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Insights in Depression Screening at a Latino-Serving, Integrated FQHC Clinic

Jacquelyn Stephenson

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Insights in Depression Screening at a Latino-Serving, Integrated FQHC Clinic

by

Jacquelyn Stephenson

A Dissertation submitted in partial satisfaction of the requirements for the degree Doctor of Philosophy in Social Policy and Social Research

June 2017
Each person whose signature appears below certifies that this dissertation in his/her opinion is adequate, in scope and quality, as a dissertation for the degree Doctor of Philosophy.

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Larry Ortiz, Professor of Social Work and Social Ecology
ACKNOWLEDGEMENTS

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<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>PPACA</td>
<td>Patient Protection and Affordable Care Act</td>
</tr>
<tr>
<td>USDHHS</td>
<td>United States Department of Health and Human Services</td>
</tr>
<tr>
<td>NIMH</td>
<td>National Institute of Mental Health</td>
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<td>PCP</td>
<td>Primary Care Provider</td>
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<tr>
<td>CRT</td>
<td>Critical Race Theory</td>
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<tr>
<td>LatCRT</td>
<td>Latino Critical Race Theory</td>
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<tr>
<td>SEM</td>
<td>Social Ecological Model of Health Promotion</td>
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<tr>
<td>CDC</td>
<td>Centers for Disease Control</td>
</tr>
<tr>
<td>PHQ-2</td>
<td>Patient Health Questionnaire-2</td>
</tr>
<tr>
<td>PHQ-9</td>
<td>Patient Health Questionnaire-9</td>
</tr>
<tr>
<td>IBHS</td>
<td>Integrated Behavioral Health Specialist</td>
</tr>
<tr>
<td>HRSA</td>
<td>Health Resources and Services Administration</td>
</tr>
<tr>
<td>FQHC</td>
<td>Federally Qualified Health Center</td>
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<tr>
<td>ICSI</td>
<td>Institute for Clinical Systems Improvement</td>
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ABSTRACT OF THE DISSERTATION

Insights in Depression Screening at a Latino-Serving, Integrated FQHC Clinic

by

Jacquelyn Stephenson

Doctor of Philosophy, Graduate Program in Social Policy and Social Research
Loma Linda University, June 2017
Dr. Susanne Montgomery, Chairperson

Depression manifests differently in Latinos when compared to other racial-ethnic groups, but little is known regarding linguistic differences among Latinos. This mixed methods study explored the depression screening processes among patients and medical providers at a Federally Qualified Health Center (FQHC) through an ethnic-linguistic lens.

Binary logistic regressions were performed to determine the effects of ethnicity and language on PHQ-2 screening rates for 10,285 adult patients seen during a primary care medical visit from 2014 to 2015; of these 4,745 (46%) patients were screened for depression. Spanish-speakers were screened for depression more often than non-Latinos and Latinos who were English-speakers. Spanish-speakers screened positive for depression 31% less often than English speaking Latinos. Additionally, a chart review was conducted on 692 patients who screened positive on the PHQ-2; 275 of these who scored ≥10 (major depression) on the PHQ-9 were included in further analysis. Controlling for demographics, we found that despite increased screening, Spanish-speakers were less likely to receive standard of care recommendations (combined psychotherapy and pharmacotherapy) than English-speaking patients.
To explore these issues contextually, key informant interviews were conducted with 6 English-speaking Latinos, 6 Spanish-speaking Latinos, 6 English-speaking non-Latinos and 7 provider participants. Semi-structured, member-checking focus groups were conducted with the four groups to validate interview themes. Participants confirmed that negative perceptions about medications, patient non-compliance, and a shortage of bilingual behavioral health specialists within the clinic impacted standard of care treatment recommendations and uptake for the Spanish-speaking Latinos. However, strength of relationships with providers and family, handoff to integrated behavioral health specialists, and motivating factors (i.e. diet and exercise) helped patients to overcome depression. Manifestation of depressive symptoms were associated with ethnic-linguistic differences. Understanding ethnic-linguistic differences further could improve screening accuracy and depression care for Latinos.
CHAPTER ONE
INTRODUCTION

Although the Patient Protection and Affordable Care Act [PPACA] of 2010 has opened healthcare access to previously uninsured Americans, and Covered California has effectively enrolled more than 450,000 additional individuals in a Medicaid expansion, it is not clear how mental health care has been affected by these programs or how mental health delivery is meeting community needs with culturally consistent assessment and treatment models. Specifically, few have examined best practices regarding depression screening for Latinos in primary care settings with culturally and linguistically appropriate modalities. The United States Census Bureau defines Latinos as those who classify themselves as Mexican, Mexican American, Chicano, Puerto Rican, Cuban, or any other Hispanic, Latino, or Spanish origin; origin “can be viewed as the heritage, nationality group, lineage, or country of birth of the person or person’s ancestors before their arrival in the United States” (https://www.census.gov/population/hispanic/).

Approximately 25% of all patients with a chronic medical condition report a depressive episode, known to negatively affect a patient’s ability to adhere to medical recommendations if not treated concurrently (Camacho et al., 2014). As the largest ethnic minority in the United States (Aponte-Rivera et al, 2014; Huang, Chung, Kroenke, Delucchi, & Spitzer, 2005; Thomas et al, 2011), it is imperative to increase the amount of culturally and linguistically appropriate mental health services to Latinos in primary care settings where much of mental health treatment occurs presently. This is particularly true in Southern California in Latino majority counties who seek treatment in primary care settings.
Cultural and Linguistic Mental Health Awareness for Latinos

The United States Department of Health and Human Services [USDHHS], Office of Minority Health (2013) defines cultural and linguistic competency as “a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals to work effectively in cross-cultural situations.” The United States Census Bureau (2013) reports that Latinos comprise approximately 17% (54 million) of the total U.S. population. Despite being the largest minority group in the United States (Aponte-Rivera et al., 2014; Huang et al., 2006; Thomas et al., 2011), and, according to the Governor’s Budget Summary 2014-15 (Brown, 2014), the largest ethnic group in the state of California, Latinos are poorly represented in large clinical studies of depression, especially with languages other than English being the most common exclusion criteria for many studies (Reuland et al., 2009).

With approximately 55% of the adult Latino population reporting Limited English Proficiency in the United States (Aponte-Rivera et al, 2013), culturally and linguistically appropriate screening, treatment, and management of this population is a growing obstacle. Barriers amongst the entire healthcare industry for this minority population include cost, transportation, low literacy levels, language barriers, distrust of medical providers, immigration and acculturation issues (Aponte-Rivera, 2013; Chang et al, 2014; Kalibatseva & Leong, 2014; Kanter et al, 2014; Thomas et al, 2011). Another well-known barrier for Latinos is difficulty accessing specialty mental health services, which is why treatment in a primary care setting is critically important (Ishikawa et al, 2014). The shortage of culturally and linguistically appropriate mental health specialists is intensifying the inferior treatment of depression in ethnic minority populations. It is
evident that both the shortage of culturally and linguistically appropriate mental health assessments and healthcare providers is impacting treatment of depression for Latinos in general, but Spanish-speaking Latinos specifically.

**Health Disparities Affecting Latinos**

The USDHHS National Institute of Health (2013) defines health disparities as “gaps in the quality of health and health care that mirror differences in socioeconomic status, racial and ethnic background, and education level.” Health disparities are preventable differences experienced by socially disadvantaged populations, which are defined based on numerous factors, such as age, gender, or even geographic location. The USDHSS United States Preventive Task Force asserts that although depression screening may occur in primary care settings, it is often not effectively linked to appropriate follow-up mental health screening, treatment, and management (USDHHS, 2012). Researchers have found that cost, stigma, poor quality of care, lack of therapists, and a weak patient/provider relationship all exacerbate mental health inequity among Latino patient populations (Aponte-Rivera et al 2014; Chang et al, 2014; Ford & Harawa, 2010; Holden et al 2014; Kanter et al 2014; Thomas, Quinn, Butler, Fryer, & Garza, 2011).

The National Institute of Mental Health, Office for Research on Disparities and Global Mental Health reports that patients with severe mental illness “die 11 to 32 years prematurely from largely preventable comorbid medical conditions, all of which occur more frequently and have earlier onset. Low rates of prevention, detection, and treatment further add to these health disparities” (Arzin, 2012). Additional barriers for Latinos include transportation problems, mental health cost concerns, unemployment, and
language barriers when accessing healthcare services (Wells, Lagomasino, Palinkas, Green, & Gonzalez, 2013). A review of ethnic diversity in 379 National Institute of Mental Health [NIMH] funded clinical trials resulted in a mean proportion of merely 9% Latino participants (Aponte-Rivera et al., 2014). Clearly research continues to be inadequate and not representative of the entire Latino population.

There is strong evidence indicating that mental health plays a crucial role in a patient’s ability to maintain their physical health; likewise, problems with physical health can seriously affect mental health and reduce treatment participation, ultimately hindering recovery (Holden et al., 2014). Hansen and Cabassa (2012) conducted focus groups with 19 Spanish-speaking immigrant, low-income Latinos with diabetes and major depression to examine help-seeking pathways to depression care. Themes emerging from this qualitative study included the recognition of need for mental health care and adherence to care. Participants were able to recognize the need for care through somatization of depressive symptoms, mood changes, and health symptoms with decreased functioning. Participants reported that positive interactions with their physicians and therapists contributed to adherence, especially since the services were offered in Spanish. Patients also reported that improvements in symptoms heightened their awareness that the treatment was working, and improvements in functioning reinforced their adherence to treatment, such as being able to return to work. It is evident that mental health screening in a primary care setting can effectively improve both mental health and physical health concurrently.
Prevalence of Depression in Latinos

Depression is a leading cause of death and disability in the United States, affecting 16% of the general population at least once during their lifetime (Camacho et al., 2014; Huang, Chung, Kroenke, Delucchi, & Spitzer, 2006; Ishikawa et al., 2014; Kalibatseva & Leong, 2014). Up to 40% of individuals with depressive symptoms first visit a community health center for care (Camacho et al., 2014). Depression prevalence amongst Latinos has been reported between 8-15% compared to 22% for non-Latino Whites (Kalibatseva & Leong, 2014). Existing literature emphasizes that depression is frequently undiagnosed or misdiagnosed and therefore often remains untreated in the Latino population due to somatization of depression symptoms (Camacho et al., 2014; Holden et al., 2014). Up to 70% of primary care visits include psychosocial concerns; patients present to their primary care provider [PCP] with physical manifestations triggered by underlying behavioral health issues (Holden et al., 2014). Unfortunately, PCPs may not be trained to screen for depression as standard health maintenance or treat mental health disturbances separately from patient reports of physical ailments.

Ultimately, the time constraints of a standard 15-minute medical visit lead to undetected mental health disparities that are overshadowed by chronic conditions and pressure for productivity (Aponte-Rivera et al., 2014). Providers are expected to generate revenue and see patients as quickly as possible, often prioritizing physical health as more important for the current visit. When depression screening does occur in a medical setting, Latinos report access to mental health care as the main barrier to receiving treatment, even when they fully intend to follow through with PCP recommendations (Ishikawa et al., 2014).
Problem Statement

Former Surgeon General, David Satcher, MD, PhD, shed light on the health inequities experienced by ethnic minorities in his report *Mental Health: Culture, Race and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General* (2001). Satcher (2001) indicates that mental health inequities are reemerging as healthcare organizations attempt to meet the demands of ACA legislation. By 2030, chronic disease mortality rate is expected to increase by approximately 20% worldwide (Thomas et al., 2014). Low rates of prevention, detection, and treatment intensify these health disparities (as cited in Holden et al., 2014). Ultimately when mental health is not addressed, treated, and monitored, physical health also worsens. Reduction of health disparities must include preventing both mental and physical illnesses.

The American Psychological Association (2014) recently released a special issue of *Psychological Services*, highlighting the inferiority of mental health services offered to ethnic minorities. Unfortunately, PCPs face competing demands (Reuland et al., 2014) and may not be adequately trained or equipped to screen, diagnose, and/or treat mental health issues (Holden et al., 2014). The United States Preventive Task Force asserts that although screening may occur in primary care settings, it oftentimes is not effectively linked to appropriate follow-up mental health screening, treatment, and management (USDHHS, 2012). Ishikawa et al. (2014) found that Latino patients’ rating of the PCP/patient relationship and PCP cultural competence were related to patients’ intention to follow treatment, but there was no significant relationship in actual uptake of the PCP’s recommendation. Their findings also revealed that medication accessibility made antidepressants the “default” treatment recommended by providers, even when
psychotherapy was preferred by patients; in fact, many patients reported at Time 2 (84 days after PCP visit) that they were still waiting for a psychotherapy appointment, and intended on complying with treatment once an appointment became available (p. 429). Lack of access to appropriate mental health services is troubling, especially with a population already experiencing poor access to healthcare in general. The integration of primary care and mental health services during the same encounter would be the preferred mechanism for treatment, however, providers in both professions are not adequately trained in these approaches, if at all.

**Significance in San Bernardino, CA**

Health care access continues to be a challenge for the residents of San Bernardino County. According to *Healthy San Bernardino County* (2013), San Bernardino County is home to 51.1% of Hispanics/Latinos, compared to 38.4% Statewide; 41% of residents in the County speak a language other than English at home (2008-2012). According to the UCLA Center for Health Policy Research’s *California Health Interview Survey* (2013), only 57.1% of adults needing care for emotional or mental health or substance abuse issues living in San Bernardino County stated that they were able to obtain help (*Healthy San Bernardino County*). The County of San Bernardino Mental Health Service Directory (2013) catalogs merely three agencies in San Bernardino City offering Spanish-speaking mental health services to its residents. Although there are other agencies in San Bernardino City with Spanish-speaking therapists, they are not advertised to the community in a manner that is easily accessible to minority populations with unique barriers such as low literacy levels and overall language barriers.
Significance of the Research

The purpose of this study is to explore cultural and linguistic characteristics comprising the assessment, recommended treatments, and causes of depression among Latino patients in a medically underserved setting, guided by Latino Critical Race Theory methodology. This study will be among one of the first to explore mental health service delivery for depression that includes a Spanish-speaker’s perspective. Insight into this subpopulation’s experience will shed light on ways to effectively provide culturally and linguistically appropriate mental health services to patients who initiate care in primary care settings. Exploring beliefs about depression among Latinos could inform mental health professionals working collaboratively in primary care settings how to address depression in a culturally and linguistically appropriate manner. Furthermore, such knowledge could provide primary care teams the support needed to appropriately assess patients for depression as proactive, preventive health maintenance screenings whether or not the patient actively seeks care for symptoms. This knowledge can assist with more culturally and linguistically specific depression screening modalities for Latinos, while also reducing barriers in depression treatment for patients who screen positive for depression in primary care settings.

Race vs. Ethnicity

According to the United States Office of Management and Budget (1978), Federal classifications for race include African Americans (blacks), American Indians and Alaska Natives, Asian, Native Hawaiian and other Pacific Islanders, and white Americans (whites). Latino (Hispanic American) is an ethnicity which may apply to a person of any
race. These broad Federal classifications were created in the 1970s for collection of census information and there is no homogenous racial or ethnic group (Satcher, 2001). Examples include Filipinos who classify themselves as Asian Latinos or Puerto Ricans who classify as black Latinos. Although the categories were formalized by the Federal government for data collection, history shows a long history of racism well before the 1970s as a tool of oppression to justify inequality. While race and ethnicity may share a common ideology of determining one’s affiliation of self via ancestry, they are clearly distinct variables. Scholars often combine the variables in studies by incorporating Latinos as a race in their analysis, not understanding the unique differences among cultural, ethnic, and social subgroups; therefore, it is crucial to employ a theory that gives voice to the unique experiences of these subgroups.

**Critical Race Theory**

It seems that there is a need to adjust focus to the paucity of mental health services available in San Bernardino, CA and the impact of shifting depression-screening responsibility to PCPs. While integrated healthcare models are emerging as a possible solution to reduce health inequities (Barksdale et al, 2014; Holden et al, 2014; Ishikawa et al, 2014; Kanter et al, 2014; Pinto-Meza et al, 2008), inadequate culturally and linguistically appropriate depression screening, treatment, and management is still not addressed. Given the significant role of race, gender, and class differences in health outcomes (Aponte-Rivera, 2014; Camacho et al, 2014; Graham, Brown-Jeffy, Aronson & Stephens, 2011; Hahm, Cook, Ault-Brutus & Alegria, 2014; Thomas et al, 2011), it is
constructive to employ Critical Race Theory as both the theoretical framework and tool for analysis of this study.

Critical Race Theory [CRT] emerged in the 1970s, post-Civil Rights Movement, out of criticism of the United States legal system’s racial structure. It is now used in other fields to analyze racial subordination, prejudice, and inequities experienced by minorities (Graham, Brown-Jeffy, Aronson, & Stephens, 2011). CRT aims at deconstructing racist premises by undermining colorblind ideology, built on the notion that race is not a factor in how people perceive each other. The core of CRT lies in the pursuit of social justice, defined as “full and equal participation of all groups in a society that is mutually shaped to meet their needs” (Malagon, Perez Huber, & Velez, 2009, p.255), with a commitment to eliminate racism and end subordination based on gender, class, sexual orientation, language, and national origin (Solorzano, 1998).

A central theme of CRT is the notion that social institutions are not culturally diverse, and often function based on the foundations, values, and principles of the dominant culture (Delgado & Stefancic, 2012). Therefore, minorities most often are compared to a dominant group, such as whites, and differences are interpreted as inferiority instead of cultural insensitivity (Calmore, 1995 as cited in Graham et al., 2011). CRT centers racism in research while challenging Eurocentric values with three main goals: to present storytelling as a valid method to examine racism, to recognize racism as a social construct while eradicating racial subjugation, and “to draw important relationships between race and other axes of domination” (Parker & Lynn, 2002, p. 10). Oftentimes studies fail to address and highlight differences within a minority group. Key tenets of CRT that address these differences are anti-essentialism (challenging the
dominant ideology), intersectionality, the centrality of experiential knowledge via storytelling, the commitment to social justice, and the incorporation a transdisciplinary perspective.

**Critical Race Theory Tenets**

**Anti-Essentialism**

According to Delgado and Stefancic (2012), essentialism reduces the experience of a category (gender or race) to the experience of one sub-group (Latinos). Studies that fail to analyze differences between subgroups assume that all oppressed people experience the same level of oppression. Given that oppression affects these categories differently, the aims and strategies employed should differ for each of these groups (Delgado & Stefancic, 2012). Given the racialization of Latinos, it is imperative to differentiate between ethnicities, cultures, and histories of oppression within the United States.

**Intersectionality**

Intersectionality seeks to explore how race intersects with gender, class, sexuality, language, and other potentially subordinating identity variables, along with organizational factors that impact the experience of People of Color; CRT includes methodologies that expose the ways organizations influence the phenomena being investigated (Malagon et al, 2009). Critical race scholars acknowledge that class oppression is not the sole cause for racial oppression (Solorzano & Yosso, 2002). Studies that analyze all Latinos into a study group usually fail to account for other potentially
subordinating identity variables. Consequently, CRT asks scholars to analyze their research instruments to ensure that they do not affirm the dominant ideology.

**Centrality of Experiential Knowledge/Storytelling**

CRT highlights the lived experience of People of Color and believes that storytelling is instrumental in helping scholars understand how, and to what extent, race mediates the phenomena being studied; People of Color create knowledge. Thus, CRT explicitly employs methodologies that center the lived experiences of People of Color (Solorzano, 1998). Additionally, there is an effort to include informants in the process of analyzing data and building theory as collaborators in the research process.

**Commitment to Social Justice**

The goal of CRT is to empower participants while identifying, analyzing, and transforming structural aspects of the research process. CRT also “requires researchers to reflect on how they employ methods as they enter and leave research sites, design interview protocols, and develop reciprocity with the communities that are a part of their research (Malagon et al, 2009, p. 257).

**Incorporating a Transdisciplinary Perspective**

The last tenet of CRT utilizes transdisciplinary knowledge and bases methodology around ethnic studies, women’s studies, history, and other schools of knowledge when constructing its theoretical premise. This leads the researcher to explore different methodologies in an effort to understand the experiences of marginalized communities.
through a transdisciplinary lens more effectively than traditional research methods (Malagon et al, 2009).

**Latino Critical Race Theory**

Latino Critical Race Theory [LatCRT] emerged in the mid-1990s to explore ethnic cultural characteristics unique to Latinos, such as language, accent, immigration, and acculturation (McCoy & Rodricks, 2015). This theory expanded research beyond the Black/White binary of CRT. AsianCRT, TribalCRT, and other branches of CRT have emerged to explore differences unique to specific racial-ethnic groups. The voices of minority populations with language barriers are often silenced with exclusion criteria in research, casting these patients into the façade of “colorblind” healthcare (Reuland et al., 2009). Studies to date often fail to add a Latino’s language preference to their intersectionality analysis, undermining the unique disparities faced by this specific population of Latinos. Additionally, the lack of culturally and linguistically appropriate assessments is a growing concern as Latinos continue to grow as the largest minority in the United States.

**Summary of Critical Race Theory**

Critical Race Theory will contribute a “comprehensive framework for connecting this study’s research endeavors, a vocabulary for advancing understandings of racial constructs and phenomena, critical analysis of knowledge production processes, and praxis for building on community-based participatory approaches linking research, practice and communities” (Ford & Airhihenbuwa, 2010). Adopting a race-conscious
framework, defined as the explicit acknowledgment of the workings of race and racism in social contexts or in one’s personal life and color blindness as positing that nonracial factors explain racial phenomena, CRT will set the foundation to analyze the depression screening and treatment process of Latinos. This study will explore the screening, treatment, and management of depression for underserved residents of San Bernardino, CA pursuing care at a FQHC. More specifically, CRT methodology will be employed to ensure that patients are not only interviewed about their experiences, but also involved in exploring the emerging themes from respective interviewees through a member-checking, end-of-study focus group in their preferred language.

**Study Aims**

This study focuses on achieving the following aims:

I. Quantitative Aim:

   1) Retrospectively investigate depression screening rates and differences in depression screening outcomes between ethnic-linguistic groups of patients seen for a medical visit from 2014-2015.

II. Mixed Methods Aims:

   2) Retrospectively investigate rates of standard of care depression treatment recommendations between ethnic-linguistic groups of patients who screened positive for depression from 2014-2015.

   3) Assess provider and patient perceptions about standard of care depression treatment recommendations and uptake.
III. Qualitative Aims:

4) Assess provider and patient perceptions about factors influencing manifestation of depression symptoms between ethnic-linguistic groups.

5) Classify answers to questions about depression in a socially just manner by including participants in member-checking focus groups (providers or patients), based on the patient’s preferred language.
CHAPTER TWO
LITERATURE REVIEW

The studies analyzing Latinos with depression typically do not examine the salience of language in their work. It is crucial to understand differences in depression screening rates, treatment compliance, and manifestation of depression for Latinos based on their preferred language, as this context will change many aspects of care including screening and access to treatment (Brown, 2014). Studies must acknowledge the impact of generalizing results for all Latinos, undermining Spanish-speaking Latinos’ experiences with accessing culturally and linguistically appropriate mental health services in their community.

Studying the Latino population as a subgroup does not consider how language impacts attitudes toward mental illness, treatment compliance and satisfaction, or manifestation of depression symptoms. Specifically, it is important to explore if these differences impact a patient’s ability to access mental health treatment based on their preferred language. Furthermore, depression incidence is reported to be significantly lower in Latinos; however, this report ignores the fact that depression may present differently in Latinos, that screening tools may not easily be translated into Spanish and maintain validity, or that treatment referrals with translators during medical encounters may be less effective for Spanish-speaking Latinos. Therefore, a theoretical framework focused on cultural and linguistic differences is essential to fully understand depression in the Latino population.
**Theoretical Underpinnings**

Beginning with a summary of the theoretical underpinnings guiding this project, the Social Ecological Model of Health Promotion will provide a framework to organize the literature based on individual, interpersonal, and organizational factors impacting depression service delivery for Latinos. Critical Race Theory will be used to critique the existing literature while offering tenets that guide methodology in a culturally and linguistically appropriate manner; operational definitions of four tenets will be first presented to identify how they will be used to critique the literature (summary of Critique can be found in Table 1 and a summary description of the same articles in Table 2). Adopting tenets and methodologies of CRT and LatCRT, this dissertation will explore whether there are differences in the screening, treatment, and manifestation of depression symptoms of Spanish-speaking Latinos pursuing primary care services based on their preferred language as compared to English-speaking non-Latinos as well as English-speaking Latinos.

**Summary of Critical Race Theory**

Centering CRT and LatCRT tenets within any research process is critical in transforming the questions asked, the methodologies employed, and the way data is analyzed. The purpose of the research becomes clear as CRT carves out a space in academia for the voices of Latinos, in whatever language they choose to speak. In this dissertation, language is a risk factor associated with ethnic stratification of Latinos that might be linked to depression treatment. Given the significant role of socioeconomic, gender, and class disparities in health outcomes (Aponte-Rivera, 2014; Camacho et al.,
2014; Graham, Brown-Jeffy, Aronson & Stephens, 2011; Hahm, Cook, Ault-Brutus & Alegria, 2015; Thomas et al., 2011), it is practical to utilize CRT tenets while incorporating language preference as a vital LatCRT demographic predictor variable to analyze differences in depression between English and Spanish-speaking Latinos and non-Latinos.

Critical Race Theory Tenet Operationalization

The following section provides operational definitions for how four CRT tenets will be used to critique the existing literature. Table 1 includes a scoring guide for each article used in this literature review to inform the Methods of this Dissertation (0-low yield, 1-medium yield, 2-high yield). A high yield indicates that the article met the conditions of the operationalization of the CRT tenets defined below.

Essentialism

Studies that group all Latinos together and compare them to another group to highlight differences in experience. It is important to note that studies utilizing purposive sampling to analyze a specific subset of Latinos are not essentialist, but their findings cannot be generalized to all Latinos.

Intersectionality

Studies that analyze a minimum of three potentially subordinating variables, such as gender, race, and age. Given the aims of this dissertation, this critique will also look specifically at whether any studies include preferred language as a purposive variable in
their analysis.

**Centrality of Experiential Knowledge/Storytelling**

Studies that provided surveys or conducted interviews or focus groups in the participant’s preferred language or qualitative studies that involved the participants in the analysis process.

**Incorporating a Transdisciplinary Perspective**

Studies conducted in integrated medical and mental health care settings. This is important in understanding how medical patients are introduced to behavioral health in a medical setting through utilization of integrated care specialists.

