Chapter 10
Integrated Depression Care Among Latinos

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Introduction

When asked to write this chapter on integrated depression care in primary care, I thought about my own experiences as a primary care provider two decades ago. At that time, there was no mental health parity and minimal or no insurance coverage of mental health conditions, and if there was coverage, there was no place to send my monolingual Spanish speaking patients, a problem that in the subsequent 20 years, remains a persistent barrier to health care access (Bridges, Andrews, & Deen, 2012). Thus, integrated care consisted of dispensing the SSRI du jour that the pharmaceutical rep had recently deposited. Yet it was also more than that. As we now know, it's the relationship with the provider that influences outcomes more than whatever technique is used and as a primary care provider who sees patients on a regular basis, one may be able to experience the privilege of being confided in and trusted by our patients. I heard from a Puerto Rican woman whose son committed suicide several years prior, upon return from Desert Storm and a Dominican woman whose children had become "too American" and no longer shared her values. There was a Mexican man, a former teacher who was experiencing a profound sense of grief due to his wife's infertility. A well-educated Ecuadorian woman quietly and tearfully spoke of having to leave her children behind while fleeing from a physically abusive husband. There was the Dominican woman who came every week with a new ailment, headaches, stomach aches, chest pain whom I prodded with the gentle question, "is there something going on in your life?" I quietly listened to the tearful Colombian woman who was grieving the loss of her 21-year-old son. "How did he die?" I asked. She responded that he was fleeing the military juntas and guerillas in Colombia, and boarded a boat that landed in Brazil. The ship's cargo of

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illegal immigrants was detained in prison and the son mysteriously was found dead the next morning. When my patient, his mother, was finally able to arrange with the Consulate to send his body back to Colombia, an autopsy was performed to determine the cause of death. It was impossible to determine the cause of death because her son's body had been disemboweled. It is in these intimate interactions that we begin to understand some of the underlying factors contributing to depression in our patients.

Depression is the leading cause of disability in the United States (Lopez, Mathers, Ezzati, Jamison, & Murray, 2001). In spite of successful treatment options for depression, 75 % of Americans do not receive adequate care (Shim, Baltrus, Ye, & Rust, 2011). Treatment rates among low-acculturated Hispanics, also referred to as Latinos and Latinos with limited English proficiency, are significantly lower (Alegría, Polo, et al., 2008; Bauer, Chen, & Alegría, 2010). People of Hispanic origin (Latinos) are the largest minority group in the United States, representing 17 % of the population (United States Census Bureau, 2013a). By 2060, it is predicted that Latinos will make up 31 % of the United States population, or approximately one in three residents (United States Census Bureau, 2012). Although, past year mental illness and depression rates for Latinos are similar or slightly less than the population as a whole, 15.3 vs. 19 (any mental illness) and 6.9 % vs. 7 % respectively for depression, this differs by ethnic background, nativity, and generational status (Alegría, Mulvaney-Day, Torres, Polo, et al., 2007; SAMSHA, 2015). Puerto Ricans have higher rates of depression than non-Hispanic Whites (Alegría, Mulvaney-Day, Torres, Polo, et al., 2007). Moreover, many Latinos have demographic characteristics that increase their vulnerability to depression: unemployment, poverty, chronic illness, exposure to violence and chronic stress, and less than a high school education (Bromet et al., 2011; March et al., 2014). Latinos are among the most impoverished of all ethnic and racial groups in the United States, with one quarter of Latinos living in poverty compared to 11.6 % of non-Hispanic Whites (Taylor, Kochhar, Fry, Velasco, & Motel, 2011; United States Census Bureau, 2013b). Among primary care populations, refugees, and monolingual Spanish-speaking populations, there is a high prevalence of affective disorders, estimated at 20–45 % due to the above-mentioned factors associated with depression (Cardemil et al., 2007; March et al., 2014; Tarricone et al., 2012). In addition, for Latino immigrants, experiences of loss of previously existing social support systems, changes in cultural values, and social roles are stressors that have been associated with depression, as well as perceived discrimination, and neighborhood safety (Alegría, Shrout, Woo, Guarnaccia, et al., 2007).

Latinos suffer from large health disparities when compared to non-Hispanic Whites (Alegría, Mulvaney-Day, Torres, Polo, et al., 2007; Alegría, Mulvaney-Day, Woo, Torres, et al., 2007; SAMSHA, 2015). Only half of Latino immigrants with severe mental health disorders receive any type of mental health treatment (SAMSHA, 2015). The rates of mental health service use from 2008 to 2012 for any mental illness were 27.3 % for Hispanics compared to 46.3 % for non-Hispanic Whites (SAMSHA, 2015). These mental health disparities also include decreased access to care and lower rates of care that conform to evidenced-based guidelines in

terms of referrals for specialty mental health care, psychopharmacology, and duration of treatment compared to non-Hispanic Whites (Alegría, Mulvaney-Day, Woo, Torres, et al., 2007; Alegría, Polo, et al., 2008; Shim et al., 2011).

Factors Contributing to Health Care Disparities

Disparities in mental health care for Latinos may be due to systemic barriers to obtaining treatment, including an insufficient supply of Medicaid specialty services in Latino neighborhoods creating long waits for treatment, lack of bilingual providers and language barriers, and lack of adequate insurance (Alegría, Polo, et al., 2008; González, Tarraf, Whitfield, & Vega, 2010; González, Vega, et al., 2010; SAMSHA, 2015). However, when taking into account many of these factors, Latino mental health care utilization is still half that of Hispanics (SAMSHA, 2015). Thus, provider and patient level factors strongly influence decisions to seek help, particularly in undiagnosed conditions when cultural factors and level of acculturation become particularly salient (Keyes et al., 2012). When Latinos do seek mental health care services, it is most often in the primary care sector (Alegría, Mulvaney-Day, Woo, Torres, et al., 2007). Although research consistently indicates that Latinos prefer therapy to medication (Dwight-Johnson et al., 2010; Interian, Lewis-Fernandez, Gara, & Escobar, 2013; Vargas et al., 2015), preferences do not determine actual uptake of treatment. In one sample of Latinos in the Northeast, there was a greater likelihood that patients would follow recommendations for pharmacological treatment, rather than psychotherapy, most likely due to the fact that medication is a much more accessible form of treatment (Ishikawa et al., 2014).

There are numerous patient-level factors contributing to low treatment rates for mental disorders among Latinos. Language barriers or educational level contributing to low mental health literacy, and stigma are significant barriers to care (Alegría, Shrout, Woo, Guarnaccia, et al., 2007; Tarricone et al., 2012). Language barriers make it difficult for the Latino patient to understand the options available to treat depression. Results of some research indicate that patients have better outcomes when they are culturally and linguistically matched with their mental health provider (Sue, 1988). However, Latino primary care providers and mental health providers, in particular, are underrepresented in the health care workforce (Jackson & Gracia, 2014).

Cultural values and beliefs, including the reluctance to share personal problems outside of the family and disclose personal problems, a value on self-sufficiency, and stigma about mental illness create barriers to treatment engagement (Cabassa, Lester, & Zayas, 2007; Caplan et al., 2013; Interian, Martinez, Guarnaccia, Vega, & Escobar, 2007; Nadeem et al., 2007; Vega, Rodriguez, & Ang, 2010). Thus, it becomes essential to understand the barriers to treatment engagement and develop a roadmap to facilitate effective and quality care for Latino patients with depression. In this chapter we will walk you through the steps of effective care from: (1) recognition of and screening for depression; (2) understanding cultural barriers

to treatment engagement; (3) strategies to improve treatment engagement; (4) providing evidenced-based treatment; and (5) situating depression care within the appropriate social, economic, and political context.

Recognition of and Screening for Depression

Depression is far more frequently diagnosed and treated in the primary care setting than in specialty mental health care (Harman, Veazie, & Lyness, 2006; Uebelacker, Wang, Berglund, & Kessler, 2006). Primary care providers (PCPs) are responsible for providing up to 80 % of all prescriptions for antidepressants (Mojtabai & Olfson, 2008). Nevertheless, access to treatment is hindered by lack of recognition in primary care in as many as 30–60 % of patients (Borowsky et al., 2000; Kamphuis et al., 2012; Mitchell, Vaze, & Rao, 2009; Schmaling & Hernandez, 2005). Primary care providers' recognition of depression is increased the more often a patient is seen (Menchetti, Belvederi-Murri, Bertakis, Bortolotti, & Berardi, 2009). However, many Latinos and individuals with limited English proficiency do not have a usual source of health care (Agency for Healthcare Research and Quality [AHRQ], 2010).

