A feminist analysis of mental health providers' perspectives of Latina women

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A FEMINIST ANALYSIS OF MENTAL HEALTH PROVIDERS’ PERSPECTIVES OF
LATINA WOMEN

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DEDICATION

This thesis is dedicated to Rosalinda and Angelica,
may you seek integrity like water seeks its level,
be resilient and continue to thrive.
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Kahlil Gibran wrote: “You work that you may keep pace with the earth and the soul of the earth...And all work is empty save when there is love.” This work would not have been possible without the love and support of my committee, my family, and my friends.

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ABSTRACT

Researchers have documented that Latina women involved in the mental health system face a number of barriers to access to services and ongoing use of services. Latina women involved in the mental health system are often viewed as at-risk. This study challenges traditional pathological views of Latina women in the mental health system. This study uses a feminist analysis to examine mental health providers’ perception of Latina women. It views Latina women as mental health system survivors and suggests that resilience and strength-based perspectives can transform the treatment of Latina women. Secondary data from twenty-two interviews with agency directors, psychiatrists, supervisors, therapists and others are analyzed using standpoint theory as a theoretical framework and a phenomenological analysis of the data. Using standpoint theory, this study also examines the positionality of the providers to determine if Latino providers have a greater understanding of Latina women than non-Latino providers. The findings show that two of the twenty-two providers viewed Latina women as resilient. The providers attributed a variety of factors, including culture of the provider, stigma, domestic violence/abuse, and resources as influencing Latina women’s access to and ongoing use of services. This study also found that Latino providers had more to say about Latina women than non-Latino providers. This study is a part of a growing body of feminist research on resilience and strengths based perspectives in the mental health system. Ultimately, this study argues that Latina women mental health system survivors should be understood from resilience and strength-based perspectives with nuanced understandings of Latino culture which could greatly impact their treatment and recovery.
Chapter 1: Introduction

Aurora Levins Morales (1999) writes, "Human beings seek integrity like water seeks its level, grow toward creative and just solutions like plants grow toward sunlight, sometimes by crooked paths, but always reaching" (p. 130). Prior to graduate school, I worked with adolescent girls in a residential treatment center. Most of the girls were Latina or Native American and were dealing with mental health and behavioral health problems. I prefer to see women and girls who are involved in the mental health system, not as ill, but as Aurora Levins Morales (1999) refers to them – as mental health system survivors. Stemming from this experience, I seek to find creative and just solutions for the problems facing Latina women who are mental health system survivors. The current mental health models are inadequate in fully capturing the lived experiences of Latina women. There is a real need to move away from pathology and into studies of strength and resilience. This thesis finds a point of collaboration between feminisms and studies on resilience in mental health. There are three levels on which the process of resilience can occur: the individual level, the familial level, and on a broader environmental level. Striving for integrity involves building strength and resilience both within the depths of an individual and in building systems of support that makes resilience possible on environmental levels. This study ultimately looks at the broader environmental level of resilience, focusing specifically on supportive agencies, like mental health services, that can help a person be resilient and thrive in the face of adversity.

Examining women's mental health and ability to thrive is important for many reasons. Although rates of psychiatric illness are the same for women and men, there are striking differences in the patterns of mental illness. The World Health Organization (WHO) Women's Mental Health fact sheet states that depressive disorders are diagnosed almost twice as often in
women than in men. WHO (2009) also states that an estimated 89% of 50 million people most directly affected by violent conflicts, civil wars, disasters, and displacement are women and children. Lifetime prevalence rates of violence against women ranges from 16%-50%. Also, depression, anxiety, psychological distress, sexual violence, poverty, domestic violence and escalating rates of substance use affect women to a greater extent than men across different countries and different settings (WHO, 2009; Worrell, 2006; Ballou & Brown, 2002). People of color experience disproportionate and unacceptably high rates of physical and mental illness despite improvements in healthcare and the elimination of legal forms of discrimination (Ballou & Brown, 2002). Elizabeth Sparks (2002) has found that women who are poor, belong to an ethnic minority, and who experience chronic mental illness are particularly marginalized in our society. They are also at risk for inadequate care and have less access to insurance, preventive measures, and information regarding specific conditions (Sparks, 2002). For these reasons, a focus on Latina women who are diagnosed with mental illness is vitally important when considering strengths and resilience.

Most research on resilience involves children and adolescents. There is a gap in the literature for resilience research on older individuals and some experts call for more research on resilience later in life (Luthar & Cicchetti, 2000; Werner & Smith, 1992). Luthar and Cicchetti (2000) argue that interventions for people should be targeted across "multiple levels of influence." This means that we must target interventions at the community, family and individual levels (Luthar & Cicchetti, 2000). Luthar and Ciccetti (2000) also state that socioeconomically disadvantaged families "often contend with multiple 'vulnerability factors'...Recognition of the complexity of their service needs has led to several calls for increased integration of service delivery" (p. 873). Access to comprehensive, multifaceted programs that produce change at the
environmental level is crucial for low-income women of color. Luthar and Ciccetti (2000) write, "Integrative, community based approaches to service delivery are critical" (p. 879). Service providers are in a unique position to impact the lives of women of color who receive mental health services. Therefore, it is important to examine the perceptions that mental health providers have about Latina women who are involved in the mental health system. Research on strengths and resilience done later in life with service providers perspectives fills a gap in the literature. This research can also provide a pathway for service providers to target meaningful and productive services to Latina women.