**Social Ecological Model of Health Promotion**

Existing literature studying Latino mental health issues can be placed into categories based on bands of influence from the Social Ecological Model of Health Promotion [SEM], which will be adopted for the framework of this literature review. The first band analyzes factors affected at the individual level, which will set the foundation for informing barriers associated with sociodemographic disparities, age and gender disparities, racial-ethnic disparities, and stigma. The second band reviews factors at the interpersonal level, which is essential in informing the importance of the role of family support in the screening, treatment, and management of depression in a patient’s preferred language. The third band reviews organizational factors impacting treatment compliance and how services rendered are influenced by language preference. The last
two bands of SEM will be defined first to offer a full explanation of the Model, but they will not be used to analyze the literature. Using Critical Race Theory and LatCRT to analyze the first three SEM bands of influence, this literature review includes both qualitative and quantitative empirical studies (see Tables 2 and 3), which guided the development of this Dissertation’s Methods presented in Chapter Four.

Formation of Social Ecological Model

The Centers for Disease Control and Prevention [CDC], a crucial operating component of the United States Department of Health and Human Services, adapted the social ecological model of health promotion from Urie Bronfenbrenner’s (1979) Ecological Framework for Human Development. Bronfenbrenner’s (1979) Ecological System Theory proposed that an entire ecological system must be analyzed to truly understand human development. The CDC’s Social Ecological Model embraces this theory to provide a framework for addressing numerous disparities and diseases in the United States. According to the CDC (2010), the Social Ecological Model of Health Promotion is a systems model with multiple “bands of influence”. The nucleus of the model revolves around the individual, which is surrounded by four larger bands of influence: interpersonal, organizational, community, and policy levels. The last two bands of influence, community level and public level, will be presented first so that the entire model is defined, then the three core levels of the SEM model will be used to present the literature (see Figure 1; Heisem, Ellsberg, & Gottemoeller, 1999).
Figure 1. Social-Ecological Model of Health Promotion.

Social Ecological Model’s Bands of Influence

Community Level

The fourth band of the SEM model represents prevention activities implemented at the community level. The CDC (2010) asserts that interventions at this level should include collaborations with community organizations and coalitions to address health disparities, promotion of health care services through expanded resources, and collaboration with mental health agencies to appropriately refer Spanish-speaking patients to culturally and linguistically appropriate treatment modalities.

Policy Level

The final SEM band represents prevention activities at the policy level, which entails the implementation of existing policy. An example of a policy is the PPACA of 2010. Organizational agencies at all levels (local, state, and federal) enforce policies that
ultimately intend on creating a healthier community under the PPACA. The federal
government writes policies that must be enacted at the state level, which is then filtered
down to local and even organizational levels. Despite the intent, policy level mandates
may exacerbate health disparities if not carefully implemented at the lower levels of the
Social Ecological Model. The Model must address all SEM bands to effectively provide
mental health screenings and services in a patient’s preferred language.

Individual Level

The nucleus of the Social Ecological Model represents the individual patient’s
knowledge, attitudes, biological, and personal historical factors that increase the
likelihood of being depressed, and access to services should they be depressed. The
model aims to influence a patient’s attitude toward several types of disparities and the
stigma of mental illness. Themes emerging in the literature review at the individual strata
include sociodemographic disparities, age and gender disparities, racial-ethnic disparities,
and mental illness stigma.

Sociodemographic Disparities

Leung, LaChapelle, Scinta, and Olvera (2014) explored factors contributing to the
development of depressive symptoms among Mexican American Latinos. This cross-
sectional analysis found four factors associated with the development of depression
symptoms: discrimination, crimes against property, access to medical care, and dramatic
loss of income. Latinos with depressive symptoms were found to be significantly more
concerned about discrimination ($M = 2.40$) than those with no depressive symptoms ($M =$
Latinos with depressive symptoms were found to be significantly more concerned about crimes against property \((M = 2.19)\) than those with no depressive symptoms \((M = 1.70)\). Latinos with depressive symptoms were found to be significantly more concerned about access to medical care \((M = 2.41)\) than those with no depressive symptoms \((M = 1.66)\). Respondents who were concerned about a dramatic loss of income were more likely to experience depressive symptoms than those with no symptoms. Unfortunately, this study did not take cultural-linguistic differences into consideration and grouped all Latinos into the same category for analysis.

**Age and Gender Disparities**

Researchers have found that age and gender impact depression treatment outcomes. A linear mixed model analysis conducted by Camacho and colleagues (2014) showed significant improvement in depression scores amongst Latinos over a 6-month period after controlling for age, gender, smoking, and diabetes. There was a significant three-way interaction between time, gender, and smoking showing that depressive symptoms among male smokers did not improve as much as male nonsmokers and females. Horevitz, Organista, and Arean (2015) also identified intersectional disparities in their semi-structured interviews with 16 Latino patients with men indicating poverty and women gender roles as exacerbating depression treatment barriers. Men reported unemployment as a primary reason for depression, therefore talk therapy would not help them with reducing their “type” of depression. On the other hand, women could not find babysitters and therefore missed therapy appointments. Everyday barriers impacting treatment compliance for both genders included low health literacy, treatment cost, and
Marianismo is a Latino cultural value defined as a female gendered role emphasizing nurturing and self-sacrifice. Ishikawa et al. (2010) found that marianismo not only affected help-seeking behaviors among females, but male participants also stated that they would not open up to their mothers about their depression because they already “suffered” enough (p. 1564). This cultural value is known to prolong depression symptoms in Latinas.

**Racial-Ethnic Disparities**

Although studies grouping Latinos into the same category can be essentialist, such studies do address the impact of race and ethnic disparities on depression screening, treatment, and manifestation of symptoms. Cook et al. (2014) investigated disparities in mental health care in whites, blacks, and Latinos. Latinos had less initiation (24.6%) and adequacy of care (9.2%) than whites (39.8%, 16.0%, respectively). Also, Latino depressive episodes were shorter (228 days compared to 257 days for whites) and had fewer psychotropic drug refills. Lastly, Latino episodes had a greater proportion of PCP visits compared to whites and blacks.

Hahm et al. (2015) examined the interaction of race/ethnicity and gender in depression screening and found that Latinos in general were more likely to be screened for depression compared to whites. Employing the CRT tenet of intersectionality, Hahm et al. (2015) then analyzed the impact of gender on depression screening. Like Cook et al., (2014), results indicated that among those with moderate or severe depression, Latino males were less likely than whites to receive any mental health care. The disparity
between Latinos and whites in receipt of adequate care was greater among males than females. Findings in the literature suggest that the disparity lies in inadequate follow through for the Latino population, regardless of referral type.

**Mental Health Stigma**

Stigma of mental illness in the Latino population is a known barrier to care for depression. Vega, Rodriguez, and Ang (2010) state that two factors may play an influential role in Latino stigma toward depression treatment: the tendency toward somatic presentations of depression (leading to misdiagnosis) and the stigma around receiving a “mental illness label” that requires taking prescribed medications. Given that there is “no dominant paradigm of stigma and how it operates to influence individuals toward or away from mental health treatment” (pg. 2), the researchers developed a stigma checklist to assist physicians in addressing depression in Latino patients. Patients reporting higher levels of perceived stigma using the stigma checklist were less likely to disclose their depression diagnosis to their family and friends and less likely to be taking antidepressant medication. Patients with stigma were less likely to be able to manage their depression and more likely to have missed scheduled visits.

Interian et al. (2010) conducted a longitudinal study with Spanish-speaking Latino primary care patients to describe the psychometric properties of four stigma measures: Perceived Discrimination Devaluation (PDD), Stigma Concerns about Mental Health Care (SCMHC), the Latino Scale for Antidepressant Stigma (LSAS), and the Social Distance (SD) scale. Patients who reported greater social distance from individuals with depression were more likely to have been receiving treatment for emotional care in the
past three months. Latinos who scored high on the SCMHC and LSAS were less likely to take antidepressants. This study did incorporate gender, age, and insurance coverage as independent variables, but English-speakers were excluded from the study instead of language being added as an additional variable for comparison.

**Interpersonal Level**

The second band of the Social Ecological Model encircles the individual band, representing prevention activities implemented at an interpersonal level. According to the CDC (2010), these preventive activities focus on overcoming individual-level barriers while also affecting cultural and social norms. Interpersonal support often comes from a patient’s family, friends, and/or health care provider.

**Role of Family Support**

Familism and familial values in Latino households are known to be protective factors with beneficial mental health outcomes. According to Ayon and Aisenberg (2010), familism focuses on familial values and well-being, as opposed to a focus on individual opportunities. There is an emphasized importance of family unity and contributing to the well-being of the family, a crucial protective factor in the SEM model. Greater familism has been associated with increases in self-esteem and decreases in internalization of symptoms including depression. Keeler, Siegel, and Alvaro (2014) found that depression symptomatology was negatively associated with familism. Familism partially mediated the relationship between depression symptomatology and the
perceived utility of familial help seeking. After controlling for gender, familism and depression scores accounted for 16% of the variance in utility of family for overcoming depression. Family members motivated participants to take the initial steps to access care through encouraging visits to their physician. Without external motivation, Spanish-speaking, immigrant, low-income Latino participants expressed resistance to accessing mental health services (Hansen & Cabassa, 2012). As a comparison, Ishikawa, Cardemil, and Falmagne (2010) found that familism influenced help seeking through processes that shaped, and were shaped by interpersonal interactions for English-speaking Latinos. It is evident that familism is an important protective factor for Latinos experiencing depression. However, literature has also found that a weak family relationship can hinder depression management.

Chang, Natsuaki, and Chen (2013) conducted a cross-sectional study examining ethnic and generational differences in family cultural conflict and family cohesion by generational status for Asian Americans and Latino Americans. Outcomes showed that first-generation Asian Americans reported greater family cultural conflict than Latino Americans. First-generation Latino Americans had the highest levels of family cohesion compared to other generations. Latino Americans who reported higher family cultural conflict and lower family cohesion were more likely to use mental health services. It is essential to assess a patient for familism to ensure that family is a protective factor as they seek help for their depression.
Organizational Level

The third band of the SEM model represents prevention activities implemented at the organization level. The CDC (2010) states that these preventive activities focus on overcoming individual-level barriers by influencing organizational policies and systems. Organizational level support systems include health clinics and Medi-Caid insurance HMO plans. These support systems can provide the coverage and benefits needed for a patient to comply with treatment. Additionally, an organization can ensure that systems are in place for proper interpreters when services cannot be rendered in the patient’s preferred language.

Treatment Compliance

Ishikawa et al. (2014) found that Latino patients’ rating of the PCP/patient relationship and PCP cultural competence were positively related to patients’ intention to follow treatment, but there was no relationship to actual uptake of the PCP’s recommendation. Findings also revealed that medication accessibility made antidepressants the “default” treatment, even when psychotherapy was preferred. At Time 1, 23% of patients had initiated uptake of the treatment recommendation, increasing to 53% at Time 2, regardless of treatment recommendation. Patients who received a medication recommendation were more likely to have followed through on the recommendation, compared with patients who received a psychotherapy recommendation (77% and 36%, respectively). An organization that completes depression screening must ensure that mental health appointments are available so that patients are not waiting
months to access the care they need at the time of the screening. Medications should not be a default alternative to psychotherapy due to the lack of therapists.

**Language Preference**

Although the studies mentioned above screened Spanish-speaking patients in their preferred language, the investigators did not analyze the impact of language preference on depression treatment outcomes. Participants from focus groups conducted by Uebelacker et al. (2012) reported that barriers to receiving care for depression included concerns about the accuracy of interpreters during their visits and receipt of medical services in their preferred language. Patients expressed that, although they could not hold their own conversation in English, they understood enough English to know that the interpreter was not translating accurately; this dynamic led to mistrust and disengagement.

Two studies compared differences in the participation of mental health treatment between English-speaking Latinos and Spanish-speaking Latinos. Aponte-Rivera et al. (2014) found that Spanish-speakers showed higher rates of uncontrolled medical illnesses and greater severity of illnesses compared to English-speakers. The study also found that depressed Spanish-speakers waited longer than English-speakers to seek help, delaying until symptoms reach an elevated level of severity before calling their doctor for an appointment. Spanish-speakers also requested clarification on the term “depression” when providers began a dialogue about the diagnosis due to the stigma associated with being labeled as having a mental health disorder.
Horevitz et al. (2015) was mentioned in the age and gender disparities section earlier in this Chapter; this study is the closest to achieving a CRT model with LatCRT factors of analysis. Not only were age, gender, and socioeconomic variables considered for demographic predictors, but the researchers also centered their analysis on a patient’s primary language. As a result, their semi-structured qualitative interviews explored factors influencing treatment uptake based on a patient’s preferred language and whether the patient received a warm handoff (introducing a patient to a mental health provider) or prescribed referral (entering in the record to contact the patient at a later date) to behavioral health.

Results of a chart review found an interaction effect between referral type and primary language. “Compared with Spanish-speaking Latinos, the odds of follow-through with behavioral health treatment were approximately 75% lower among English-speaking Latinos who received a warm handoff” (Horevitz et al., 2015, p.826). Horevitz and colleagues then conducted qualitative interviews to further explain the findings of the chart review. Results of the interviews showed that English speakers were more frustrated with the clinic and expressed a greater distrust and apprehension about the quality of care received. Spanish speakers were more likely to report a close relationship with their PCP, but poverty and low health literacy were barriers contributing to follow-through on a behavioral health appointment. English speakers were more likely to question behavioral health treatment, and therefore significantly less likely to engage when receiving a warm handoff. In this innovative study, monitoring illness severity, warm handoffs, and proper interpretation systems affected whether the patient complied with depression treatment. Although this article yields the highest score for the CRT
framework defined, the main limitation of this study is that a non-Latino control group was not included to determine whether any differences emerge by ethnicity.

Social Ecological Model Summary

It is evident that there is a need to develop a study that deliberately builds its methods with high yield in all CRT tenets to truly capture the Latino experience with depression. Although the existing literature scored a moderate yield in storytelling (1.31), there was little to no yield in anti-essentialism (0.56), intersectionality (0.75), and incorporation of a transdisciplinary perspective (0.88). Even with a higher yield in storytelling, most of the studies were quantitative surveys conducted in Spanish. Only one qualitative study included participants as active researchers who validated their experiences via member-checking focus groups.

The literature is clear that Latinos experience and respond to depression differently than other racial-ethnic groups. It is evident that family plays an essential role in depression treatment for Latinos. Additionally, trust in the patient-provider relationship is known to be a key factor in a patient’s intent to follow depression treatment recommendations. The Social Ecological Model emphasizes the need for all bands of influence to work together in identifying and managing depression in Latinos.
<table>
<thead>
<tr>
<th>Reference</th>
<th>Study Type (Qualitative, Quantitative, or Mixed Methods)</th>
<th>CRT Critique</th>
<th>Rating Score (0-2)</th>
<th>SEM Category</th>
<th>Identified Disparities</th>
</tr>
</thead>
</table>
| Aponte-Rivera et al. (2014) | Quantitative                                             | 1. Anti-essentialism: only compared Spanish-speaking Hispanics to “English speakers”  
2. Intersectionality: none; did not analyze sociodemographic variables for differences within groups; preferred language not analyzed  
3. Experiential Knowledge: hired bilingual/bicultural staff to increase reliability and internal validity; random assignment into treatment group; familismo-family allowed to participate in treatment, increasing participant’s comfort level.  
4. Transdisciplinary perspective: merged medical office space and Spanish-speaking site, due to population seeking mental health services with primary care physician; used patient navigators to reduce barriers to accessing treatment | Anti-essentialism: 1  
Intersectionality: 0  
Experiential Knowledge: 2  
Transdisciplinary perspective: 2  
Total Rating: 5 | Individual; Organizational | Spanish-speakers had lower education, were mostly female, uninsured; had more uncontrolled medical conditions, higher depression severity, mean symptom severity scores, and previous suicide attempts; Spanish-speakers did not feel that their physician adequately explained the term “depression”; Spanish-speaking patients often took medications prescribed outside the U.S. |
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<tbody>
<tr>
<td>Camacho et al. (2014)</td>
<td>Quantitative</td>
<td>Anti-essentialism: 0</td>
<td>Intersectionality: 1</td>
<td>Experiential Knowledge: 2</td>
<td>Transdisciplinary perspective: 2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>5</td>
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<tr>
<td>Chang, Natsuaki, and Chen (2013)</td>
<td>Quantitative</td>
<td>Anti-essentialism: 1</td>
<td>Intersectionality: 2</td>
<td>Experiential Knowledge: 2</td>
<td>Transdisciplinary perspective: 0</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>5</td>
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</table>

**Additional Information:**
- **Individual**
  - Family conflicts, financial stressors, and dealing with ongoing chronic medical conditions increased depression symptoms.
- **Interpersonal**
  - Third-generation Latino-Americans had higher family conflicts than Asian Americans; First-generation had the highest levels of family cohesion among both groups;
Chang et al. (2014)  Qualitative

1. Anti-essentialism: included non-Hispanic whites as control group; included Blacks, Asians and Latinos as minorities

2. Intersectionality: analyzed race, ethnicity, and primary language

3. Experiential Knowledge: questionnaire provided in English, Spanish, Chinese, or Vietnamese

4. Transdisciplinary perspective: recruited from hospitals and satellite community health centers, but no indication of integrated behavioral health services

<table>
<thead>
<tr>
<th>Anti-essentialism</th>
<th>Individual</th>
<th>Minorities were less likely than non-Hispanic whites to complete their initial screening survey; Latinos and Blacks were more likely to agree to be contacted than non-Hispanic whites; Among Latinos; preferred language was associated with willingness to be contacted for research; Spanish-speaking Latinos were more likely than English-speakers to agree to be contacted for research; patients with higher PHQ-2 scores were more likely to agree to be contacted for further research.</th>
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<tbody>
<tr>
<td>2</td>
<td>2</td>
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<tr>
<td>Intersectionality: 2</td>
<td>Experiential Knowledge: 1</td>
<td></td>
</tr>
<tr>
<td>Transdisciplinary perspective: 1</td>
<td>Total Rating: 6</td>
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</table>

2
Cook et al. (2014)  
Quantitative  
1. Anti-essentialism: provides a racial-ethnic comparison of whites, Blacks, and Latinos  
2. Intersectionality: only analyzes racial-ethnic differences; preferred language not analyzed  
3. Experiential Knowledge: retrospective, no patient contact  
4. Transdisciplinary perspective: none; Medical Expenditure Panel Survey data  
Anti-essentialism: 2  
Intersectionality: 0  
Experiential Knowledge: 0  
Transdisciplinary perspective: 0  
Total Rating: 2  
Individual  
Latino episodes had higher proportion of PCP visits, but less initiation or adequacy of care when compared to whites.

Hahm, Cook, Ault-Brutus, and Alegria (2015)  
Quantitative  
1. Anti-essentialism: included non-Hispanic whites as control group; included Blacks, Asians, and Latinos in analysis  
2. Intersectionality: analyzed racial-ethnic variable and gender; preferred language not analyzed  
3. Experiential Knowledge: retrospective, no patient contact  
4. Transdisciplinary perspective: community health clinic integration of mental health care into primary care department  
Anti-essentialism: 2  
Intersectionality: 1  
Experiential Knowledge: 0  
Transdisciplinary perspective: 2  
Total Rating: 5  
Individual  
Latino male patients with moderate or severe depression were less likely than whites to receive mental health care; disparities between Latinos and whites in receipt of mental health care and of adequate care was greater among males than females.
<table>
<thead>
<tr>
<th>Study</th>
<th>Methodology</th>
<th>Anti-essentialism</th>
<th>Intersectionality</th>
<th>Experiential Knowledge</th>
<th>Transdisciplinary perspective</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hansen &amp; Cabassa (2012)</td>
<td>Qualitative</td>
<td>1. Anti-essentialism: purposive sampling of only Spanish-speaking Latinos</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td></td>
<td></td>
<td>2. Intersectionality: none; preferred language not analyzed</td>
<td></td>
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<td>3. Experiential Knowledge: interview conducted in Spanish</td>
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<td></td>
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<td>4. Transdisciplinary perspective: patients with diabetes and depression recruited from a previously conducted randomized control study</td>
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<td></td>
<td></td>
<td>2. Intersectionality: preferred language, gender, age, and referral</td>
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<td></td>
<td></td>
<td>3. Experiential Knowledge: included patients who did and did not attend treatment after referral</td>
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<tr>
<td></td>
<td></td>
<td>4. Transdisciplinary perspective: integrated behavioral health services in health care setting</td>
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</table>

Latinos associated the need for formal care in relation to acute somatic symptoms, functional impairment, and mood changes; help-seeking barriers included self-reliance, language barriers, stigma, competing health demands, and structural barriers.

Individual; Organizational

Poverty and low literacy were common barriers to attending therapy sessions, especially Spanish-speakers; medication preferred by 43% of study; English-speakers expressed frustration with the clinic, greater distrust, and apprehension about the quality of care received.
<table>
<thead>
<tr>
<th>Study</th>
<th>Study Type</th>
<th>Design</th>
<th>Sample Characteristics</th>
<th>Anti-essentialism</th>
<th>Intersectionality</th>
<th>Experiential Knowledge</th>
<th>Transdisciplinary perspective</th>
<th>Total Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interian et al. (2010)</td>
<td>Quantitative</td>
<td>1. Anti-essentialism: purposive sample of only Spanish-speaking Latinos</td>
<td>2. Intersectionality: adjusted for age, gender, marital status, education, and medical insurance; preferred language not analyzed</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td></td>
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<td>3. Experiential Knowledge: baseline interviews conducted in preferred language</td>
<td></td>
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<td>4. Transdisciplinary perspective: medical patients with depression</td>
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<tr>
<td>Ishikawa, Cardemil, &amp; Falmagne (2010)</td>
<td>Qualitative</td>
<td>1. Anti-essentialism: purposive sample of Latino men and women; no control group</td>
<td>2. Intersectionality: only reported differences in gender (marianismo); preferred language not analyzed</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Experiential Knowledge: conducted interviews in English or Spanish at preferred place</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Transdisciplinary perspective: social services agency recruitment</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Individual: Latinos with higher stigma were less likely to be taking antidepressant medications.

Female participants reported burden with taking on so much responsibility; both men and women participants reported a desire to alleviate their own mothers’ burdens (marianismo).
<table>
<thead>
<tr>
<th>Study</th>
<th>Methodology</th>
<th>Anti-essentialism</th>
<th>Intersectionality</th>
<th>Experiential Knowledge</th>
<th>Transdisciplinary perspective</th>
<th>Total Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ishikawa et al. (2014)</td>
<td>Quantitative</td>
<td>1. purposive sample of Latinos only</td>
<td>2. age, immigration status, and acculturation analyzed; preferred language not analyzed</td>
<td>3. 71% of interviews conducted in Spanish</td>
<td>none</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Anti-essentialism: 0</td>
<td>Intersectionality: 2</td>
<td>Experiential Knowledge: 2</td>
<td>Transdisciplinary perspective: 0</td>
<td>Total Rating: 4</td>
</tr>
<tr>
<td>Keeler, Siegel, and Alvaro (2014)</td>
<td>Qualitative</td>
<td>1. purposive sample of Spanish-speaking Mexican Americans</td>
<td>2. controlled for gender; preferred language not analyzed</td>
<td>3. secondary analysis with no patient contact; parent study conducted with all Spanish materials</td>
<td>none</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Anti-essentialism: 0</td>
<td>Intersectionality: 0</td>
<td>Experiential Knowledge: 1</td>
<td>Transdisciplinary perspective: 0</td>
<td>Total Rating: 1</td>
</tr>
</tbody>
</table>

Keeler, Siegel, and Alvaro (2014) found higher depression symptomatology associated with lower familialism scores, lower perception that family support can be a useful means to overcome depression, and comfort in asking family for help with depression. Higher depression symptomatology was also associated with lower familialism scores.
<table>
<thead>
<tr>
<th>Study</th>
<th>Methodology</th>
<th>Anti-essentialism</th>
<th>Intersectionality</th>
<th>Experiential Knowledge</th>
<th>Transdisciplinary perspective</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leung, LaChapelle, Scinta, and Olvera (2014)</td>
<td>Qualitative</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Uebelacker et al. (2012)</td>
<td>Qualitative</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

- **Anti-essentialism**: 0
- **Intersectionality**: 0
- **Experiential Knowledge**: 1
- **Transdisciplinary perspective**: 0
- **Total Rating**: 1

**Individual**

Individuals with discrimination concerns were twice as likely to self-report depressive symptoms; those who had experienced a dramatic loss of income were 1.1 times more likely to have depressive symptoms than those employed.

**Individual; Organizational**

Vulnerability, social connection and engagement, language, culture, insurance/money, stigma, disengagement, information, and family were identified as barriers of receiving care; mistrust in use of interpreters in medical visits.
<table>
<thead>
<tr>
<th>Study</th>
<th>Study Type</th>
<th>Anti-essentialism</th>
<th>Intersectionality</th>
<th>Experiential Knowledge</th>
<th>Transdisciplinary perspective</th>
<th>Total Rating</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vega, Rodriguez, and Ang (2010)</td>
<td>Quantitative</td>
<td>purposive</td>
<td>none</td>
<td>completed in Spanish</td>
<td>none</td>
<td>2</td>
<td>Patients reporting higher levels of perceived stigma were less likely to disclose their depression diagnosis to their family or friends, less likely to be taking antidepressants, less likely to be able to manage their depression and more likely to have missed scheduled visits.</td>
</tr>
<tr>
<td>Wells, Lagomasino, Palinkas, Green, &amp; Gonzalez (2013)</td>
<td>Qualitative</td>
<td>mostly Latino</td>
<td>none</td>
<td>telephone interviews in patient’s preferred language</td>
<td>recruited from emergency department and screened for depression</td>
<td>3</td>
<td>There was a lack of readiness to seek help despite acknowledgement of diagnosis; patients reported negative perceptions about antidepressant medications, even with no previous use; socioeconomic and cultural barriers impeded treatment.</td>
</tr>
</tbody>
</table>
Critical Race Methodology

A critical race methodology can effectively ensure that this dissertation covers all potentially subordinating variables at all levels of the SEM model, exploring differences in the assessment, treatment, and manifestation of depression for English-speaking non-Latinos, English-speaking Latinos and Spanish-speaking Latinos. Solorzano and Yosso (2002) created critical race methodology based on a theoretically grounded research approach. Although grounded theory exists, “there is limited research employing a critical race approach with quantitative or mixed methods” (Solorzano & Yosso, 2002, p. 42). Critical race methodology thus seeks to build theory from the lived experiences of the study participants through a reflective research process and a pursuit for social justice. Bernal (2002) asserts, “one’s identity is not based on the social construction of race but rather is multidimensional and intersects with various experiences” (p. 118). The framework employs five elements to inform research questions asked, methodologies employed, and the way data is analyzed (Malagon et al., 2009). These five elements derive from the Critical Race Theory tenets mentioned earlier: intersectionality, challenging the dominant ideology, social justice, experiential knowledge, and centering CRT in the research process via a transdisciplinary perspective. DeCuir-Gunby and Walker-Devose (2013) suggest the use of a multiphase mixed methodology longitudinal design. Both data types are collected in multiple phases with each phase informing the next. Although the heart of this dissertation lies in the voice of the participants during qualitative interviews and focus groups, depression scores were first analyzed quantitatively to guide the direction of the story. Qualitatively we were then able to
determine if Latinos experience depression differently based on their language preference.