Although the United States Preventive Services Task Force (USPSTF) (USPSTF) (2009) has recommended screening of all patients for depression in the primary care setting when systems are in place to provide appropriate treatment and follow-up, most patients do not receive screening. Instead primary care providers rely on their own clinical judgment, which is much less effective in detecting depression than the use of formal screening instruments (AHRQ, 2013). The Patient Health Questionnaire (PHQ-9) (Kroenke, Spitzer, & Williams, 2001) is the most commonly used depression screener in primary care. It is a 9-item scale with a sensitivity of 88 % and a specificity of 88 % for major depression at a score of greater than or equal to 10 (Kroenke et al., 2001). When the PHQ-9 is used to screen it aids in the initiation of treatment (Moore et al., 2012); however, it has not been shown to be consistently used in primary care (Fuchs et al., 2015; Gilbody, Richards, Brealey, & Hewitt, 2007). A shorter version of the PHQ-9, the PHQ-2 just uses the first two questions of the PHQ-9:

> "To what extent have you been bothered by the following:
>
> (1) Little interest or pleasure in doing things and
> (2) Feeling down, depressed, or hopeless?" (Kroenke, Spitzer, & Williams, 2003).

The PHQ-2 is highly sensitive as a first step in the screening process when followed by the PHQ-9 and can be self-administered in the waiting room.

For patients who may not be literate in Spanish or English there is a bilingual computerized voice recognition screener that is as reliable as paper and pencil administration Muñoz, McQuaid, González, Dimas, and Rosales (1999)(or an Interactive Voice Response System which can be used via phone screening, Kim et al., 2012).

While the PHQ-9 has been shown to be reliable in Spanish-speaking populations (Diez-Quevedo, Rangil, Sanchez-Planell, Kroenke, & Spitzer, 2001; Wulsin, Somoza, & Heck, 2002), there are instances where the validity may be questionable for Latino immigrants (Caplan et al., 2010). In a study of 177 predominantly Colombian, Ecuadorian, and Dominican immigrants in primary care, 21 participants perceived that they had a mental health problem, but did not meet criteria for depression on the PHQ-9 (subjective depression). Participants' descriptions of symptoms had a predominantly somatic component. The most common complaints were *ánimo bajo* (low energy) and *decaimiento* (weakness). Participants with "subjective" depression had mean scores of somatic symptoms and depression severity that were significantly lower than the participants with "objective" depression and significantly higher than the group with no depression ($P < 0.0001$). Therefore, it is possible that some Latinos with depression may be missed by traditional depression screeners. These patients still have significant distress and impairment. To avoid having these patients "fall through the cracks," it is important to take into account culturally accepted idiomatic and behavioral expressions of distress and the meaning of illness for the individual and develop alternative ways of screening for depression (Sentell & Braun, 2012).

Self-Rated Health. One of the often cited reasons that primary care providers do not formally screen is lack of time. Many providers prefer a targeted approach of screening people they believe to be at high risk. If this approach seems more feasible in one's particular setting, certainly all patients with chronic illness should be screened given the high comorbidities of depression and chronic illness (Ducat, Philipson, & Anderson, 2014; Houts, Lipinski, Olsen, Baldwin, & Hasan, 2010; Scott et al., 2007). Given the time constraints in primary care, one very important question to ask about is self-rated health. How would you rate your health?

Self-rated health has been defined as the intersection of biology and culture since it relies upon lay meanings of symptoms (Jylha, 2009). Self-rated health has consistently been a predictor of mortality, primarily because it encompasses more than a biomedical definition of health, and includes functional abilities, social relationships, mental health, and spirituality. In one study of Puerto Ricans in the Northeast, depressive symptoms, functional problems, allostatic load (an indicator of the biological stress response), and physical comorbidities strongly predicted self-rated health (Todorova et al., 2013). Thus, one simple, fast, and potentially effective screening method would be to add in an open-ended question on self-rated health: "How would you rate your health? Responses range from 1 to 5: 1—Excellent (Excelente), 2—Very Good (Muy Buena), 3—Good, (Buena), 4—Fair (Regular), 5—Poor (Mala)" ***in addition to using the PHQ-2 as described above***.

Once you are satisfied that your patient has depression that cannot be managed with watchful waiting, the next question is how do you effectively convey that information to your patient, in a manner that is acceptable to the patient? Many Latinos will not follow-up on a recommendation to seek treatment in the specialty mental health care sector (De Figueiredo, Boerstler, & Doros, 2009) or even within an integrated primary care behavioral health care system (Caplan & Whittemore, 2013).

Understanding Cultural Barriers to Treatment Engagement

Treatment engagement is a concept that encompasses identification of a mental health problem, the decision to seek professional care, maintaining engagement throughout the course of care, adherence to treatment, and minimization of drop-out (Interian et al., 2013). For Latinos, the low cultural congruence of behavioral health treatment is a strong contributing factor to lower rates of treatment engagement (Vargas et al., 2015). The level of a Primary Care Provider's (PCP) cultural competence can determine the uptake of a recommendation to seek care for depression (Ishikawa et al., 2014). For example, Latinos use Spanish idioms to refer to affective feelings that don't necessarily translate well into English. In addition, the use of somatic symptoms to express emotional distress is also very common (Cheng, Chen, & Cunningham, 2007; Elder, Ayala, Parra-Medina, & Talavera, 2009; Katon, 1982; Rogler, Cortes, & Malgady, 1994). Providers not familiar with these types of behaviors might have difficulty making an accurate diagnosis and providing the appropriate referrals to treatment (Vargas et al., 2015).

What are Latino cultural values and how might they influence care? Latino values differ by ethnic group, class, level of acculturation, and geographic area. However, there are a few values that transcend between group differences. One particular cultural value among Latinos, *Familismo*, or the belief in strong family connections and unity, is believed to have a major influence, both positive and negative, upon help-seeking (Villatoro, Morales, & Mays, 2014). The value of *Familismo* may influence help-seeking either due to stigma or reluctance to disclose personal problems to outsiders, or fear of burdening one's family or guilt about being depressed (Dunn & O'Brien, 2009).

In Latino culture, *Machismo* (male gender roles) may be evidenced in behaviors that include honor, pride, and responsibility (Arciniega, Anderson, Tovar Blank, & Tracey, 2008) but may also include traits such as high alcohol consumption and a sense of entitlement and control within the family (Edelson, Hokoda, & Ramos-Lira, 2007). *Marianismo*, derived from beliefs about the Virgin Mary is an ideal female role that exalts endurance of suffering, submission, and self-sacrifice and the responsibility for mothers to create peaceful family relationships (Andres-Hyman, Ortiz, Paris, Davidson, & Añez, 2006). Acculturation can result in changing gender roles, that increase women's power, but also can increase familial stress. Latino culture emphasizes that men should be the breadwinners and women, the homemakers. Thus, traditional male and female roles in Latino culture may inhibit help-seeking.

The cultural value of *Personalismo*, or the importance of individual relationships and social interactions, rather than institutional loyalties, has strong implications for quality of care. Research has shown that the quality of the PCP relationship with the patient in terms of trustworthiness, genuineness, and openness in communication style will positively affect the outcomes of treatment recommendations (Kravitz et al., 2011). Moreover, the cultural value of *Respeto* (respect) for people in positions of authority will make it less likely that Latinos will voice disagreement or a reluctance to follow treatment recommendations.

Cultural and religious values are also apparent in many Latinos' attitudes towards coping with depression. For many Latinos, depression signifies weakness of character, lack of faith in God, an inability to confront life's challenges (Caplan & Cordero, 2015). Many Latinos believe that depression can be overcome by willpower (*fuerza de voluntad*), not paying attention to it, (*no darle mente*) or controlling oneself (*controlarse*) (Vargas et al., 2015). Latinos tend to have higher endorsement of cognitive escape/avoidance and distancing as a way of coping with physical and emotional health issues (Munet-Vilaró, Gregorich, & Folkman, 2002). Although some types of escapist coping are related to negative mental health outcomes (Folkman & Moskowitz, 2004), in some instances, the use of such strategies (wishful thinking, daydreaming) may actually reflect hope and are thus, not necessarily negative.

Strategies to Improve Treatment Engagement

There are a number of important tools to enable the PCP to most effectively overcome barriers to treatment engagement and effectively increase the likelihood that the patient will agree to a recommendation for treatment of depression. These strategies may include: (a) ethnographic interviewing, (b) the warm hand-off, increasing health literacy, (c) minimizing stigma, and (d) creating a working alliance.

Ethnographic Interviewing

Ethnographic interviewing is a means to understanding of the patient's perceptions of illness. Attention to cultural aspects of care is a critical component in engaging patients in care (Balan, Moyers, & Lewis-Fernandez, 2013; Benish, Quintana, & Wampold, 2011). There are specific assessment questions designed to understand the sociocultural contexts of people's health care needs (Kleinman, 1980) the noted medical anthropologist, recommends the following eight questions:

1. "What do you call the problem?
2. What do you think has caused the problem?
3. Why do you think it started when it did?
4. What do you think the sickness does? How does it work?
5. How severe is the sickness? Will it have a long or a short course?
6. What kind of treatment do you think the patient should receive?
7. What are the chief problems the sickness has caused?
8. What do you fear most about the sickness?"

Beginning a conversation about depression treatment with some version of the above questions will help to clarify treatment expectations for both the provider and patient (Fernandez et al., 2011).

