eased, however, by the fact that the PCP introduced them to the BHS in the secure environment of the exam room. This model took away some

of the discomfort of seeing a mental health professional and instead became a simple matter of one specialist transferring the patient's needs to another.

That said, some patients were still somewhat hesitant about meeting with the BHS, largely due to preconceptions and stigma around receiving mental health services. Typically, these preconceptions about mental health had been transmitted by their own family, country and/or culture of origin and included notions that one needing such services was "insane" or had incapacity to "think right" and "function in life". Participants also reported ambivalence around their child being referred to the BHS, for fear that their son or daughter may be found mentally ill, or with something "wrong in the head". Nevertheless, these thirteen participants eventually overcame their initial fear and agreed to meet with the BHS because their PCP had suggested it. The assumption was that if the doctor was recommending the service, it must be beneficial.

Participants also made meaning of the behavioral health practices learned at the clinic. These practices were mainly related to eating healthy, visiting the doctor regularly, exercising, feeling positive and taking proper care of their children. Patients also acknowledged the importance of being able to discuss issues with and get support from a professional, as this afforded them the opportunity to "talk with someone," "vent with a psychotherapist," and "keep a positive attitude." It should be noted, however, that these observations were made during the post-treatment interviews, when their situations and presenting problems had already improved.

*Research Question #2: What criteria do Latinas use to determine whether or not to return for a follow up visit with the Behavioral Health Specialist?*

In discussing what influenced their decision about whether or not to return for a follow-up session with the BHS, participants consistently highlighted the personal qualities of and the approach used by the BHS. The positive qualities most cited by the participants included a friendly and welcoming greeting; making and maintaining eye contact while speaking; a soft tone of voice; smiling; including both children and adults in the conversation; good listening skills, paraphrasing what patients had said; body language that showed responsiveness to what has been said; ability to make others feel understood through words of empathy and facial expressions; being patient; and showing cultural sensitivity. The BHS also showed interest in and included other family members in the sessions. She communicated with the parent about children's needs and feelings; instilled hope by normalizing individual situations and stressing positive prognoses; showed a willingness to help by responding to doubts and questions; provided comfort by making patients feel comfortable and relaxed; showed empathy, compassion and understanding when feelings were expressed; and responded to requests in a timely fashion.

The BHS's personal qualities and approach was a factor in whether patients opted to remain in the first session and discuss the presenting problem(s) and any negative feelings or behaviors they or their children were experiencing. Furthermore, the way in which the BHS approached that initial visit determined whether participants were willing to return for a follow-up session.

The other criteria that determined whether Latina patients returned for a follow-up session were the clinical approach and skills demonstrated by the BHS during the initial session. These included assessing the patient's situation by asking appropriate questions

about her health and any past and/or present need for medication; her feelings and behaviors; and her personal strengths as well as those of her family.

Patients also cited the BHS's problem-solving skills; ability to focus on the positive aspect of the situation and show support when pros and cons were explained; and normalize ambivalence. Participants who were seeking treatment for their children were influenced by the BHS's ability to provide tools and exercises to assist them with parenting, including models for improved communication with children; validation of children's and parents' feelings. She provided guidance around rebuilding attachment through re-connecting and sharing acts of reconciliation and acceptance. The BHS also provided guidance to the family as a whole, using the family therapy model; incorporated circular questioning to support certain family values and structures while challenging others; liaised with other professionals and advised parents about following up with specialists. It was also important to participants that the BHS encouraged an exploration and expression of feelings and provided practices that the family could easily incorporate into their daily lives and focused on the solution rather than in the problem.

Patients appreciated the fact that the BHS explained the confidentiality policy, namely, that information shared at the clinic will remain within the premises. Finally, they found the BHS's cultural competency; including the ability to speak Spanish was also a significant factor in whether they returned for a follow-up visit.

*Research question #3: What criteria do Latinas use to determine whether or not they decide to return to the clinic for subsequent visits to the BHS?*

When asked about the factors that influenced their decision to continue receiving behavioral health services, patients focused primarily on the outcomes of previous

appointments; in other words, whether their presenting symptoms had improved and whether they had made progress on the original issue. For parents bringing their children in for treatment, these outcomes included an increased level of awareness of their children's physical and emotional needs, improved approaches to parenting and healthier ways of managing their own emotions.

Other positive outcomes cited by participants included their children being able to express anger in constructive ways (i.e., speaking about their feelings rather than screaming and fighting). Parents also reported that their children's anxiety levels appeared to decrease and families overall were interacting better after seeing the BHS. The BHS also provided referrals to speech specialists and psychiatrists and liaised with the children's schools.