To ensure that all elements were considered for this dissertation, groups were split by language preference to let the patients decide if language is a significant factor in the screening, treatment, and manifestation of their depression. This comparison ensured the social justice element of CRT through full and equal participation of all groups mutually shaped to meet their needs; non-Latino English-speakers were included in the analysis to serve as a comparison group to English- and Spanish-speaking Latinos. Splitting Latinos into more discrete categories for comparison challenges the dominant ideology found in the majority of the literature review. Experiential knowledge was covered through the use of storytelling in interviews and qualitative focus groups, offering an additional method for Latino voices to be heard in a language they are most comfortable expressing themselves. Lastly, the element of a transdisciplinary perspective guides the research process, which explores the dynamic of screening for depression in an integrated primary care setting.

**Conclusion**

Most publications focusing on depression screenings to date have failed to examine differences between Latinos based on language preference. The dearth of existing studies that analyze the impact of language preference on depression treatment outcomes ascertains the importance of this study. There is no doubt that physical and mental health outcomes intersect; therefore, it is crucial to address mental health in primary care settings where patients first present with symptoms. Using a mixed methods
design that explored language differences for Latinos screened for depression in a primary care setting is a paramount addition to the literature, especially to build theory from the lived experiences of these groups in the pursuit of social justice.
<table>
<thead>
<tr>
<th>Reference</th>
<th>Purpose</th>
<th>Design and Sampling Method</th>
<th>Sample Size and Characteristics</th>
<th>Variables</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aponte-Rivera et al. (2014)</td>
<td>To identify and evaluate the demographic and clinical factors that differ between Spanish and English speaking Hispanics following through with behavioral health treatment</td>
<td>Retrospective analysis of screening evaluations at two clinics: one Spanish-speaking and one English-speaking</td>
<td>N=1,174; Gender: 43.2% male; Age: $M = 38.5$ ($SD = 11.4$); Ethnicity: 23.3% Hispanic; Language preference: 23.4% Spanish</td>
<td>DV: language IVs: age, gender, ethnicity, race, marital status, number of children, education, insurance, HAMD score, previous behavioral health diagnoses, substance abuse</td>
<td>Spanish-speaking subjects with depression had higher suicide attempts and delay seeking help than English speakers with depression. Uncontrolled medical conditions were more prevalent in the Spanish-speaking clinic. Familismo: family members participated in appointments, increasing patients’ comfort levels.</td>
</tr>
<tr>
<td>Camacho et al. (2014)</td>
<td>To investigate whether a culturally-tailored problem-solving intervention delivered by a trained DCS would improve depressive symptoms over a 6-month period among Latino patients in a FQHC by the California-Mexico border</td>
<td>Longitudinal Sampling Method: Convenience sample of participants referred to IMPACT program</td>
<td>N=189; Gender: 72.5% female; Age: $M = 52.5$ ($SD = 11.7$)</td>
<td>DV: depression score (PHQ-9) IVs: age, gender, smoking status, diabetes diagnosis</td>
<td>Results showed significant improvement in PHQ-9 scores over 6-months after controlling for IVs. A three-way interaction between time, gender, and smoking showed that depressive symptoms among male smokers did not improve as much as non-smoking males and females.</td>
</tr>
</tbody>
</table>
Chang, Natsuaki, and Chen (2013) To examine ethnic and generational differences in family cultural conflict and family cohesion and how the effects vary by generational status for Latino Americans and Asian Americans

Cross-sectional Sampling Method: Stratified probability sampling

Latino American n=2,554; Asian American n=2,095; Gender: 46% male; Age range: 18 and over; Birth country: 30% born in the U.S.

DV: lifetime mental health service use

IVs: family cultural conflict, family cohesion, immigration-related characteristics

First-generation Asian Americans reported greater family cultural conflict than Latino Americans; First-generation Latino Americans had the highest levels of family cohesion compared to other generations; Latino Americans reporting higher family cultural conflict and lower family cohesion were more likely to use mental health services.

Cook et al. (2014) To investigate disparities in mental health care episodes amongst whites, blacks, and Latinos

Cross-sectional Sampling Method: Secondary analysis of MEPS data collected from 2004-2005

N=5,161 (whites=2,594; blacks=1,134; Latinos=1,433)

DV: Initiation of care, quality of care, utilization of care

IVs: race, ethnicity, PHQ-2, gender, age, physical health variables, income, education, insurance coverage, employment, marital status

Compared with whites (39.8%/16.0%), Latinos had less initiation (24.6%, p<.001) and adequacy of care (9.2%, P<.001). Latino episodes were shorter (228 days compared to 257 days for whites) and had fewer psychotropic drug fills. Latino episodes had a greater proportion of PCP visits
<table>
<thead>
<tr>
<th><strong>Hahm, Cook, Ault-Brutus, and Alegria (2015)</strong></th>
<th><strong>To examine the interaction of race-ethnicity and gender in depression screening, receipt of any mental health care, and receipt of adequate care</strong></th>
<th><strong>Cross-sectional Sampling Method:</strong> Secondary analysis via electronic chart data abstraction</th>
<th><strong>N=65,079; Age range: 18 and over; Marital status: 41.9% married</strong></th>
<th><strong>DVs: depression screening (PHQ-9), any depression treatment (one or more visits), adequate depression treatment (four or more visits)</strong></th>
<th><strong>Latinos were more likely to be screened for depression compared with whites; Among those with moderate or severe depression, Latino males were less likely than whites to receive any mental health care. The disparity between Latinos and whites in receipt of any mental health care and of adequate care was greater among males than females</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interian et al. (2010)</strong></td>
<td><strong>To describe the psychometric properties of four stigma measures with a sample of Spanish-speaking Latino primary care patients</strong></td>
<td><strong>Longitudinal Sampling Method:</strong> Convenience sample of participants recruited through local clinics</td>
<td><strong>N=200; Gender: 85% female; 95% Spanish language interview; Education: 61% less than high school; Insurance coverage: 90% insured; Employment status: 34% employed</strong></td>
<td><strong>IVs: gender, age, insurance coverage, taking antidepressant medications</strong></td>
<td><strong>Patients who reported greater social distance from individuals with depression were more likely to have been receiving treatment for emotional care in the past three months (OR=.70, p&lt;.05); Latinos who scored high on the SCMHC (OR=.64, p&lt;.05) and LSAS (OR=.77, p&lt;.05) were less likely to have been taking antidepressant medications</strong></td>
</tr>
<tr>
<td>Study</td>
<td>Objective</td>
<td>Design/Methods</td>
<td>Participants</td>
<td>DV/IV/IVs</td>
<td>Results/Findings</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Ishikawa et al. (2014)</td>
<td>To examine factors related to Latino patients’ uptake of their PCP’s recommendations for depression treatment</td>
<td>Longitudinal Sampling Method: Convenience sample of participants drawn from a pool of patients who scored above 10 on the PHQ-9</td>
<td>N=90; Gender: 83% female; Age: $M = 38.9$ ($SD = 11.2$); Immigrant status: 93% immigrant; Years since immigration: $M = 16.3$ ($SD = 9.6$); Marital Status: 44% married; Education: 48% less than high school; Insurance: 86% insured; Language: 71% Spanish</td>
<td>DV: uptake of treatment recommendation Intermediate: intention to follow up on a referral for mental health care IVs: patient rating of PCP-patient working alliance, patient ratings of PCP cultural competence, sociodemographic variables</td>
<td>At Time 1, 23% of patients had initiated uptake of the treatment recommendation, increasing to 53% at Time 2. Patients who received a medication recommendation were more likely to have followed through on the recommendation, compared with patients who received a psychotherapy recommendation (77% and 36%, respectively).</td>
</tr>
<tr>
<td>Keeler, Siegel, and Alvaro (2014)</td>
<td>To explore if reduction in favorable perceptions of familial relations impacts help-seeking among Mexican-Americans with depression</td>
<td>Cross-sectional Sampling Method: Secondary analysis of data collected from participants at a swap meet in Arizona</td>
<td>N=74; Age: $M = 30$ ($SD = 12$); Gender: 52% male; Relationship status: 42% married; Education: 49% less than high school; Yearly income: &lt;$20,000; Birth country: 59% Mexico</td>
<td>DVs: Family support and comfort with family IV: depression symptomatology (BDI-II) Mediating: familism</td>
<td>Depression symptoms were negatively associated with familism. Familism partially mediated the relationship between depression symptomatology and the perceived utility of familial help seeking. After controlling for gender, familism and depression 16% of the variance in utility of family to overcome depression.</td>
</tr>
<tr>
<td>Authors</td>
<td>Research Question</td>
<td>Study Design</td>
<td>Sampling Method</td>
<td>N</td>
<td>Gender Distribution</td>
</tr>
<tr>
<td>-------------------------</td>
<td>------------------------------------------------------------------------------------</td>
<td>----------------------</td>
<td>--------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Leung, LaChapelle, Scinta, and Olvera (2014)</td>
<td>To explore factors contributing to the development of depressive symptoms among Mexican Americans and Latinos and the help-seeking behaviors they exhibit when dealing with mental health problems</td>
<td>Cross-sectional</td>
<td>Convenience sampling—attendance of participants at a health fair</td>
<td>90</td>
<td>67.8% female</td>
</tr>
<tr>
<td>Vega, Rodriguez, and Ang (2010)</td>
<td>To develop a validated stigma checklist to assist physicians in addressing depression in Latino patients</td>
<td>Cross-sectional</td>
<td>Secondary analysis via medical record review</td>
<td>200</td>
<td>82.5% female</td>
</tr>
</tbody>
</table>

Patients reporting higher levels of perceived stigma using the checklist were less likely to disclose their depression diagnosis to their family and friends (p<.05) and also less likely to be taking depression medication. Patients with stigma were less likely to be able to manage their depression and more likely to have missed scheduled appointment visits.
<table>
<thead>
<tr>
<th>Reference</th>
<th>Purpose</th>
<th>Design</th>
<th>Sampling Method</th>
<th>Sample Size and Characteristics</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hansen &amp; Cabassa (2012)</td>
<td>To examine help-seeking pathways to depression care of low-income Latinos with diabetes and major depression</td>
<td>Focus group discussions</td>
<td>Convenience sampling; Recruitment through previously conducted randomized control study at a community health center</td>
<td>N=19 Spanish-speaking, immigrant, low-income Latinos; Age: M = 57 (SD = 5.8); Gender: 84.2% female; Insurance coverage: 63.2%; Place of birth: 94.7% born in Mexico; Years in the U.S.: M = 25.1 (SD = 10.8)</td>
<td>Themes: 1. Recognition of need for care; 2. Treatment initiation; 3. Adherence to care.</td>
</tr>
<tr>
<td>Horevitz, Organista, and Arean (2015)</td>
<td>To identify predictors of Latino patients’ decision to follow through with referrals to depression treatment in an integrated primary care setting, including type of referral</td>
<td>Semi-structured interviews</td>
<td>Convenience sampling; patients referred for depression treatment in a federally qualified health center</td>
<td>N=16 Latino patients, 18-65 years, PHQ-9 ≥9, referred to a therapist; Gender: 73% female; Preferred language: 81% Spanish; Insurance coverage: 56% uninsured</td>
<td>Themes: 1. Illness narrative; 2. Sense of connection/trust for patients with same PCP; 3. Readiness; 4. Everyday barriers.</td>
</tr>
<tr>
<td>Authors</td>
<td>Title</td>
<td>Methodology</td>
<td>Sample Size</td>
<td>Demographics</td>
<td>Themes</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------------------------------------------------------</td>
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<td>-------------</td>
<td>---------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Ishikawa, Cardemil, &amp; Falmagne (2010)</td>
<td>To explore help-seeking pathways and help-receiving experiences among Latinos.</td>
<td>In-depth interviews</td>
<td>N=13</td>
<td>Gender: 61.5% female; Employment status: 46.2% employed; HIV status: 38.5% living with HIV</td>
<td>1. Integrated personal, family, and cultural perspectives to shape ideas of suffering and healing; 2. Determining what kind of help to utilize; 3. Gauging treatment satisfaction.</td>
</tr>
</tbody>
</table>
Wells, Lagomasino, Palinkas, Green, & Gonzalez (2013) To examine barriers and facilitators to depression treatment among low-income, predominantly Latino emergency department patients

<table>
<thead>
<tr>
<th>Semi-structured telephone interviews</th>
<th>Convenience sampling-recruited from parent study of patients who screened positive for depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>N= 24 emergency department patients</td>
<td>Age range: 18-62 years of age; Gender: 79% female; Ethnicity: 95.8% Latino; Preferred Language: 66.7%, Insurance coverage: 79.2% uninsured; Marital status: 66.7% married or living with partner; Employment status: 66.7% unemployed; Education: 87.5% education level under grade 12</td>
</tr>
</tbody>
</table>

Themes: 1. Perceptions about depression and depression treatment; 2. Barriers to depression treatment; 3. Facilitators to depression treatment engagement.
CHAPTER THREE
PRELIMINARY RESEARCH

EXPLORING DEPRESSION SCREENING ADMINISTRATION AND
OUTCOMES WITH LATINOS: AN ETHNIC-LINGUISTIC ANALYSIS

Jacquelyn Stephenson, PhD, MSW
Kelly R. Morton, PhD
Brian Distelberg, PhD
Larry Ortiz, PhD, MSW
Susanne Montgomery, PhD

In preparation for submission to the Hispanic Journal of Behavioral Sciences
Abstract

Research has found that Latino adults report lower levels of depressive symptoms than their non-Latino counterparts. Few studies to date have analyzed administration and outcomes of a standardized depression-screening tool, the Patient Health Questionnaire-2 (PHQ-2), in medical settings through an ethnic-linguistic lens. Binary logistic regressions were performed to determine the effects of ethnicity and language on PHQ-2 administration rates for 10,285 adult patients seen during a medical visit in 2014 or 2015 at a low income, mainly Latino serving FQHC. Additionally, this study explores ethnicity and language administration of PHQ-2 screening outcomes for the 4,745 (46%) patients who were screened for depression during this timeframe. Results indicate that Latinos and Spanish-speakers are screened for depression more often than non-Latinos and English-speakers. Moreover, Spanish-speakers screened positive for depression during a medical visit 31% less often than English speakers. We suggest that future outcomes monitoring should conduct outcomes evaluation through an ethnic-linguistic lens, analyzing Spanish- and English-speaking Latinos separately.

Keywords: depression, adults, medical patients, screening, Spanish-speakers
Introduction

Depression is a leading cause of death and disability in the United States, affecting 16% of the general population at least once during their lifetime (Camacho et al., 2014; Huang, Chung, Kroenke, Delucchi, & Spitzer, 2006; Ishikawa et al., 2014; Kalibatseva & Leong, 2014), yet approximately 40% of individuals with depression symptoms first visit a medical doctor for care (Camacho et al., 2014). A well-known barrier to Latinos is difficulty accessing bilingual specialty mental health services, which is why this population prefers treatment in a primary care setting (Ishikawa et al, 2014). A shortage of bilingual providers, cost, transportation, low literacy levels, language barriers, and distrust of medical providers (Aponte-Rivera, 2013; Chang et al, 2014; Kalibatseva & Leong, 2014; Kanter et al, 2014; Thomas et al, 2011) were common barriers reported by Spanish-speaking Latinos. Additionally, depression prevalence amongst Latinos has been reported to occur in only 8-15% of persons compared to 22% in non-Latino whites (Kalibatseva & Leong, 2014).

Despite being the largest minority group in the United States (Aponte-Rivera et al, 2014; Huang et al, 2006; Thomas, Quinn, Butler, Fryer, & Garza, 2011), Latinos are poorly represented in clinical studies of depression; especially when most studies exclude Spanish-speakers from participation (Reuland et al, 2009). A review of ethnic diversity in 379 NIMH funded clinical trials resulted in a mean proportion of merely 9% Latino participants (Aponte-Rivera et al., 2014). There is clearly a need to consciously recruit Latinos into research to truly understand this population’s experience with depression symptomatology and preferred treatments.
Depression and Physical Health

There is strong evidence that mental health plays a crucial role in a patient’s ability to maintain their physical health; likewise, problems with physical health can seriously affect mental health and reduce treatment participation, ultimately hindering recovery (Holden et al., 2014). Hansen and Cabassa (2012) conducted focus groups with 19 Spanish-speaking, immigrant, low-income Latinos with diabetes and major depression to examine help-seeking pathways to depression care. Themes emerging from this qualitative study included the recognition of need for mental health care and adherence to care. Patients could recognize the need for care through somatization of depressive symptoms, mood changes, and health symptoms with decreased functioning. Patients reported that positive interactions with their physicians and therapists contributed to adherence, especially since the services were offered in Spanish. Patients reported that improvements in symptoms heightened their awareness that the treatment was working, and improvements in functioning reinforced their adherence to treatment, such as being able to return to work. It is evident that mental health screening in a primary care setting can effectively improve both mental health and physical health concurrently.

Demographic Differences in the Impact of Depression Screening

When specific demographic characteristics are examined, such as age, gender and ethnicity, these factors have a significant relationship with depression screening administration. Hahm, Cook, Ault-Brutus, & Alegria (2015) examined the interaction of race-ethnicity, age, and gender in depression screening and found that Latinos in general were more likely to be screened for depression than whites. Hahm et al. (2015) then
analyzed the impact of age and gender on depression screening. Among those with moderate to severe depression, older Latino males were less likely than whites to receive any mental health care. The disparity between Latinos and whites in receipt of adequate care was greater among males than females, regardless of age.

Although it is understood that ethnicity can lead to differences in depression prevalence, studying the Latino population as a subgroup does not take into account how depression is manifested for Spanish-speaking Latinos. Understanding that a lower depression prevalence on traditional screening measures in the Latino population may be linked to a need to deliver mental health care differently for Latinos; especially in Spanish-speaking Latinos. Therefore, a theoretical framework focused on ethnic and linguistic differences is essential to fully understand depression screening and treatment in the Latino population. The purpose of this study is to determine the effects of ethnicity and language on depression screening administration and outcomes for Latinos and non-Latinos. Based on previous research and theory concerning depression screening and outcomes for Latino adults, the following hypotheses will be tested:

1. **Hypothesis 1 (H1):** Latinos will be screened more often with the PHQ-2 during a medical visit than non-Latinos.

2. **Hypothesis 2 (H2):** Spanish-speakers will score positive on the PHQ-2 less often than English-speakers.
Methods

Participants and Demographic Measures

Participants in the first analysis were 10,285 adult patients (32.1% male, 67.9% female) who were seen at a FQHC in Southern California for a primary care medical visit in the calendar years of 2014 and 2015. Participants’ ages ranged from 18 to 98 (M = 42.22 years, SD 15.35 years). Of these, 61.5% were Latino and 20.9% indicated Spanish as their preferred language. All demographics were self-reported at intake, confirmed annually, and recorded in the electronic medical record (NextGen). Only participants 18 and older who indicated an ethnicity of Latino or not Latino and a preferred language of English or Spanish were included in the study; therefore 4,986 patients were excluded from the study. As indicated in the Results, 4,745 patients were screened in the first analysis and therefore included in the second analysis. Table 4 presents demographics by analysis.

Measure

The FQHC in the study adopted the Patient Health Questionnaire-2 (PHQ-2) as their standardized depression screening tool. The PHQ-2 is a brief 2-item instrument based on DSM-V (2013) diagnostic criteria for depression. This instrument was designed for use within the limited time of a primary care setting (Wulsin, Somoza, & Heck, 2002). The Patient Health Questionnaire-2 (PHQ-2) asks, “Over the last two weeks, how often have you been bothered by any of the following problems: 1) little interest or pleasure in doing things and 2) feeling down, depressed, or hopeless”. The items are rated on a 4-point Likert scale from 0 (not at all) to 3 (nearly every day).
Table 4. Demographics by analysis.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Screening Administration (yes/no) (n=10,285)</th>
<th>Screening Outcome (positive/negative) (n=4,745)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean Age (SD) [years]</td>
<td>$m = 44.22; sd = 15.35$</td>
<td>$m = 43.28; sd = 14.94$</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>3300 (32.1)</td>
<td>1402 (29.5)</td>
</tr>
<tr>
<td>Female</td>
<td>6985 (67.9)</td>
<td>3343 (70.5)</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Latino</td>
<td>3957 (38.5)</td>
<td>1690 (35.6)</td>
</tr>
<tr>
<td>Latino</td>
<td>6328 (61.5)</td>
<td>3055 (64.4)</td>
</tr>
<tr>
<td>Language</td>
<td></td>
<td></td>
</tr>
<tr>
<td>English</td>
<td>8133 (79.1)</td>
<td>3550 (74.8)</td>
</tr>
<tr>
<td>Spanish</td>
<td>2152 (20.9)</td>
<td>1195 (25.2)</td>
</tr>
</tbody>
</table>

Scores range from 0-6; a score of $\geq 3$ is positive for depression and should lead to further screening on the PHQ-9. Therefore, any patient with a PHQ-2 score in their medical record was coded as YES screening administered vs. NO screening not administered for anyone without a PHQ-2 score in their electronic medical record. Those patients in the first analysis who were coded as YES (n=4,745) were included in the second analysis to determine screening results, coded as POSITIVE (PHQ-2 $\geq 3$) vs. NEGATIVE (PHQ-2 $< 3$).
**Procedure**

This study received approval from the institutional review board to obtain secondary, de-identified data for this analysis from the electronic medical record. Given that the requirement to screen patients for depression at FQHCs was not enforced until 2014 (HRSA, 2013), any PHQ-2 screening administered at any point during the study period (2014-2015) was counted for the primary analysis. The electronic medical record was used to extract whether patients received a PHQ-2 at any point during the study period. Patients without a PHQ-2 score in the data file were marked as NO for depression screening administration. All patients screened (YES) had a PHQ-2 score in the extract. Given that the PHQ-2 asks patients about symptoms in the previous two weeks, a condition was entered in the electronic medical record extract to pull the patient’s highest score on the PHQ-2 during the study period. It is possible for a patient to have scored negative on the PHQ-2 at some point during the study period but positive at another time point.

Data was analyzed using the statistical software SPSS, version 23.0 to conduct two binary logistic regressions and crosstab analysis for depression screening administration (yes/no) and outcomes (positive/negative) of Spanish-speaking Latinos, English-speaking Latinos, and English-speaking non-Latinos.

**Results**

Binary logistic regression analyses were conducted to examine the role of ethnicity and language on depression screening administration for the primary analysis and depression screening outcomes for the secondary analysis. Due to previous literature
that has shown a connection between age and gender on depression screening administration (Hahm et al., 2015), we will hold these variables constant in each model conducted in the analyses. Given that nobody in this study reported their ethnicity as non-Latino and preferred language as Spanish, we were not able to run an interaction effect for ethnicity and language, resulting in three groups: Spanish-speaking Latinos, English-speaking Latinos, and English-speaking non-Latinos.

**Depression Screening Administered**

A binary logistic regression analysis was conducted to assess the association between ethnicity and language on depression screening administration: controlling for age and gender in the first block, $\chi^2 (1, 10,285) = 72.90; p < .001$; followed by ethnicity $\chi^2(1, 10,285) = 108.04; p < .001$, and then language $\chi^2(1, 10,285) = 150.902; p < .001$.

Evaluation of odds ratios and corresponding confidence intervals (95%) within the full model examined the strength of the individual predictors. Criterion for significance was set at $p < 0.05$. The final model correctly classified 56.2% of cases. Table 5 presents a summary of results.

All variables were significant predictors of depression screening administration of the PHQ-2 during a medical visit in the final model: Age (OR = 1.01, p < .001), gender (OR = 1.22, p < .001), ethnicity (OR = 1.13, p < .01) and language (OR = 1.43, p < .001). Results indicate that females were screened for depression more often than males. Additionally, Latinos were screened for depression more often than non-Latinos. Lastly, Spanish-speakers were screened for depression more often than English-speakers.
Table 5. Binary logistic regression results for depression screening administration.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OR</td>
<td>p</td>
<td>95% CI</td>
</tr>
<tr>
<td>Constant</td>
<td>.50  **</td>
<td>.42  **</td>
<td>.46  **</td>
</tr>
<tr>
<td>Age</td>
<td>1.01  **</td>
<td>1.01, 1.01</td>
<td>1.01  **</td>
</tr>
<tr>
<td>Gender</td>
<td>1.27  **</td>
<td>1.16, 1.38</td>
<td>1.25  **</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>1.28  **</td>
<td>1.18, 1.38</td>
<td>1.13  *</td>
</tr>
<tr>
<td>Language</td>
<td>1.43  **</td>
<td>1.29, 1.59</td>
<td></td>
</tr>
</tbody>
</table>

Classification = 54.2%  Classification = 55.5%  Classification = 56.2%

*p < .01, **p < .001

Depression Screening Results

A binary logistic regression analysis was conducted to assess the association between ethnicity and language on depression screening outcomes for the 4,745 patients who were screened from 2014 to 2015 during a primary care medical visit: controlling for age and gender in the first block, $\chi^2(1, 4,745) = 22.01; p < .001$; followed by ethnicity $\chi^2(1, 4,745) = 52.44; p < .001$, and then language $\chi^2(1, 4,745) = 96.79; p < .001$.