The Warm Hand-Off

Due to the cultural value of *Personalismo* it is recommended that the referral to the mental health provider who is situated in the primary care setting be accomplished by personally introducing the patient to the mental health provider (Manoleas, 2008). This is believed to reduce stigma and aid in uptake of the referral. However, a recent study examining that hypothesis showed the many nuances in context and implementation of the warm hand-off. The warm hand-off did not make a difference in uptake for referrals among Spanish-speaking primary care patients and actually diminished the likelihood of seeing a specialist among English-speaking participants (Horevitz, Organista, & Arean, 2015). Details of the precise manner the hand-off was implemented in this study are lacking and in some instances, a warm-hand off conducted by a Medical Assistant rather than personally by the PCP may have been off-putting for patients. Nevertheless, these data indicate that it may be premature to endorse the concept of the warm hand-off.

Increasing Health Literacy

Health literacy and the understanding of depression as a treatable illness may also affect help seeking behaviors (Horner-Johnson, Dobbertin, Lee, & Andresen, 2014; Koskan, Friedman, & Messias, 2010; US Department of Health and Human Services, 2015). Although unique culture-specific life experiences are shared by many Latino groups, their understanding, responses to distress and depression, and the seriousness they place on the expression of distress may differ (Myers et al., 2015). Among some Latinos, there is the belief that succumbing to depression will eventually lead to craziness (Vargas et al., 2015). Latinos may label their illness as "stress," rather than depression (Caplan et al., 2010; Vargas et al., 2015). Major stressors that impact the mental health in the lives of Latino cultural groups living in the U.S. include health, family, and intergenerational conflict, discrimination, underemployment and exploitive employment, financial issues, and unsafe living environments (Falcon, Todorova, & Tucker, 2009; Greenberg, 2006). Trying to adapt to a new lifestyle and the impact of dissimilar cultural norms can generate anxiety and emotional dissonance that contributes to or creates other major sources of emotional distress (McIntyre, Korn, & Matsuo, 2008; Nicklett & Burgard, 2009; Torres & Rollock, 2007). While stressful events are experienced by many, Latinos tend to disregard the effect daily stressful events have on their mood and well-being (Munet-Vilaró, Folkman, & Gregorich, 1999; Winkelman, Chaney, & Bethel, 2013).

Minimizing Stigma

Mental health diagnoses often result in experiences of stigma and shame for the person bearing the diagnosis. Indeed, labeling a person is one of the underlying mechanisms in the process of stigmatizing and individual (Link, Yang, Phelan, &

Collins, 2004). Labeled people can be negatively categorized by the dominant society as "us and them," resulting in separation, status loss, and discrimination. Thus, other words that convey emotional distress might be more acceptable to the patient and result in greater acceptance of the need for treatment. "Stress," "family problems," are much less laden with negative connotations and are something people can understand.

Working Alliance

The PCP's working alliance is a key factor in a patient's decision to follow-up on treatment recommendations, although stated intention is not necessarily correlated with actual behavior (Ishikawa et al., 2014). Creating trusting bonds that leads to shared decision-making and understanding patients' views about treatment, their expectations of the kind of care they should be receiving are the most important ways to enhance patients' satisfaction with care (Julius, Novitsky, & Dubin, 2009; Lin & Fagerlin, 2014). The RESPECT framework for cultural assessment, based on the series of eight questions developed by Kleinman (listed above), provides a model for culturally competent assessment in the medical setting (Mostow et al., 2010). RESPECT is an acronym for Respect, Explanatory model, Sociocultural context, Power, Empathy, Concerns and fears, and Therapeutic alliance/trust.

Respect and *empathy* are attitudes that demonstrate to the patient that his/her concerns are valued and he/she is understood. The patient's *explanatory model* is his/her understanding of what is the cause of his/her illness. The *sociocultural context* denotes factors in a person's life that may contribute to the current state of health and expectations for treatment, such as poverty, stress, and social support. *Power* refers to the importance of acknowledging that the patient is in a vulnerable position and that there is a difference between patients and health care providers in terms of access to resources, knowledge level, and control over outcomes. The loss of power and control that a patient faces can contribute to *concerns and fears* about treatment, illness outcomes, and the future. These concepts can enhance communication and assessment skills and create a working alliance characterized by trust.

Providing Evidenced-Based Behavioral Interventions in Primary Care

The most comprehensive type of integrated behavioral healthcare (IBH) occurs when the mental health professional is embedded within the primary care team. Preliminary outcomes of this model indicates that it reduces depression, disparities in treatment engagement, increases satisfaction, and may reduce stigma and other barriers to care (Bridges et al., 2014). IBH has the potential to decrease disparities in quality of treatment.

Although evidenced-based psychotherapeutic treatment is equally effective in minorities and non-Hispanic Whites, they are less frequently utilized for Latino patients. Latinos are much less likely than non-Hispanic Whites to receive minimally adequate care, defined as four or more visits with a provider while taking antidepressant medication or eight or more visits with a specialty mental health provider (Alegría, Canino, et al., 2008). Between one half and two thirds of the population are likely to drop out of treatment, a statistic that is much worse among Latinos (Corrigan, 2004). Latinos are three times more likely than non-Hispanic Whites to stop going to therapy prematurely (Olfson, Moitabai, Sampson, Hwang, & Kessler, 2009).

Integrated mental health care requires innovative models of care delivery that address provider, systems-level barriers, and patient level barriers. These include the use of culturally modified interventions; technological innovations to mental health care delivery, and the use of community health workers and peer counselors.

Culturally Modified Interventions

Culturally modified psychotherapeutic and psychoeducational interventions can be used in primary care and have been shown to reduce health care disparities (Interian, Allen, Gara, & Escobar, 2008). The interventions with the strongest evidence base for use in Latinos with depression include Cognitive Behavioral Therapy (CBT), Behavioral Activation (BA), Mindfulness and Motivational Interviewing.

1. *CBT*. CBT is a widely recognized evidenced-based treatment for depression that is as effective in Latinos as in non-Hispanic Whites (Alegría, Ludman, et al., 2014; Miranda et al., 2003). Interian et al. (2008) have developed a culturally modified (Cognitive Behavioral Therapy) CBT intervention that was effectively piloted in the primary care setting. This intervention used the methods of CBT which include cognitive interventions that help patients recognize and identify patterns of thinking that contribute to negative self-evaluations. CBT also focuses on behaviors strategies that will counteract the effects of depression such as assertiveness training, relaxation, and increasing pleasurable activities (Beck et al., 1979). Cultural modification was employed by using a case-conceptualization approach that acknowledged the specific stressors that are predominant among low-income Hispanics. It was also employed in specific recommendations for behavioral strategies. For example, assertiveness training was adapted to include the cultural value of respect (*respeto*) so that assertiveness could be employed while maintaining respect. Similarly, cultural values were used to illustrate the value of changing cognitions such as (*poniendo de su parte*) or putting in effort.
2. *Behavioral activation*. Studies indicate that the application of behavioral activation therapy is effective in depression. Behavioral activation treatment (BAT) for

depression addresses problems a patient is experiencing in life that are not considered rewarding. Inaction is the most common depressive reaction to life situations that are not considered rewarding. Basic behavioral activation strategies are usually used in combination with cognitive behavioral therapy and initially target the inertia that occurs in depression. In BAT, emphasis is given to engaging the patient in activities that are considered rewarding and can be mastered; less emphasis is given to problems related to thoughts and biological processes (Lejuez, Hopko, Acierno, Daughters, & Pagoto, 2011). The patient is coached by the therapist to take an active participation in decision-making by establishing goals and begin to take steps to re-engage in life despite the lack of motivation or the negative feelings (Barry & Edgman-Levitan, 2012). Collaboration in the decision-making process is important when applying BA (Alegría, Carson, et al., 2014; Dimidjian, Barrera, Martell, Munoz, & Lewinsohn, 2011) and requires that both the client and clinician share information and that BA activities take into account the patients' cultural values and preferences (Barry, 2012; Comas-Diaz, 2006).

3. *Mindfulness-meditation*. Another approach is mindfulness-meditation which is a method that has been used for more than two decades to treat psychiatric disorders including depression (Chiesa & Serretti, 2011). It has been successfully culturally modified and can be used in the primary care setting as a brief intervention to improve symptoms in people with chronic illness (Gucht, Takano, Broeck, & Raes, 2015; Keyworth et al., 2014). This approach emphasizes focused, nonjudgmental awareness of experiences happening in the present moment as an alternative to worrying about future situations. Some studies have found that this therapy can help patients improve their quality of life and particularly with bilingual patients, help them manage their stress and anxiety (Roth & Robbins, 2004). Mindfulness-based stress reduction (MBSR) is a series of techniques that an individual or group of individuals can use such as informal mindfulness, yoga, and mindful breathing, that teaches directed attention to reduce anxiety (Keng, Smoski, & Robins, 2011) and depression (Deyo, Wilson, Ong, & Koopman, 2009; Godfrin & Van Heeringen, 2010).
4. *Motivational interviewing*. The use of motivational interviewing (MI), that is, the process of talking to a person in an empathetic and nonconfrontational way is an approach that can create confidence in the patient to actively participate in treatment decisions and facilitate interaction between the provider and the patient (Balan et al., 2013; Lewis-Fernandez et al., 2013). This approach can be effective when providers use cultural terms and idioms patients are familiar with to explain symptoms, distinguish medically unexplained symptoms, and differentiate them from significant clinical signs (Añez, Paris, Bedregal, Davidson, & Grilo, 2005; Britigan, Murnan, & Rojas-Guyler, 2009; McCaffery, Smith, & Wolf, 2010; Sentell & Braun, 2012).