As mentioned earlier, the participants' integrated care experience was centered around the trust they had for their PCP, as well as the connection between the PCP and the BHS. That said, it was the improvement in symptoms that most heavily influenced the participants and experienced as a result of the clinical advice and guidance provided by BHS that served as the primary motivating factor in whether participants returned for a third appointment, sometimes more. Most participants reported an average of three follow-up sessions with the BHS.

While the participants expressed satisfaction with the clinical aspects of their meetings with the BHS, perhaps the most telling aspect of the study were their overall feelings about their experiences at the clinic. Participants reported feeling comfortable, confident, understood, hopeful, protected and guided, particularly due to the BHS's cultural proficiency. They also appreciated being able to see the psychotherapist in the same health

clinic in which they received medical services and not having to think about extra payments. Trust in God; some participants even stated that they enjoyed the experience.

### **Researcher's Experience, Assumptions and Biases**

There were a few important factors influencing my experience throughout the study, including my previous knowledge about the integrated care model, having previous experience providing services as a Behavioral Health Specialist at the same clinics where the study was carried out. My familiarity with the clinic and the clinic's awareness of my previous experience, fostered confidence around the purposes and parameters of the study as well as my ability to carry it out.

I worked closely with two full-time Behavioral Health Specialists, one from the adult clinic and the other from the pediatric clinic, while recruiting the participants. Once I had received consent from the clinics' administrators, the BHS randomly chose forty patients who had seen a BHS in the last two years and provided the list of patients to me for contact.

When I received permission to talk to participants about what the study was about, I contacted approximately thirty patients from the list provided by the BHS, some participants accepted to take part in the study during the first telephone contact. The positive response from participants initiated over the phone, and this continued during the interviews. Most of the visits began with a warm welcome to the participant's home. Participants asked me about my journey to their place, and most offered me a drink before the beginning of the interview; some even offered me a snack.

During the interview, I explained in more detail the main goal of the study, and then confidentiality as well as other protocols were signed before moving on to the collection of demographic information.

I focused on building a rapport with participants, beginning with the first telephone contact and continuing throughout the interview process. Participants appeared open and trusting, which encouraged me to ask more substantive questions about their integrated care experience. Some participants were even willing to share current personal issues that were causing them distress.

There were several factors that facilitated the trust between the participants and myself, and these factors ultimately influenced the study's outcomes. These influential factors included my fluency in Spanish, my familiarity with the clinic and knowledge of the integrated care program. I am a PhD candidate from a Latin-American background, and Spanish is my first language; therefore, in addition to my knowledge about mental health and integrated care services, I also had an understanding of the participants' culture. I also had an excellent relationship with the clinic's BHSs and medical staff, a fact that was noted by some of the participants during the interviews.

My experience was also strongly influenced by the support of the academic committee, especially from the methodologist, and main adviser. They supervised the planning and execution of the study by guiding and advising me during some crucial parts of the data organization and analysis.

The participants of the study were representative of the Latina population receiving medical services at the clinics, and their narratives held strong similarities. The common thread was their ambivalence and fear before meeting with the BHS, as well as their satisfaction with treatment outcomes.

From the outset of the study it was to some extent assumed that the participants' experience in integrated care had been positive, which was a strong factor in their decision

to take part in the interviews. I also believed that this positive experience would set the tone for the interviews themselves. This was largely true; however, there was one participant in the study who had experienced originally a negative experience, and a year later a positive experience in integrated care.

### **Relevance of the Study to Existing Literature**

There have been numerous studies about the incorporation of medical and mental health services under an Integrated Care model, however, those studies have relied primarily on the reports of the medical care providers, mental health providers, and administrative personnel (Doherty, 1995; Finney et al., 1990; Hemmings, 1997; Katon, 1995; Kates et al., 1997; Mauksch & Leahy, 1993; McDaniel et al., 1992; McDaniel et al., 1995; Miranda & Munoz, 1994; Peek & Heinrich, 1995; Regier et al., 1993; Sells & Smith, 1996; Scott & Freeman, 1992). That said, there was a scarcity of literature on patients' opinions about the integrated care program, and no information provided directly from patients at an integrated care program, and no literature about Latino or Latina patients in integrated care.

This study helps to close that gap by collecting information in the participants' own voices. The interviews echoed some of the previous studies in that they revealed barriers to access health and mental health services. They also confirmed that Latinas are generally more likely to accept mental health support from their general health care provider than to seek separate mental health services. Many Latinas feel that they should have the ability to cope with life's problems on their own and with the help of family members; this belief underscores the importance of cultural sensitivity on the part of therapists. This supports the theory that the integrated care model, in which primary care providers refer patients

for mental health services, is beneficial. That fact that medical and mental health services are offered in the same location made it easier for patients to access services, and dispenses with some of the barriers and cultural stigma as well.