Evaluation of odds ratios and corresponding confidence intervals (95%) within the full model examined the strength of the individual predictors. Criterion for significance was set at $p < 0.05$. The final model correctly classified 85.2% of cases. Table 6 presents a summary of results.
Table 6. Binary logistic regression results for depression screening results.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OR</td>
<td>p</td>
<td>95% CI</td>
</tr>
<tr>
<td>Constant</td>
<td>.09</td>
<td>**</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>1.01</td>
<td>***</td>
<td>1.01, 1.02</td>
</tr>
<tr>
<td>Gender</td>
<td>1.18</td>
<td>.99, 1.42</td>
<td>1.22</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>.63</td>
<td>***</td>
<td>.53, .74</td>
</tr>
<tr>
<td>Language</td>
<td>.45</td>
<td>***</td>
<td>.35, .57</td>
</tr>
<tr>
<td>Classification</td>
<td>85.4%</td>
<td>Classification</td>
<td>85.4%</td>
</tr>
</tbody>
</table>

*p < .05, **p < .01, ***p < .001

All variables in the final model were significant predictors of PHQ-2 depression screening outcomes: Age (OR = 1.01, p < .001), gender (OR = 1.29, p < .01), ethnicity (OR = .83, p < .05) and language (OR = .45, p < .001). Results indicate that females screened positive for depression on the PHQ-2 more often than males. Latinos and Spanish-speakers, on the other hand, screened positive for depression on the PHQ-2 less often than non-Latinos and English-speakers, respectively.

Discussion

The purpose of the present study was to determine the effects of ethnicity and language on depression screening administration and outcomes in a primary care medical setting. Ethnicity and language were found to individually predict depression screening administration and outcomes; especially in Spanish-speaking Latinos. As indicated in the literature, findings indicate that although Latinos are screened more often for depression,
they have a lower rate of screening positive for depression. In addition, this seems to be especially true for Spanish-speakers. Specifically, Spanish-speakers were positive for depression less often than English-speakers.

Language and Depression

Latinos are screened more often for depression and yet language differences exist in the outcomes of a standardized depression-screening instrument often administered in a medical setting. Results indicate that, as hypothesized, being a Latino predicts higher levels of PHQ-2 depression screening administration in a medical setting. These results have been supported by previous research (Hamm et al., 2015). Additionally, the results of the present study indicate that Spanish-speaking Latinos score negative for depression on the PHQ-2 more often than either English-speaking Latinos or non-Latinos. Although an interaction was not possible with this dataset, Figure 2 shows the importance of incorporating ethnicity and language into the analysis of depression screening. Although Spanish-speakers were screened more often than English-speakers, only 8.2% screened positive for depression compared to 15% of Latino English-speakers and 18.9% of non-Latino English-speakers. There are clear differences in the report of depression between Spanish-speaking Latinos and English-speakers; this difference in screening outcomes calls for future research to explore depression screening and outcomes through an ethnic-linguistic lens.

Limitations of Study

Although this study has shown the importance of both ethnicity and language in
depression screening and outcomes, there are several study limitations to be aware of when interpreting these findings. First, data was collected in a predominantly Latino-serving clinic, which may affect generalizability. Future research should be conducted with other minority groups. Additionally, measurement issues should be noted since administration occurred in a medical setting with staff who were not trained in behavioral health and the requirement to screen medical patients was a new concept. Finally, depression prevalence is measured with a two-item standardized depression-screening instrument, which could be problematic in proper identification of depression symptoms. While an interaction effect could not be explored in this study since nobody reported as Spanish-speaking, non-Latinos, Figure 1 shows the importance of incorporating language in addition to ethnicity when studying behavioral health in Latino populations.
Figure 1. Ethnic-linguistic analysis of depression screening administration and outcomes.
Conclusion and Suggestions for Future Research Directions

To date, this is one of the first studies that specifically look at depression screening administration and outcomes for Latinos through an ethnic and linguistic lens. The present study identifies that ethnicity and language do affect the relationship between depression screening administration and outcomes. Future research should expand on this finding by examining depression screening processes to learn about culturally and linguistically appropriate depression-screening. Empirical evidence concerning depression screening administration to Spanish-speakers would give further information on processes that link linguistic characteristics to depression prevalence across ethnicity. More specifically, future research should explore how language and ethnicity may lead to Spanish-speaking Latinos reporting lower levels of depression prevalence and the effectiveness of the PHQ-2 with Spanish-speakers and other minorities whose primary language is not English.
CHAPTER FOUR

METHODOLOGY

Despite a national attempt to increase access to healthcare, it is not clear how access to care for mental health has been affected or how delivery will address culturally and linguistically appropriate depression screening and treatment modalities. The literature reinforces that depression manifests differently in the Latino population when compared to other racial-ethnic groups, and further emphasizes differences experienced based on gender, age, language preference, and other potentially subordinating identity variables. It is evident that a culturally and linguistically-focused study, guided by Critical Race Methodology, is needed in the field to truly understand how to provide optimal care to medically underserved, depressed Latino patients in the Inland Empire.

Overview

This Chapter begins with an overview of our study aims, as described in our introductory Chapter, followed by a listing of our research hypotheses. This will be followed by a discussion of the methodology employed in this study. The preliminary research activities described in Chapter Three (Aim 1) have informed the design of this mixed methods study.

Research Hypotheses

Table 7 below displays the hypotheses tested in this study. Aim 1, which was tested and presented in Chapter Three as preliminary research, is included in the table for completeness.
### Table 7. Summary of research aims and hypotheses.

<table>
<thead>
<tr>
<th>Study Aims</th>
<th>Hypotheses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pilot Aim 1: Intersectionality</strong></td>
<td><strong>Hypothesis 1 (H1):</strong> Latinos will be screened more often with the PHQ-2 during a medical visit than non-Latinos (Hamm et al., 2015)</td>
</tr>
<tr>
<td>Investigate depression screening rates and differences in depression screening outcomes between ethnic-linguistic groups of patients seen for a medical visit from 2014-2015.</td>
<td><strong>Hypothesis 2 (H2):</strong> Spanish-speaking Latinos will score positive on the PHQ-2 less often than non-Latinos and English-speakers (Kalibatseva &amp; Leong, 2014)</td>
</tr>
<tr>
<td><strong>Aim 1: Transdisciplinary Perspective</strong></td>
<td><strong>Hypothesis 1 (H1):</strong> Providers will recommend pharmacotherapy as their default treatment recommendation for depression, regardless of ethnic-linguistic group (Ishikawa et al., 2014)</td>
</tr>
<tr>
<td>Investigate rates of standard of care depression treatment recommendations between ethnic-linguistic groups of patients who screened positive for depression from 2014-2015.</td>
<td><strong>Hypothesis 2 (H2):</strong> There will be different beliefs about standard of care depression treatment recommendations and uptake amongst provider and ethnic-linguistic groups (Horevitz et al., 2015)</td>
</tr>
<tr>
<td><strong>Aim 2: Anti-Essentialism</strong></td>
<td><strong>Hypothesis 3 (H3):</strong> Spanish-speaking Latinos will be less likely to follow through with depression treatment recommendations than English-speakers (Ishikawa et al., 2014)</td>
</tr>
<tr>
<td>Assess provider and patient perceptions about standard of care depression treatment recommendations and uptake.</td>
<td><strong>Hypothesis 4 (H4):</strong> There will be different beliefs about the manifestation of depression symptoms amongst providers and Spanish-speaking Latinos when compared to English-speakers, regardless of ethnicity (pilot study)</td>
</tr>
<tr>
<td><strong>Aim 3: Intersectionality</strong></td>
<td><strong>Hypothesis 5 (H5):</strong> Groups will validate emerging themes showing different beliefs about the manifestation of depression symptoms amongst provider and ethnic-linguistic groups (pilot study)</td>
</tr>
<tr>
<td>Assess provider and patient perceptions about factors influencing manifestation of depression symptoms between ethnic-linguistic groups.</td>
<td></td>
</tr>
<tr>
<td><strong>Aim 4: Experiential Knowledge</strong></td>
<td></td>
</tr>
<tr>
<td>Classify answers to questions about depression in a socially just manner by including participants in member-checking focus groups (providers or patients), based on the patient’s preferred language.</td>
<td></td>
</tr>
</tbody>
</table>
Quantitative Retrospective Chart Review

Demographics

Demographics used in our analyses were pulled from the site’s electronic medical record system and include: patients’ age, gender, ethnicity, and language preference. The population of interest for this portion of the study included a subpopulation of adults seen from 2014 to 2015 for medical visits at a FQHC. Inclusion criteria included patients who reported English or Spanish as their preferred language, indicated Latino or Non-Latino as their ethnicity, scored positive on the Patient Health Questionnaire-2 [PHQ-2] at least once from 2014 to 2015 and scored ≥10 on the PHQ-9, an indicator of major depression. We excluded 4,053 patients with negative scores on the PHQ-2 and an additional 417 patients with a PHQ-9 ≤ 9. These criteria warranted a sample of 275 participants for retrospective analysis.

Measures

PHQ-2 Questionnaire

The Patient Health Questionnaire-2 is a brief 2-item instrument based on DSM-V diagnostic criteria for depression, designed for use in primary care settings (Wulsin et al, 2002). The PHQ-2 asks, “Over the last two weeks, how often have you been bothered by any of the following problems: 1) little interest or pleasure in doing things and 2) feeling down, depressed, or hopeless”. The items were rated on a 4-point Likert from 0 (not at all) to 3 (nearly every day). Scores range from 0-6 and the instrument considers a total score of 3 or higher as positive. It comprises the first two items of the longer version of
the instrument, the Patient Health Questionnaire-9 [PHQ-9] — which is a full depression scale of the PHQ instruments.

**PHQ-9 Questionnaire**

The PHQ-9 is a brief 9-item instrument that is also based on DSM-V diagnostic criteria as a depression screening tools (Wulsin et al, 2002). The 4-point Likert scale (0-not at all to 3-nearly every day), refers to the previous 2-week interval. Total scores of 5, 10, 15, and 20 represent cut points for mild, moderate, moderately severe, and severe depression, respectively, with a total score ranging from 0 to 27. The PHQ-9 adds 7 items to the PHQ-2 items: 3) trouble falling or staying asleep, or sleeping too much, 4) feeling tired or having little energy, 5) poor appetite or overeating, 6) feeling bad about yourself—or that you are a failure or have let yourself or your family down, 7) trouble concentrating on things, such as reading the newspaper or watching television, 8) moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual, and 9) thoughts that you would be better off dead or of hurting yourself in some way; and, “if you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? (rated on a not difficult at all to extremely difficult scale.” According to the PHQ Instruction Manual, “this single patient-rated difficulty item is not used in calculating any PHQ score or diagnosis but rather represents the patient’s global impression of symptom-related impairment” (p. 2). This question is useful in assisting a primary care provider’s (PCP) decision to initiate or adjust treatment, given its strong association “with both psychiatric
symptom severity as well as multiple measures of impairment and health-related quality of life” (p.2).

**Standard of Care**

According to the Institute for Clinical Systems Improvement’s Health Care Guideline: *Depression in Primary Care*, patients with a score of 10 or above on the PHQ-9 should receive treatment recommendation of combined psychotherapy and pharmacotherapy. Therefore, PCP treatment recommendations from the retrospective chart review were used to create the dependent variable for the analysis: standard of care. Patients who received other recommendations (psychotherapy only, pharmacotherapy only, a PCP intervention (education, breathing exercises, or physical therapy) or no recommendation) were coded as not having received standard of care depression treatment recommendation.

**Procedure**

Patients meeting inclusion criteria of age, ethnicity, language, and positive PHQ-2 were included in the retrospective chart review. Provider’s recommended treatment and patient’s treatment uptake were explored through chart review procedures described below.

**Recommended Treatment**

As mentioned above, PCP treatment recommendations were used to create the dependent variable for the analysis: standard of care. Patients who received other
recommendations were coded as not receiving standard of care depression treatment recommendation.

**Data Analysis**

All quantitative data was analyzed with SPSS version 23.0 for all descriptive and correlation analyses. For describing the demographic characteristics of our samples, we reported the total number and proportion of participants for categorical variables, and means and standard deviations for continuous variables. Logistic regressions were applied accordingly to assess predictors of care recommendations for patients screened as mild to severely depressed.

**Semi-Structured Key Informant Interviews**

**Overview**

Employing a CRT methodological framework, a semi-structured interview allows new ideas to be explored during the interview as a result of what the interviewee says, compared to a structured interview that discourages diversion from the questions. In this study, PCPs and patients are considered community experts that offer insight on the patterns of screening Latinos for depression in primary care settings.

Generic key informant (KI) procedures guided the conduct of both provider and patient interviews. The purpose of key informant interviews is to collect information from community experts to gain insight on the nature of problems and obtain recommendations for solutions. The interview tools in this study contained outlined scripts and a list of open-ended questions relevant to patterns of screening for depression.
in primary care settings. Both provider and patient KIs, described in detail below, contained an introduction that establishes the purpose of the study and reviews informed consent processes, key questions designed to elicit information regarding the depression screening process, probing questions that encouraged participants to reflect more deeply on their experiences, closing questions that provided the participants an opportunity to provide any additional information or recommendations in addressing the issue explored, and an invitation to participate in a semi-structured validation, member-checking focus-group, described in detail later in this Chapter.

For the semi-structured qualitative interviews, we received permission from the primary author to adapt questions previously explored by Horevitz et al. (2015), including clinic history, depression narrative, depression treatment, IBHS handoff experience, receipt of behavioral health referral, and pathways/decision to follow-up to explore cultural beliefs about depression. The new topic called “Integrated Behavioral Health” was also included in the patient version of the interview to explore experiences with handing off to integrated staff for same-day counseling. Since questions answered in a one-on-one setting versus a social interactive setting may differ, we invited participants to small feedback focus groups to explore patterns of responses to the qualitative interviews. Thus, at the end of the interview, participants were asked if they would like to participate in a member-checking focus group in their preferred language. Participants were asked,

“After all of our interviews are completed, we would like to get a group of patients together to help us look at common topics from the interviews. Would you be interested in attending?”
Patient Interviews

Demographics

Purposive sampling was used to recruit 18 patients who screened positive on the PHQ-2 and had a score of 10 or above on the PHQ-9. Participants were selected if they were: Spanish-speaking Latinos, English-speaking Latinos, or English-speaking non-Latinos. Sample size estimations for recruitment sub-groups were guided by conservative estimates of “usual” shared levels of agreement among sub-groups of participants (saturation). These criteria warranted a sample size of approximately 5-7 participants per subgroup. A total of 32 patients consented to be interviewed, but 10 could not be reached or did not return messages and 4 decided not to participate. Therefore, 6 patients in each subgroup participated in the study.

Recruitment Methods

Patients who scored positive on the PHQ-2 during their medical visit were invited to participate in the study via flyer distribution by nursing staff (see Appendices A and B for sample flyers in English and Spanish, respectively). Medical staff were given a script to assist them in explaining the study and asked the patient if they were interested in participating in the study. If a patient was interested in participating in the study, the researcher met the patient in the exam room to introduce the study, obtain consent, and schedule an interview within two months.
Measure

All interviewees, in addition to answering the qualitative questions adapted from Horevitz et. al (see Appendices C and D for Interview Guides in English and Spanish, respectively), completed a brief set of quantitative questions about demographics and language use. These questions allowed us to further contextualize their pattern of responses to the qualitative interviews and employ an intersectional analysis based on CRT methodological techniques, ensuring that differences among subgroups were highlighted in this study.

Demographics

The first part of the interview consisted of a section called “Biography”; this section entails questions aimed at providing a comprehensive account of participants’ number of children, marital status and length of marriage, length of time living in the area, and current employment.

Language Use

The second part of the survey assessed participants’ language use. This section was adapted from Marin and Gamboa’s (1996) Bidimensional Acculturation Scale for Hispanics. The scale’s six questions mainly focus on language use and preference, which demonstrated very high internal consistency (alpha=0.97). The questions query participants on language use through four response choices (1= almost never, 2= sometimes, 3= often, 4= almost always). The first three questions assess participants’ perceptions on their ability to 1) speak English, 2) speak English with friends, and 3)
think in English. The following three questions ask the same about Spanish language use: participants’ perceptions on their ability to 1) speak Spanish, 2) speak Spanish with friends, and 3) think in Spanish.

**Procedure**

Participants who submitted a contact information sheet were contacted approximately two months after their initial PHQ-2 screening to confirm the interview at their preferred time and location. Interviews were conducted at the clinic, at the patient’s home, and over the telephone, lasting from 30 to 60 minutes. Standard procedures for obtaining consent were conducted before interviews commenced (see Appendices E and F for English and Spanish, respectively). Participants were notified that the interview would be recorded; all participants agreed.

**Provider Interviews**

**Demographics**

The population of interest for this portion of the study included providers (including residents) rendering medical services who screened patients for depression at a FQHC in 2016. Purposive sampling was used to ensure that providers from different clinics were represented: residency clinic with full integration, mid-size clinic with limited behavioral health services, and a PA-led satellite clinic with no behavioral health on site.
**Recruitment Methods**

Providers were recruited at monthly Provider Meetings and resident didactic sessions (see Appendix G for Provider sign-up sheet). Sample size estimations were guided by conservative estimates of shared levels of agreement among participants. Traditional qualitative sample size estimations suggested a provider sub-group sample size of approximately 5-7 participants; 7 providers participated in the study.

**Measure**

A semi-structured interview guide (Appendix H) was used for all provider qualitative interviews to assure comparable questions explored. For triangulation purposes the interview questions for the providers were very like those of the patients. They were adapted, with permission from Elizabeth Horevitz, from “Depression Treatment Uptake in Integrated Primary Care: How a “Warm Handoff” and Other Factors Affect Decision Making by Latinos” (Horevitz et al., 2015). Questions were revised to capture the experience of the provider administering the treatment recommendation for depression instead of a patient receiving the referral. For example, instead of asking “Did your provider connect you with a counselor the same day as your medical visit?” this interview asks the provider “How often do you connect your patients with a counselor the same day as their medical visit?” This 26-question interview is comprised of the following topics: biography, clinic history, language use (described in Aim 3 below), depression narrative, depression treatment, integrated behavioral health specialist[IBHS] handoff, behavioral health referral, and pathways/decision to follow-up. Given the integration of behavioral health programs available at the FQHC clinic, a new topic called “Integrated
Behavioral Health” was entered into the interview; this section explored same-day counseling, which is a different dynamic than “warm-handoff” explored by Horevitz and colleagues. Ten questions specifically related to the patient experience were removed from the provider version of the survey.

**Procedure**

Participants who expressed interest in participating in an interview were contacted to confirm their preferred date, time and location. Interviews were conducted in the clinic, lasting between 20 to 40 minutes. Standard procedures for obtaining consent were conducted before interviews commenced (See Appendix I-Informed Consent- Provider). Interviews were audiotaped with participant permission and transcribed verbatim. Transcribed interviews were entered into QDA Miner, version 5 to create and analyze emerging themes from the interviews.

**Data Analysis**

Qualitative data was analyzed using emergent coding methods as well as a lens from CRT Methodology techniques as informed in Solorzano and Yosso (2002). CRT methodology seeks to build theory from the lived experiences of the study participants through a reflective research process and a pursuit for social justice (Solorzano and Yosso, 2002). The framework employs five elements to inform research questions asked, methodologies employed, and the way data is analyzed (Malagon et al., 2009). These five elements derive from the Critical Race Theory tenets described in Chapter One: intersectionality, challenging the dominant ideology, social justice, experiential
knowledge, and centering CRT in the research process via a transdisciplinary perspective. This technique was most suitable to ensure that CRT tenets guided both the study design and research analysis of this dissertation.

Transcribed interviews were analyzed with two levels of coding: emergent (to allow new and unexpected information to emerge) and confirmatory (to develop a codebook), which was then applied to all interview transcripts by two coders. In addition, theory based codes were added based on the literature. Once independent coding was completed on a subset of eight interviews, coders explored resulting themes (groups of codes “hanging” together) to organize the emerging themes. Agreement/disagreement was explored by constant comparison methods, resulting in 94% congruence for interviews.

**Semi-Structured Validation, Member-Checking Focus Groups**

End-of-study focus groups that review provisional findings are often used as a form of member validation. End-of-study focus groups are good research practice in that, as with triangulation, they furnish additional data which provide a stimulus to qualify, deepen and extend the initial analysis” (Bloor, 2001, p.15). Running a focus group with members who participated in the research provides a forum to validate themes with others experiencing a similar situation. Members are presented with results from previously conducted research, and then asked to identify and come to a consensus on relevant themes.
Demographics

A total of four Spanish-speaking Latinos (one male/three females), four English-speaking Latinos (two males/two females), and four English-speaking non-Latinos (two males/two females) and nine providers (four males/five females) participated in their respective focus group.

Recruitment Methods

Participants who completed the key informant interviews were invited by the person who interviewed them to participate in a member-checking, end-of-study focus group in their preferred language, English or Spanish, and reported ethnicity, Latino or non-Latino. Participants who did not partake in an interview were also invited to participate during their medical visit and were consented at the focus group. Additional providers were invited to a separate provider-specific group at a resident didactic session. Because our main analysis focused on validating differences between these groups in a safe social setting of “same” persons, a total sample of 12-18 participants was required (4-6 per subgroup).

Procedure

Focus group guides, adapted from Learnhigher (2015) were available for the facilitators in both English (Appendix J) and Spanish (Appendix K). The guide provided instructions on how to run a focus group session and scripted questions with an introduction, ice breaker, exploration and confirmation of interview themes, and closing question that asked participants for any other recommendations on how to improve
mental health service delivery. Participants of the member-checking focus group were trained on qualitative analysis techniques. Transcribed answers from all interviews were provided to the participants, who placed answers into emerging themes. The CRT tenet of experiential knowledge guided these focus groups in that researchers merely mediated the discussion, but participants ultimately validated the themes based on their analysis of the transcription segments.

It was vital for the moderator of these focus groups to set ground rules, use open-ended questions to explore emerging themes, continuously check back with the members to validate the emerging themes while taking accurate notes, summarize the focus group with a concise list of themes, and review the purpose of the study to make sure nothing has been missed before ending the group.

Data Analysis
Once clear about pattern of responses from qualitative interviews, we used this information to help develop the guide for four confirmatory, end-of-study focus groups, which were used to do member checking on our interpretation/analyses of findings. Once conducted, focus groups were also transcribed verbatim and coded. One focus group was independently coded by two coders to compare the themes emerging from the qualitative interviews. Agreement/disagreement was explored by constant comparison methods, also reaching 94% congruence.

Ethical Considerations
Institutional Review Board approval was obtained from Loma Linda University to
comply with ethical and professional standards to protect human subjects, set forth by the ethical three principles set forth in the Belmont Report: respect for persons, beneficence, and justice. IRB principles are engrained in the ideology of CRT Methodology. IRB certification has been completed by researchers to ensure that participants’ rights are fully protected throughout the entire study by acknowledging patient autonomy, maximizing possible benefits and minimizing possible harm to patients, and in selecting subjects, distributing the burdens and benefits of research equally among the various segments of society.
CHAPTER FIVE

RESULTS

ANALYZING STANDARD OF CARE DEPRESSION TREATMENT RECOMMENDATIONS AT AN INTEGRATED FEDERALLY QUALIFIED HEALTH CENTER: A MIXED METHODS, ETHNIC-LINGUISTIC ANALYSIS

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Abstract

Introduction: The Institute for Clinical Systems Improvement recommends that primary care providers (PCP) screen patients for depression during a medical visit using a standardized screening tool, and recommend appropriate follow-up when the screening is positive for depression symptoms. However, depression prevalence in Latinos is estimated at 8-15% compared to 22% in non-Latino whites. This study aimed to identify how language and ethnicity impacted standard of care depression treatment recommendations for patients who screened with major depression during a medical visit at a Federally Qualified Health Center (FQHC) in Southern California.

Methods: The primary author conducted a chart review of 692 patients who screened positive for depression on the Patient Health Questionnaire-2 (PHQ) during a medical visit in 2014 or 2015 at a FQHC followed by qualitative semi-structured interviews with 18 patients and 7 providers. Only 275 patients with a PHQ-9 of 10 or above (major depression) were included in the analysis.

Results: After controlling for age, gender, and race, a binary logistic regression was performed to determine the effects of language and ethnicity on standard of care depression treatment recommendations (combined psychotherapy and pharmacotherapy) for 275 patients. When ethnicity was included in the final model, Spanish-speaking Latinos were 72% less likely to receive standard of care recommendations from their PCP than English-speaking patients. Interviews confirmed that negative perceptions about medications, patient non-compliance, and a shortage of bilingual behavioral health specialists within the clinic impacted standard of care treatment recommendations and uptake for the Spanish-speaking group.
Conclusions: In this study, Spanish-speaking Latinos did not receive or follow through with standard of care depression treatment recommendations as often as English-speakers. Future studies should explore reasons why language is a barrier to standard of care depression treatment recommendations for Latinos and explore culturally and linguistically sensitive methods to effectively treat Spanish-speakers for depression in an integrated setting.

Keywords: major depression, adult Latinos, standard of care, Federally Qualified Health Centers, depression guidelines
Introduction

Up to 70% of primary care visits include psychosocial concerns and approximately 40% of patients first present with depression symptoms at a community health center for care (Holden et al., 2014; Camacho et al., 2015) The Health Resources and Services Administration [HRSA] defines federally qualified health centers [FQHCs] as “community-based health care providers that receive funds from the HRSA Health Center Program to provide primary care services in underserved areas”. FQHCs may be community health centers and must meet a stringent set of requirements for continuation of funding, including annual reporting on a set of clinical quality measures; one of these measures looks at patients who were screened yearly for depression using a standardized tool and, if positive, have a follow-up plan documented (HRSA, 2016). FQHCs often follow guidelines from the USDHHS, Agency for Healthcare Research and Quality for guidance with these clinical quality measures. The recommended guideline for depression from the Institute for Clinical Systems Improvement [ICSI] includes cultural considerations when implementing depression-screening and follow-up processes at one’s organization, which is especially important for Latino populations (Mitchell, Trangle, Degnan, et al., 2013).

The United States Census Bureau reports that Latinos comprise approximately 17% (54 million) of the total U.S. population. However, Latinos are poorly represented in large clinical studies of depression, usually due to language exclusion criteria (Reuland et al., 2009). Approximately 55% of the adult Latino population report Limited English Proficiency (LEP) in the United States (Aponte-Rivera et al., 2014); therefore, proper depression assessment, treatment, and management of this population are growing

Studies have found that the compatibility of the client-therapist relationship match (ethnicity and/or language) and the client-therapist relational style (warmth and high interpersonal regard) were positively related to a patient’s willingness to report depression symptoms during a medical visit (Ishikawa et al., 2010). However, reporting depression symptoms and receiving standard of care treatment recommendations during a medical visit are two separate components of depression care. Given the dearth of culturally and linguistically driven studies examining depression treatment recommendations for Latino populations, this mixed methods study will examine if language and ethnicity impact standard of care recommendations from a PCP. The results of this study could inform physicians, healthcare organizations, and mental health providers to be aware of cultural and linguistic factors affecting depression in Latinos, and guide future research to include language as a key variable of analysis for depression.