This research uses a feminist framework to review the literature around resilience and mental health. Latina feminisms provide an understanding of women who are diagnosed with mental illness, not as individuals who are abnormal and need help, but as resilient women part of larger social systems of oppression. This perspective paves a way for us to look at Latina women mental health system survivors as resilient and able to thrive. This research reviews the literature in five sections. First, I work towards a new perspective of deficit-based models for mental illness and move towards a feminist understanding of models based around strengths and resilience. Second, I look at Latina feminisms and at feminist psychologists’ perspectives of mental health. Third, I provide a review of the literature on resilience, risk and protective factors, and connection. Fourth, I examine Latina women's resilience. Finally, I review feminist research methods and discuss standpoint theory. This research finds a gap in the literature around Latina women's mental health and that there is a need for a more in-depth understanding of resilience at the environmental levels.

In this research, I use interviews and coding already created by the Latina Mental Health Needs Study (LMHN). In their study, the LMHN team interviewed mental health service
providers to examine the central mental health issues of Latina women in the Metropolitan Chicago area, the services that are provided to Latina women, and the barriers to accessing services (Renfro et al., in press). This thesis reframes the investigation from a feminist perspective and looks at resilience as it relates to Latina women mental health system survivors’ access to services. Mental health service providers’ perception greatly impacts the experience of Latina women in the mental health system. Their recommended services are influenced by the lens through which they perceive and understand the source of “mental illness” in Latina women.

The purpose of this study is to establish the current point of view of mental health service providers and how they perceive Latina women in the mental health system. This study proposes that a focus on strengths and resilience provides a meaningful framework to understand Latina women involved in the mental health system. This study uses standpoint theory as a theoretical framework for the methodology. In light of the current research on mental health and framing research with feminist perspectives, this thesis examines four questions:

(1) How do mental health system providers perceive or understand Latina women as clients?

(2) What factors do mental health system service providers believe influence Latina women’s access to services?

(3) What factors do mental health service providers believe influence Latina women to continue using services?

(4) Does a mental health service provider’s positionality impact their perception of Latina women involved in the mental health system?

Informed by the literature review on resilience, I hypothesize that:

Hypothesis 1: Mental health service providers, due to the prevailing focus on pathology, will not perceive Latina women as resilient women who can thrive.
Hypothesis 2: Mental health service providers will attribute (a) culture, (b) gender, and (c) race as factors that affect Latina women’s access to services.

Hypothesis 3: Mental health service providers will attribute (a) culture, (b) gender, and (c) race as factors that affect Latina women’s continuing use of services.

Hypothesis 4: Latina women service providers will be more attuned to the nuances of (a) culture, (b) gender, and (c) race than other service providers.

This study uses a combination of inductive and deductive research methods to analyze the data to answer these questions. Ultimately, I suggest an approach to treatment of Latina women that comes from resilience and strengths based perspectives which give a more holistic understanding of the women and provides for better outcomes.
Chapter 2: Literature Review

Moving Outside the Box of Biology and Pathology

Feminist theorizing allows us to gain new perspectives on mainstream theories and models around mental health issues for Latina women. Despite a lack of strong evidence, human behavior is increasingly being attributed to biology (Ballou & Brown, 2002). Many of the biologically-based models focus on deficits and vulnerability. The focus on biology ignores other factors that contribute to women’s mental health. One popular theory called the Stress-Vulnerability model (also known as the Diathesis-Stress model) claims that both stress and biological vulnerability contribute to symptoms of mental illness. This model places biology at the center. Here is a diagram of the model from the Substance Abuse and Mental Health Services Administration website (2008):

**Figure 1. Stress Vulnerability Model**

![Stress-Vulnerability Model](image-url)

Source: Substance Abuse and Mental Health Services Administration's National Health Information Center (2008)
These biologically based models have been critiqued by feminist psychologists and others as focusing too much on pathology and not enough on strengths (Denner, 2006; Worrell, 2001; Masten, 2001; Espin, 1993). From a feminist perspective, there are many problems with the Stress-Vulnerability model. The model places biology in the center ignoring a person’s wellness, resilience and strengths. It pathologizes the individual. This model also puts coping on the individual. The idea that a person is individually responsible for illness and recovery (through biology and coping) does not take into account broader social systems at work. There may be some biological reasons for mental illness, but people are also a part of systems - both supportive and oppressive. An understanding of the broader systems at work is important when considering a person’s mental health.