The existing literature also explores the benefits of the communication and consultation between primary care providers and mental or behavioral therapists (Doherty, 1995; Finney et al., 1990; Grames, 2006; Kates et al., 1997; Katon, 1995; Mauksch & Leahy, 1993; McDaniel et al., 1992; McDaniel et al., 1995; Miranda & Munoz, 1994; Peek & Heinrich, 1995; Regier et al., 1993; Scott & Freeman, 1992) It notes the value Latinas place on the personality of the mental health provider; the friendliness, respect and cultural sensitivity demonstrated by the therapist is extremely important in building a strong relationship and increases both the acceptance of such services and the likelihood of follow-up.

As stated earlier, the participants' answers to the interview questions supported information on the barriers to access mental health services and health services described in existing literature. These barriers include: concerns about payment; lack of health insurance; fear; lack of knowledge about mental health; and stigma about mental illness and those who receive mental health care services. Guarnaccia et al., (2005), as well as Vega and Lopez (2001) stated that the lack of health benefits and low wages are also frequently mentioned barriers to seeking mental health care. The relative lack of Spanish-speaking mental health care providers, coupled with a lack of information about services in Spanish, also served as a deterrent to Latinas in need of such services.

The current study found that while Latinas may be reluctant to seek out mental health care providers, they do feel comfortable talking with their primary medical doctor

(PCP) about their personal and family problems. The eighteen participants reported that they trusted their doctor and listened to what he or she recommended; in fact, they all stated that they preferred long-standing relationships with their doctors to creating a bond similar to friendship. As indicated in the existing literature, it is not common for Latinos to make an appointment with a psychotherapist (Brooks, 1990; Grzywacz et al., 2010; Ortega & Alegria, 2002). Two of the participant in the study explicitly stated that if the psychotherapy service had not been offered by the doctor and was not accessible in the same clinic, they would not have attended the sessions with the BHS. One of the participants said that she would have never made an appointment with a mental or behavioral health professional on her own, while nine participants reported that they felt comfortable sharing their personal and family problems with the PCP and would follow his/her advice regarding their mental and/or behavioral health concerns.

According to existing literature, women are more likely to use medical and mental health services than men (Ortega & Alegria, 2002). This was reaffirmed during the process of finding participants for the present study. The study was originally designed to interview Latinas and Latinos who had attended integrated health services; however, I soon discovered that a much smaller number of Latino men attended services at the clinic. The majority of potential participants in the study, whose names were provided to me by the clinic, were women, with the exception of about seven men. The eighteen patients who accepted the offer to participate in the study were women. During two of the interviews the participant's partner joined in; however, these men chose to take a back-seat role and mainly listened to what the women had to say about their medical appointments, their children's medical check-ups, and attending sessions with BHS.

As previously mentioned, the existing literature described a level of familiarity that made it more likely that patients would seek proper care (Cabassa et al., 2006; Guarnaccia et al., 2005; Kouyoumdjian et al., 2003). This familiarity in part comes from the previous use of mental health services and from the knowledge about where to seek such mental health treatments (Cabassa et al., 2006). Three participants in the study reportedly had already seen the BHS walking along the clinic's hallways and had even been briefly introduced to them by their medical provider; another two said that they had been in therapy prior to taking part in the study. As a result, these five participants did not experience feelings of fear or ambivalence when the PCP had suggested seeing the BHS in the clinic.

The participants were also asked how they defined mental health; five participants defined mental health as having a positive outlook, being emotionally balanced, and being tolerant. Their accounts echoed what Ortega and Alegria reported in their 2002 study, which concerned perceptions in the Latino community around mental health, namely, one's ability to cope with life's problems on one's own and with the help of family. Although in the current study, these perceptions were not always explicitly stated, they often seemed aligned with the notion that mental health is by definition an attitude of contentment that enables a person to handle stressors and other life events.

The literature concerning integrated care discusses the type of approach a BHS should take when meeting with a patient, particularly one who may be reluctant about seeking mental health assistance (Kouyoumdjian et al., 2003; Vega, & Lopez, 2001). That said, this information was collected primarily from the health care providers. In contrast, the current study collected the opinions of the patients, in their own words, with results

that consistently echoed the previous literature (Cabassa et al., 2006; Kouyoumdjian et al., 2003; Mulvaney-Day & Alegria, 2011) mentioned several qualities in the BHS that would make them more likely to return to follow-up visits, including: the manner in which the BHS greeted the patient; his/her approach to the patient's symptoms, and most importantly his/her listening skills and ability to make others feel understood.

The ideal BHS also included other family members when it was beneficial to do so, and was committed to instilling hope, promoting confidence in patients' ability to overcome challenges, and responding rapidly and accurately to patient symptoms and concerns. As expressed consistently throughout the interviews, the personality and approach of the BHS during the initial consultation strongly influenced participants' decision as to whether to attend the follow up-session. As one woman, "Maria" noted, "We must feel comfortable before we can feel confident to talk and trust our personal matters". This statement clearly illustrates the way patients need to feel in the presence of a psychotherapist before they can open up about their lives and mental and behavioral challenges. The BHS must clearly demonstrate certain characteristics when working with a patient that could become client.