**Methods**

A mixed methods design was used to explore standard of care depression treatment recommendations for patients screened for depression at an FQHC. First, a chart review of quantitative data was conducted for patients who screened positive for depression during a medical visit to examine the treatment recommendations prescribed by their PCP (primary care provider). Next, qualitative interviews were conducted with
patients who screened positive for major depression (PHQ-9 ≥ 10) and should have been prescribed treatment by their PCP. Providers working at the FQHC were recruited at Provider Meetings and resident didactic sessions. Member checking, validation focus groups were conducted with 4 participants in each patient group and 9 providers, consisting of both participants and non-participants of the interviews.

Chart Review Procedure

This study received approval from the institutional review board to obtain access to electronic medical records for eligible participants from an FQHC. The primary author conducted an electronic chart review of 275 patients who screened ≥ 10 on the PHQ-9 during a medical visit in 2014 or 2015, and reported their ethnicity as Latino or Non-Latino and a preferred language of English or Spanish. Data were de-identified and recorded in a password-protected Excel spreadsheet on a secured server. Data collected included demographics, PHQ-9 scores, and PCP depression treatment recommendations. Data was analyzed using the statistical software SPSS, version 23.0 to conduct a binary logistic regression analysis.

Measures

Patient Health Questionnaire-9 (PHQ-9)

The Patient Health Questionnaire-9 (PHQ-9) is an instrument based on DSM-V diagnostic criteria for depression, designed for use in primary care settings (Wulsin, Somoza & Heck, 2002) that includes 2 items from the short form (PHQ-2) and 7 additional items rated on a 4-point Likert scale (0-not at all to 3-nearly every day). A
PHQ-9 cutscore of 10 has an 88% sensitivity and 88% specificity for the diagnosis of major depressive disorder (Kroenke, Spitzer & Williams, 2001). According to Institute for Clinical Systems Improvement (ICSI, 2016), “the PHQ-9 has been validated as a tool for both detecting and monitoring depression in primary care settings”. Additionally, the PHQ-9 has a specificity of 0.85 and sensitivity of 0.77. The PHQ-9 has been validated for use in primary care settings (Wulsin, Somoza & Heck, 2002) and the factor structure of the nine items is comparable when tested with Latino and non-Latino white patient groups (Huang et al., 2006).

**Standard of Care**

The Institute for Clinical Systems Improvement’s Health Care Guideline: *Depression in Primary Care* (2016) specifies that patients with a score of 10 or greater on the PHQ-9 should receive treatment recommendations of combined psychotherapy and pharmacotherapy and chart audits of these recommendations were coded as YES standard of care (combined therapy) vs. NO not standard of care (psychotherapy only, pharmacotherapy only, a PCP intervention-education, breathing exercises, or physical therapy, or no recommendation).

**Qualitative Interviews**

Semistructured qualitative interviews with patients and providers were used to explore factors influencing standard of care depression treatment recommendation and uptake. The primary author received permission to modify an interview guide used in a study conducted by Horevitz, Organista, and Arean (2015) to align the questions with the
FQHC’s integrated setting. Purposive sampling was used to recruit 18 patients who screened positive (≥10) on the PHQ-9. Participants were selected based on ethnic-linguistic characteristics: Spanish-speaking Latinos, English-speaking Latinos, or English-speaking non-Latinos. Seven providers who screen patients for depression were invited to participate in the study and selected on the basis of their primary site: residency clinic with full integration, mid-size clinic with limited behavioral health services, and a PA-led satellite clinic with no behavioral health on site.

A total of 32 patients consented to be interviewed, but 10 could not be reached or did not return messages and 4 decided not to participate; all 7 providers who consented to participate in the study were interviewed. Member checking, validation focus groups were conducted with the four groups. Each of the patient groups had 4 participants and the provider group had 9 participants, who included participants who did and did not complete an interview; new participants signed consent forms prior to participation in the focus group. Participants were offered a $5 gift card to Target, Wal-Mart, or Starbucks for their time. Interviews lasted 30-45 minutes, were conducted by the first author, and were recorded and transcribed verbatim. Spanish-language interviews were translated by a certified translator and back translated to ensure language equivalency.

Inductive and deductive methods were used to analyze the interviews. The interview data were coded with QDA Miner and were analyzed by the first author and a research assistant by using a codebook created from theoretical and emergent themes from individual interviews. We explored how a positive, negative, or neutral perception of psychotherapy and pharmacotherapy may have differed between and among the groups.
Results

Chart Review

Table 8 characterizes demographic characteristics for 275 patients with qualifying PHQ-9 scores.

Table 8. Demographic characteristics for patients with PHQ ≥ 10 between 2014-2015.

<table>
<thead>
<tr>
<th>Variables</th>
<th>n=275</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean Age (SD) [years]</td>
<td>m = 44.92; sd = 13.61</td>
</tr>
<tr>
<td>Mean PHQ-9 (SD) [score]</td>
<td>m = 18.10; sd = 4.32</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>202 (73.5)</td>
</tr>
<tr>
<td>Male</td>
<td>73 (26.5)</td>
</tr>
<tr>
<td>Race</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>171 (62.2)</td>
</tr>
<tr>
<td>Black/African American</td>
<td>43 (15.6)</td>
</tr>
<tr>
<td>Asian</td>
<td>4 (1.5)</td>
</tr>
<tr>
<td>American Indian/Alaskan Native</td>
<td>5 (1.8)</td>
</tr>
<tr>
<td>Native Hawaiian/Pacific Islander</td>
<td>1 (0.4)</td>
</tr>
<tr>
<td>More than One Race</td>
<td>4 (1.5)</td>
</tr>
<tr>
<td>Unknown/Not Reported</td>
<td>47 (17.1)</td>
</tr>
<tr>
<td>Patient Ethnicity</td>
<td></td>
</tr>
<tr>
<td>Latino</td>
<td>135 (49.1)</td>
</tr>
<tr>
<td>Not Latino</td>
<td>140 (50.9)</td>
</tr>
<tr>
<td>Patient’s Preferred Language</td>
<td></td>
</tr>
<tr>
<td>English</td>
<td>248 (90.2)</td>
</tr>
<tr>
<td>Spanish</td>
<td>27 (9.8)</td>
</tr>
</tbody>
</table>
Participants’ ages ranged from 18 to 85 years ($\mu=44.92$; $SD=13.61$). The majority of patients were female (73.5%), white (62.2%), English-speakers (90.2%), and about half of the participants were Latino (49.1%). Mean PHQ-9 score was 18.10 ($SD=4.32$), indicating moderate severe depression.

A binary logistic regression analysis was conducted to assess the association between language and ethnicity on standard of care depression treatment recommendation: controlling for age, gender, and race in the first block, $\chi^2 (3, 275) = 3.92; p = .27$ was not a significant fit to the data. The inclusion of ethnicity in block 2 was also not a significant fit to the data ($\chi^2 (1, 275) = 1.14; p = .29$), but the inclusion of language in the third block made the final model significant ($\chi^2 (1, 275) = 4.45; p = .04$). Evaluation of odds ratios and corresponding confidence intervals (95%) within the full model examined the strength of the individual predictors. Criterion for significance was set at $p < 0.05$. The final model correctly classified 54.2% of cases. Table 9 presents a summary of results.

Age and language were the only significant predictors of standard of care depression treatment recommendations during a medical visit in the final model (respective ORs = .98 and .39, $p < .05$), although ethnicity was trending toward significance (OR = 1.58, $p = .08$). Results indicate that Spanish-speaking Latinos were less likely to receive standard of care depression treatment recommendations during a medical visit.
Table 9. Logistic regression of demographic characteristics predicting standard of care depression treatment recommendations.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Model 1</th>
<th></th>
<th>Model 2</th>
<th></th>
<th>Model 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OR</td>
<td>p</td>
<td>95% CI</td>
<td>OR</td>
<td>p</td>
</tr>
<tr>
<td>Constant</td>
<td>.13</td>
<td></td>
<td>1.76</td>
<td></td>
<td>4.24</td>
</tr>
<tr>
<td>Age</td>
<td>.88</td>
<td>.97, 1.00</td>
<td>.98</td>
<td>97, 1.00</td>
<td>.98</td>
</tr>
<tr>
<td>Gender</td>
<td>1.18</td>
<td>.51, 1.51</td>
<td>.88</td>
<td>.51, 1.52</td>
<td>.92</td>
</tr>
<tr>
<td>Race</td>
<td>.51</td>
<td>.72, 1.95</td>
<td>1.20</td>
<td>.73, 1.98</td>
<td>1.20</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
<td>1.30</td>
<td>.80, 2.10</td>
<td>1.58</td>
</tr>
<tr>
<td>Language</td>
<td></td>
<td></td>
<td>.39</td>
<td></td>
<td>* .16, .95</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Classification</th>
<th>Classification</th>
<th>Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>= 56.7%</td>
<td>= 54.2%</td>
<td>=54.2%</td>
</tr>
</tbody>
</table>

*p < .05

Qualitative Interviews

Qualitative interviews were conducted through purposive sampling to explore standard of care depression treatment recommendations through an ethnic-linguistic analysis for 18 patient participants and 7 provider participants. Six English-speaking non-Latinos (three males and three females), six English-speaking Latinos (one male and five females), six Spanish-speaking Latinos (one male and five females), and seven providers (two males and five females) participated in the interviews. The majority of English-speaking Latinos (83.3%) and non-Latinos (83.3%) reported receipt of standard of care depression treatment recommendations from their PCP compared to only two Spanish-speaking Latino participants (33.3%). The majority (n=5 of 7) providers reported active recommendation of standard of care depression treatment recommendations to their patients.
Inductive and deductive qualitative analyses were used to expand upon quantitative results by exploring themes related to how ethnicity and language may have influenced standard of care depression treatment recommendations and uptake. Three primary themes were identified and validated: perception of depression treatment recommendations (including medications, counseling, and a combined standard of care recommendation), receipt of depression treatment recommendations, and barriers impacting treatment recommendations.

**Perception of Depression Treatment Recommendations**

The majority of the PCPs (71%) reported that they prefer to recommend standard of care depression treatment to patients with major depression. One provider, a bilingual, bicultural female, stated that the majority of her patients are Latino and resistant to medications and so she prefers to recommend counseling and exercise, then medication if the patient still needs help with depression. While half of the English-speaking non-Latinos (n=3 of 6) expressed positive feelings about standard of care depression treatment recommendations, the majority of PCPs (55%) were neutral about the efficacy of combined psychotherapy and pharmacotherapy. However, when asked separately about counseling and medications, there was a notable difference in patient responses. The majority (n=4 of 6; 67%) of English-speaking non-Latino patients had positive experiences with antidepressant medications while the majority of Latinos (n=4 English speakers and n=5 Spanish speakers) reported negative experiences or perceptions about antidepressant medications, even if they had never taken an antidepressant. Most Spanish-speaking Latinos (n=5 of 6) felt that medicine, in general, is bad for you and
should only be taken if absolutely necessary, validating the Latina provider’s observation with her patients.

“I’m not sure about the medication 100% as far as I think it may also make me lazy or lethargic and tired”

– English Speaking, White Latino Patient

“Me hace mucho daño la medicina y trato de evitarla lo más que puedo”

Translation: “Medicine does a lot of damage to me and so I try to avoid it as much as I can.”

– Spanish Speaking, White Latina Patient

The majority of patient participants (n=12 of 18) had positive things to say about counseling. Although only one Spanish-speaking Latino was able to get into counseling at the clinic, the majority of Spanish-speaking Latinos (n=4 of 6) had some sort of therapy (group or individual) in the past and reported positive experiences. Half of the English-speaking non-Latinos (n=3 of 6) expressed concerns (lack of rapport with therapist) or negative experiences with counseling (did not learn skills to cope with depression or scheduling issues, such as multiple rescheduled or cancelled appointments).

“I was surprised that the appointments are monthly and not at least biweekly or something a little more frequent”

– English Speaking, White non-Latino Patient

“I have not learned any coping skills or received anything that I feel is helpful in trying to overcome or manage my depression. Talking once a year doesn’t really do much.”

– English Speaking, White non-Latina Patient

Receipt of Depression Treatment Recommendations

The majority of English-speakers (n=10 of 12), regardless of ethnicity, received a standard of care depression treatment recommendation from their PCP. One Latino patient lost his son and was severely depressed, but did not receive pharmacotherapy; although in the interview he expressed an interest in trying an antidepressant in addition
to the recommended therapy, the participant did not notify his PCP. One non-Latino patient called the clinic’s Behavioral Health department herself since she only received pharmacotherapy from her PCP.

The interviews confirmed this study’s quantitative findings with Spanish-speaking Latinos: the majority (n=4 of 6) did not receive standard of care depression treatment recommendations; none (n=2) followed through with standard of care treatment recommendations. Half of Spanish-speaking Latinos (n=3 of 6) did not receive a referral to psychotherapy. One patient who did receive a standard of care recommendation was non-compliant with her medications and did not call behavioral health to schedule an appointment due to transportation issues. The other patient who received standard of care recommendation did not fill the prescription; she reported that the bilingual integrated clinical psychologist agreed to see her because her depression severity was getting worse over the months and she was not able to make an appointment with the Behavioral Health department due to a shortage of Spanish-speaking therapists. The last patient only received a referral to Behavioral Health, but was told that she would be put on the waitlist since there was no Spanish-speaking therapist in the Department at that time.

“No podía con el consejero en esos días porque solo había una persona disponible en inglés. Yo hablo inglés pero para sacar tus sentimientos, para sacar todo lo que traes, necesitaba hacerlo en español. Me dijeron que estaban buscando la ayuda también en español.

Translation: “I could not see the counselor in those days because there was only one person available in English. I speak English but to get your feelings out, to get out everything you have, I needed to do it in Spanish. They told me that they were looking for help in Spanish as well.”

— English Speaking, White Latino Patient
Barriers Impacting Treatment Recommendations

Aside from the Spanish-speaking Latino group’s negative perception of medications, non-compliance with treatment recommendations, and a shortage of bilingual behavioral health specialists, the majority of patients (n=14 of 18) and all providers (n=7) reported barriers that directly impacted depression treatment recommendations. Structural barriers such as transportation (n=3 of 18) or work hours (n=2 of 18) were reported as common barriers for treatment recommendation uptake, usually in reference to psychotherapy. Patients (n=7 of 18) and providers (n=6 of 7) reported issues with access to timely appointments, appointment availability, and frequency of psychotherapy visits. English-speakers noted barriers with pharmacotherapy, such as refill requests (n=2 of 6 Latinos), issues with medication adjustments (n=2 of 12), and inability to contact the clinic over the phone to make a behavioral health appointment (n=3 of 12). Spanish-speaking Latinos shared that although their provider recommended psychotherapy (n=4 of 6) or pharmacotherapy (n=1 of 6), they did not follow through with the treatment recommendation, which some providers (n=3 of 7) noted as well. More than half of the providers (n=4 of 7) noted a lack of consistency among nursing staff with regards to depression screening administration. Some participants (n=8 of 18) noted a shortage of behavioral health therapists, indicating that there was only one therapist available and that psychiatry services were offered in a residency clinic with limited hours. Most providers (n=6 of 7) expressed the need for more bilingual and bicultural behavioral health therapists for long-term counseling services.
Discussion

This study provides insight into the effect of patient preferred language regarding receiving standard of care depression treatment recommendations. The data reveal that language and to some degree ethnicity do have an effect on depression treatment recommendations of PCPs. Age and language individually predicted receipt of standard of care by a PCP. Qualitative interviews confirmed that the majority of Spanish-speaking Latinos did not receive standard of care depression treatment recommendations and had negative perceptions about pharmacotherapy leading to a lack of care for depression in this group. When standard of care was recommended to Spanish-speaking Latinos, nobody followed through with the recommendation of medication and psychotherapy. Despite negative feelings about medications, English-speaking Latinos who were interviewed did follow-through with standard of care recommendations including both medication and psychotherapy. Barriers impacting treatment recommendations confirmed themes from the literature: negative perception about pharmacotherapy, patient non-compliance with recommendations, and a shortage of behavioral health specialists in general as well as a shortage of therapists who speak Spanish (Aponte-Rivera, 2013; Ishikawa et al., 2010; Kanter et al, 2014; Thomas et al, 2011).

Limitations of Study

This study is limited in that only two languages and two broad ethnic groups were examined. Future studies should examine other minority groups and Spanish-speaking non-Latinos for comparisons. Also, because diagnosis and treatment recommendations occurred during the course of a usual primary care visit rather than a visit specifically
focused on mental health, the symptoms may have been underreported thereby underestimating these effects. Lastly, out of the 692 charts reviewed, 403 patients (58.2%) had a PHQ-9 score of 9, just under the 10 point cutscore. Although a score of 9 is not considered major depression, previous studies (Horevitz et al., 2015) have analyzed patients who are on the cusp of major depression by including patients with a PHQ-9 score of 9 or above. Seeing how the majority of the patients with positive PHQ-9 scores in the initial review were 9, future studies could explore how many of these patients received standard of care depression treatment recommendations after further dialogue with their PCP or IBHS.

**Conclusion**

Studying the Latino population as a subgroup does not account for language preferences impact on attitudes toward mental illness, treatment recommendations, and overall reduction of depressive symptoms over time. Results of the present study indicate that being a Spanish-speaking Latino is related to fewer standard of care depression treatment recommendations by PCPs. It is known that there is a shortage of mental health specialists across the nation and more so in underserved community health centers that serve Latino populations. Therefore, policymakers should implement loan forgiveness programs to recruit mental health specialists to FQHCs, similar to recruiting efforts for primary care providers and nurses.
CHAPTER SIX
OTHER RESULTS

This chapter describes main study findings from the qualitative interviews to answer the remaining research questions. In addition to the aforementioned themes from the mixed methods results (perception of depression treatment recommendations, receipt of depression treatment recommendations, and barriers impacting treatment recommendations), six additional themes were validated, all of which are presented in the following subsection through an ethnic-linguistic lens. These included strength of clinical relationships with staff, PCP, therapist, and IBHS; handoff experience with IBHS and behavioral health; barriers impacting depression; stigma; patient motivation; social supports; and mental health narrative. We present the last theme through a LatCRT lens by grouping responses according to their alignment with the PHQ-9 screening questions. The purpose of the grouping is to explore whether depression symptomatology manifests differently among Latinos based on language.

Themes

Strength of Clinical Relationships

Most patients (please note while we report numbers who indicated feeling this way, some of the other respondents may have agreed as well but it may not have come up in our interview) reported positive clinical relationships with their PCP (n=16 of 18), clinical staff (n=11 of 18), IBHS (n=8 of 18), and therapists (n=7 of 18), while providers reported positive clinical relationships with their patients (n=5 of 7). Both patients (n=10 of 18) and resident providers (n=2 of 7) expressed frustration with continuity and
inability to see the same person at subsequent visits. All Latino patients (n=12) reported positive experiences with their PCP. English-speaking non-Latino participants expressed concerns about not being able to build rapport with their therapist (n=1 of 6) or difficulty communicating with their resident provider (n=2 of 6). The responses below exemplify participants’ concerns with clinic staff.

“The one [therapist] I have talked to, unfortunately I feel very guarded in what I say”
— English Speaking, White non-Latina Patient

“I don’t think [my doctor] listens to me enough…she’s not understanding what these headaches are doing and how these headaches are affecting me”
— English speaking, African-American, non-Latino Patient

One provider expressed concern with translation during a medical visit:

“I’m always a little suspicious about the translation that’s happened because…I know sometimes I’ll hear words that I definitely didn’t say and so I wonder about communication.”
— English Speaking, Asian non-Latina Provider

**Handoff Experience**

While half of the Spanish-speaking Latinos (n=3 of 6) reported positive experiences with the IBHS handoff, the majority of Latinos (n= 8 of 9) were neutral about the handoff to an IBHS on the day that they screened positive for depression at their medical visit. Only one English-speaking non-Latino reported a handoff experience and expressed frustration with having to repeat herself to the IBHS, but overall felt that the experience took care of “two birds with one stone”.

“[The doctor] was listening and is seemed like she got more absorbed than she wanted to because she called someone else in to talk to me…and I was like ‘I have to say everything all over again’”
— English Speaking, White non-Latina Patient
On the other hand, one patient had not been aware that IBHS services were available at her medical visit and shared her experience with the unanticipated handoff process, which she saw as very positive.

“Since I have never gone through this, …I was just expecting for maybe the doctor to see me and let me know I had depression, then tell me ‘here’s a number for the Behavioral Health department, make an appointment.’ I wasn’t expecting them that same day to connect me with someone”

— English Speaking, White Latina Patient

However, only four patients reported a handoff experience to Behavioral Health. English-speaking Latinos (n=2 of 6) reported neutral to good handoff experiences. The statements below describe handoff experiences among English-speaking non-Latinos (positive) and Spanish-Latinos (negative).

“[The doctor] had somebody actually go with me to behavioral health to set up an appointment on the spot. That was good”

— English Speaking, White non-Latina Patient

“La muchacha [IBHS] me dijo dónde estaba el lugar que tenía que ir y fuimos. No más que en ese momento no estaban disponibles. Estoy esperando a que me llamen.”

Translation: “The girl [IBHS] told me where the place was where I needed to go and we went. It’s just that in that moment they had nothing available. I am waiting for them to call me.”

— Spanish Speaking, White Latina Patient

While providers at the fully integrated site stated that they were able to handoff patients to IBHS more than half of the time with a positive perception (n=3 of 7), providers working at satellite sites expressed an inconsistency with staffing of IBHS (n=4 of 7), which made it difficult for patients to build a rapport with the IBHS staff. The statements below asserted differences in a provider’s handoff experience based on their clinic.
“Having a warm handoff is absolutely essential. It’s one of the best things I’ve experienced yet in healthcare! … The amount of insight into a patient that I’m able to get from talking to an IBHS…it’s amazing”

– Bilingual, White Latina Provider at the Fully Integrated Clinic

“They aren’t always available because there is only one here at a time now. They would be with one client while I’m in need of help”

– Clinically Bilingual White Non-Latino Provider at the Limited-Integration Satellite Clinic

“I’m at a satellite clinic so it’s not like I can just call them and have them come to the room. They have to be scheduled”

– Bilingual White Latina Provider at the Satellite Clinic with No Integration

Social Support

Some patients (n=3 of 18) and most providers (n=5 of 7) felt supported by the clinic, especially with referrals, medications, and the variety of services offered in house. The statements below assert some of the ways that patients and providers felt supported by the clinic.

“I like the services that they provide. I feel every time I come in, for whatever reason I’m being seen, they provide the care I need… I feel like they’re doing the job”

– English Speaking, White Latina Patient

“Here, in this practice, behavioral is so available that I have better success at getting people to do behavioral medicine approaches than I have historically because of the warm handoff, going right in and meeting them”

– Clinically Bilingual non-Latino Provider

The majority of patients felt that family (n=13 of 18) and friends (n=9 of 18) were supporting them in the midst of their depression. Spanish-speaking Latinas (n=3 of 5) shared how their faith and support from church was a crucial support for them during their depression. A provider also mentioned how praying with patients often is something that is really important for that person, expressing appreciation that the clinic allows him the opportunity to pray with his patients.
**Patient Motivation**

Patients reported a variety of activities that motivate them while also alleviating their depression symptoms. English-speaking non-Latinos reported playing video games (n=2 of 6), while Spanish-speaking Latinos stated that listening to music (n=1 of 6) and eating better (n=2 of 6) alleviated their depression symptoms. Latinos, regardless of language, expressed that getting out of the house (n=5 of 12) and exercising (n= 6 of 12) made them feel better. Latina mothers (n=2 of 10) expressed how their children were key motivating factors to overcome depression. The statements below asserted the importance of family support (familismo) in Latino culture.

“I want to be able to be there, to be in the moment, to spend time with my daughter and enjoy talking to her. I don’t want her to grow up feeling like I was unattached”

— English Speaking, White Latina Patient

“Le pedía a Dios que me diera fortaleza, quererme más a mí misma y a mis hijos, acercarme más a ellos.”

*Translation:* “I asked God to give me strength, to love myself and my children more.”

— Spanish Speaking, White Latina Patient

**Barriers Impacting Depression**

Although barriers impacting treatment recommendations have been noted, patients and providers also shared barriers they believe impact the patients’ depression. Over half of the six patients in each group (n=4 English-speaking Latinos; n=4 English-speaking non-Latinos; and n=5 Spanish-speaking Latinos) stated that they were currently unemployed. Spanish-speaking Latinos (n=5 of 6) reported health issues, such as obesity, hypertension, arthritis, diabetes, seizure disorder, and a broken leg due to an accident, as major issues (and thus barriers) that impact their depression. Half of the English-speaking
non-Latinos (n=3 of 6) reported stroke, diabetes, and a bad back as key health barriers while English-speaking Latinos (n=2 of 6) reported fibromyalgia and a cancer scare as contributors to their depression. This points to a strong bi-directional relationship of physical health and mental health: poor physical health resulted in poor mental health, in addition, many presented with mental health issues based on somatization that the providers then traced back to depression.

Not surprising there also remain structural access barriers. These included transportation (n=3 of 18), work or school hours (n=2 of 18), and issues with insurance (n=2 of 18), such as being dropped from their parent’s insurance or issues with transitioning from one psychiatrist to another across counties, leading to a delay in medication refill. Patients also expressed familial conflict between siblings (n=2 of 18), parents (n= 2 of 18), and adult children (n=2 of 18) as a major barrier contributing to their depression and/or seeking help. One Spanish-speaking Latina female expressed marital issues with her husband. In both cases the family, they felt, would not be supportive for them to seek help for their depression.

Specifically, many noted cultural barriers to help seeking for Latino patients. A Spanish-speaking Latino male expressed frustration with not being able to work due to his seizure disorder and how his family is constantly asking him to stop helping around the house in case he gets another “attack”. The statements below illustrate how depression impacts a Latina based on the cultural value of marianismo.

“Para ellos uno siempre tiene que estar bien. Para ellos la mama nunca le duele, nunca llora, nunca tiene hambre.”

*Translation:* “To them one always has to be fine. To them the mom never hurts, never cries, is never hungry.”