   Many Latinos have the misconception that medications used in the treatment of depression are addictive (Interian et al., 2007; Vargas et al., 2015) and are not aware that depression has a genetic component (Caplan et al., 2013). This misconception can result in patients not accepting or adhering to their medication

treatment. The use of motivational interviewing when integrated to psychopharmacotherapy sessions is reported to effectively facilitate interaction between the provider and the patient and improve adherence to medication for depression (Balan et al., 2013; Lewis-Fernandez et al., 2013). Motivational pharmacotherapy offers the provider and patient the opportunity to use their respective expertise when deciding medication treatment, encourages self-efficacy in patients so they can overcome barriers and can incorporate language and relevant cultural aspects that help the patient become engage in their pharmacotherapy. A motivational interviewing study on anti-depressive medication adherence that was adapted for Latinos found that the intervention was effective in helping patients change their conceptual and emotional viewpoint of adhering to medication treatment from a perceived mandated therapy to a personal and motivational way to fight (l*uchar*) for improving their mental health (Interian, Martinez, Rios, Krejci, & Guarnaccia, 2010).

Technology

Technological innovations to mental health care delivery include the use of mobile apps, computer-based applications of psychotherapy and psychoeducation, and telephone-based therapy. Telephone-based psychotherapy has shown to be effective in reducing levels of depression and improving mood (Ludman, Simon, Tutty, & Von Korff, 2007). A Spanish language culturally modified telephone CBT was more effective and cost saving than face-to-face CBT among Latino patients (Kafali, Cook, Canino, & Alegría, 2014).

Case Management and Community Health Workers

Many Latino immigrants in the U.S. might not have the social links or intercultural competence needed to learn how to access and utilize mental health care services that can assist them to cope with depression (Torres, 2010; Torres & Rollock, 2007). Community health workers (*promotoras*) are widely used in public health interventions and chronic disease prevention, because of their knowledge of the cultural and communities from which they are from and their ability to provide support, advocacy, and education.

1. *Peer to Peer Communication*. Similar to the support provided by Community Health Workers, peers can provide advocacy and increase access to care for people experiencing stigmatizing conditions, such as mental illness (Deering et al., 2009). Peer counseling programs have been successfully used to prevent depression among low income, minority families at high risk for depression (Acri, Olin, Burton, Herman, & Hoagwood, 2014; Boyd, Diamond, & Bourjolly, 2006). Among Latino populations, peers have also been used to implement depression screening and treatment engagement interventions through messages of

empowerment and patient activation or psychoeducation to train patients to ask questions and interact in a collaborative manner with their PCPs (Alegría, Polo, et al., 2008).

Situating Depression Care Within the Appropriate Social, Economic, and Political Context

The concept of integrated care is a misnomer if it solely refers to the incorporation of behavioral health care in the primary care setting. There is no such thing as "integrated behavioral health care is one fails to address the underlying social determinants of health that are among the primary root causes of depression: economic inequalities, discrimination, poverty, interpersonal violence (IPV), and lifelong exposure to adverse events" (Myers et al., 2015) and societal stigma that is a barrier to help-seeking for many people with depression (Corrigan, Morris, Michaels, Rafacz, & Rusch, 2012).

All ethnic and racial minority groups have poverty rates exceeding the national average for non-Hispanic Whites of 11.6%. Among racial groups, the highest national poverty rates were for American Indians and Alaska Natives (27.0%) followed by Blacks or African Americans (25.8%) and Native Hawaiians and Other Pacific Islanders (17.6%). By country of origin among Asians, poverty rates were highest for Vietnamese (14.7%) and Koreans (15.0%). Among Hispanics, poverty rates are highest for Dominicans, exceeding Blacks at 26.3%, followed by, Puerto Ricans (25.6%), Guatemalans, and Mexicans (24.9%) and Salvadoreans (18/9%) (Macartney, Bishaw, & Fontenot, 2013). Contributing to the high rates of poverty and psychosocial stressors among Dominicans and Puerto Ricans and African Americans are the two and three times higher than average rates of single parent homes with children under 18 when compared to non-Hispanic whites (Vespa, Lewis, & Kreider, 2013).

As a primary care provider, you may feel that it would be impossible to address societal factors that contribute to ill health. Thinking in this manner will ultimately lead to burn-out as you recognize that your treatment is essentially bandaging wounds. One of the most important ways to address the needs of our patients is to partner with communities and become informed of the community's health needs. Is the neighborhood too unsafe for children and parents to walk outside for exercise? Do the local corner groceries provide low fat products and fresh fruits? Is there are bus depot emitting fumes which contribute to high rates of asthma? Are there green spaces in the community? Working with Community Boards to identify and address health issues within the community is an effective way to ensure the long-term health of your patients.

A very high risk population that is often overlooked in primary care are patients with current or past histories of domestic violence, child abuse, and gender-based violence. Due to societal and economic stressors and cultural norms, racial and

ethnic minorities, particularly immigrants in the United States may be at even greater risk for adverse psychiatric consequences of IPV. Lifetime prevalence of IPV, including rape, physical violence, and stalking among ethnic and racial minorities are significantly higher than among White women (Black et al., 2010).

Legal status in the United States is a societal aspect that creates barriers to care that affects many immigrant families. Immigration status impedes help-seeking behavior and provides a readily available mechanism by which women can be coerced. Women may silently endure domestic violence because of fears of being deported and losing their children. Some may fear that their partners will be jailed or deported leaving them without any financial support. Most immigrant women are not aware of the legal protections available to them (Bhuyan & Senturia, 2005) such as the U.S. Violence against Women Act (VAWA) which allows battered women living in the United States to petition for permanent resident status even if they leave their American partner.

Many immigrant and minority women will not disclose intimate details of their personal lives (Hamdy, 2004; Nicolaidis et al., 2011).

Internalized or self-perceived stigma inhibits help-seeking for depression, as well as IPV. Stigma also operates at the structural institutional level. Less funding is given to mental health research compared to other disorders and residential treatment facilities for psychiatric patients are often located in undesirable neighborhoods. Therefore, it is important to advocate for societal changes in mental health care and recommend that our patients join advocacy organizations such as the National Alliance for Mental Illness (NAMI) which has extensive programming and learning materials in Spanish.

Screening and Prevention of Domestic Violence. The United States Preventive Services Task Force has recently provided new guidelines recommending routine screening for IPV among women of childbearing age 18–46 (Moyer & U.S. Preventive Services, 2013). There is ample evidence of the benefits of screening as the health care risks of unaddressed IPV are great, including the chronic health conditions mentioned above; poor birth outcomes in pregnant women experiencing IPV (El-Mohandes, Kiely, Gantz, & El-Khorazaty, 2011; Shah, Shah, & Knowledge Synthesis Group on Determinants of Preterm/LBW Births, 2010); and chronic and persistent mental illnesses. Screening can be accomplished with the simple four question HITS which has strong validity in English- and Spanish-speaking populations.

As a provider, you may be thinking that you don't want to open that can of worms; however, women who experience IPV have greater psychological problems than women who have not experienced IPV, including PTSD, depression, low self-esteem, substance abuse, anxiety, eating disorders, and suicide attempts (Black et al., 2010; Coker et al., 2002; Edelson et al., 2007). Treating depression without addressing the underlying domestic violence that carries with it a high risk of injury or death is tantamount to malpractice. Effective interventions exist such as home visits, counseling, referrals to community service agencies and creating safety plans that have served to prevent these adverse outcomes, such as IPV in pregnancy; assaults and risk for homicide and prematurity in neonates (McFarlane, Groff, O'Brien, & Watson, 2005).

Truly integrated depression care for Latinos requires a multifaceted, interdisciplinary approach starting with community-based efforts at prevention, culturally sensitive screening, appropriate referrals, strategies to improve adherence and minimize drop-out, and effective behavioral interventions within the health care setting.

References

Acri, M., Olin, S. S., Burton, G., Herman, R. J., & Hoagwood, K. E. (2014). Innovations in the identification and referral of mothers at risk for depression: Development of a peer-to-peer model. *Journal of Child and Family Studies, 23*, 837–843. doi:10.1007/s10826-013-9736-z.

Agency for Healthcare Research and Quality (AHRQ). (2010). *National healthcare disparities report, 2010*, Rockville, MD. Retrieved May 22, 2015, from http://www.ahrq.gov/research/findings/nhqrdr/nhqrdr10/minority.html.