Two of the eighteen participants referred to BHS's informal, friendly approach as something they would typically see with family members, and which fostered a similar connection. One woman went so far as to say that interacting with the BHS felt like speaking to a mother figure, implying a high level of mutual trust and respect.

The participants' responses regarding the BHS's approach reinforce the findings of earlier studies that emphasize the importance of these qualities for Latino patients. For example, the work of Atkinson, Ponce & Martinez (1984) suggesting that client-therapist

ethnic matching has no influence on client's perception about therapist credibility given by Mexican-American. Their 1984 study found that cultural sensitivity and openness from the BHS, as well as an understanding of the main issues and feelings commonly experienced by immigrant patients and clients, was important. Fontes and Thomas (1996) also found that cultural curiosity and openness to clients' cultural backgrounds was important in order to create a strong relationship or "cultural fit" between the clinician and the client. Grames (2006) referred to the use of the medical – behavioral health model of services as an appropriate and effective means to overcome cultural barriers to treatment.

Grames' work also explored the benefits of combining the medical and mental-behavioral health needs in the same location. According to the study, patients find it easier to follow up with mental-behavioral health session(s) if they are offered in the same location as medical services; this is due to patients' familiarity and trust with the clinic and staff, as well as it being logistically simpler to go to one place for all services. The importance of the communication between medical staff and behavioral health staff to address patients' behavioral concerns was also suggested (Grames, 2006), as these professionals know different aspects of the patients' profile. In addition, patients' awareness of this consultation between the BHS and PCP further encouraged trust of service providers and the overall process.

## **Conclusions**

The personal nature of this study, as well as the way the information was collected (interviews), make the conclusions drawn from that information heavily influenced by the primary actors. The first is the Latina participant/patient at the clinic who agreed to discuss her culture, beliefs, practices, life experiences, and medical history. The second

person influencing these conclusions is the mental-behavioral health clinician, who before becoming a researcher specializing in such narratives trained as a systemic family therapist, later specializing in integrated care services and working alongside physicians. The third person influencing the conclusions was myself, I examined the possibility of carrying out the study, planned and organized the ideas, consulted with the committee and prepared methodologies for the enquiry, and interpreted and analyzed the collected testimonials and experiences.

This study has sought to document and understand the experiences of Latina patients treated under an integrated health care model. It highlighted aspects of their experience, which were positive, such as the willingness to open up to the PCP. It only reaffirmed the barriers to mental health services discussed in the existing literature, the most significant of which is the ambivalence and even fear around accepting mental-behavioral services, which is primarily based upon the stigma around mental illness and its treatment instilled in them by their families and their culture. The integrated health care model utilized by the clinics in this study demonstrated ways in which these barriers can be overcome and even make accessing services a positive experience, by building upon the trust Latino and Latina patients tend to place in their PCP. As the interviews with the participants revealed, they were more willing to accept mental health services when suggested by their PCP, and they were also comforted by the fact that these services were provided in the same facilities as their medical care.

This study further reveals, through the patients' own testimonies, the positive experience around mental health services, most notably the rapport they had with the BHS. Specifically, they noted that their BHS was positive, gentle, empathic, supportive and

understanding. The BHS also provided excellent clinical guidance, through metaphors, exercises and parenting tools that enabled and empowered patients. Perhaps most important was the high level of cultural competence displayed by the BHS, which has been determined in numerous studies as critical in providing medical and mental services to Latinos and Latinas.

One of the cases in particular highlighted the value of cultural sensitivity when providing mental health services. A PCP referred a young girl to integrated care services after she refused to let the PCP, in company of another medical staff, conduct a thorough examination during her yearly check-up. The PCP instantly suspected that the girl had been sexually abused and consulted with the BHS, who in turn carried out a detailed family assessment. After interviewing the mother, father and each child, including the patient, the BHS concluded that no sexual abuse had taken place. The girl's reluctance to submit to a medical exam stemmed from her mother's warning to never let anyone see or touch her private parts. It was simply her way of protecting her children.

This case is an excellent example of the need for culturally aware and culturally competent clinicians. In his 1998 study, Lozano conveyed that trust-building, establishing an authentic rapport and promoting self-esteem with elderly Latinos yielded better therapeutic results in social work and psychotherapy, as well as other medical disciplines. A good rapport between care provider and patient promotes acceptance of and compliance with treatment plans; that said, such a rapport includes an understanding and respect for cultural beliefs and traditions. This includes providing parents with at-home approaches that help their children, are aligned with their beliefs, promote confidence and improve the parent-child relationship.