Ballou and Brown (2002) state that human behavior is increasingly being forced into the box of biology even though there is a lack of strong empirical evidence to support these models. Feminist psychologist Judith Worrell (2006) writes, “There is a continuing need for models that recognize factors contributing to risks and challenges to women’s psychological health, as well as opportunities for promoting wellness, resilience in the face of challenge and adversity, strength, persistence, and empowerment” (p. 29). Worrell (2001) also argues for a feminist approach that moves toward developing new approaches to address the sources and solutions to women’s distress. She emphasizes the mounting dissatisfaction with traditional models of women’s mental health and the absence of women from psychological research and scholarship. Worrell (2001) argues that medical models designed to reduce symptoms may bring short relief, but end up sending a person back to the toxic environments from which their symptoms originated. Similarly, Natalie Porter (2002) states that although theory in western clinical psychology is swinging back from describing human beings from an individualist perspective,
practice has not kept pace, especially in mental health and diagnostic areas. She claims that we need a list of strengths as powerful and as validating as “the florid vocabulary of diseases found in the DSM-IV to combat our national obsession with pathology” (Porter, 2002, p. 271). She asserts that the deficit model is incongruous with the feminist perspective which focuses more on “growth, flexibility, resilience, and implementing new strategies when old ones fail” (Porter, 2002, p. 271).

**Feminist Perspectives**

Many feminists have taken a different perspective on distress, and have developed new definitions, arguing that distress is not centered in biology. Laura Brown (1994) reframes distress, not as a disease, but as communication about unjust systems. She looks at disease as a possible indicator of health and a capacity to resist patriarchy, even at a cost. She claims that this reframing is a "revolutionary development" coming from feminist theorizing and applied to psychological practice. Similarly, Ballou and Brown (2002) state that the ways in which the “normal” and “abnormal” are portrayed in mainstream mental health professions are intricately connected to the experiences of oppression and the sources of resilience arising from structures of gender, culture, class, race and sexuality. This is also important when realizing that, in the mental health culture of the 21st century, making distress and difficulty equivalent to disease or psychopathology can become profitable. With this corporate model of illness comes the discounting assumption that if a person experiences distress or difficulty coping then they are “ill, broken, and unable to perform at acceptable levels consistently” (Ballou & Brown, 2002, p. xviii). Feminist scholars continue to critique the mainstream model of attributing legitimate reports of distress to biology rather than to external causes. These external causes can include power inequities and discrimination in the sociocultural environment (Worrell, 2001). Also,
distress may be an attempt or manifestation of attempts at resilient responses in extraordinary circumstances, rather than a failure of resilience (Ballou & Brown, 2002).

One must take dominant systems into account when considering the situation of Latina women diagnosed with mental illness. Judith Jordan and Linda Hartling (2002) emphasize that members of the dominant group typically design, develop, conduct and interpret research. Feminists argue that the dominant group tends to categorize themselves as normal, while placing those who do not fit in with the ideals of normality as ill, pathological, or abnormal (Hartling, 2009; Jordan & Hartling, 2002; Porter, 2002; Espin, 1997). Even in studies of resilience, the dominant focus on individualism influences the research. Hartling (2009) explains that traditional Western-European theories of psychological development have a tendency to focus on individual strengths in the study of resilience. She writes, “In a cultural context in which the dominant group values individual achievement and independence, relational factors may be disregarded or dismissed” (Hartling, 2009, p. 55). Instead, there must be equal or more focus on relational resilience (Hartling, 2009; Jordan & Hartling, 2002). Oliva Espin (1997) describes a process by which the culture provides an individual with the needed support to live, develop, and feel “normal.” Espin (1997) writes, “Indeed, even models of ‘craziness’ have to meet standards that are culturally acceptable. Explanations of the etiology of psychological disturbance may vary cross-culturally to include spirit possession vs. the chemicals in the brain or events in your past” (p. 449). Currently, the dominant group has a plethora of negative psychopathological diagnoses with very little focus on people's strengths. We must include a focus on strengths and resilience, not just pathology as the dominant discourse in psychology has done in the past.

Andrea Nicki (2001) also looks at mental illness, not as pathology, but as a result of unjust systems. She argues that much psychiatric disability is closely linked to trauma and that
mental illness thrives in environments with “prejudice, discrimination, sexist socialization, social inequalities, marginalization or poverty” (Nicki, 2001, p. 81). She also makes the claim that although medications can treat symptoms of mental illness this does not mean that biology alone is the cause of the illness. She compares this to a cancer patient living near a toxic waste dump. The primary cause of cancer in this case is certainly not in their genes or biological makeup (Nicki, 2001). Nicki (2001) discusses the fact that mental illness is found predominantly among groups such as “women, homosexuals, the poor, the unemployed, or homeless, the physically disabled, the racially marginalized or the elderly” (p. 91). She argues that members of oppressed groups are more likely to develop psychiatric disability with their minds overwhelmed by the negative realities in their lives. Feminist theory of psychiatric disability is focused on the oppression of the mind by a society that rejects what Nicki (2001) calls “the alternative mental states of the psychiatrically disabled” (p. 100). In short, the existing evidence about mental illness, particularly in light of the impact of social structures on mental health, suggests that biology should not be at the center of analysis.