– Spanish Speaking, White Latina Patient
“[Depression] was affecting my home where I wouldn't want to get up and do things. I have little ones at home so, of course, being a stay at home mom, I still have to get up to take them to school. I still have to get breakfast, lunch, dinner, when they're home on vacation. When they come home from school, I have to have dinner ready, have the house clean and I was tending to leave things. My house was beginning to look like how I felt”

– English Speaking, White Latina Patient

Providers (n=2 of 7) also expressed cultural and linguistic barriers when treating Latino patients with depression. One provider expressed her own cultural barrier in respect to treating Spanish-speaking Latinos while a bilingual Latina provider expressed her experience with discussing depression with Latino patients; the responses below exemplify these provider challenges:

“I don’t know if I feel completely comfortable that I’m being effective with my Spanish-speaking patients with depression because I don’t know how they’re perceiving it. I don’t know if they say they’re doing well, if that really means they’re doing well just because I know there’s my own language and cultural barriers”

– English Speaking Asian Non-Latina Provider

“I am not really comfortable letting my patients know that they screened positive for depression symptoms because of the stigma that when someone has depression, then something is wrong psychologically and within the culture, people do not feel comfortable doing that. I really have to prime things before I tell people that they have depression”

– Bilingual, White Latina Provider

**Stigma of Depression**

Every patient (n=18) reported some stigma regarding depression. Many patients (n=13 of 18) felt like they were being judged by others regarding their depression or that they were misunderstood. Some patients (n=3 of 18) stated that friends and family told them that depression was not a big deal and that they should get over it. One patient shared her daughter’s reaction when she shared that she was depressed.
“One of my daughters doesn’t even want to talk to me because she says every time she talks to me; she feels depressed herself. She tells me that I’m negative… She asked me ‘mom, since when have you started telling people about how you feel? You taught us not to tell people about how you feel. You always have to show a smile’. I told her that I’m not sure. Maybe I wanted people to feel sorry for me”

– English Speaking, White Latina Patient

Some patients (n=3 of 18) reported that people could tell that they were depressed by just looking at them and were treated differently as a result. Others (n=6 of 18) expressed that they would not tell their friends or family that they had depression for fear of judgment, ridicule, or being diminished in their eyes. They (n=9 of 18) felt that the word depression was a stigma in itself. The statements below highlight male patients’ perception about the word depression.

“In my adult years I never believed in depression. My buddies would always say that depression was an illness and I would say that’s hogwash… If you wake up every morning and see the beautiful sun…there’s no reason for anybody to be depressed. I never thought it was a sickness. I just thought people were talking gibberish until it happened to me”

– English Speaking African-American Non-Latino Patient

“It’s a strong word and I feel like only crazy people use that… they did use the word depression but I really had to face it. It’s the truth, I am feeling depressed”

– English Speaking, White Latino Patient

One patient shared how she educates her friends and family about the diagnosis to destigmatize and normalize depression.

“I think depression is something that is not really looked into that much. We [Latinos] talk about having a cold or cough and taking medicine for that. People are open to talking about cancer and getting treatment or going to support groups, but depression, I feel, is something seen as negative… so I feel the need to tell my friends and family about signs and symptoms to look for because in my case, my family didn’t see the signs and didn’t know…I just want to bring a little awareness in case they’re going through it or have somebody, a loved one or a friend, that’s going through it”

– English Speaking, White Latina Patient
Mental Health Narrative

During the interview, participants were asked to describe what depression feels like to them or if they had other names for those feelings. The majority of patients experienced depression as social withdrawal (n=15 of 18) and affect (crying, impacted sleep) (n=13 of 18). Patients reporting situations such as unemployment (n=2 of 18), health issues (n=8 of 18), physical abuse or bullying (n=2 of 18), and bereavement (n=1 of 18) as key causes of depression. Providers were asked what depression looks like to them in their patients. Providers reported affect (n=7 of 18) as the primary indicator of depression in patients, followed by anxiety (n=5 of 18), somatization of symptoms (n=4 of 18), and even saw it related to patient non-compliance (n=3 of 18).

Table 10 presents a summary of depression manifestation based on interview responses by group member and sorted by PHQ-9 questions. Multiple comments made by a patient about depression symptoms, such as feeling sad or crying, were only counted once per row. Analyzing participant answers through a LatCRT lens results in unique findings for Spanish-speaking Latinos. Results indicate that the first two questions of the PHQ-9 (the PHQ-2 brief screening used in most medical settings) worked well for English-speakers (n=9 of 12 for each question). Although most of the Spanish-speaking Latinos also experienced depression as little interest or pleasure in doing things (n=5 of 6) and feeling down, depressed, or hopeless (n=4 of 6), every single Spanish-speaking Latino participant (n=6) made a statement in their interview indicating that they were feeling bad about themselves or that they were a failure or have let themselves or their family down (question #6). Spanish-speaking Latinos made reference to familism in previous themes, an important cultural value for Latinos.
Table 10. Summary of depression manifestation on the PHQ-9 questionnaire by group.

<table>
<thead>
<tr>
<th>Over the last 2 weeks, how often have you been bothered by any of the following problems?</th>
<th>English-speaking Non-Latino</th>
<th>English-speaking Latino</th>
<th>Spanish-speaking Latino</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>5</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>4</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down</td>
<td>3</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

Note: Total number based on number of respondents per question. Items in bold indicate the questions two highest totals per group.

English-speaking Latinos (n=3 of 6) and an African-American male participant also expressed how depression was affecting their family dynamic negatively, whether with their children, spouse, or parents. The unemployed males in the group (n=2 of 4) expressed how they felt like they were not contributing to the home and were embarrassed that they were living with their parents. Aside from being a gendered stigma, the participants expressed frustration with not being able to contribute to the
household, therefore feeling as though they were letting their family down. Both participants suffer from health issues (stroke and seizure disorder), but regardless the participants still felt bad about not being employed.

**Summary**

Qualitative data suggested unique ethnic and linguistic qualities regarding depression manifestation in Latinos. Although some cultural undertones were present with English-speaking Latinos, their depression more closely represented that of non-Latinos. Because we split the groups by ethnicity and language, we were able to explore the depression experience of Latinos in a culturally and socially just manner.

Participants cited the importance of clinical relationships when seeking help for depression, the value of the handoff experience during a medical visit, the significance of family support with their depression, and activities that motivate patient to alleviate depression symptoms. Participants shared common barriers impacting depression and stigma about the diagnosis. Providers were able to confirm signs they look for when screening patients for depression and preconceived notions about how to initiate a dialogue about depression with Latino patients. Lastly, mental health narrative results indicated that depression symptomatology was conceptualized differently in Spanish-speaking Latinos when looking at the PHQ-9 questionnaire. Findings suggest that standardized questionnaires, especially the PHQ-2 (short form) may not be capturing the depression experience of culturally and linguistically unique patients. Although the PHQ-9 seems to be appropriate for some patients, there is definite need to explore its use with Spanish-speakers.
CHAPTER SEVEN
DISCUSSION/CONCLUSION

The purpose of this study was to examine provider and patient beliefs about depression among Latinos seeking care at an FQHC from an ethnic and linguistic perspective. We collected data from patients based on ethnic-linguistic characteristics to examine variation in depression assessment, treatment, and manifestation between these groups using Critical Race Methodology through a LatCRT lens. Additionally, provider data was analyzed to add their voice to the story instead of merely presenting quantitative results about their depression screening and treatment recommendation rates. The results provide insights into the relationship between ethnicity and language on perception of depression treatment recommendations, receipt of depression treatment recommendations, barriers impacting treatment recommendations, strength of clinical relationships, handoff experience, barriers impacting depression, stigma, patient motivation, social supports, and mental health narrative, among Latinos.

A conceptual model informed by Critical Race Methodology and, more specifically, LatCRT Theory guided the selection of ethnicity and language as variables to be examined in this study. Anti-essentialism guided the decision to separate Latinos by language preference before exploring differences as compared to non-Latinos. The inclusion of intersectionality variables confirmed that ethnicity and race were significant identity subordinating variables when analyzing depression in Latinos in addition to age, gender and race. Storytelling was employed both in the mixed methods design in addition to giving voice to participants via participation in member-checking validation focus groups, partnering with the participants as researchers in the development of experiential
knowledge. Transdisciplinary perspective was provided through recruitment of both patient and provider participants at an integrated FQHC during a medical setting. Overall, this dissertation, in its methodology, made an active commitment to socially just research processes for Latinos, non-Latinos, and providers, actively working together to gain insight into depression screening processes.

**Research Aims**

**Quantitative Aim**

Retrospectively investigate depression screening rates and differences in depression screening outcomes between ethnic-linguistic groups of patients seen for a medical visit from 2014-2015. The hypotheses tested are:

H1: Latinos will be screened more often with the PHQ-2 during a medical visit than non-Latinos (Hamn et al., 2015)

H2: Spanish-speakers will score positive on the PHQ-2 less often than English-speakers (Kalibatseva & Leong, 2014)

Two hypotheses were tested for the preliminary research aim. In particular, the preliminary study attempted to improve our understanding of depression screening processes to inform the methods of the overall study.

The study reveals that Latinos were statistically significantly screened more often than non-Latinos for the first hypothesis. This was not surprising since higher screening rates have been seen before in the literature (Hamn et al., 2015), which was used to form the hypothesis. Additionally, Spanish-speaking Latinos screened positive for depression
on the PHQ-2 less often than English-speakers, once again confirming what is known in the literature (Kalibatseva & Leong, 2014).

Mixed Methods Aims

Investigate rates of standard of care depression treatment recommendation between ethnic-linguistic groups of patients who screened positive for depression from 2014-2015 and assess provider and patient perceptions about standard of care depression treatment recommendations and uptake. Favorable findings noted above allowed for testing of our second aim hypotheses:

H1: Providers will recommend pharmacotherapy as their default treatment recommendation for depression, regardless of ethnic-linguistic group (Ishikawa et al., 2014)

H2: There will be different beliefs about standard of care depression treatment recommendations and uptake amongst provider and ethnic-linguistic groups (Horevitz et al., 2015)

H3: Spanish-speakers will be less likely to follow through with depression treatment recommendations than English-speakers (Ishikawa et al., 2014)

Several hypotheses were tested in this research aim. Results from a logistic regression showed that Spanish-speaking Latinos were 72% less likely to receive standard of care depression treatment recommendations during a medical visit than English-speakers, regardless of ethnicity. Interviews confirmed that negative perceptions about medications, patient non-compliance, and a shortage of bilingual behavioral health specialists within the clinic impacted standard of care treatment recommendations and
uptake for the Spanish-speaking group. These findings supported our second research aim asserting significant differences in standard of care depression treatment recommendations between ethnic-linguistic groups.

**Qualitative Aims**

Assess provider and patient perceptions about factors influencing manifestation of depression symptoms between ethnic-linguistic groups and classify answers to questions about depression in a socially just manner by including participants in member-checking focus groups with providers and patients, based on the patient’s preferred language. The two hypotheses for the qualitative aims are:

**H4:** There will be different beliefs about the manifestation of depression symptoms amongst providers and Spanish-speaking Latinos when compared to English-speakers, regardless of ethnicity (pilot study)

**H5:** Groups will validate emerging themes showing different beliefs about the manifestation of depression symptoms amongst provider and ethnic-linguistic groups (pilot study)

Qualitative data validated unique ethnic and linguistic qualities regarding depression manifestation in Latinos. Despite cultural undertones with English-speaking Latinos, their depression manifested more closely to the experience of non-Latinos.

Participants of the member checking focus groups were paramount in classifying interviewee answers to themes. Participants confirmed the importance of relationships when dealing with depression, such as the need for rapport with their doctor, the value of a warm handoff to an IBHS, the influence of family support on their depression, and
motivating factors to minimize depression symptoms. Barriers and stigma are always common themes that emerge when speaking about depression, but participants shared how even using the word depression in a dialogue with providers, family, and friends was difficult. Providers were able to confirm common symptoms they search for when screening patients for depression while sharing how they initiate a dialogue about depression with Latino patients based on preconceived beliefs or experiences. Lastly, mental health narrative results demonstrate that depression symptomatology manifested differently in Spanish-speaking Latinos when analyzed with the PHQ-9 questionnaire.

**Practice Implications**

*Improving Depression Screening Rates and Treatment Uptake*

Healthcare professionals screening patients for depression should recognize the importance of understanding how cultural and linguistic characteristics may impact manifestation of depression in minority populations. Here we examined beliefs about depression in a predominantly Latino serving clinic with low socioeconomic status. While our data shows patient preference for psychotherapy, it is uncertain whether Latinos would follow through with treatment recommendations if bilingual and bicultural behavioral health specialists become available (Ishikawa et al., 2014). For Spanish-speaking Latinos, standard of care depression treatment recommendations were viewed as culturally incongruent due to negative perception regarding pharmacotherapy, despite help-seeking behaviors, although no recommendations were provided for an alternative treatment preference.
Nonetheless, treatment recommendations need to be tailored to patient preference to ensure successful treatment and management of depression symptoms. The belief system documented in this study is not suggestive of an approach that challenges standardized instruments and treatment recommendations. Essentially, we are suggesting that, similar to findings indicating that the PHQ-2 may not be culturally and linguistically appropriate for Spanish-speaking Latinos, standard of care depression treatment recommendations may indeed not be standard for culturally and linguistically unique patients. Adjusting screening and treatment techniques in a culturally and linguistically conscious manner may improve treatment compliance in these unique populations.

Provider recommendations point toward the need to improve screening rates through utilization of clinical support staff. While the screening instrument itself should not be standardized to all patients in an essentialist fashion, there is a need to strategically screen patients for depression while also considering unique characteristics such as ethnicity, race, language, gender, and socioeconomic status. Clinics should implement systems to ensure that all staff routinely screen patients for depression as standard health maintenance, just like a flu shot, pap smear, or mammogram. As suggested by a Latina patient, dialogue regarding depression should be discussed just like a cough or cold to normalize the discussion and diagnosis.

Recruiting efforts for bilingual and bicultural mental health professionals should be a priority for integrated organizations. Social work programs often offer stipend opportunities for students who commit to work at a child welfare agency or child protective services after graduation. Similar programs should be created to increase the mental health workforce in underserved medical settings.
Limitations

There are several limitations to this study, suggesting potential research opportunities in the future. First, the use of purposive sampling of patients may have introduced selection bias. However, a random sample was not feasible given the intentional design of the research aims. The findings from this study may not be generalizable beyond the geographical location in which it was conducted.

The study was designed to recruit patients as they screened positive for depression during their medical visit. Consequently, the study’s design could have recruited patients who were being told they were depressed for the first time in their life. Although the study was founded on the reality that Latinos have historically been excluded from research, recruiting challenges were underestimated. For example, it took 6 months after IRB approval to conduct all patient interviews and the majority of consented participants were lost to follow-up. Ironically the Spanish-speaking Latino group was the first set of interviews completed in the study.

Patients completing interviews before or after a medical appointment may have felt rushed to complete the interview, potentially impacting responses to the interview questions; similar findings occurred with providers who chose to complete their interview before or after their clinic.

Cultural sensitivity issues presented unique challenges. The researchers were only successful with recruiting one Spanish-speaking Latino man. To mitigate the potential challenge of attrition, we offered the option of conducting interviews over the telephone. Despite an interest in participating in the focus group, this participant was not able to get a ride to the clinic. Additionally, familism was a key factor during recruitment.
Oftentimes family, who influenced participation, or declination of participation, in the study, accompanied Latino patients to their medical appointments and oftentimes spoke on behalf of the patient, especially an accompanying husband or parent (Ayon & Aisenberg, 2010).

Depression prevalence in the clinic was measured with a two-item brief standardized depression-screening instrument, which has shown to be problematic in proper identification of depression symptoms for minority populations. Additionally, measurement issues should be noted since administration occurred in a medical setting with nursing staff who were not trained on behavioral health diagnoses. Furthermore, clinical staff were asked to recruit patients while also completing their normal activities of a medical visit. It was reported that staff oftentimes forgot or were too busy to ask a patient if they were interested in participating in the study. When a patient was identified as eligible for the study, the methodology did not ask patients who were not interested in the study to provide reasons for declining to participate. This information could inform future research efforts by analyzing whether similar demographic characteristics are more likely to decline participation in mental health research.

Our study raises questions for future research. Differences in manifestation of depression should be examined quantitatively with a larger sample. Additionally, it is necessary to compare treatment uptake with a larger subset of patients. This could lead to improvements in culturally and linguistically catered depression treatment screening, recommendations, resulting in greater uptake in Latino populations.

While this study focused on patients with major depression, it was previously noted that over half of the patients who screened positive on the PHQ-2 were one point
away from being classified with major depression. ISCI recommendation for patients with a score less than 10 suggests behavioral activation. Additionally, it is implied that a follow-up PHQ-9 is conducted in future visits given the recommendation to consider referral to behavioral health for evaluation if there is no improvement after one or more months. Therefore, it is necessary to conduct a longitudinal review of patients with PHQ-9 scores between 5-9 to ensure that patients on the cusp of depression are not left untreated.

This study is among one of the first to analyze depression in underserved medical settings through an ethnic-linguistic perspective. The study also included a provider’s perspective in the depression screening and treatment process for their clinic. Although this study included a variety of subgroups, future studies should seek to increase sample size to confirm the findings. The study is also strengthened by the mixed methods design, exploring patients’ and providers’ perceptions from screening to treatment uptake to actual manifestation of depression symptoms. The results of this study have significant implications for clinical practices and policymakers to broaden their approaches to improve screening accuracy and uptake of treatment recommendations among Latinos through culturally and linguistically appropriate screening methods.

**Conclusion**

Depression is a common problem among Latinos but culturally and linguistically appropriate screening instruments are yet to be developed. Specifically, mental health related studies conducted with Latinos indicate a number of cultural factors impacting depression symptoms. As discussed in Chapter One, prevalence of depression in Latinos
is lower than whites across the United States. Literature suggests that depression is often undiagnosed in medical settings due to somatization of symptoms and lack of provider training in proper identification of symptoms. Specific barriers faced by Spanish-speaking Latinos was confirmed by this study include transportation issues, language barriers, acculturation issues, and difficulty accessing mental health services (Aponte-Rivera, 2013; Ishikawa et al, 2014; Kalibatseva & Leong, 2014). Research with Latinos indicates that depression often stems from familial conflict. This study supports these findings and takes it one step further by confirming that depression manifestation in Spanish-speaking Latinos is associated with a concern of disappointing their family.

Differences in depression manifestation in Spanish-speaking Latinos, negative perception of pharmacotherapy, and a shortage of bicultural and bilingual mental health professionals are key factors that highlight the need for further research that incorporates both ethnicity and language in studies with Latinos. Other than reported intent to follow through with psychotherapy recommendations (Ishikawa et al., 2014), little is known about actual referral uptake among Spanish-speaking Latinos. Understanding perceptions about standard of care depression treatment recommendations and manifestation of depression symptoms in Latinos may provide new insight to creating culturally and linguistically appropriate screening instruments and treatment modalities. Furthermore, trainings catered to medical providers and clinical staff could inform staff on the importance of building relationships when screening and treating depressed Latinos.

This study has uncovered an innovative way to understand beliefs about depression screening, treatment, and manifestation of symptoms among Latinos seeking care in medical settings. Although several studies have examined the association between
race or ethnicity and depression among Latinos, this is the first study, to our knowledge, that also included language, a control group, and providers to the design. The use of Critical Race Methodology provided a foundation of systematically analyzing results in a socially just manner for Latinos and providers. We discovered unique perceptions about depression in male participants. Despite having a chronic medical disability, unemployed men still felt strongly that they were letting their families down in some manner, which was a key factor in the manifestation of their depression symptoms. As indicated in the literature, we affirmed that despite receipt of standard of care depression treatment recommendations, non-Latinos were more critical of handoff experiences to, and receipt of, behavioral health services. Most importantly, we discovered that feeling like one is letting their family down influenced the depression experience of Spanish-speaking Latinos more so than feeling down, depressed, or hopeless.
REFERENCES


You are invited to participate in a research study about depression

• We want to know what you think about depression and our depression screening process here at SACHS

• The interview will take 1-1 ½ hours and can be done in person or over the phone

• The interview can be done in English or Spanish

• You must be at least 18 years of age

• You will receive a small GIFT for your time

Are you interested in learning more about this study?

___ Yes ___ No

If so, please fill out the information below:

Name: ____________________________
Address: __________________________
Phone Number: _____________________

Preferred Language:
___ English ___ Spanish

Preferred Contact Method:
___ Letter ___ Phone
Tu estas invitada a participar en una encuesta sobre la depresión

- Queremos saber que piensas sobre la depresión y nuestro proceso de evaluación de depresión aquí en SACHS
- La entrevista tomará 1-1 ½ hora y puede ser en persona o por teléfono
- La entrevista puede hacerse en Inglés o Español
- Tienes que tener por lo menos 18 años de edad
- Usted recibirá un pequeño REGALO por su tiempo

Participar es VOLUNTARIO

Te interesa aprender más sobre esta entrevista?

___ Si   ___ No

Si es sí, favor de llenar la información abajo:

Nombre: ________________________________
Dirección: ________________________________
______________________________
Numero de Tel: ________________________________

Lenguaje Preferido:
___ Inglés ___ Español

Método de Contacto Preferido:
___ Carta ___ Teléfono
APPENDIX C

INTERVIEW GUIDE- ENGLISH-SPEAKING PATIENTS

Interview Schedule
Adapted from Horevitz et al. (2015) and Marin & Gamboa (1996)

INTRODUCTION

Thank you for agreeing to take part in this interview for my student research study. We are looking for input on how to improve care for patients with depression at SACHS. Your input will help us improve our care. The interview should last between 60-90 minutes. As a reminder, you signed a consent form during your medical visit stating that you were interested in being a part of this study. Would you like me to review the consent again before we proceed?

[If patient answers yes, READ INFORMED CONSENT. Pause for questions. Remind patient that they received a copy to take home with them and offer another copy, if desired]

If it is alright with you, I'm going to start recording now so I can go over our conversation later, and I will double check that the recording device is working. [Test].

LANGUAGE USE

So, I want to start off by asking you some questions about language.

Please answer the questions with the following options;
(4) almost always; (3) often; (2) sometimes; or (1) almost never.

1. How often do you speak English?
2. How often do you speak in English with your friends?
3. How often do you think in English?
4. How often do you speak Spanish?
5. How often do you speak in Spanish with your friends?
6. How often do you think in Spanish?

BIOGRAPHY

TRANSITION: "Now I'd like to ask some questions to get to know you better"

7. How long have you lived in the area?
8. Where were you born?
9. Tell me about your current employment?
   a. Prompt: Are you currently working? If so, full time or part time?
10. Do you have any children? (if yes, how many?)
11. Are you married? (if yes, how long?)
Interview Schedule
Adapted from Horevitz et al. (2015) and Marin & Gamboa (1996)

CLINIC HISTORY

12. How long have you been a patient at SACHS??
   a. *Prompt:* How did you decide to get medical care here?
13. How do you feel about the health care you receive at this clinic??
   a. *Probe:* Tell me more……………Why? What makes you feel this way?
14. Do you have a regular provider that you usually see at the clinic?? If yes,
   a. *Prompt:* How would you describe your relationship with your health care
      provider?
15. Do other members of your immediate family receive care at the clinic??
   a. *Prompt:* Why or why not?
16. Do you feel that you have been able to get the care you need at this clinic??
   a. *Prompt:* Does anything ever get in the way of getting the medical care that you
      need? (e.g., transportation, child care, work hours, finances).

DEPRESSION NARRATIVE

TRANSITION: (“I’d like to talk with you a little bit more specifically about your experience
with depression…”)

At your last medical appointment you answered questions on a screening form that indicated
that you have been experiencing symptoms of depression.

17. Do you remember this? [The questions asked about feeling sad, changes in your sleep,
   eating, activity, etc.]
18. Can you describe what depression feels like to you? Or do you have other names for
   these feelings?
   a. *Probes:* always feeling sad, headaches, stomach aches, being seen as difficult
19. Do you do anything to take care of your depression?
   a. *Prompt:* What makes you feel better? What makes you feel worse? (Tell me
      more about that)
20. Does your family know you are feeling depressed?
   a. *Prompt:* Can you describe how they have reacted to your symptoms?
21. Do you ever feel concerned about what others might think about your depression?
   a. *Prompt:* Why or why not?
22. Have you used medications or counseling for your depression? Has it helped?
23. What are your feelings about medication vs. counseling for treating depression?
24. Do you use any other treatments for your depression?
   a. *Probe:* Does this work for you? Why or why not?
DEPRESSION TREATMENT

25. On the day your doctor became concerned about your depression symptoms, why had you gone to the clinic?
   a. Probe: family, symptoms, functioning, and expectations of the visit?
26. Prior to coming into the clinic, how had you been feeling?
   a. Probe: Why now? Sought treatment elsewhere? Tried other remedies/sources of support (e.g., church, friend, family)?
27. How would you describe the quality of your relationship with your doctor…? How would you describe your interaction with your doctor that day?
   a. Prompt: Was it your usual care provider? How would you describe your comfort level with that provider?
28. Did your doctor talk with you about depression at that visit?
   a. Prompt: Do you recall him/her saying anything about depression?

REFERRAL

Transition: At SACHS, there is a team of specialists or counselors that help treat depression. Many times patients are referred to a counselor for depression treatment.

29. Tell me about that visit day – did your doctor refer you to a counselor? If yes, Tell me about that day when your doctor referred you for a counseling appointment for depression.
   a. Prompt: What was your experience like?
   b. What did your doctor tell you about the counseling program and what to expect?
30. What was your understanding of why you were being referred?

INTEGRATED BEHAVIORAL HEALTH

Sometimes your doctor brings in a specialist or counselor to talk with patients about depression symptoms during their medical visit.

31. Did your provider connect you with a counselor the same day as your medical visit? (If no, skip to 34)
32. Did he/she send somebody into your exam room to speak with you?
   a. Prompt: How was that person introduced to you?
   b. What did that person speak with you about?
33. What was it like meeting with the counselor?
   a. Prompt: Did you understand why you were meeting with them?
Interview Schedule
Adapted from Horevitz et al. (2015) and Marin & Gamboa (1996)

b. Did it make sense to you?

34. How did you feel about seeing the counselor for your depression?
   a. Probes: Are you hopeful about your treatment with your counselor?

35. Were you walked over to the Community Resource Center to make an appointment?

PATHWAYS/DECISION TO FOLLOW-UP

TRANSITION: I’d like to ask you specifically about your decision to see the counselor or not after your doctor referred you.