Agency for Healthcare Research and Quality, Rockville, MD. (April 2013). *Screening for depression in adults*. Retrieved May 20, 2015, from http://www.ahrq.gov/professionals/clinicians-providers/resources/depression/depsum1.html.

Alegría, M., Canino, G., Shrout, P. E., Woo, M., Duan, N., Vila, D., … Meng, X. -L. (2008). Prevalence of mental illness in immigrant and nonimmigrant U.S. Latino groups. *American Journal of Psychiatry, 165,* 359–369. doi:10.1176/appi.ajp.2007.07040704.

Alegría, M., Carson, N., Flores, M., Li, X., Shi, P., Lessios, A. S., … Shrout, P. E. (2014). Activation, self-management, engagement, and retention in behavioral health care: A randomized clinical trial of the DECIDE intervention. *JAMA Psychiatry, 71*(*5*), 557–565. doi:10.1001/jamapsychiatry.2013.4519.

Alegría, M., Ludman, E., Kafali, E. N., Lapatin, S., Ramirez, R., Vila, D., … Canino, G. (2014). Effectiveness of the engagement and counseling for Latinos (ECLA) intervention in low-income Latinos. *Medical Care*, *52*(*11*), 989–97.

Alegría, M., Mulvaney-Day, N., Torres, M., Polo, A., Cao, Z., & Canino, G. (2007). Prevalence of psychiatric disorders across Latino subgroups in the United States. *American Journal of Public Health, 97*(1), 68–75. PMCID: PMC1716243.

Alegría, M., Mulvaney-Day, N., Woo, M., Torres, M., Gao, S., & Oddo, V. (2007). Correlates of past-year mental health service use among Latinos: Results from the National Latino and Asian American study. *American Journal of Public Health, 97*, 76–83.

Alegría, M., Polo, A., Gao, S., Santana, L., Rothstein, D., Jimenez, A., … Normand, S. L. (2008). Evaluation of a patient activation and empowerment intervention in mental health care. *Medical Care*, *46*, 247–256.

Alegría, M., Shrout, P. E., Woo, M., Guarnaccia, P., Sribney, W., Vila, D., … Canino, G. (2007). Understanding differences in past year psychiatric disorders for Latinos living in the US. *Social Science & Medicine*, *65*, 214–226.

Andres-Hyman, R. C., Ortiz, J., Paris, M., Davidson, L., & Añez, L. M. (2006). Culture and clinical practice: Recommendations for working with Puerto Ricans and other Latinas(os) in the United States. *Professional Psychology: Research and Practice, 6*, 694–701.

Añez, L. M., Paris, M., Jr., Bedregal, L. E., Davidson, L., & Grilo, C. M. (2005). Application of cultural constructs in the care of first generation Latino clients in a community mental health setting. *Journal of Psychiatric Practice, 11*(4), 221–230.

Arciniega, G. M., Anderson, T. C., Tovar Blank, Z. G., & Tracey, T. J. G. (2008). Toward a fuller conception of machismo: Development of a traditional *Machismo* and *Caballerismo* scale. *Journal of Counseling Psychology, 55*(1), 19–33. Retrieved from http://dx.doi.org/10.1037/0022-0167.55.1.19.

Balan, I. C., Moyers, T. B., & Lewis-Fernandez, R. (2013). Motivational pharmacotherapy: Combining motivational interviewing and antidepressant therapy to improve treatment adherence. *Psychiatry, 76*(3), 203–209. http://dx.doi.org/10.1521/psyc.2013.76.3.203.

Barry, M. J. (2012). Shared decision making: Informing and involving patients to do the right thing in health care. *The Journal of Ambulatory Care Management, 35*(2), 90–98. doi:10.1097/JAC.0b013e318249482f.

Barry, M. J., & Edgman-Levitan, S. (2012). Shared decision making--Pinnacle of patient-centered care. *The New England Journal of Medicine, 366*(9), 780–781. doi:10.1056/NEJMp1109283.

Bauer, A. M., Chen, C. N., & Alegría, M. (2010). English language proficiency and mental health service use among Latino and Asian Americans with mental disorders. *Medical Care, 48*(12), 1097–1104.

Benish, S. G., Quintana, S., & Wampold, B. E. (2011). Culturally adapted psychotherapy and the legitimacy of myth: A direct-comparison meta-analysis. *Journal of Counseling Psychology, 58*(3), 279–289. doi:10.1037/a0023626.

Bhuyan, R., & Senturia, K. (2005). Understanding domestic violence resource utilization and survivor solutions among immigrant and refugee women: Introduction to the special issue. *Journal of Interpersonal Violence, 20*(8), 895–901.

Black, M. C., Basile, K. C., Breiding, M. J., Smith, S. G., Latlers, M. L., Merrick, M. T., … Stevens, M. R. (2010). *National Intimate Partner and Sexual Violence Survey (NISVS) 2010 Summary Report*.

Borowsky, S. J., Rubenstein, L. V., Meredith, L. S., Camp, P., Jackson-Triche, M., & Wells, K. B. (2000). Who is at risk of nondetection of mental health problems in primary care. *Journal of General Internal Medicine, 15*(6), 381–388.

Boyd, R. C., Diamond, G. S., & Bourjolly, J. N. (2006). Developing a family-based depression prevention program in urban community mental health clinics: A qualitative investigation. *Family Process, 45*, 187–203.

Bridges, A. J., Andrews, A. R., Villalobos, B. T., Pastrana, F. A., Cavell, T. A., & Gomez, D. (2014). Does integrated behavioral health care reduce mental health disparities for Latinos? Initial findings. *Journal of Latina/o Psychology, 2*(1), 37–53.

Bridges, A. J., Andrews, A. R. I., & Deen, T. L. (2012). Mental health needs and service utilization by Hispanic immigrants residing in mid-southern United States. *Journal of Transcultural Nursing, 23*, 359–368. doi:10.1177/1043659612451259.

Britigan, D. H., Murnan, J., & Rojas-Guyler, L. (2009). A qualitative study examining Latino functional health literacy levels and sources of health information. *Journal of Community Health, 34*(3), 222–230. doi:10.1007/s10900-008-9145-1.

Bromet, E., Andrade, L. H., Hwang, I., Sampson, N. A., Alonso, J., de Girolamo, G., … Kessler, R. C. (2011). Cross-national epidemiology of DSM-IV major depressive episode. *BMC Medicine*, *9*, 90–94.

Cabassa, L. J., Lester, R., & Zayas, L. H. (2007). "It's like being in a labyrinth": Hispanic immigrants' perceptions of depression and attitudes toward treatments. *Journal of Immigrant and Minority Health, 9*(1), 1–16. Retrieved from http://dx.doi.org/10.1007/s10903-006-9010-1.

Caplan, S., Alvidrez, J., Paris, M., Escobar, J., Desai, M., Whittemore, R., … Scahill, L. (2010). Subjective versus objective: An exploratory analysis of Latino primary care patients who have self-perceived depression, but do not Fulfill PRIME-MD Patient Health Questionnaire (PHQ-9) Criteria for Depression. *The Primary Care Companion to the Journal of Clinical Psychiatry, 12*(5), e1–e12. doi: 10.4088/PCC.099m00899blu.

Caplan, S., & Cordero, C. (2015). Development of a faith-based mental health literacy program to improve treatment engagement among Caribbean Latinos in the Northeastern United States of America. *International Quarterly of Community Health Education, 35*, 199–214.

Caplan, S., Escobar, J., Desai, M. M., Paris, M., Alvidrez, J., Scahill, L. D., … Whittemore, R. (2013). Cultural influences upon causal beliefs about depression among Latino immigrants: Faith and resilience. *Journal of Transcultural Nursing, 24*, 68–77.

Caplan, S., & Whittemore, R. (2013). Barriers to treatment engagement for depression among Latinas. *Issues in Mental Health Nursing, 34*(6), 412–424. doi:10.3109/01612840.2012.762958.

Cardemil, E. V., Adams, S. T., Calista, J. L., Connell, J., Encarnacion, J., Esparza, N., … Wang, E. (2007). The Latino mental health project: A local mental health needs assessment. *Administration and Policy in Mental Health and Mental Health Services Research, 34,* 331–341.

Cheng, E. M., Chen, A., & Cunningham, W. (2007). Primary language and receipt of recommended health care among Hispanics in the United States. *Journal of General Internal Medicine, 22*(Suppl 2), 283–288. doi:10.1007/s11606-007-0346-6.

Chiesa, A., & Serretti, A. (2011). Mindfulness based cognitive therapy for psychiatric disorders: A systematic review and meta-analysis. *Psychiatry Research, 187*(3), 441–453. doi:10.1016/j.psychres.2010.08.011.

Coker, A. L., Davis, K. E., Arias, I., Desai, S., Sanderson, M., Brandt, H. M., & Smith, P. H. (2002). Physical and mental health effects of intimate partner violence for men and women. *American Journal of Preventive Medicine, 2*, 260–268.