## **Implications and Recommendations for Practice and Applications**

The participants' visits with the BHC revealed symptoms and their origins, most of which related to systemic and family matters. The narratives discussed the presence of trauma derived from unhealthy early attachment and adult attachment. There were also reports of domestic violence, abandonment, unresolved losses and grief, stress due to financial difficulty, immigration issues, and lack of support.

Treatments for these and other mental and behavioral health challenges were multifold – they were diagnosis-centered, child-centered and parenting-focused; they included medication, one-on-one therapy and family therapy. The treatments offered to the adult mothers were mainly individual work with the BHS. The treatments used were solution-focused, couple and parenting-focused, and were mainly based on Cognitive Behavioral Therapy (CBT), and attachment-based.

As mentioned earlier, the study's findings strongly recommend that medical and mental health practitioners, health educators and other staff involved in the health care sector become aware of the cultural needs of Latina patients. With a greater understanding of the values and beliefs held by their patients, PCPs could be more perceptive around symptoms, even when those patients do not verbalize them. Culturally sensitive mental health staff could take the more personal approach favored by Latinos, thereby improving patient/ client retention and increasing the likelihood that patients/ clients will complete appropriate mental-behavioral health treatments.

The existing literature, as well as the responses from this study's participants, shows that Latinas prefer to see a Spanish-speaking professional, ideally of Latino background. That said, the health care provider's ethnicity is not nearly as important as a

high level of cultural awareness and the ability to communicate with them in Spanish. In this study, one BHS (a psychotherapist) was not Latina, yet patients reportedly felt comfortable with her in their sessions because of her cultural competency and warm, respectful manner.

It is recommended that health clinics serving minority groups, particularly Latinas, pilot integrated care programs so that medical providers can consult and collaborate with mental-behavioral health providers. Medical providers should be given training on cultural competency and integrated care, which as a model of service can benefit patients and potentially decrease long-term costs from urgent visits to the emergency room.

As mentioned above, while there is a reasonable amount of literature regarding Latinos and mental health services (Cabassa et al., 2006; Grames, 2006; Grzywacz et al., 2010; Mulvaney-Day & Alegria, 2011; Ortega & Alegría, 2002; Santiago-Rivera, Arredondo & Gallardo-Cooper, 2002; Vega & Lopez, 2001), there is no literature that recorded the personal experiences of Latinas receiving those services, particularly in integrated care settings. By collecting those experiences through a phenomenological approach, the present study allowed me to gain critical insight into the barriers that prevent Latina patients to receiving proper care, including culturally held beliefs and stigmas, and possibly assist caregivers in overcoming them. It would therefore be beneficial to use the same approach to collect the experiences of patients from other minority groups in similar settings. Further research should also include the outcomes of such treatment so it can be used by the mental-behavioral and medical sectors. Information about the meaning of health and mental health in other cultures will be especially important, as these often determine the level of compliance with treatment. Clinics such as those covered in this

study are the front line of health care, and the providers there have the first and best opportunity to observe mental health challenges and refer patients to the proper therapist. In doing so, the integrated health care model is excellent for early intervention and treatment and the reduction of emergency room visits, thereby saving millions in health care costs each year. It could also prevent much needless suffering to patients by educating them around mental health and offering them tools they can use on a daily basis while remaining aligned with their own beliefs and values.

### **Final Reflections**

This study is the culmination of years of work on the part of my research, including content and process. Long before I designed the interview questions or began searching for participants, I was providing psychotherapy services as a Family Therapist and as a Behavioral Health Specialist. In this capacity I was passionate not only about providing guidance and support, but about the qualitative enquiry; namely, collecting my clients' narratives and understanding the way they construct their meaning. Through this work, I have witnessed many of the barriers to health care experienced by Latinas, as well as the benefits of the integrated health care model explored in this study. I also discovered that this is an area in which more research is needed, through the exploration of programs similar to the one chronicled in this study and interviewing patients about their experiences.

The richness of the data in this study suggests a usefulness that extends well beyond publication and into more practical arenas such as teaching conferences and workshops. The candor of the eighteen participants about their experiences with integrated health, coupled with the insightful information provided by the two Behavioral Health Specialists,

five medical doctors, and the clinics themselves would serve as a strong foundation for future research.

One of the critical findings of the study was the willingness of patients to talk about what is causing them concern and distress, but only after establishing a level of comfort and trust with health care providers. These providers are welcoming, gentle and empathic; they are also talented clinicians who can produce tangible results. As I collected their stories, I was grateful to be included in the circle of trust that began with the primary care provider and continued with the BHS as part of the integrated care services offered at the clinic. That trust led to their willingness to participate in the study.

The other important aspect of their integrated health experience was the way doctor, BHS and the researcher welcomed, accepted, respected and responded to patients opened the access to the narratives, and stories made meaning. Furthermore, participants were encouraged to take an active role in their treatment as well as in the study, thus empowering them around mental health challenges and perhaps dispelling some of the stigma passed down to them from their families and culture.