The pioneering essay by Naomi Weisstein *Kinder, Kueche, Kirche as Scientific Law: Psychology Constructs the Female* (1968) and the now classic book by Phyllis Chesler *Women and Madness* (1972) both argue that mental illness in women is essentially due to social context and an unsuccessful attempt to overcome female powerlessness. Weisstein (1968) writes that psychologists must look at social context in which individuals live and turn away from looking at the “inner dynamic” as the cause of pathology. I do not believe that mental illness is *exclusively* due to the social context in which women live. However, the current models focus primarily on biology and ignore the effects social contexts have on women’s health. While behavior is
complex and multidetermined, the main focus of the feminist psychology is that social dynamics profoundly influence human behavior (Worrell, 1997).

Aarti Dua (2006) reviewed the literature and concluded that feminists do not agree whether pathology lies entirely in oppressive social and political structures. However, she emphasizes the profound overrepresentation of the poor and people of color among those diagnosed with schizophrenia. She also finds that in the literature the pathology and “wrongness” of the oppressive social structures is less open to dispute. This has been a focus of feminist psychologists for a long time (Dua, 2006). Dua (2006) also notes that “pathology is an indication that someone is struggling to resist patriarchy, but doing so with tools that are not adequate to the task at hand” (p. 266). In contrast to prevailing practice where traditional models focus on the nature and specifics of a person’s distress, feminists theorize a person’s strengths, skills and competencies first. Dua argues that feminist theorizing on distress pays careful attention to the sources of strength, resilience and resistance present and available in individuals, their cultures and their surrounding environments. She writes that the questions raised by feminists’ focus has to do with the capacity to withstand, transform, and subvert oppressive and potentially damaging experiences; thus, the person is theorized as an active, interactive agent. In this personal, social, and political process various forms of both distress and well-being may be outcomes (Dua, 2006). It is important to note that the focus on resilience is not unique to feminist theorizing; however, it is central in feminist diagnostic thinking (Dua, 2006). Feminist theorizing gives particular attention to the ways the disenfranchised and marginalized express resilience.

Aurora Levins Morales (1999) emphasizes the importance of including mental health system survivors in feminist politics. She argues that the liberation movement for mental health
system survivors is dissociated from women’s movements. This dissociation must end so that feminists and mental health system survivors can come to a point of collaboration. Other theorists have argued for including disability in feminist politics as well (Wendell, 2001; Thomson, 1994). In fact, viewing disability as a social construction can be the first theoretical step toward moving the discourse away from pathology and into politics (Thomson, 1994). Ethnicity, race and sexuality are frequently knitted into current feminist analysis, but the leap towards seeing disability as a stigmatized social identity is rarely taken (Thomson, 1994). Viewing survivors of the mental health system as a part of stigmatized social groups enables us to tap into ways of feminist theorizing that lead to resistance and empowerment. Also, developing theories around mental health that understand survivors of the mental health system as part of a sociopolitical group is one step towards integrating individual and social concerns for well being.

Feminism can provide creative and just solutions to the problems of the deficit based models. Aida Hurtado (2003) discusses multiple systems of oppression. She writes:

Chicana feminists agree with white feminists that patriarchy oppresses them. They diverge however, from white feminisms, because their analysis of patriarchy does not focus exclusively on individual rights denied to them by men. Instead, Chicana feminisms propose that their subordination is the result of multiple systems of oppression that include gender, race, ethnicity, class and sexuality. It is from this bocacalle (intersection) that they situate their feminisms. (p. 20)

This emphasizes the importance of including an understanding of intersecting oppressions in our understanding of mental health system survivors. In advocating for Latina feminism, Hurtado creates a concept of relational dovetailing. Relational dovetailing is a concept of feminism where "each feminist theoretical advancement dovetails into our existing knowledge of women's oppression" (Hurtado, 2003, p. 96). Mental health system survivors must be included in these
theoretical advancements. Ultimately, Latina feminisms call for a holistic approach to theorizing women's condition and focus on "theory in the flesh," taking experiences into account when theorizing. Latina women dealing with mental health issues have experiences that must be taken into account.

Looking at mental health from a feminist perspective, placing strengths at the center, resilience becomes a critical concept for research. Judith Worrell (2001), like other feminist psychologists, calls for a move beyond symptom focused research into a more inclusive model that reflects strengths, agency, resilience, and maintenance of productive wellbeing over time. She argues that the hallmark of feminist psychology has been its emphasis on promoting empowerment, personal strength, and resilience in the face of past, current, and future adversity. She contrasts feminist psychology with the intrapsychic models that mainly target the deficits in girls and women (Worrell, 2001). Empowerment is a major part of feminist theorizing. Empowerment can serve to strengthen and protect women from further environmental assaults (Brown, 1994; Worrell, 2001). Gloria Anzaldua (2002) writes that empowerment “provides the knowledge, strength, and energy to persist and be resilient in pursuing goals” (p. 571). Worrell (2001) describes that symptom-focused practice often results in an immediate relief of symptoms, but with high relapse rates. In contrast, Worell (2001) states, “feminist practice will flourish best” when it focuses on useful and testable models of the “healthy woman in a healthy environment and actively works towards achieving this goal” (p. 341). Worrell argues that when women are empowered, the same stressful situations can provide an opportunity to demonstrate resilience in the face of adversity.