Comas-Diaz, L. (2006). Latino healing: The integration of ethnic psychology into psychotherapy. *Psychotherapy (Chicago, Ill.), 43*(4), 436–453. doi:10.1037/0033-3204.43.4.436.

Corrigan, P. W. (2004). How stigma interferes with mental health care. *American Psychologist, 59*, 614–625.

Corrigan, P. W., Morris, S. B., Michaels, P. J., Rafacz, J. D., & Rusch, N. (2012). Challenging the public stigma of mental illness: A meta-analysis of outcome studies. *Psychiatric Services, 63*(10), 963–973. doi:10.1176/appi.ps.201100529.

De Figueiredo, J. M., Boerstler, H., & Doros, G. (2009). Failure of high-risk minority patients to show up for outpatient psychiatric treatment. *International Journal of Mental Health, 38*, 91–105. 2009-08142-005.

Deering, K. N., Shannon, K., Sinclair, H., Parsad, D., Gilbert, E., & Tyndall, M. W. (2009). Piloting a peer-driven model to increase access and adherence to antiretroviral therapy and HIV care among street-entrenched HIV-positive women in Vancouver. *AIDS Patient Care and STDs, 23*, 603–609.

Deyo, M., Wilson, K. A., Ong, J., & Koopman, C. (2009). Mindfulness and rumination: Does mindfulness training lead to reductions in the ruminative thinking associated with depression? *Explore (NY), 5*(5), 265–271. doi:10.1016/j.explore.2009.06.005.

Diez-Quevedo, C., Rangil, T., Sanchez-Planell, L., Kroenke, K., & Spitzer, R. L. (2001). Validation and utility of the Patient Health Questionnaire in diagnosing mental disorders in 1003 general hospital Spanish inpatients. *Psychosomatic Medicine, 63*, 679–686.

Dimidjian, S., Barrera, M., Jr., Martell, C., Munoz, R. F., & Lewinsohn, P. M. (2011). The origins and current status of behavioral activation treatments for depression. *Annual Review of Clinical Psychology, 7*, 1–38. doi:10.1146/annurev-clinpsy-032210-104535.

Ducat, L., Philipson, L. H., & Anderson, B. J. (2014). The mental health comorbidities of diabetes. *JAMA, 312*(7), 691–692. doi:10.1001/jama.2014.8040.

Dunn, M. G., & O'Brien, K. M. (2009). Psychological health and meaning in life: Stress, social support, and religious coping in Latina/Latino immigrants. *Hispanic Journal of Behavioral Sciences, 31*, 204–227. doi:10.1177/073998630934799.

Dwight-Johnson, M., Lagomasino, I., Hay, M. J., Zhang, P. L., Tang, M., Green, J. M., & Duan, N. (2010). Effectiveness of collaborative care in addressing depression treatment preferences among low-income Latinos. *Psychiatric Services, 61,* 1112–1118. doi:10.1176/appi.ps.61.11.1112.

Edelson, M. G., Hokoda, A., & Ramos-Lira, L. (2007). Differences in effects of domestic violence between Latina and non-Latina women. *Journal of Family Violence, 1*(22), 1–10.

Elder, J. P., Ayala, G. X., Parra-Medina, D., & Talavera, G. A. (2009). Health communication in the Latino community: Issues and approaches. *Annual Review of Public Health, 30*, 227–251. doi:10.1146/annurev.publhealth.031308.100300.

El-Mohandes, A. A., Kiely, M., Gantz, M. G., & El-Khorazaty, M. N. (2011). Very preterm birth is reduced in women receiving an integrated behavioral intervention: A randomized, controlled trial. *Maternal & Child Health Journal, 15*, 19–28.

Falcon, L. M., Todorova, I., & Tucker, K. (2009). Social support, life events, and psychological distress among the Puerto Rican population in the Boston area of the United States. *Aging & Mental Health, 13*(6), 863–873. doi:10.1080/13607860903046552. Pii 916452718.

Fernandez y Garcia, E., Franks, P., Jerant, A., Bell, R. A., & Kravitz, R. L. (2011). Depression treatment preferences of Hispanic individuals: Exploring the influence of ethnicity, language, and explanatory models. *Journal of the American Board of Family Medicine, 24*, 39–50. doi:10.3122/jabfm.2011.01.100118.

Folkman, S., & Moskowitz, J. T. (2004). Coping: Pitfalls and promise. *The Annual Review of Psychology, 55*, 745–774. http://dx.doi.org/10.1146/annurev.psych.55.090902.141456.

Fuchs, C. H., Haradhvala, N., Hubley, S., Nash, J. M., Keller, M. B., Ashley, D., … Uebelacker, L. A. (2015). Physician actions following a positive PHQ-2: Implications for the implementation of depression screening in family medicine practice. *Families, Systems, & Health, 33*(*1*), 18–27. doi:10.1037/fsh0000089.

Gilbody, S., Richards, D., Brealey, S., & Hewitt, C. (2007). Screening for depression in medical settings with the patient health questionnaire (PHQ): A diagnostic meta-analysis. *Journal of General Internal Medicine, 22*(11), 1596–1602. doi:10.1007/s11606-007-0333-y.

Godfrin, K. A., & Van Heeringen, C. (2010). The effects of mindfulness-based cognitive therapy on recurrence of depressive episodes, mental health and quality of life: A randomized controlled study. *Behaviour Research and Therapy, 48*(8), 738–746. doi:10.1016/j.brat.2010.04.006.

González, H. M., Tarraf, W., Whitfield, K. E., & Vega, W. A. (2010). The epidemiology of major depression and ethnicity in the United States. *Journal of Psychiatric Research, 44*(15), 1043–1051. http://doi.org/10.1016/j.jpsychires.2010.03.017.

González, H. M., Vega, W. A., Williams, D. R., Tarraf, W., West, B. T., & Neighbors, H. W. (2010). Depression care in the United States: Too little for too few. *Archives of General Psychiatry, 67*, 37–46. doi:10.1001/archgenpsychiatry.2009.168.

Greenberg, A. B. J. (2006). *Stress and mind/body health: Hispanics*. Retrieved February 2, 2008, from http://www.greenbergresearch.com/articles/1800/2340_apa06_Hispanic_final.pdf.

Gucht, K., Takano, K., Broeck, N., & Raes, F. (2015). A mindfulness-based intervention for economically disadvantaged people: Effects on symptoms of stress, anxiety, and depression and on cognitive reactivity and overgeneralization. *Mindfulness, 6*, 1042. doi:10.1007/s12671-014-0353-8.

Hamdy, S. L. (2004). *Sexual victimization in Indian Country: Barriers and resources for native women seeking help*. Harrisburg, PA: VAWnet. Retrieved November 4, 2013, from http://www.vawnet.org.

Harman, J. S., Veazie, P. J., & Lyness, J. M. (2006). Primary care physician office visits for depression by older Americans. *Journal of General Internal Medicine, 21*, 926–930.

Horevitz, E., Organista, K. C., & Arean, P. A. (2015). Depression treatment uptake in integrated primary care: How a "Warm Handoff" and other factors affect decision making by Latinos. *Psychiatric Services, 66*, 824–830. doi:10.1176/appi.ps.201400085.

Horner-Johnson, W., Dobbertin, K., Lee, J. C., & Andresen, E. M. (2014). Disparities in health care access and receipt of preventive services by disability type: Analysis of the medical expenditure panel survey. *Health Services Research, 49*(6), 1980–1999. doi:10.1111/1475-6773.12195.

Houts, A. C., Lipinski, D., Olsen, J. P., Baldwin, S., & Hasan, M. (2010). Use of the patient care monitor to screen for depression in adult cancer patients interviewed with the structured clinical interview for DSM-IV. *Psycho-Oncology, 19*(4), 399–407.

Interian, A., Allen, L. A., Gara, M. A., & Escobar, J. I. (2008). A pilot study of culturally adapted cognitive behavior therapy for Hispanics with major depression. *Cognitive and Behavioral Practice, 15*(1), 67–75. doi:10.1016/j.cbpra.2006.12.002.

Interian, A., Lewis-Fernandez, R., Gara, M. A., & Escobar, J. I. (2013). A randomized-controlled trial of an intervention to improve antidepressant adherence among Latinos with depression. *Depression and Anxiety, 30*(7), 688–696. doi:10.1002/da.22052.

Interian, A., Martinez, I. E., Guarnaccia, P. J., Vega, W. A., & Escobar, J. I. (2007). A qualitative analysis of the perception of stigma among Latinos receiving antidepressants. *Psychiatric Services, 58*(12), 1591–1594. http://dx.doi.org/10.1037/a0012820.

Interian, A., Martinez, I., Rios, L. I., Krejci, J., & Guarnaccia, P. J. (2010). Adaptation of a motivational interviewing intervention to improve antidepressant adherence among Latinos. *Cultural Diversity & Ethnic Minority Psychology, 16*(2), 215–225.

Ishikawa, R. Z., Cardemil, E. V., Alegría, M., Schuman, C. C., Joseph, R. C., & Bauer, A. M. (2014). Uptake of depression treatment recommendations among Latino primary care patients. *Psychological Services, 11*(4), 421–432. doi:10.1037/a0035716.