The study's findings propose an improved access to mental-behavioral health services. Ultimately, this study illustrates tools that assist clinicians and providers in making treatment a more beneficial, positive experience for their patients. The results documented herein encourage providers to embrace reflexivity and professional humility when serving patients and clients. The participants' responses also give great insight into the need for providers to have greater cultural competency. This will give them a more comprehensive understanding of the unique circumstances and presenting symptomatology before a formal assessment is issued. Finally, the study reaffirms the fact

that each encounters between patient and doctor, or between medical professionals, should not be underestimated, but used as an opportunity to assess, promote greater understanding, and provide a higher level of care.

## REFERENCES

- Applewhite, S. L. (1998). Cultural competence practice with elderly Latinos. *Journal of Gerontological Social Work*, 30: 1, 1-15.
- Atkinson, D. R., Ponce, F.G., & Martinez, F.M. (1984). Effects of ethnic, sex, and attitude similarity on counselor credibility. *Journal of Counseling Psychology*, 31, 588-590.
- Blount A., & Bayona, J. (1994). Toward a system of integrated primary care. *Family Systems Med*, 12(2), 171-182.
- Blount, A. (1998). *Integrated Primary Care: The Future of Medical and Mental Health Collaboration*. New York, NY: W. W. Norton.
- Blount, A. (2003). Integrated primary care: Organizing the evidence. *Families System & Health*, 21, 121-134.
- Brooks, T. (1990). Pitfalls in communication with Hispanic and African-American patients: Do translators help or harm? *Journal of the National Medical Association*, 84(11), 941-947.
- Budman, S.H., Demby, A. B., & Feldstein, M. L. (1984). A controlled study of the impact of mental health treatment on medical care utilization. *Medical Care*, 22(3), 216-222.
- Cabassa, L. J., Zayas, L. H., & Hansen, M. C. (2006). Latino adults' access to mental health care: a review of epistemological studies. *Admission and Policy in Mental Health Services Research*, 33(3), 316-330.
- Charmaz, K. (2000). Grounded theory: objectivist and constructivist methods. In Denzin, N.K. and Lincoln, Y.S. (Eds.), *Handbook of Qualitative Research*, 2<sup>nd</sup> ed. Thousand Oaks, CA: Sage Publications. pp. 509-535.

- Cohen, D., & Crabtree, B. F. (2006). Qualitative Research Guidelines Project. Retrieved from <http://www.qualres.org/HomeSemi-3629.html>
- Coleman, J. V., & Patrick, D. L. (1976). Integrating mental health services into primary medical care. *Medical Care*, 14(8), 654-661
- Coleman, J. V., Patrick, D. L., Eagle, J., & Hermalin, J. A. (1979). Collaboration, consultation and referral in an integrated health-mental health program at HMO. *Social Work in Health Care*, 5(1), 83-96
- Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. London: Sage Publications.
- Creswell, J. W. (2003). *Research design qualitative, quantitative, and mixed methods approaches*. London: Sage Publications.
- Crotty, M. (1998). *The foundation of social research: Meaning and perspective in the research process*. London: Sage Publications.
- Documet, P. I., & Sharma, R. K. (2004). Latinos' health care access: financial and cultural barriers. *Journal of Immigrant Health*, 6(1), 5-13.
- Doherty, W. (1995). The why's and the levels of collaborative family health care. *Family Systems Medicine*, 13(3-4), 275-281.
- Doherty, W. J., McDaniel, S. H., & Bair, M. A. (1996). Five levels of primary care/ behavioral healthcare collaboration. *Behavioral Healthcare Tomorrow*, 5 (5), 25-27
- Feierabend, R. H., & Bartee, Z. (2004). A collaborative relationship between a community mental health center and family practice residency program. *Family, Systems & Health*, 22(2), 231-237.