36. Did you visit/not visit the counselor? Why/why not?

37. Did you have any expectations about the appointment with the counselor?
   a. Prompt: What did you think would happen at the visit?
   b. Any concerns or worries about seeing the counselor?
   c. Any hopes about seeing the counselor?

38. Did you talk with your family about being referred to the counselor? Why/why not?
   a. (If yes) how did your family react to the idea of you talking with a counselor about depression?
   b. (If no) how do you think they would react?

39. Did you talk with your friends about being referred to the counselor? Why or why not?
   a. (If yes) how did your friends react to the idea of you talking with a counselor about depression?
   b. (If no) how do you think they would react?

COOL DOWN

TRANSITION: Thank you for talking with me.

40. Is there anything else you think I should know about your experience with depression or depression care?

41. In thinking about your clinic, how might services be improved for people experiencing depression?

After all of our interviews are completed, we would like to get a group of patients together to help us look at common topics to make certain we understand what are patients are telling us. Would you be interested in attending? □ Yes □ No
[If yes, “great, I will put that down so we can contact you later”. If no, “ok, thank you”.

This concludes our interview. Thank you so much for your time.
APPENDIX D

INTERVIEW GUIDE - SPANISH-SPEAKING PATIENTS

Entrevista Programada
Adaptada por Horrevitz et al. (2015) y Marin & Gamboa (1996)

INTRODUCCION

Gracias por aceptar participar en esta entrevista para mi estudio de investigación de estudiante. Estamos buscando información sobre cómo mejorar el cuidado a los pacientes con depresión en SACHS. Su aportación ayudará a mejorar nuestros programas en esta clínica. La entrevista debe durar entre 60-90 minutos. Como recordatorio, firmaron un consentimiento durante su visita médica indicando que estaban interesados en formar parte de este estudio. Le gustaría que yo revise el consentimiento de nuevo antes de continuar?

[If patient answers yes, READ INFORMED CONSENT. Pause for questions. Remind patient that they received a copy to take home with them and offer another copy, if desired].

Si usted está de acuerdo, Voy a empezar a grabar para que yo pueda revisar nuestra conversación después, y comprobar que el dispositivo de grabación está trabajando. (Prueba)

USO DE LENGUAJE

Por lo tanto, quiero empezar haciéndole algunas preguntas acerca del lenguaje.

Favor de contestar las preguntas con las siguientes opciones:
(4) casi siempre; (3) a menudo; (2) a veces; o (1) casi nunca.

1. ¿Con qué frecuencia hablan inglés?
2. ¿Con qué frecuencia usted hablar en inglés con sus amigos?
3. ¿Con qué frecuencia usted piensa en inglés?
4. ¿Con qué frecuencia habla español?
5. ¿Con qué frecuencia usted hablar en español con sus amigos?
6. ¿Con qué frecuencia usted piensa en español?

BIOGRAFÍA

TRANSICIÓN: “Ahora me gustaría hacer algunas preguntas para poder conocerla mejor”

7. ¿Cuánto tiempo ha vivido en el área?
8. ¿Dónde nació usted?
9. Hábleme de su empleo actual?
   a. Preguntar: ¿está actualmente trabajando? Si es así, tiempo completo o tiempo parcial?
10. ¿Tiene hijos? (Si la respuesta es sí, ¿cuántos?)
11. ¿Está casado? (Si la respuesta es sí, ¿por cuánto tiempo?)
Entrevista Programada
Adaptada por Horevitz et al. (2015) y Marin & Gamboa (1996)

HISTORIA CLINICA

12. ¿Durante cuánto tiempo ha sido paciente en SACHS?
   a. Pro siga: ¿Cómo llegó a recibir atención médica en esta clínica?
13. ¿Cómo se siente acerca de la atención médica que usted recibe en la clínica?
   a. Investigue: DIGAME MAS..............Por qué? ¿Qué le hace sentir de esta manera?
14. ¿Tiene usted un proveedor habitual que suele ver en la clínica? Si es si,
   a. Pro siga: ¿Cómo describiría su relación con su proveedor de atención de la salud?
15. ¿Otros miembros de su familia inmediata reciben atención en la clínica?
   a. Pro siga: ¿Por qué o por qué no?
16. ¿Siente que ha podido acceder a la atención que usted necesita en esta clínica?
   a. Pro siga: ¿Hay algo que impida obtener la atención médica que usted necesita?
   (por ejemplo, transporte, cuidado infantil, horarios de trabajo, finanzas).

DEPRESION NARRATIVA

Transición ("Me gustaría hablar con usted un poco más específicamente sobre su experiencia con la depresión o la tristeza...")

En su última cita médica usted contesto las preguntas de un formulario de evaluación que indica que ha venido experimentando síntomas de depresión.

17. ¿Te acuerdas de esto? [Las preguntas hechas sobre sentirse triste, cambios en dormir, comer, actividad, etc.]
18. Puede describir cómo se siente la depresión para usted? ¿O tienes otros nombres para estos sentimientos?
   a. Investigar: siempre se siente triste, dolores de cabeza, dolores de estómago, que se consideran difíciles
19. Hacen algo para cuidar de su depresión?
   a. Pro seguir: ¿Qué la hace sentir mejor? ¿Qué la hace sentir peor? (Digame mas)
20. ¿Su familia sabe que está depresivo?
   a. Pro seguir: ¿Puede describir cómo han reaccionado a sus síntomas?
21. ¿Alguna vez se ha sentido preocupado por lo que otros puedan pensar acerca de su depresión?
   a. Pro seguir: ¿Por qué o por qué no?
22. ¿Ha utilizado medicamentos o asesoramiento para tu depresión? ¿Ha ayudado?
23. ¿Cuáles son sus sentimientos acerca el medicamento vs. Consejería para tratar la
Entrevista Programada
Adaptada por Horovitz et al. (2015) y Marin & Gamboa (1996)

depresión?
24. ¿Utiliza otros tratamiento para la depresión?
a. Investiga: ¿Funciona para usted? ¿Por qué o por qué no?

TRATAMIENTO DE LA DEPRESION

25. El día que su médico se preocupó por sus síntomas de depresión, ¿por qué había ido a la clínica?
a. Investigué: la familia, los síntomas, problemas médicos, las expectativas de la visita?
26. Antes de venir a la clínica, cómo se había estado sintiendo?
a. Investigué: ¿Por qué ahora? Buscó tratamiento en otro lugar? Probo otros remedios/fuentes de apoyo (por ejemplo, amigos, familia, iglesia)?
27. ¿Cómo describiría usted la calidad de su relación con su médico? ¿Cómo descritaría su interacción con su médico ese día?
a. Pro siga: Fue su proveedor de atención de la habitual? ¿Cómo describiría su nivel de comodidad con esa médico?
28. ¿Su médico habló con usted acerca de la depresión en esa visita?
a. Pro siga: ¿Recuerda a él/ella diciendo algo acerca del tratamiento de la depresión?

REFERENCIA

Transición: en su clínica SACHS, hay un equipo de especialistas o asesores que ayudan en el tratamiento de la depresión. Muchas veces los pacientes son remitidos a un consejero para el tratamiento de la depresión.

29. Dígame sobre ese día de visita- ¿su médico le remitió para una sesión de consejería para la depresión? Si es sí,
a. Pro siga: ¿Cómo fue su experiencia?
b. ¿Qué le dijo su médico acerca del programa de consejería y qué esperar?
30. ¿Cuál fue su entendimiento de por qué estaba siendo referida?

SALUD DE CONDUCTA INTEGRADA

A veces el médico trae a un especialista o consejero para hablar con los pacientes sobre los síntomas de depresión durante su visita médica.

31. ¿Su proveedor le conectó con un consejero el mismo día de la visita médica? (Si no, vaya a 34)
32. ¿Él/ella enviaron a alguien en la sala de exámenes para hablar con usted?
a. Pro siga: ¿Cómo fue que la persona presentada a usted?
Entrevista Programada
Adaptada por Horevitz et al. (2015) y Marin & Gamboa (1996)

b. ¿Acerca de qué hablo esa persona con usted?
33. ¿Cómo fue hablar con el consejero?
   a. Pro siga: ¿usted entendió por qué estas reunándose con ellos?
   b. Hizo sentido para usted?
34. ¿Cómo se sintió ver el consejero para su depresión?
   a. Investigué: ¿tiene esperanzas en el tratamiento con su consejero?
35. La llevaron al Centro de recursos de la comunidad para hacer una cita?

MANERAS/DECISIÓN DE SEGUIMIENTO

TRANSICIÓN: Me gustaría preguntarle concretamente acerca de su decisión para ver
el consejero después de su médico lo refirió.

36. Has visitado/O no al consejero? ¿Por qué o por qué no?
37. ¿Tienes alguna expectativa sobre la cita con el consejero?
   a. Pro siga: ¿qué piensas sucedería en la visita?
   b. Cualquier duda o inquietud acerca de ver al consejero?
   c. Alguna esperanza de ver el consejero?
38. ¿Hablo usted con su familia sobre estar siendo referido al consejero? ¿Por qué o por
   qué no?
   a. (Si la respuesta es sí) ¿Cómo su familia reacciona a la idea de hablar con un consejero
   psicológico acerca de la depresión?
   b. (Si no) ¿Cómo cree que reaccionarían?
39. ¿Hablo con sus amigos sobre estar siendo referido al consejero? ¿Por qué o por qué
   no?
   a. (Si la respuesta es sí) ¿Cómo reaccionaron sus amigos a la idea de que hablar con un
   consejero psicológico acerca de la depresión?
   b. (Si no) ¿Cómo cree que reaccionarían?

TRANQUILIZARSE

TRANSICION: Gracias por hablar conmigo.

40. ¿Existe algo que creo que debería saber acerca de su experiencia con la depresión o
    la depresión cuidado?
41. Al pensar en su clínica, cómo pueden mejorarse los servicios para las personas que
    sufren depresión?
Entrevista Programada
Adaptada por Herevitz et al. (2015) y Marin & Gamboa (1996)

Después que todas nuestras entrevistas son completadas, nos gustaría tener un grupo de pacientes para ayudarnos a mirar juntos en temas comunes para asegurarnos que entendemos lo que los pacientes nos están diciendo. ¿Estaría interesado en asistir? □ Sí □ No

[Si es sí, "grandioso, voy a tomar nota de modo que podamos ponernos en contacto con usted más adelante". Si no, "está bien, gracias".]

Esto concluye nuestra entrevista. Muchas gracias por su tiempo.
APPENDIX E

INFORMED CONSENT - ENGLISH PATIENTS

LOMA LINDA UNIVERSITY
School of Social Work and Social Ecology

Research Consent Form
SACHS Patient

You are invited to take part in a research survey on depression screening during a medical visit. This project will help us know if we are explaining what you need to do to care for your depression in a way that helps you. My name is Jacquelyn Stephenson. I am an employee at SAC Health System and a doctoral student at Loma Linda University in the Social Policy and Social Research program working under the supervision of Dr. Susanne Montgomery. This project is required for my doctoral degree.

What the study is about: The purpose of the study is to learn about your beliefs about depression and your own experiences with mental health services you may have received or have been referred to receive recently in this clinic. You are invited to volunteer for this research study because as a patient you indicated you may be depressed during one of your medical visits.

What you will be asked to do: If you agree to be in this study, you will be asked to take part in one interview that will last about an hour to an hour and a half and will be scheduled about two months after you sign up for the study. The interview will take place at SAC Health System or at a time and place of your choice or by telephone. I will be recording the interview to make sure that I do not miss anything you say. This interview will include questions about you and your beliefs on the causes, symptoms, and treatments for depression. At the end of the interview, you will be asked if you are interested in participating in a group activity once all interviews are completed. This group activity will take place at SAC Health System approximately six months after you sign up for the study. The group activity will also last about an hour to an hour and a half. The group will review the summary of everyone’s answers to have participants come up with common themes about depression and make certain the researchers are interpreting the answers correctly. Your participation in the group activity is also voluntary.

Risks and benefits: There are minimal risks to you in taking part in this study. This study poses no greater risk to you than what you routinely encounter in day-to-day life, but may cause a little anxiety when talking about your personal health issues and your beliefs about depression. There is a small chance that your confidentiality could be breached. However, to protect your identity, the information you provide will be kept private; and, your name will not be on any information from this study. I will assign a unique code to your interview rather than using your name. The interviews will be stored in a locked cabinet in a locked room in the Department of Social Work and Social Ecology at Loma Linda University. Information from interviews will be entered into a computer data file, linked to the unique code assigned to you, and will be password protected. Information identifying you will only be available to the study personnel. Although you will not benefit personally, this study could benefit the community by helping health care workers better understand the barriers you face when accessing treatment for depression, which can lead to an improvement of health care services in our community.
Your answers will be confidential: Your name will not be connected with your answers so no one will know how you answer the questions.

Taking part is voluntary: Your participation in this study is voluntary. You may refuse to participate or withdraw once the study has started. You do not give up any legal rights by participating in this study. If you do not want to answer a certain question you may decline. Your decision whether or not to participate or terminate at any time will not affect your future medical care or standing with the researchers or any organization. Your medical care at SACHS will remain unchanged whether or not you are in this study and no matter what you say in the interview. Your doctors will not know what you say in the interview.

Cost: There is no cost to participate in this study though you may need to travel to SACHS for the interview. If you are seen as a patient at SACHS or for follow-up care at SACHS, you will be responsible for any co-payments and/or deductibles as required by your insurance.

Payment: You will receive a $5 gift card for completing the interview and an additional $5 to participate in the group activity.

If you have questions: Call Jacquelyn Stephenson during routine office hours at (909) 800-8306 or contact her by email at jstephenson@llu.edu with any additional questions or concerns. You may also contact her research advisor, Susanne B. Montgomery, PhD, MD, MPH at (909) 651- 5881 or by email at smontgomery@llu.edu. You may call someone unrelated to this project about questions or complaints: Maryellen Westerberg, SACHS Norton Clinic Research Director, at 909-382-7131 or MWesterb@llu.edu or Patient Relations at Loma Linda University at 909-558- 4647 or patientrelations@llu.edu.

Statement of Consent: I have read the contents of the consent form and have listened to the verbal explanation given by the investigator. My questions concerning this study have been answered to my satisfaction. Signing this consent document does not waive my rights nor does it release the investigators, institution or sponsors from their responsibilities. I hereby give voluntary consent to participate in this study. I will be given a copy of this consent form after signing it.

_______________________________    ________________________________
Signature of Subject                  Printed Name of Subject

Date

Investigator Statement: I have reviewed the contents of this consent form with the person signing above. I have explained potential risks and benefits of the study. A signed copy of the consent form will be provided to the participant, and I will also keep a copy for myself.

_______________________________    ________________________________
Signature of Investigator              Printed Name of Investigator

Date
APPENDIX F

INFORMED CONSENT- SPANISH PATIENTS

FORMA DE CONSENTIMIENTO PARA ENCUESTA
PACIENTE DE SACHS

Están invitados a participar en una encuesta de investigación sobre la detección de depresión durante una visita médica. Este proyecto nos ayudará a saber si estamos explicando lo que usted necesita hacer para cuidar de su depresión de una manera que le ayude. Mi nombre es Jacqueline Stephenson. Soy un empleado en el sistema de salud SAC y estudiante de doctorado en la Universidad de Loma Linda en el programa de investigación Social y Política Social de trabajo bajo la supervisión del Dr. Susanne Montgomery. Este proyecto es necesario para mi doctorado.

De qué trata el estudio: El propósito del estudio es aprender acerca de sus creencias sobre la depresión y sus propias experiencias con los servicios de salud mental que usted puede haber recibido o recibió recientemente en esta clínica. Te invitamos a ser voluntario de esta investigación ya que como paciente indica que puede estar deprimido durante una de sus visitas médicas.

Lo que se le pedirá que haga: Si está de acuerdo que en este estudio, se le pedirá participar en una entrevista que durará aproximadamente una hora a una hora y media y será programado unos dos meses después de firmar en el estudio. La entrevista se llevará a cabo en el sistema de salud de SAC o en la hora y lugar de su elección o por teléfono. Yo estaré grabando la entrevista para asegurarme de que no falle nada que decir. Esta entrevista incluye preguntas sobre usted y sus creencias sobre las causas, síntomas y tratamientos para la depresión. Al final de la entrevista, se le pedirá si usted está interesado en participar en una actividad de grupo una vez se completen todas las entrevistas. Esta actividad se llevará a cabo en el sistema de salud de SAC aproximadamente seis meses después de firmar en el estudio. La actividad también durará aproximadamente una hora a una hora y media. El grupo revisará el Resumen de las respuestas de todos para que los participantes hablen de temas comunes sobre la depresión y asegurarse de que los investigadores interpreten las respuestas correctamente. Su participación en la actividad del grupo también es voluntaria.

Riesgos y beneficios: Existen riesgos mínimos para usted al participar en este estudio. Este estudio no posee mayor riesgo para usted que lo habitualmente encontramos en la vida cotidiana, pero puede causar un poco ansiedad al hablar de sus problemas de salud personal y sus creencias sobre la depresión. Hay una pequeña posibilidad que podría su confidencialidad podría ser violada. Sin embargo, la información que usted proporcione será mantenida en privado. No se revelará su nombre en la información que sale de este estudio. Todos los registros que identifican serán confidenciales. También, para proteger su identidad, se asignó un código único a tu entrevista en lugar de utilizar su nombre. La entrevista se almacenará en un gabinete bajo llave en una habitación cerrada en el Departamento de trabajo Social y ecología Social en la Universidad de Loma Linda. Información de las entrevistas se incorporarán a un fichero de datos de computadora relacionados con el código único asignado a usted, y a ser protegido por contraseña. Información que le identifica sólo estará disponible para el estudio personal. Aunque usted no se beneficiará personalmente, este estudio podría ser de beneficio a la comunidad; ayudando a los trabajadores de salud a mejor entender las barreras que enfrentas al tener acceso a tratamiento para la depresión que
puede conducir a un mejor servicio de salud en nuestra comunidad.

**Sus respuestas serán confidenciales:** Su nombre no será conectado con sus respuestas por lo que nadie sabrá cómo respondió a las preguntas.

**Participar es voluntario:** Su participación en este estudio es voluntaria. Usted puede negarse a participar o retirarse en la primera ocasión que le haya sido presentado este estudio. Usted no renunciará a ningún derecho legal por participar en este estudio. Si no desea responder a cierta pregunta que puede disminuir su decisión si desea o no participar o terminar en cualquier momento, no afectará su futura atención médica o pie con los investigadores o cualquier organización. Su atención médica en SACHS no cambiará si desea o no participar en este estudio. Haremos lo que dice en la entrevista. Sus médicos no sabrá lo que dice en la entrevista.

**Costo:** No hay ningún costo para participar en este estudio, aunque puede que necesite viajar a SACHS para la entrevista. Si usted es un paciente de SACHS o se le da seguimiento en SACHS, usted será responsable de cualquier copago o deducibles según sea necesario por su seguro.

**Pago:** usted recibirá una tarjeta de regalo de $5 para completar la entrevista y $5 adicionales para participar en la actividad del grupo.

**Si tiene preguntas:** Llame a Jacquelyn Stephenson durante horas de oficina al (909) 800-8306 o o contáctela por correo electrónico al jstephenson@llu.edu con alguna pregunta adicional o dudas. También puede contactar a su consejera, Susanne B. Montgomery, PhD, MD, MPH al (909) 651-5881 o en línea a Smontgomery@llu.edu. Usted puede llamar a alguien no relacionado a este proyecto para preguntas o quejas: Maryellen Westerberg, SACHS Norton Directora Clínica de Estudios, al 909-382-7131 o MWesterb@llu.edu o Relaciones del Paciente en la Universidad de Loma Linda al 909-558-4647 o patientrelations@llu.edu.

**Declaración de consentimiento:** He leído el contenido de la forma de consentimiento y he escuchado la explicación verbal dada por el investigador. Mis preguntas acerca de este estudio han sido contestadas a mi satisfacción. Firmar este documento de consentimiento no renuncio a mis derechos ni se desprende de los investigadores instituciones o patrocinadores de su responsabilidad. Por la presente doy consentimiento voluntario para participar en este estudio. Dará una copia de este consentimiento después de firmarlo.

<table>
<thead>
<tr>
<th>Firma del Sujeto</th>
<th>Nombre letra de molde del Sujeto</th>
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<th>Fecha</th>
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**Declaración del Investigador:** He revisado el contenido de este formulario de consentimiento con la persona que firmó arriba del investigador. He explicado los riesgos y beneficios patenciales de estudio. El participante recibirá una copia firmada del formulario de consentimiento, y también mantendrá una copia para mí.

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<tr>
<th>Firma del Investigador</th>
<th>Nombre Letra de molde del Investigador</th>
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APPENDIX G

PROVIDER RECRUITMENT SIGN-UP SHEET

Provider Sign-Up Sheet

If you are interested in participating in the study: *Understanding patterns of screening for depression at a predominantly Latino-serving Federally Qualified Health Center in the Inland Empire*, please provide your contact information below along with potential dates and times to schedule an interview.

Please note that interviews must be conducted outside of working hours.

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
<th>Email Address</th>
<th>Potential Dates/Times for Interview</th>
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Loma Linda University
Adventist Health Science Center
Institutional Review Board
Approved #01/02/16

Chair
APPENDIX H

INTERVIEW GUIDE - PROVIDERS

Provider Interview Schedule
Adapted from Horevitz et al. (2015) and Marin & Gamboa (1996)

INTRODUCTION

Thank you for agreeing to take part in this interview for my dissertation to help us learn more about access to mental health care at SACHS. This interview should last between 45-60 minutes and the information may be used to enhance the behavioral health programs at SACHS. We will begin by reviewing a consent form that you will need to sign before we proceed. You will receive a copy to take home.

[Pause for questions]

If it is okay with you, I’m going to start recording now to make sure I capture everyone’s responses. I will double check that the recording device is working. [Test]

BIOGRAPHY

So, I want to start off by asking you some questions to get to know you better.

1. What is your gender?
2. What is your race?
3. What is your ethnicity?
4. What languages do you speak?

CLINIC HISTORY

1. How long have you worked at SACHS?
2. What department do you work for?
3. How do you feel about the health care you provide at the clinic?
   a. Probe: Tell me more...............Why? What makes you feel this way?

LANGUAGE USE

TRANSITION: “Now I’d like to ask some questions about language”

Please answer the questions with the following options:
(4) almost always; (3) often; (2) sometimes; or (1) almost never.

4. How often do you speak English?
5. How often do you speak in English with your friends?
6. How often do you think in English?
7. How often do you speak Spanish?
8. How often do you speak in Spanish with your friends?
9. How often do you think in Spanish?

DEPRESSION NARRATIVE

TRANSITION: (“I’d like to talk with you a little bit more specifically about your experience with screening your patients for depression during their medical visit...”)

10. How do you know that a patient needs to be screened for depression?
11. Can you describe what depression looks like to you?
   a. *Probe:* What signs do you look for that prompts you to screen for depression?
12. When do you use medication vs. counseling for treating depression?
13. Do you offer any alternate treatments for depression?
   a. *Probe:* Why or why not?

DEPRESSION TREATMENT

14. How do you let patients know that they screened positive for depression symptoms?
   a. Are you comfortable doing so? What makes you feel this way?
15. What treatment options do you recommend for your patients who exhibit depression?
16. How do you decide what treatment is best for the patient?
   a. What factors do you consider when deciding depression treatment?
   b. Do you consider patient’s language preference when deciding treatment?

INTEGRATED BEHAVIORAL HEALTH/REFERRAL

*At this clinic, there are social workers, psychologists, and psychology students to help patients with their behavioral health needs. There are also external IEHP and community referrals. Let’s talk about how you decide the best treatment options for patients who are depressed.*

17. How often do you connect your patients with a behavioral health specialist the same day as their medical visit?
18. Are there any barriers you face as a physician when handing off to a behavioral health specialist for additional screening?
19. How do you let the patient know that a behavioral health specialist will be entering the room?
20. Do you ever have your clinical staff walk your patient over to the Community Resource Center and Behavioral Health Services department to make an appointment?
PATHWAYS/DECISION TO FOLLOW-UP

TRANSITION: I’d like to ask you specifically about your patient following through with your treatment recommendation.

21. When do you ask the patient to return for a follow-up appointment after a positive depression screening?
22. How do you know if your patient followed through with your treatment recommendation?
23. How do you assess if the treatment you recommended is working for them?
24. Who follows up when a patient to make sure that they followed through with your recommendation?
25. How do you know if your patient is doing better with their depression?
26. How helpful are the notes from the Behavioral Health department or behavioral health specialist?
   a. Do they help you provide depression care for your patient?

COOL DOWN

TRANSITION: Thank you for talking with me.

27. How would you describe the quality of your relationship with your patients?
28. Is there anything else you think I should know about your experience with screening your patients for depression during their medical visits?
29. In thinking about your clinic, how might services be improved for people experiencing depression?

This concludes our interview. Thank you so much for your time.
APPENDIX I

INFORMED CONSENT - PROVIDER

Loma Linda University
School of Social Work and Social Ecology
Research Consent Form
SACHS Provider

You are invited to take part in a research survey on depression screening during a medical visit. This project will help us know if we are explaining depression and treating depression well at SACHS. My name is Jacquelyn Stephenson. I am an employee of SAC Health System and a doctoral student at Loma Linda University in the Social Policy and Social Research program working under the supervision of Dr. Susanne Montgomery. This project is required for my doctoral degree.

What the study is about: The purpose of the study is to learn about your beliefs about depression and to learn more about your own experiences treating depression in your clinic. You are invited to volunteer for this research study because you are a provider at SACHS that screens patients for depression in a medical setting.

What you will be asked to do: If you agree to be in this study, you will be asked to take part in one interview that will last about an hour to an hour and a half. The interview will take place at SAC Health System or at a time and place of your choice or by telephone. I will be recording the interview to make sure that I do not miss anything you say. This interview will include questions about you and your beliefs on the symptoms and treatments for depression. At the end of the interview, you will be asked if you are interested in participating in a group activity once all interviews are completed. This group activity will take place at SAC Health System approximately six months after you sign up for the study. The group activity will also last about an hour to an hour and a half. The group will review the summary of everyone’s answers to have participants come up with common themes about depression and make certain the researchers are interpreting the answers correctly. Your participation in the group activity is also voluntary.