Jackson, C. S., & Gracia, J. N. (2014). Addressing health and health-care disparities: The role of a diverse workforce and the social determinants of health. *Public Health Reports, 129*(Suppl 2), 57–61.

Julius, R. J., Novitsky, M. A., & Dubin, W. R. (2009). Medication adherence: A review of the literature and implications for clinical practice. *Journal of Psychiatric Practice, 15*, 34–44. doi:10.1097/01.pra.0000344917.43780.77.

Jylha, M. (2009). Self-rated health between psychology and biology. A response to Huisman and Deeg. *Social Science & Medicine, 70*, 655–657. doi:10.1016/j.socscimed.2009.11.004.

Kafali, N., Cook, B., Canino, G., & Alegría, M. (2014). Cost effectiveness of a randomized trial to treat depression among Latinos. *The Journal of Mental Health Policy and Economics, 17*, 41–50.

Kamphuis, M. H., Stegenga, B. T., Zuithoff, N. P. A., King, M., Nazareth, I., de Wit, N. J., & Geerlings, M. I. (2012). Does recognition of depression in primary care affect outcome? The PREDICT-NL study. *Family Practice, 29*, 16–23. doi: 10.1093/fampra/cmr049.

Katon, W. (1982). Depression - Somatic symptoms and medical disorders in primary care. *Comprehensive Psychiatry, 23*(3), 274–287. doi:10.1016/0010-440x(82)90076-1.

Keng, S. L., Smoski, M. J., & Robins, C. J. (2011). Effects of mindfulness on psychological health: A review of empirical studies. *Clinical Psychological Reviews, 31*(6), 1041–1056. doi:10.1016/j.cpr.2011.04.006.

Keyes, K. M., Martins, S. S., Hatzenbuehler, M. L., Blanco, C., Bates, L. M., & Hasin, D. S. (2012). Mental health service utilization for psychiatric disorders among Latinos living in the United States: The role of ethnic subgroup, ethnic identity, and language/social preferences. *Social Psychiatry and Psychiatric Epidemiology, 47*(3), 383–394. http://doi.org/10.1007/s00127-010-0323-y.

Keyworth, C., Knopp, J., Roughley, K., Dickens, C., Bold, S., & Coventry, P. (2014). A mixed-methods pilot study of the acceptability and effectiveness of a brief meditation and mindfulness intervention for people with diabetes and coronary heart disease. *Behavioral Medicine, 40*(2), 53–64. doi:10.1080/08964289.2013.834865.

Kim, H. G., Geppert, J., Quan, T., Bracha, Y., Lupo, V., & Cutts, D. B. (2012). Screening for postpartum depression among low-income mothers using an interactive voice response system. *Maternal and Child Health Journal, 16*, 921–928. doi:10.1007/s10995-011-0817-6.

Kleinman, A. (1980). *Patients and healers in the context of culture*. Berkeley, CA: University of California Press.

Koskan, A., Friedman, D. B., & Messias, D. K. H. (2010). Health literacy among Hispanics: A systematic research review (1992-2008). *Hispanic Health Care International, 8*(2), 65–76. doi:10.1891/1540-4153.8.2.65.

Kravitz, R. L., Paterniti, D. A., Epstein, R. M., Rochlen, A. B., Bell, R. A., Cipri, C., … Duberstein, P. (2011). Relational barriers to depression help-seeking in primary care. *Patient Education and Counseling, 82,* 207–213. doi:10.1016/j.pec.2010.05.007.

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine, 16*, 606–613.

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2003). The Patient Health Questionnaire-2: Validity of a two-item depression screener. *Medical Care, 41*, 1284–1292. http://dx.doi.org/10.1097/01.MLR.0000093487.78664.3C.

Lejuez, C. W., Hopko, D. R., Acierno, R., Daughters, S. B., & Pagoto, S. L. (2011). Ten year revision of the brief behavioral activation treatment for depression: Revised treatment manual. *Behavior Modification, 35*(2), 111–161. doi:10.1177/0145445510390929.

Lewis-Fernandez, R., Balan, I. C., Patel, S. R., Sanchez-Lacay, J. A., Alfonso, C., Gorritz, M., … Moyers, T. B. (2013). Impact of motivational pharmacotherapy on treatment retention among depressed Latinos. *Psychiatry, 76*(*3*), 210–222. doi: 10.1521/psyc.2013.76.3.210.

Lin, G. A., & Fagerlin, A. (2014). Shared decision making: State of the science. *Circulation: Cardiovascular and Quality Outcomes, 7*, 328–334. http://dx.doi.org/10.1161/CIRCOUTCOMES.113.000322.

Link, B., Yang, L. H., Phelan, J. C., & Collins, P. Y. (2004). Measuring mental illness stigma. *Schizophrenia Bulletin, 30*(3), 511–541.

Lopez, A. D., Mathers, C. D., Ezzati, M., Jamison, D. T., & Murray, C. J. L. (2001). Global burden of disease and risk factors. In *Systematic analysis of population health data*. London: J. Onwhyn.

Ludman, E. J., Simon, G. E., Tutty, S., & Von Korff, M. (2007). A randomized trial of telephone psychotherapy and pharmacotherapy for depression: Continuation and durability of effects. *Journal of Consulting and Clinical Psychology, 75*(2), 257–266. http://dx.doi.org/10.1037/0022-006X.75.2.257.

Macartney, S., Bishaw, A., & Fontenot, K. (2013). Poverty rates for selected detailed race and Hispanic groups by state and place: 2007–2011. *American Community Survey Briefs.* U.S. Census Bureau, 2007–2011 American Community Survey. ACSBR/11-17. Retrieved November 15, 2013, from http://www.census.gov/prod/2013pubs/acsbr11-17.pdf.

Manoleas, P. (2008). Integrated primary care and behavioral health services for Latinos: A blueprint and research agenda. *Social Work in Health Care, 47*, 438–454.

March, D., Luchsinger, J. A., Teresi, J. A., Eimicke, J. P., Findley, S. E., Carrasquillo, O., & Palmas, W. (2014). High rates of depressive symptoms in low-income urban Hispanics of Caribbean origin with poorly controlled diabetes: Correlates and risk factors. *Journal of Health Care for the Poor and Underserved, 25*(*1*), 321–331. doi:10.1353/hpu.2014.0027.

McCaffery, K. J., Smith, S. K., & Wolf, M. (2010). The challenge of shared decision making among patients with lower literacy: A framework for research and development. *Medical Decision Making, 30*(1), 35–44. doi:10.1177/0272989x09342279.

McFarlane, J. M., Groff, J. Y., O'Brien, J. A., & Watson, K. (2005). Prevalence of partner violence against 7,443 African American, White, and Hispanic women receiving care at urban public primary care clinics. *Public Health Nursing, 22*, 98–107. doi:10.1111/j.0737-1209.2005.220203.x.

McIntyre, K. P., Korn, J. H., & Matsuo, H. (2008). Sweating the small stuff: How different types of hassle result in the experience of stress. *Stress and Health, 24*, 383. doi:10.1002/smi.1190. Retrieved from www.interscience.wiley.com.

Menchetti, M., Belvederi-Murri, M., Bertakis, K., Bortolotti, B., & Berardi, D. (2009). Recognition and treatment of depression in primary care: Effect of patients' presentation and frequency of consultation. *Journal of Psychosomatic Research, 66*, 335–341.

Substance Abuse and Mental Health Services Administration, (SAMSHA). (2015). *Racial/ethnic differences in mental health service use among adults*. HHS Publication No. SMA-15-4906. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Miranda, J., Duan, N., Sherbourne, C., Schoenbaum, M., Lagomasino, I., Jackson-Triche, M., & Wells, K. B. (2003). Improving care for minorities: Can quality improvement interventions improve care and outcomes for depressed minorities? Results of a randomized, controlled trial. *Health Services Research, 38,* 613– 630. doi:10.1111/1475-6773.00136.

Mitchell, A. J., Vaze, A., & Rao, S. (2009). Clinical diagnosis of depression in primary care: A meta-analysis. *Lancet, 374*, 609–619. doi:10.1016/S0140-6736(09)60879-5.

Mojtabai, R., & Olfson, M. (2008). National patterns in antidepressant treatment by psychiatrists and general medical providers: Results from the national comorbidity survey replication. *Journal of Clinical Psychiatry, 69*, 1064–1074. http://dx.doi.org/10.4088/JCP.v69n0704.

Moore, M., Ali, S., Stuart, B., Leydon, G. M., Ovens, J., Goodall, C., & Kendrick, T. (2012). Depression management in primary care: An observational study of management changes related to PHQ-9 score for depression monitoring. *The British Journal of General Practice, 62*(*599*), e451–e457. Retrieved from http://dx.doi.org/10.3399/bjgp12X649151.

Mostow, C., Crosson, J., Gordon, S., Chapman, S., Gonzalez, P., Hardt, E., … David M. (2010). Treating and precepting with RESPECT: A relational model addressing race, ethnicity, and culture in medical training, *Journal of General Internal Medicine 25*(*Suppl 2*), 146–154.