- Finney, J. W., & Riley, A. W., & Michael F. C. (1991). Psychology in primary health care: effects of brief targeted therapy on children's medical care utilization. *Journal of Pediatric Psychology, 16*(4), 447-461.
- Fontes, L. A., & Thomas, V. (1996). *Family Therapy Source Book* (pp. 256-282). New York: Guilford Press.
- Gallegos, J. S., Tindall, C., & Gallegos, S. (2008). The need for advancement in the conceptualization of cultural competence. *Advances in Social Work, 9*(1), 51-62.
- Gatchel, R. J., & Oordt, M. S. (2003). *Clinical health psychology and primary care, practical advice and clinical guidance for successful collaboration*. Washington DC, American Psychological Association.
- Grames, H., (2006). Depression, anxiety, and ataque de nervios: the primary mental health care model in a Latino population. *Journal of Systemic Therapies, 25*(3), 58-72.
- Grzywacz, J., Quandt, S., Chen, H., Ison, S., Kiang, L., Vallegos, Q., & Ascury, T. (2010). Depressive symptoms among Latino farmworkers across the agricultural season: structural and situational influences. *Cultural Diversity and Ethnic Minority Psychology, 16*(3), 335-43.
- Guarnaccia, P. J., Martinez, I., & Acosta, H. (2005). Mental health in the Hispanic immigrant community: an overview. *Journal of Immigrant and Refugee Services, 3*(1-2), 21-46.
- Hemmings, A. (1997). Counseling in primary care: A randomized controlled trial. *Patient Education and Counseling, 32*(3), 219-30.
- Hunter, C. L., Goodie, J. L., Oordt, M. S., & Dobmeyer, A. C. (2009). *Integrated behavioral health in primary care: Step-by-step guidance for assessment and intervention*. Washington, D.C., American Psychological Association.

- James, L., & Folen, R. (Ed.). (2005). *The primary care consultant: the next frontier for psychologists in hospitals and clinics*. Washington, D.C.: American Psychological Association.
- Kates, N., Craven, M., Crustolo, A. M., Nikolau, L., & Allen, C. (1997). Integrating mental health services within primary care. *General Hospital Psychiatry, 19*(5), 324-32.
- Katon, W. (1995). Collaborative care: patient satisfaction, outcomes, and medical cost-offset. *Family System Medicine, 13*(3-4), 351-65
- Kitzinger, J. (1994). The methodology of focus groups: the importance of interaction between research participants. *Sociology of Health, 16*, 103-121.
- Kitzinger, J. (1995). Introducing focus groups. *British Medical Journal, 311*, 299-302.
- Klinkman, M., & Okkes, I. (1998). Mental health problems in primary care: A research agenda. *The Journal of Family Practice, 47*(5), 379-384.
- Koch, H. C. H. (1979). Evaluation of behavior therapy intervention in general practice. *Journal of the Royal College of General Practitioners, 29*(203), 337-340.
- Kroenke, K., & Mangelsdorff, D. (1989). Common symptoms in ambulatory care: incidence evaluation, therapy, and outcome. *The American Journal of Medicine, 86*(3), 262-266.
- Kouyoumdjian, H., Zamboanga, B. L., & Hansen, D. J. (2003). Barriers to community mental health services for Latinos: treatment considerations. *Clinical Psychology: Science and Practice, 10*(4), 394-422.
- Kruger, R. A. (1988). *Focus Groups: A Practical Guide for Applied Research*. Sage, London.
- Lincoln, Y., & Guba, E. (1985). *Naturalistic Inquiry*. Newbury Park, CA: Sage Publications.
- Lopez, S. R. (2000). The Mental Health Needs of the Hispanics in the United States. *Proceedings of the national congress for Hispanic mental health, 63-72*: SAMHSA.

- Lozano, S. (1998). Culturally competent practice with elderly latinos. *Journal of Gerontological Social Work*, 30(1-2), 1-15.
- Mauksch, L. B., & Leahy, D. (1993). Collaboration between primary care medicine and mental health in an HMO. *Family System Medicine*, 11(2), 121-135.
- McDaniel, S. H., Hepworth, J., & Doherty, W. (1992). Medical family therapy with couples facing infertility. *The American Journal of Family Therapy*, 20(2), 101-122.
- McDaniel, S. H., Campbell, T. L., & Seaburn, D. B. (1995). Principals for collaboration between health and mental health providers in primary care. *Family Systems Medicine*, 13(3-4), 283-298.
- McLeod, C. C., Budd, M. A., McClelland, D. C. (1997). Treatment of somatization in primary care. *General Hospital Psychiatry*. 19(4), 251-258.
- Merriam, S. B. (1995). What can you tell from an N of 1?: Issues of validity and reliability in qualitative research. *PAACE Journal of Lifelong Learning*, 4, 51-60.
- Miranda, J., & Munoz, R. (1994). Intervention for minor depression in primary care. *Psychosomatic Medicine*, 56(2), 136-142.
- Morgan, D. L., & Kruger, R. A. (1993). When to use focus groups and why. In Morgan, D.L. (Eds.), *Successful Focus Groups: Advancing the State of the Art* (pp. 1-19). London: Sage Publications.
- Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology*, 52(2), 250-260.
- Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage Publications.