Instead of focusing on individual psychopathology, some theorists advocate for strengths-based perspectives and focus on resilience instead (Denner, 2006; Dua, 2006; Healy, 2005;
Ballou & Brown, 2002; Masten, 2001; Saleebey, 2001, O'Leary, 1998). These theorists move away from pathology based models. Dennis Saleebey (2001), founder of the Strengths-Based Perspective, explains that a main reason for strengths and resilience research comes from a critique of "society’s obsession and fascination with pathology, problems, moral and interpersonal aberrations, violence and victimization" (p. 78). Similarly, Virginia O'Leary (1998) writes that "psychologists have recently called for a move away from vulnerability/deficit models to focus instead on triumphs in the face of adversity" (p. 426). Ann Masten (2001) writes about prevailing deficit models as well. She states that resilience is actually a common phenomenon which surprised theorists who were so used to prevailing models of psychopathology (p. 234).

What is Resilience?

The move from focusing on pathology to focusing on strength led researchers to focus on the construct of resilience. Resilience has been defined in a variety of ways. Walsh (2003) defines resilience as the "ability to withstand and rebound from disruptive life challenges" (p. 1). Garza, Reyes, and Trueba (2004) define resilience as "the ability to confront and resolve problems and the capacity to utilize personal or social resources to enhance limited possibilities" (p. 11). Hartling (2009) defines resilience as "the ability to achieve good outcomes in one's life after experiencing significant hardships or adversities, such as poverty, family discord, divorce, lack of access to educational opportunities, racism, etc." (p. 53). Despite a variety of ranging definitions, researchers typically define resilience in three ways: (1) Good outcomes after experiencing adverse conditions; (2) maintaining competence under conditions of threat; and (3) recovery after trauma. (Jordan & Hartling, 2002; Luthar, 2000; Masten, 2001; Smith, 2008; Hartling, 2009)
The literature stresses the importance of distinguishing between "resilience" and "resiliency." Resilience is a dynamic developmental process that is used as the maintenance of positive adjustment under challenging life conditions (Luthar, 2000, p. 46). Resiliency is used as a personality trait (Luthar, 2000; Luthar & Cicchetti, 2000). There is an emphasis in the literature on clear definitions of resilience - as a process or phenomenon of positive adaptation despite adversity, and not as a personal characteristic. The term "resiliency" is used as a personal characteristic (Luthar & Cicchetti, 2000).

Resilience is seen not as a trait, but as a process. Resilience occurs on multiple levels including: (1) individual characteristics; (2) family environment including ties and support; and (3) characteristics of the environment including support systems like churches or mental health services (Garza et al., 2004; Garmezy, 1991; Jordan & Hartling, 2002). Resilience is seen as a process of good outcomes and as a process of adaptation despite adversity. Luthar and Cicchetti (2000) write:

> Resilience is a dynamic process wherein individuals display positive adaptation despite experiences of significant adversity or trauma. This term does not represent a personality trait or an attribute of the individual. Rather, it is a two dimensional construct that implies exposure to adversity and the manifestation of positive adjustment outcomes. (p. 858)

Resilience inevitably needs to be a combination of serious risk experiences and a relatively positive psychological outcome despite those experiences (Rutter, 2006; Luthar, 2000). Research on resilience has also found a value-added construct as well. This means that some individuals who experience trauma adapt and even grow by strengthening their resistance to later stress. This is called a "steeling" effect (Rutter, 2006; O'Leary, 1998; Healy, 2005). Masten (2001) found that resilience arises from dynamic interactions within and between the organism and the environment. She notes, however, that a systematic study of the patterns and pathways is still
young. Masten (2001) writes, "The new frontier for resilience research is understanding these processes at multiple levels, from genes to relationships, and investigating how the individual as a complex living system interacts effectively and ineffectively over time with the systems in which it is embedded" (p. 233). Researchers have found that during the process of resilience people can be resilient in some situations but not in others. People can also be resilient at some times in their lives but not in others (Rutter, 2006). This points to the importance of longitudinal studies.

One important longitudinal study was completed by Emmy Werner and Ruth Smith (1992). Werner and Smith conducted a ground-breaking study on resilience of 505 individuals from birth to ages 31-32 on the island of Kauai, Hawaii starting in mid-1950. Over the 30+ years of the study, they used interviews, surveys, and life-event checklists. They found that one out of three high-risk children grew into competent young adults who "loved well, worked well, played well, and expected well" (Werner & Smith, 1992, p. 192). Werner and Smith also found that all the resilient young people in the study had at least one person who accepted them unconditionally. They concluded that resilient men and women showed (1) personal competence and determination, (2) support from a spouse or mate, and (3) faith (Werner & Smith, 1992).