Risks and benefits: There are minimal risks to you in taking part in this study. This study poses no greater risk to you than what you routinely encounter in day-to-day life, but may cause a little anxiety when talking about your patient care experiences. In order to protect your identity, the information you provide will be kept private. Your name/identity will not be revealed in any papers, presentations, and reports coming out of this study. All records that identify you will be held confidential. Also, to further protect your identity, I will assign a unique code to your particular interview. Data from this study will be stored in a locked cabinet in a locked room in the Department of Social Work and Social Ecology at Loma Linda University. Information from interviews will be entered into a computer data file, linked to the unique code assigned to you, and will be password protected. Information identifying you will only be available to the study personnel. Though all of these safeguards will be in place, there is still a small chance of breach of confidentiality. Although you will not benefit personally, this study could benefit the community by helping health care workers better understand the barriers you face when referring patients for depression treatment, which can lead to an improvement of health care services in our community.

A Seventh-day Adventist Institution

SOCIAL WORK AND SOCIAL ECOCY
1898 Business Center Dr., San Bernardino, CA 92408
(909) 379-7572 fax: (909) 379-7594
Your answers will be confidential: Your name will not be connected with your answers so no one will know how you answer the questions. No other physicians or administrators at SACHS will know how you personally answer the questions though the findings of the study overall will be shared with SACHS and in other professional settings.

Taking part is voluntary: Your participation in this study is voluntary. You may refuse to participate or withdraw once the study has started. You do not give up any legal rights by participating in this study. If you do not want to answer certain questions you may decline. Your decision whether or not to participate or terminate at any time will not affect your employment or standing with the researchers or any organization.

Cost: There is no cost to participate in this study though you may need to travel to SACHS for the interview.

Payment: You will receive a $5 gift card for completing the interview and an additional $5 to participate in the group activity.

If you have questions: Call Jacquelyn Stephenson during routine office hours at (909) 800-8306 or contact her by email at jstephenson@llu.edu with any additional questions or concerns. You may also contact her research advisor, Susanne B. Montgomery, PhD, MD, MPH at (909) 651-5881 or by email at smontgomery@llu.edu. You may call someone unrelated to this project about questions or complaints: Maryellen Westerberg, SACHS Norton Clinic Research Director, at 909-382-7131 orMWesterb@llu.edu or Patient Relations at Loma Linda University at 909- 558-4647 or patientrelations@llu.edu.

Statement of Consent: I have read the contents of the consent form and have listened to the verbal explanation given by the investigator. My questions concerning this study have been answered to my satisfaction. Signing this consent document does not waive my rights nor does it release the investigators, institution or sponsors from their responsibilities. I hereby give voluntary consent to participate in this study. I will be given a copy of this consent form after signing it.

_________________________________________  _______________________________________
Signature of Subject                         Printed Name of Subject

_________________________________________
Date

INVESTIGATOR’S STATEMENT: I have reviewed the contents of this consent form with the person signing above. I have explained potential risks and benefits of the study. A signed copy of the consent form will be provided to the participant, and I will also keep a copy for myself.

_________________________________________
Signature of Investigator

_________________________________________
Date

Loma Linda University
Adventist Health Science Center
Institutional Review Board
Approved 9/23/16  Void after 9/14/17
Chair

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APPENDIX J

FOCUS GROUP GUIDE- ENGLISH

Focus Group Schedule
Adapted from Learnhigher (2005)

Note to facilitators: Instructions to you are in standard print. Questions for you to read out are in bold.

Running the Focus Group Sessions

The purpose of the focus group is to validate experiences shared about the depression screening process at SACHS. It is important to remember that you are seeking to reach a group viewpoint as far as possible. You should try to get everyone involved in the discussion. This does not mean that everyone must have the same view, but the discussion should lead to some conclusions. You need to record both majority and minority views.

Before the group assembles, test the recording equipment to make sure it is working and that the sound is recording at an acceptable level.

Once people are settled, check with the group whether they all know each other. If not start by going round the group and getting everyone to introduce themselves. You may not be able to do this if the group all know one another beforehand, but you can develop it as the session proceeds. For your own convenience it helps to draw a 'map' of where everyone is sitting. Assign everyone a number once they are seated and link the participant code with their name in the password protected Excel file. This will help when transcribing the focus group.

Make sure that everyone is comfortable before you start and that everyone can see each other.

Read out the statement on confidentiality:

Opinions expressed will be treated in confidence among project staff for the purpose of validating everyone's experiences with the depression screening process at SACHS. All responses will remain anonymous. This session will be recorded like your interview to make sure that I do not miss anything.

Check that there are no objections to the use of the audio recorder; then switch it on.

You need to start off by reiterating the purpose of the meeting.

I'm very grateful to you all for sparing time to help me validate themes about depression screening this [morning/afternoon/evening]. Today I want to concentrate on discussing the depression screening process at your clinic and I'd particularly like you to help me validate some themes that I found in the interviews with all of you. There are no right or wrong opinions, I would like you to feel comfortable saying what you really think and how you really feel.

Then to get the conversation going, use a simple opener:
Is everyone familiar with the purpose of the depression screening done at the clinic?

This gives an opportunity to go round the group if the conversation doesn’t start naturally. Encourage people to expand on a Yes/No answer. In some groups the discussion will automatically turn to the emerging themes that resulted from the interviews – in others you will need to prompt. For example,

What does everyone think about the depression screening handed out at the clinic?

Once you have established purposes use prompts to turn the discussion towards validating the themes. Display the tentative themes by grouping together quotes that are similar. Let the group first confirm that the quotes are similar enough to be in the same theme.

Here are some quotes from the interviews. Let’s review them and start to put similar ones together.

Validating the themes from the interviews should be the focus of the discussion (rather than just getting people to talk about depression in general), so allow plenty of time and let people ‘go off at a tangent’ for short periods. However, your role is to keep the conversation on track, but using as little direct intervention as possible. Remind the group that you are particularly interested in their perspective with the depression screening process.

Is everyone ok with the groups? Ok, now let’s talk about what to name these groups. What is a good name for each group?

Keep a close eye on the time and ensure that you don’t over-run the allocated slot. In the last few minutes do the following:

Try to summarise the discussion in very broad terms:

It sounds as if you are all comfortable with the categories you all created. To summarize, you have [x] groups that you have called [list themes].

Give the group chance to make final changes or suggestions:

Is there anything you would like to change?

Finally thank the group for their time and tell them that the discussion has been most valuable.

At the end of the session, facilitators should make some notes about the session - how they felt it went, if there where any problems etc.
APPENDIX K

FOCUS GROUP GUIDE- SPANISH

Focus Group Schedule
Adapted from Learahigher (2005)

Note to facilitators: Instructions to you are in standard print. Questions for you to read out are in bold.

Running the Focus Group Sessions

The purpose of the focus group is to validate experiences shared about the depression screening process at a SACHS. It is important to remember that you are seeking to reach a group viewpoint as far as possible. You should try to get everyone involved in the discussion. This does not mean that everyone must have the same view, but the discussion should lead to some conclusions. You need to record both majority and minority views.

Before the group assembles, test the recording equipment to make sure it is working and that the sound is recording at an acceptable level.

Once people are settled, check with the group whether they all know each other. If not start by going round the group and getting everyone to introduce themselves. You may not be able to do this if the group all know one another beforehand, but you can develop it as the session proceeds. For your own convenience it helps to draw a ‘map’ of where everyone is sitting. Assign everyone a number once they are seated and link the participant code with their name in the password protected Excel file. This will help when transcribing the focus group.

Make sure that everyone is comfortable before you start and that everyone can see each other.

Read out the statement on confidentiality:

Las opiniones expresadas serán tratadas con confidencialidad entre el personal del Proyecto; con el fin de validar las experiencias de todos sobre el proceso de prueba de la depresión en SACHS. Todas las respuestas permanecerán anónimas. Esta sesión será grabada como su entrevista para asegurarse de que no falte nada.

Check that there are no objections to the use of the audio recorder; then switch it on.

You need to start off by reiterating the purpose of the meeting.

Estoy muy agradecida a usted por todo su tiempo que me ayuda a validar temas acerca la prueba de depresión (mañana/mediodía/tarde). Hoy quiero concentrarme en discutir el proceso de depresión en su consultorio. Particularmente me gustaría me ayude a validar algunos temas que encontré en las entrevistas con usted. No hay opiniones correctas o equivocadas, Yo quisiera que usted se sienta cómodo diciendo lo que realmente piensa y como se siente realmente.

Then to get the conversation going, use a simple opener:
Then to get the conversation going, use a simple opener:

**Todas están familiarizados con el proceso de prueba de depresión hecha en la clínica?**

*This gives an opportunity to go round the group if the conversation doesn’t start naturally. Encourage people to expand on a Yes/No answer. In some groups the discussion will automatically turn to the emerging themes that resulted from the interviews – in others you will need to prompt. For example,*

**Qué piensan todos sobre la prueba de depresión dada en la clínica?**

Once you have established purposes use prompts to turn the discussion towards validating the themes. Display the tentative themes by grouping together quotes that are similar. Let the group first confirm that the quotes are similar enough to be in the same theme.

**Aquí están algunas citas de la entrevista. Veamos y luego empezaremos a poner las citas similares juntas.**

Validating the themes from the interviews should be the focus of the discussion (rather than just getting people to talk about depression in general), so allow plenty of time and let people ‘go off at a tangent’ for short periods. However, your role is to keep the conversation on track, but using as little direct intervention as possible. Remind the group that you are particularly interested in their perspective with the depression screening process.

**Están todos de acuerdo con los grupos? Ok, ahora vamos a hablar sobre qué nombre le damos a estos grupos. Cual sería un buen nombre para cada uno de estos grupos?**

Keep a close eye on the time and ensure that you don’t over-run the allocated slot. In the last few minutes do the following:

**Try to summarise the discussion in very broad terms:**

**Suena como que usted está cómodo con las categorías que usted creo. Para resumir, usted tiene (n) grupos que usted ha llamado (temas de la lista).**

Give the group chance to make final changes or suggestions:

**Hay algo que le gustaría cambiar?**

Finally thank the group for their time and tell them that the discussion has been most valuable.

At the end of the session, facilitators should make some notes about the session - how they felt it went, if there where any problems etc.
APPENDIX L

INSTRUCTIONS TO AUTHORS:

HISPANIC JOURNAL OF BEHAVIORAL SCIENCES

Manuscripts: Articles submitted for publication must be prepared in American English and must conform to the guidelines described in the *Publication Manual of the American Psychological Association* (6th edition); submissions not meeting this requirement will be returned. Manuscripts should not exceed 25 double-spaced pages in total length and should be submitted electronically as MS Word files (Windows Vista users, please save files down to the pre-2007, .doc versions; your submission will be returned otherwise). Authors should include a separate cover file with manuscript title, author(s), affiliation, each author’s contact information, short biographical paragraphs of each author, and any acknowledgments. The manuscript file should include an abstract of no more than 150 words, followed by 4 to 5 keywords. Authors’ names should not appear anywhere other than on the cover file.

Figures and tables: Figures and tables should be placed at the end of the manuscript file and numbered in the order they appear in text. An in-text callout should be inserted on a separate line just after the paragraph where each figure or table should appear (example: “[Figure 1 here]”). All figures should be submitted in the original program in which they were created (JPG, TIFF, or EPS; Microsoft Application Files are acceptable for line art). Any scanned images should be set at 1200 dpi for line art and 300 dpi for color or grayscale.
Previously copyrighted material: Material taken directly from a copyrighted source should be clearly identified, and the copyright holder’s written permission to reproduce it should be submitted to the editor. Permission in e-mail format is acceptable; authors may also submit the Copyright Permission Request Form completed by the copyright holder. **Note:** Obtaining permission to reproduce copyrighted material is the author’s responsibility, as is payment of any fees the copyright holder may request. Because obtaining reprint permission can be time consuming, it is recommended that authors begin this process as soon as possible.

Submissions should be e-mailed to Dr. Amado M. Padilla, Editor, *Hispanic Journal of Behavioral Sciences*, Center for Educational Research, Stanford University; e-mail: apadilla@stanford.edu. Submission of a manuscript implies commitment to publish in the journal. Authors submitting manuscripts to the journal should not simultaneously submit them to another journal, nor should manuscripts have been published elsewhere in substantially similar form or with substantially similar content.

The *HJBS* also publishes film and book review essays, book reviews, and review notes of books and film of interest to the journal's readership. All inquiries concerning books for review and/or submission of review type manuscripts should be sent to the editor: apadilla@stanford.edu.

Authors who want to refine the use of English in their manuscripts might consider utilizing the services of SPi, a non-affiliated company that offers Professional Editing Services to authors of journal articles in the areas of science, technology, medicine or the
social sciences. SPi specializes in editing and correcting English-language manuscripts written by authors with a primary language other than English. Visit http://www.prof-editing.com for more information about SPi’s Professional Editing Services, pricing, and turn-around times, or to obtain a free quote or submit a manuscript for language polishing.

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APPENDIX M

INSTRUCTIONS TO AUTHORS: JOURNAL OF THE AMERICAN BOARD OF FAMILY MEDICINE

Aims and Scope

_JABFM_ publishes original material from authors with new knowledge to contribute to the understanding and advancement of family medicine research and clinical practice. _JABFM_ also serves as an important forum for the specialty of family medicine, and as a source of news from the ABFM.

Print and online publication is simultaneous, with six bimonthly issues per year. Approximately 900 print copies of each issue are in circulation. Online hits (access events) per month averaged 43,477 (home page) and 532,271 (total) in 2015.

Features

- **Original Research** on evidence-based clinical care, primary care research, or health services.

- **Clinical Reviews** with in-depth, critical analysis of the literature on clinical problems, disease entities, or treatment modalities. Systematic reviews are preferred.

- **Evidence-based Clinical Medicine** papers on the diagnosis and management of common clinical problems in primary care, as well as cost-and-outcome studies.
• **Clinical Guidelines and Primary Care** proposals by various specialty, governmental, or healthcare organizations, with critical commentary from a primary care perspective.

• **Ethics Features** comprising research, commentary, or case-focused questions.

• **Family Medicine and the Health Care System** papers that study or comment on patterns of care.

• **Health Policy** issues from a national perspective.

• **Reflections on Family Medicine** comprising essays, creative prose, or poetry on humanistic concerns, professional experiences, or personal perspectives.

• **Special Communications** on a variety of topics, including the role of the family physician or research methods.

• **Brief Reports** with teaching points of significant clinical relevance.

• **Family Medicine World Perspective** reports on the practice or education of family physicians around the world.

• **Research Letters** provide a synopsis of the research at hand.

• **Commentaries, Editorials** on issues in family medicine.

• **Letters to the Editor** on current topics or recent articles, paired with the author's reply whenever possible.

• **Rapid Responses** to recent articles on the *JABFM* website at [www.jabfm.org](http://www.jabfm.org).

• **Board News** from the American Board of Family Medicine.

• **Editorial Office News & Notes** updates and changes to editorial policies and news from the editorial office.


**Editorial Policies Supporting Ethics in Research & Biomedical Publication**

**Authorship / Contributorship**


2. Authorship should be limited to no more than 8 authors.

3. Each author should meet all three of these criteria:

   Substantial contributions to the conception and design, acquisition, or analysis and interpretation of data;

   Drafting the paper or revising it critically for important intellectual content;

   Final approval of the version to be published.

4. All authors should take public responsibility for their manuscripts.

5. Corresponding authors

   - will be identified as such in the published article.
   - must be willing to submit the actual data for editorial review with the manuscript,
   - if asked by the editor.
should be prepared to explain the order of the authors names.

6. Contributors should be named in the Acknowledgments, noting what they did; for example, leading organizations, acquiring funding, collecting data, contributing patients, preparing the manuscript, etc.

7. Authors of papers from research groups, practice-based research networks, or multi-site collaborations should see: Flanagin A, Fontanarosa PB, DeAngelis CD. Authorship for research groups. JAMA, 2002; 288 (24): 3166-3168; available here.

Conflicting & Competing Interests

_JABFM_ adheres to policies that increase disclosure and transparency related to competing interests or conflicts of interest, including:


DeAngelis CD, Fontanarosa PB, Flanagin A. Reporting financial conflicts of interest and relationships between investigators and research sponsors. JAMA, 2001; 286 (1): 89-91; available here.

_JABFM_ expects authors to disclose any commercial associations that pose, or have the appearance of posing, a conflict of interest in connection with the submitted article, including but not limited to:

- employment
• consultancies
• stock ownership or other equity interests
• patent-licensing arrangements
• honoraria
• paid expert testimony
• personal relationships
• academic competition
• intellectual passion

Any potential conflicts of interest or competing interests must be disclosed upon submission. This applies to all types of manuscripts, including letters to the editor. Failure to include this information will delay the manuscript at check-in.

Duplicate Publication

Manuscripts are considered only if they have not been previously published in print or electronic format, and with the understanding that they are not under consideration elsewhere. If there is any doubt about what might constitute duplicate publication, authors should include with their submission copies of possibly duplicative materials that have been previously published, or that are under consideration elsewhere. Authors should avoid self-plagiarism. This restriction does not apply to abstracts or press reports published in connection with scientific meetings. Exceptions for unusual circumstances will be considered on a case-by-case basis.
**Informed Patient Consent**

Patients and research participants must give full, informed consent to participate in research studies, case studies, and other projects leading to publication. All case reports submitted must have a signed Patient Consent Form for each patient mentioned in order for the JABFM to review the manuscript.

A copy of the patient consent form can be accessed [here](#).

**Peer Reviewer Confidentiality**

Peer reviewers agree to treat all information in manuscripts as confidential and must disclose any real or perceived competing interests or conflicts of interest before accepting a request.

**Permissions**

Materials taken from other sources must be accompanied by a written statement from both author and publisher giving *JABFM* permission for reproduction. For papers still in press, written permission must be submitted from at least one author. It is the submitting authors' responsibility for any fees associated with copyright permissions.

**Responsible Conduct of Research**

Authors must indicate that Institutional Review Board approval was obtained for the research protocol. *JABFM* adheres to the ICMJE Recommendations on the Protection of Research Participants, available at [www.icmje.org](http://www.icmje.org).
Case Series

Case series are preferred over the report of a single patient. For guidance in preparing a case series, refer to: McCarthy et al. How to write a case report. Fam Med, 2000; 32 (3): 190-195; available here. All descriptions of patients require written consent. Please refer to the Informed Patient Consent section.

Copyright Transfer

Upon acceptance, transfer of copyright to the JABFM is required of all authors of the manuscript. This form is available here. Accepted manuscripts will not enter the production stage until all authors have submitted a signed Copyright Transfer Form.

Double Blinding

JABFM prefers to blind peer reviewers to the names of authors, while recognizing that this is not always completely possible. You will be asked to submit your title page(s) as a separate file. Authors should consider, where feasible, removing other obvious references to authors' names in the body of the manuscript.

ICMJE Guidelines

Authors should adhere to guidelines of the International Committee of Medical Journal Editors (ICMJE) in the ICMJE Recommendations for the Conduct, Reporting,

**Funding Statement**

The title page should include a funding statement. Funding statements should include all sources of funding or financial support, direct or indirect and regardless of size, for all authors. If there were no sources of funding, please so state. Failure to include this information will delay the manuscript at check-in. Authors will also be required to supply this information when submitting the manuscript.

**Length**

**Full-length articles** (e.g., original research, review articles) are generally 3500 words or less, not counting the abstract or data displays.

**Brief reports, special communications, editorials**, should be 1500 words or less.

**Research letters** should run approximately 600 words or less, should have a brief structured abstract, may have one table and/or figure, and should have no more than five references.

**Letters to the Editor** should be less than 600 words and have no more than a few references.
Meta-Analyses

Meta-analyses should follow the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) Statement: www.prisma-statement.org

NIH-Funded Research

The JABFM recognizes that as of April 7, 2008, all peer-reviewed publications reporting findings from studies funded by the NIH must be submitted to PubMed Central, the NIH’s free digital archive of biomedical and life sciences journal literature in the United States. Per the NIH Public Access Policy, such NIH-funded publications must be made available no later than 12 months after the official date of publication.

The JABFM grants the author the right to provide a copy of the accepted, peer-reviewed version of the manuscript (ie, the final version that the author submitted through the Rapid Review System) to PubMed Central through the NIH Manuscript Submission system. This does not include the copyedited and formatted version used in the print and online publication, which may be a slightly updated version of the submitted manuscript because of corrections that may occur during the copyediting process. Authors are reminded that all manuscripts published by the JABFM are protected by copyright through the American Board of Family Medicine. The JABFM requests that the manuscript submitted to PubMed Central be hyperlinked to the final online version.
published on the *JABFM*’s website. The corresponding author may make the manuscript available immediately in PubMed Central after publication in the *JABFM*.

As a courtesy to our authors, the *JABFM* will submit a copy of the accepted, peer-reviewed version of the manuscript to PubMed Central. To do so, we will need your full grant number and the name of the Principle Investigator (PI) associated with the grant. Please note that if we do submit the manuscript on your behalf, the PI will still need to log-in to the NIH Manuscript Submission system and approve the submission.

Please notify the Journal at jabfm@med.wayne.edu if you would like us to submit your manuscript for you. If we do not hear from you, we will assume you are taking care of this requirement on your own. Please note that it is the author's responsibility to ensure that all NIH guidelines and policies are followed. The *JABFM* cannot place any guarantee on scholarly information submitted to PubMed Central.

**Randomized Controlled Trials**

Randomized controlled trials should be organized according to CONSORT (Consolidated Standards of Reporting Trials) guidelines, available here [Moher D, Schulz KF, Altman, DG. The CONSORT Statement: Revised Recommendations for Improving the Quality of Reports of Parallel-Group Randomized Trials. Ann Int Med, 2001; 134 (8): 657-662.]

Please also see Piaggio et al. Reporting of Noninferiority and Equivalence Randomized Trials: An Extension of the CONSORT Statement. JAMA, 2006;295:1152-1160; available here.
Research Reports

Research reports should be organized using the IMRAD (Introduction, Methods, Results and Discussion) format. Refer to the ICMJE Recommendations at [www.icmje.org](http://www.icmje.org) for details.

Review Articles

Review articles should use SORT (Strength of Recommendation Taxonomy) to grade diagnostic and treatment recommendations, available [here](http://www.icmje.org).

Manuscript Content & Organization

Abstract

1. The word count for the abstract is separate from that of the body of the paper.

2. Whenever possible, the abstract should have a structured format, using section headers appropriate to the text, such as background or introduction, methods, results, discussion, conclusions, etc.

3. All research articles and commentaries should include abstracts, which allows indexing services to better discover *JABFM* articles and gives published articles more potential readership. If a structured abstract does not apply to your paper, the *JABFM* will also accept an unstructured abstract.
Body of Manuscript, First Page

1. The body of the manuscript, submitted in a separate file from the title page, should begin with only the title of the manuscript on the first page. The second page should then start with the body of the manuscript.

2. Authors should also consider removing other obvious references to author names in the body of the manuscript, where feasible.

   Figures / Illustrations

1. Figures and illustrations should be high resolution and professional quality.

2. Symbols, lettering, and numbering should be clear, and these elements should be large enough to remain legible after the figure has been reduced.

3. Figures should have legends descriptive enough to permit interpretation without referring to the text. Submit figure legends on a separate page.

4. Figures will only be published in color if it adds to meaning for the reader.

5. Figure titles, labels, and explanatory notes should have sufficient detail to permit interpretation without referring to the text.

6. Once a manuscript is accepted for publication, authors must provide separate files for all illustrations and figures (including charts and graphs) in high-quality, camera-ready, reproducible form. Lists of acceptable file types and instructions are available here. JABFM strongly encourages authors to submit figures in separate digital files at the
outset. However, if necessary, for review purposes figures may be embedded in the manuscript, after the tables.

7. Original photos or artwork in hard copy are not accepted.

**Formatting / Style**

1. Manuscripts should be double spaced throughout, including references.

2. Page numbers should appear on all pages.

3. Word (or similar word-processing) files are best for submission. PDFs will not be accepted.

4. Auto-formatting, text boxes, graphics boxes, or drawings may prevent file conversion and should not be used in the body of the manuscript.

5. Abbreviations are discouraged, except for units of measurement. The first time an abbreviation appears, it should be in parentheses after the words for which it stands.

6. Generic names of drugs should be used, rather than brand names.

7. Gender bias should be avoided and gender-inclusive language used whenever possible.

8. Footnotes in the body of the manuscript are not accepted.

9. Table and figure titles need to include detailed, descriptive information on the sample and time/context of data collection, when possible.
References

1. The reference list should not include manuscripts in preparation, manuscripts submitted for publication but not yet accepted, observations, or personal communications. References to unpublished material may include material accepted for publication but not yet published (e.g. in press), and presentations made at scientific or professional meetings.

2. List all authors when there are 6 or fewer; when there are 7 or more, list the first 3, then et al. For examples refer to:


3. References should be double-spaced using in-line numerals, and should start on a separate page.

4. Use superscripts or in-line parentheses in the body of the manuscript to indicate references.

5. References first cited in tables or figure legends must be numbered so that they are in sequence with references cited in the text.
6. Authors are responsible for checking the accuracy of their reference citations.

**Tables**

*JABFM* follows AMA style for tables. The AMA style guide may be consulted for detail beyond these notes:

1. Please use Microsoft Word's table feature. Excel files may not be submitted, although the cells may be copied and pasted into Word.

2. Excessive tabular data are discouraged.

3. Auto-formatting, text boxes, graphics boxes, and drawings may prevent file conversion and should not be used.

4. Tables should appear at the end of the manuscript, double spaced and placed on separate sheets. Insert in the body of the manuscript a bracketed note as to the approximate placement of each table; e.g., [Insert Table 1].

5. Table titles, labels, and explanatory notes should have sufficient detail to permit interpretation without referring to the text.

6. Footnotes should use the following symbols, in this sequence: * (asterisk), ±(dagger), ± (double dagger), ± (section mark), || (parallel mark), ± (paragraph symbol), # (number sign), ** (asterisk, repeated), ±± (dagger, repeated), ±± (double dagger, repeated), etc.
**Title Page**

In order to facilitate double-blinding during the peer review process, we ask that the title page be submitted in a separate file; this is required when submitting through the manuscript submission system, Editorial Manager. Editorial Manager will automatically blind the title page for peer reviewers.

- Title page file(s) must contain:
  - Title
  - Author names and affiliations
  - Conflicting and Competing Interests
  - Funding Statement
  - Acknowledgements (for all contributors, except authors)
  - Word count

**Manuscript Submission**

**Access**

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   - Title page (Required)
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   - Manuscript and References (Required)
   - Tables (Optional)
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   - Appendices (Optional)
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- Abstract
- Funding statement
- Conflict of interest statement
- Classifications / Keywords
- Recommendation of 2 peer reviewers
- Response to reviewers (for revised manuscripts)