Moyer, V. A., & U.S. Preventive Services Task Force. (2013). Screening for intimate partner violence and abuse of elderly and vulnerable adults: U.S. preventive services task force recommendation statement. *Annals of Internal Medicine, 158*(6), 478–486. doi:10.7326/0003-4819-158-6-201303190-00588.

Munet-Vilaró, F., Folkman, S., & Gregorich, S. (1999). Depressive symptomatology in three Latino groups. *Western Journal of Nursing Research, 21*(2), 209–224.

Munet-Vilaró, F., Gregorich, S., & Folkman, S. (2002). Factor analysis of the Spanish version of the ways of coping questionnaire. *Journal of Applied Social Psychology, 32*(9), 1938–1954.

Muñoz, R. F., McQuaid, J. R., González, G., Dimas, J., & Rosales, V. (1999). Depression screening in a women's clinic: Using automated Spanish- and English-language voice recognition. *Journal of Consulting & Clinical Psychology, 67*, 502–510.

Myers, H. F., Wyatt, G. E., Ullman, J. B., Loeb, T. B., Chin, D., Prause, N., … Liu, H. (2015). Cumulative burden of lifetime adversities: Trauma and mental health in low-SES African Americans and Latino/as. *Psychological Trauma: Theory, Research, Practice, and Policy, 7*(*3*), 243–251. doi:10.1037/a0039077.

Nadeem, E., Lange, H. M., Edge, D., Fongwa, M., Berlin, T., & Miranda, J. (2007). Does stigma keep poor young immigrant and U.S.-born Black and Latina women from seeking mental health care? *Psychiatric Services, 58*, 1547–1554.

Nicklett, E. J., & Burgard, S. A. (2009). Downward social mobility and major depressive episodes among Latino and Asian-American immigrants to the United States. *American Journal of Epidemiology, 170*(6), 793–801. doi:10.1093/aje/kwp192.

Nicolaidis, C., Perez, M., Mejia, A., Alvarado, A., Celaya-Alston, R., Galian, H., & Hilde, A. (2011). 'Guardarse las cosas adentro' (keeping things inside): Latina violence survivors' perceptions of depression. *Journal of General Internal Medicine*, *26*(*10*), 1131–1137. PMID: 21626052.

Olfson, M., Moitabai, R., Sampson, N. A., Hwang, I., & Kessler, R. C. (2009). Dropout from outpatient mental health care in the United States. *Psychiatric Services, 60*, 898–907. doi:10.1176/appi.ps.60.7.898.

Rogler, L. H., Cortes, D. E., & Malgady, R. G. (1994). The mental-health relevance of idioms of distress anger and perceptions of injustice among New-York Puerto-Ricans. *Journal of Nervous and Mental Disease, 182*(6), 327–330. doi:10.1097/00005053-199406000-00003.

Roth, B., & Robbins, D. (2004). Mindfulness-based stress reduction and health-related quality of life: Findings from a bilingual inner-city patient population. *Psychosomatic Medicine, 66*(*1*), 113–123. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/14747645.

Schmaling, K. B., & Hernandez, D. V. (2005). Detection of depression among low-income Mexican Americans in primary care. *Journal of Health Care for the Poor and Underserved, 16*, 780–790.

Scott, K. M., Bruffaerts, R., Tsang, A., Ormel, J., Alonso, J., Angermeyer, M. C., … Von Korff, M. (2007). Depression-anxiety relationships with chronic physical conditions: Results from the world mental health surveys. *Journal of Affective Disorders, 103*(*1–3*), 113–120. doi:10.1016/j.jad.2007.01.015.

Sentell, T., & Braun, K. L. (2012). Low health literacy, limited English proficiency, and health status in Asians, Latinos, and other racial/ethnic groups in California. *Journal of Health Communication, 17*(Suppl 3), 82–99. doi:10.1080/10810730.2012.712621.

Shah, P. S., Shah, J., & Knowledge Synthesis Group on Determinants of Preterm/LBW Births. (2010). Maternal exposure to domestic violence and pregnancy and birth outcomes: A systematic review and meta-analyses. *Journal of Women's Health, 19*, 2017–2031.

Shim, R. S., Baltrus, P., Ye, J., & Rust, G. (2011). Prevalence, treatment, and control of depressive symptoms in the United States: Results from the National Health and Nutrition Examination Survey (NHANES), 2005–2008. *Journal of the American Board of Family Medicine, 24*, 33–38.

Sue, S. (1988). Psychotherapeutic services for ethnic minorities: Two decades of research findings. *American Psychologist, 43*, 301–308. doi:10.1037/0003-066X.43.4.301.

Tarricone, I., Stivanello, E., Poggi, F., Castorini, V., Marseglia, M. V., Fantini, M. P., Berardi, D. (2012). Ethnic variation in the prevalence of depression and anxiety in primary care: A systematic review and meta-analysis. *Psychiatry Research*, *195*, 91–106.

Taylor, P., Kochhar, R., Fry, R., Velasco, G., Motel, S. (2011). Twenty-to-one: Wealth gaps rise to record highs between Whites, Blacks, and Hispanics. Pew Research Center, *Social and Demographic Trends*. Retrieved from http://www.pewsocialtrends.org/files/2011/07/SDT-Wealth-Report_7-26-11_FINAL.pdf.

Todorova, I. L. G., Tucker, K. L., Pescador, M., Jimenez, A. K., Lincoln, S. A., & Falcón, L. M. (2013). Determinants of self-rated health and the role of acculturation: Implications for health inequalities. *Ethnicity & Health, 18*, 563–585.

Torres, L. (2010). Predicting levels of Latino depression: Acculturation, acculturative stress, and coping. *Cultural Diversity and Ethnic Minority Psychology, 16*(2), 256. doi:10.1037/a0017357.

Torres, L., & Rollock, D. (2007). Acculturation and depression among Hispanics: The moderating effect of intercultural competence. *Cultural Diversity & Ethnic Minority Psychology, 13*(1), 10–17. doi:10.1037/1099-9809.13.1.10.

Uebelacker, L. A., Wang, P. S., Berglund, P., & Kessler, R. C. (2006). Clinical differences among patients treated for mental health problems in general medical and specialty mental health settings in the National Comorbidity Survey Replication. *General Hospital Psychiatry, 28*, 387–395. http://dx.doi.org/10.1016/j.genhosppsych.2006.05.001.

United States Census Bureau. (2012). *U.S. Census Bureau projections show a slower growing, older, more diverse nation a half century from now*. Retrieved from http://www.census.gov/newsroom/releases/archives/population/cb12-243.html.

United States Census Bureau. (2013a). *ACS Demographic and housing estimates 2012 American Community Survey 1-Year Estimates*. Retrieved from http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_12_1YR_DP05&prodType=table.

United States Census Bureau. (2013b). Poverty rates for selected detailed race and Hispanic groups by state and place, 2007–2011. *American Community Survey Briefs*. Retrieved from http://www.census.gov/prod/2013pubs/acsbr11-17.pdf.

United States Preventive Services Task Force (USPSTF). (2009). *Screening for depression in adults*. Retrieved from http://uspreventiveservicestaskforce.org.

US Department of Health and Human Services. (2015). *Access to health services*. Washington, DC: DHHS. Retrieved from http://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services.

Vargas, S. M., Cabassa, L. J., Nicasio, A., De La Cruz, A. A., Jackson, E., Rosario, M., …. Lewis Fernandez, R. (2015). Toward a cultural adaptation of pharmacotherapy: Latino views of depression and antidepressant therapy. *Transcultural Psychiatry, 52*(2), 244–273. doi:10.1177/1363461515574159.

Vega, W. A., Rodriguez, M. A., & Ang, A. (2010). Addressing stigma of depression in Latino primary care patients. *General Hospital Psychiatry, 32*(2), 182–191. doi:10.1016/j.genhosppsych.2009.10.008.

Vespa, J., Lewis, J. M., & Kreider, R. M. (2013). America's families and living arrangements: 2012 Population characteristics P20-570. U. S. Census Bureau, *American Community Survey, 2011*. Retrieved November 15, 2013, from http://www.census.gov/prod/2013pubs/p20-570.pdf.

Villatoro, A. P., Morales, E. S., & Mays, V. M. (2014). Family culture in mental health help-seeking and utilization in a nationally representative sample of Latinos in the united states: The NLAAS. *American Journal of Orthopsychiatry, 84*(4), 353–363.

Winkelman, S. B., Chaney, E. H., & Bethel, J. W. (2013). Stress, depression and coping among Latino migrant and seasonal farmworkers. *International Journal of Environmental Research and Public Health, 10*(5), 1815–1830. doi:10.3390/ijerph10051815.

Wulsin, L., Somoza, E., & Heck, J. (2002). The feasibility of using the Spanish PHQ-9 to screen for depression in primary care in Honduras. *Primary Care Companion of the Journal of Clinical Psychiatry, 4*, 191–195.