Another important study by Hauser, Allen, and Golden (2006) studied resilience in young people who had prolonged psychiatric hospitalization. This study examined sixty-seven people who were psychiatrically hospitalized in their teens and looked at their lives ten years later. Over the ten years of the study, they completed annual interviews and used a supplemental battery of well-established assessments. They found that nine out of the sixty-seven hospitalized teens were thriving. As compared with average outcomes, Hauser et al. (2006) concluded that characteristics of resilience include: personal agency and a concern to overcome adversity, a self-reflective
style, and a commitment to relationships.

There are two approaches to resilience. The variable-focused approach and the person-focused approach. The variable-focused approach uses multivariate statistics to measure the degree of risk or adversity, outcome, and potential qualities of the individual or environment. Person-focused approaches compare people who have different profiles to see how they are different from other groups of people (Masten, 2001). Masten (2001) concludes that a combination of variable-focused and person-focused studies give a short list of attributes: connections to competent and caring people in the family and community, cognitive and self-regulation skills, positive views of the self, and motivation to be effective in the environment (Masten, 2001, p. 234).

**Risk and Protective Factors.** Risk and protective factors are typically a main focus of resilience researchers (Luthar & Cicchetti, 2000; Garmezy, 1991). Risk and protective factors can depend on where the central effects lie - in other words, they can be used interchangeably depending on the construct (Luthar & Cicchetti, 2000). Researchers found that risk and protective factors form a triad of (a) personality-disposition factors (b) a supportive family environment and (c) an external support system (Garza et al., 2004; Garmezy, 1991; Werner & Smith, 1992). On the individual level, temperament (such as activity level), reflectiveness in meeting new situations, cognitive skills, and positive responsiveness to others are all factors that contribute to resilience. On the family level, warmth, cohesion, and the presence of some caring adult are important. On the level of environment and external support systems, a teacher, caring agency, or a church that create ties to the larger community contribute to resilience (Garmezy, 1991).

Risk factors are characteristics or experiences that put a person at risk for negative
outcomes. Risk factors are numerous (Saleebey, 2001) and can include "socioeconomic disadvantage and associated risks, parental mental illness, maltreatment, urban poverty and community violence, chronic illness, and catastrophic life events" (Luthar, 2000, p. 544). Masten (2001) found risks that include socioeconomic status (SES), tabulations of number of life events that have occurred in recent months or a lifetime, massive community trauma, low birth weight, divorce, and cumulative risk calculations that combine these different kinds of risk factors. Despite all these risk factors, the compelling reality is that resilience researchers find convergent findings about those who are able to bounce back despite risk (Masten, 2001; Werner & Smith, 1992).

Protective factors associated with resilience converge across studies. Some internal protective factors include: temperament, intelligence, self-esteem, internal locus of control, mastery, and social support (Jordan & Hartling, 2002; Garza et al., 2004; Saleebey, 2001; Rutter, 1985; Werner & Smith, 1992). Some researchers look for resilience in people who excel in many domains, while others require excellence in one area with average performance in others (Rutter, 1985). Rutter (1985) emphasizes that protective factors are not synonymous with positive experiences. The role of protective factors is to "modify the response to later adversity rather than to foster normal development in any direct sense" (p. 600). Rutter (1985) reports that much has been written about effective coping skills but what appears most important is not so much the specific method of coping, but the existence of a coping process at all. Smith (2008) discusses the importance of protective factors for those with health problems and found that active coping, social support and personal characteristics like optimism promote resilience. The findings show that there are two main features that protective factors provide for people: secure stable affectionate relationships and experiences of success and achievement (Rutter, 1985).
Although risk and protective factors are a major part of resilience research, there is a distinction. In studies of risk and protective factors, researchers assume that risk and protective factors will be broadly similar in everyone and that outcomes depend on the mix and balance between them. Resilience, in contrast, recognizes huge variations in people’s responses to the same experiences and assumes that understanding the variation illuminates the different causal factors. This holds implications for both prevention and treatment strategies (Rutter, 2006).

In a study of a high-risk African American population, Aiim et al. (2008) found that future studies about psychosocial factors are needed. They completed their study with 259 patients exposed to at least one severe traumatic event. Using interviews and a multinomial logistic regression to identify psychosocial factors associated with resilience, they found that forty-seven patients were resilient. Aiim et al. (2008) conclude that, "Future studies are needed to identify which psychosocial factors are consistently associated with resilience and determine to what extent these factors may be modifiable through clinical intervention" (p. 1574).

One striking feature of resilience is how common resilience actually is (Masten, 2001). Saleebey (2001) writes, "The resilience of the human spirit - in the face of all manner of assaults on its integrity, safety, and even life itself - is not to be underestimated...We cannot always assume about people that the resilient ones are here and the vulnerable ones are there. Each of us has both possibilities within us and around us" (p. 75). Because of the prevailing focus on pathology for Latina women mental health system survivors, a crucial realization is that the possibility that resilience lies within each of us.