- Mulvaney-Day, N. E., & Alegria, M. (2011). Preferences for relational style with mental health clinicians: A qualitative comparison of african american, latino and non-latino white patients. *Journal of Clinical Psychology, 67*(1), 31-44.
- Mumford, E., Schlesinger, H. J., Glass, G. V., Patrick, C., & Cuerdon, T. (1984). A new look at evidence about reduced cost of medical utilization following mental health treatment. *The American Journal of Psychiatry, 141*(10), 1145-1158.
- Murray, C. J. L., & Lopez, A. D. (1996). The Global burden of disease: A comprehensive assessment of mortality and disability for diseases, injuries, and risk factors in 1990 and projected to 2020: *Vol. 1 Of Global Burden of Disease and Injury Series*. Cambridge, MA: Harvard University Press.
- O'Donohue, W. T., Byrd, M. R., Cummings, N. A., & Henderson, D. A. (2005). *Behavioral integrated care: treatments that work in the primary setting*. New York, N.Y.: Brunner-Routledge.
- Ortega, A. N., & Alegría M. (2002). Self-reliance, mental health need, and the use of mental healthcare among island Puerto Ricans. *Mental Health Services Research, 4*(3), 131–140.
- O'Sullivan, M. J., & Lasso, B. (1992). Community mental health services for Hispanics: A test of the culture compatibility hypothesis. *Hispanic Journal of Behavioral Science, 13*, 455-468.
- Peek, C. J., & Heinrich, R. L. (1995). Building a collaborative healthcare organization from idea to invention to innovation. *Family System Medicine, 13*(3-4), 327-342.
- Regier, D. A., Narrow, W. E., Rae, D. S., Manderscheid, R. W., Locke, B. Z., & Goodwin, F. K. (1993). The de Facto US mental and addictive disorders service system.

- Epidemiologic catchment area prospective 1 – year prevalence rates of disorders and services. *Mental and Addictive Disorders Service*, 50(2), 85-94.
- Santiago-Rivera, A., Arredondo, P., & Gallardo-Cooper, M. (2002). *Counseling Latinos and La Familia*. Sage Publications, Inc. California.
- Scott, A., & Freeman, C. (1992). Edinburgh primary care depression study: Treatment outcome, patient satisfaction, and cost after 16 weeks. *British Medical Journal*, 304, 883-7.
- Sells, S. P., & Smith, T. E. (1996). An ethnographic study of client and therapist perceptions of therapy effectiveness in a university-based training clinic. *Journal of Marital and Family Therapy*, 22(3), 321-342.
- Smith, J. A. (1995). Semi-structured interviews and qualitative analysis. In Smith, J.A., Harre, R. & Langenhove, L.V. (Eds.), *Rethinking Methods in Psychology* (pp. 9–26). London: Sage Publications.
- Strauss, A., & Corbin, J. (1998). *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*. 2<sup>nd</sup> Edition. London. Sage Publications.
- Todahl, J. L., Linville, D., Smith, T. E., Barnes, M. F., & Miller, J. K. (2006). A qualitative study of collaborative health care in a primary care setting. *Families Systems & Health*, 24(1), 45-64.
- US Census Bureau (2000). US Department of Commerce, Economic and Statistic Administration. *Colorado Summary Population and Housing Characteristics*. Issued July 2002, p. 46.
- US. Department of Health and Human Services. (2001). *Mental Health: Culture, Race, and Ethnicity-A Supplement to Mental Health: A Report of the Surgeon General*. Rockville,

MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Centre for Mental Health Services.

Vega, W. A., & Lopez, S. R. (2001). Priority issues in Latino mental health services research. *Mental Health Services Research*, 3(4), 189-200.

## APPENDIX A

### Interview Questions

1. What comes to your mind when you think about health?
2. What is the understanding and opinion about health in your culture, including your beliefs about health?
3. What do you do to take care of your health?
4. What do you think about mental health or behavioral health?
5. What is the understanding and opinion about mental health in your culture, including your beliefs about mental health?
6. What is your opinion about a behavioral health provider visiting you during your visit to the medical doctor?
7. On a scale from 1 to 10, where 1 is poor and 10 is excellent, how would you rate your experience with a Behavioral Health Specialist? Why?
8. What would you like to see different from your experience with integrated care?
9. What motivated you to come to your follow up appointment with the Behavioral Health Specialist after the first time you met with her during your visit with your medical doctor? [Or what influenced you to decline the follow up visit?]  
[Questions 12-14 for those who attended follow-up appointment only]
10. What is your opinion about the follow up visit (second or third visit) with the behavioral Health Specialist compared to the consultation session during your visit with your medical doctor?
11. What impact did the follow up visit have on your emotional and physical being?
12. What impact has this second or third visit had on your family?

13. Is there anything that you would suggest to change in this process?

To be asked privately (either by phone or in person)

1. What was the issue/concern that brought you to a follow-up appointment?

Alternatively, What was the issue / concern for which you were referred?

2. On a scale of 1-10, with 10 being high, how much were you struggling with this concern at the initial visit?

3. How much were you struggling with it at the second visit? How much are you struggling with it now?

Final question (key question):

What is your opinion about the impact that integrated health care has in the community?