**Connection in the Community.** Some researchers frame community and family level protective factors as based on the individual’s ability to attract others through their life course. However, others suggest that community and family level protective factors can help individuals
regardless of individual attractiveness, intelligence, or ability (Werner & Smith, 1992). This research examines the importance of community connection for Latina women dealing with mental health issues. Jordan and Hartling (2002) introduce the concept of *relational resilience*. They suggest that growth occurs in connection. They write, "Although many investigations are grounded in individualist theories of development, much of the research on resilience points in a relational direction, suggesting that *resilience grows through connection*" (p. 57). Jordan and Hartling (2002) developed the Relational Cultural Theory which moves away from pathologizing women's behavior and development and moves towards a relational model of mutual development. In this theory, relationships are mutual and reinforce resilience. Harvard Professor Robert Putnam (2000) writes that studies "...have established beyond reasonable doubt that social connectedness is one of the most powerful determinants of our well being...happiness is best predicted by the breadth and depth of one's social connections." (p. 326) Similarly, Werner and Smith (1992) find that on the road to recovery the most troubled individuals in their study had significant turning points towards recovery when they met a caring friend or married an accepting and supportive spouse (p. 195) Aida Hurtado (2003) writes that "Feminists of Color have emphasized the deconstruction of privilege based on stigmatized multiple group memberships. The *sitio* of Chicana feminisms is social identity, *not* personal identity" (p. 167). Also, Virginia O'Leary (1998) found that "social relationships may be key to women's thriving" and that individuals with greater support are less likely to be effected by stressful events and are more likely to maintain good physical and mental health.

Relational Cultural Theory theorizes that *all* people can benefit from relationships, specifically growth fostering relationships (Jordan & Hartling, 2002), and that resilience is not necessarily a characteristic in individual tough people (Hartling, 2009). Hartling (2009) writes:
Relational Cultural Theory moves us beyond a myopic emphasis on individual development and individual strengths and encourages the study of relational development and relational strengths. RCT would propose that relationships are a primary source of one’s ability to be resilient in the face of personal and social hardships or trauma. Furthermore, relationships are a primary source of experiences that strengthen the individual characteristics commonly associated with resilience. (p. 54)

Relational Cultural Theory also suggests that relationships are constructed within the social and cultural contexts in which they exist. Hartling (2009) writes, "A cultural context can facilitate or obstruct ones opportunities to participate in relationships necessary for strengthening one's ability to be resilient" (p. 55). As Jordan and Hartling (2002) point out, racism, sexism, heterosexism, and classism affect people's ability to "engage and participate in growth-fostering relationships." (p. 53)

Similarly, Werner and Smith (1992) find that environments can range from facilitative to non-facilitative in their study of resilient individuals from Kauai, Hawaii. They also find that resilient boys and girls all had several close friends and they relied on informal networks of kin, teachers, and neighbors for counsel and support in times of crisis (Werner & Smith, 1992). Elizabeth Sparks (1998) explored the resilience of African-American mothers on welfare. Through interviews and a review of the literature, her review found that to overcome adversity including poverty, racism, and social stigmatization, mothers engaged in connection, collaboration, and community action (Sparks, 1998). These studies show that connection with others is an essential part of resilience.

Froma Walsh (2003) discusses family resilience. A family resilience framework creates an opportunity for personal and relational transformation and growth that can be forged out of adversity (Walsh, 2003). Walsh writes that a family resilience framework "combines ecological and developmental perspectives to view family functioning in relation to its broader sociocultural
context and evolution over the multigenerational life-cycle" (p. 3). A family resilience framework uses the same framework as found in resilience research and looks for common elements in situations of trauma or crisis. A family resilience framework studies effective family responses taking into account each family's unique perspective, resources, and challenges (Walsh, 2003). By looking at Relational Cultural Theory, the study of relational resilience, and taking family resilience into account, one realizes that resilience is a dynamic term that can provide deep insights into the reality of Latina women's mental health and wellness.

**Latina Women's Mental Health Issues and Resilience**

Latinas dealing with mental health issues face a great many problems and barriers to getting help. Landrine (1995) reports that studies of Latina mental health show that Latinas are clearly a group ‘at risk’ for high levels of psychosocial stress due to discrimination, cultural role conflicts, immigration trauma, language barriers, and lowered levels of financial, educational, and medical resources. A Report of the Surgeon General (Department of Health and Human Services [DHHS], 1999) informs that mental health disorders are disabling conditions and that the stigma associated with mental illness is a major obstacle preventing people from getting help. Women of color are underrepresented in mental health research. They also have less access to, and availability of, mental health services (DHHS, 1999). Latinas also appear to be reluctant to seek mental health services for reasons including the perception that mental health services are only for the severely impaired, to cultural beliefs about the importance of enduring suffering, to the lack of knowledge about available services (Landrine, 1995). Much of the literature on Latina women focuses on depression, early pregnancy, violent and pathological behavior, and suicide (Denner, 2006). Oliva Espin (1997) summarizes from a multitude of studies and concludes that the transitions created by immigration often result in loneliness, strain and fatigue.
from the effort to adapt and cope, feelings of rejection, confusion in terms of role expectations, "shock" from the differences between two cultures, and a sense of impotence resulting from an inability to function competently in the new culture (Espin, 1997). She also found that for groups undergoing acculturation, females are more frequently expected to maintain traditional roles and virtues through a focus on preserving 'tradition' (Espin, 1997). Nicole Buchanan and Marcia Martinez (2005) presented a paper about resilience among Latina women. They explain that women of color receive poorer quality of mental health care. Some of the barriers to accessing mental health services include financial barriers, lack of insurance, shame associated with mental illness, lack of trust for mental health services, and stereotypical attitudes and sex role bias – including that women should be devoted to their families. Also, they emphasize that the intersections of race and gender experienced by Latinas are virtually ignored in both clinical practice and empirical research (Buchanan & Martinez, 2005).

Despite the multiple risk factors for good mental health, Latina women are resilient and have the ability to thrive. Enrique Trueba (1999) writes extensively about Latina/o resilience. He writes:

Resiliency is a term that means different things to different people. In the context of our discussion on immigrants, I would conceive of resiliency as the capacity of immigrants to withstand pain, to survive physically and psychologically in circumstances that require enormous stamina and determination (such as crossing the border many times and doing farm work for several years) as well as the psychological flexibility they need to adapt to a different lifestyle in the absence of their familiar environment. Resiliency is shown when a person persists in the face of serious problems and challenges, with a clarity of goals and a serious intention to complete a task. (p. 157)

Trueba theorizes that the spiritual quality of Latinos helps them to (1) select support systems and resources to survive physically, psychologically and culturally; (2) to use resources reciprocally
to retain long-term support; (3) to create networks and the exchange of goods and services to meet needs and solve problems; and (4) to engage in social and cultural events that serve to maintain group identity and cohesiveness (Trueba, 1999). Trueba (1999) also lists "religious faith, kinship structure, old belief systems, and personal investment in one another as a way of life" (p. 160) as the extraordinary cohesive and complex force that is the Mexican culture. Garza, Reyes, and Trueba (2004) write, "The resiliency of Mexican families and communities is an important concept to understand...Its sociocultural and psychological basis and its intimate link to the collective commitment to maintaining their language and sense of 'community' are central to our discussion" (p. 13). They maintain that women show endurance, determination, and a capacity to organize themselves into a political force to fight for their children (Garza et al., 2004).

One area in which Latina feminisms speak to the experience of strengths in Latina women includes the concept of Differential Consciousness. Chela Sandoval developed the idea of a Differential Consciousness where those who experience multiple oppressions develop a certain consciousness which enables them to move among and between different positions of resistance. Differential consciousness paves a survival strategy for those who experience a position of multiple oppressions (Sandoval, 2000). Differential Consciousness provides a rich source of inner resilience.

Relationships are often forged based on shared language. Language is an important aspect of the immigration process and in finding resilience among immigrant girls. Emma Perez (1991) writes, “Language, after all, is power. Third World people know that to learn the colonizer’s language gives one access to power and privilege, albeit controlled, qualified power” (p. 165). Language can be a major barrier for Latina women attempting to access services.
However, when bilingual or Spanish speaking staff are available, language can become a gateway for recovery and resilience. Espin (1999) finds in her experience as a therapist that even among immigrants who are fluent in English, the first language is the language of emotions. Speaking in English may distance immigrant women from important parts of themselves. On the other hand, a second language can act as a vehicle to express the “inexpressible” in the first language. Espin (1997) writes, “I contend that the language in which messages about sexuality are conveyed to and encoded by the immigrant impacts the language chosen to express sexual thoughts, feelings, and ideas and reveals important clues to one's identity process” (p. 443). For immigrants, language – both the native tongue and English – appears to serve as an instrument that can enhance intimacy or provide distance in relationships and self-definition (Espin, 1997). Hurtado (2003) writes that “Chicana feminists struggle to decolonize language, to burst open discourses to allow for the possibility of a liberatory consciousness” (p. 20). Here we see that Latina feminisms once again provide an avenue for wellness for women.

By taking Latina feminisms into account, we are better able to build a path of resilience for those coping with the problems of thought and emotion that come with mental illness. Hurtado writes, “Chicana feminisms advocate a holistic approach to theorizing women’s condition to include love, sex, and emotion” (Hurtado, 2003, p. 102). Since mental health concerns deal with problems of thoughts and emotion, this holistic approach is crucial. Mental health is a vital part of a person's lived experience. By taking into account all oppressions, we can build a better understanding about the overall health and wellness of individuals and communities. Hurtado (2003) writes,

The situationally based resistance is usually documented by Chicana feminists through cuentos (stories), myths (e.g. La Llorona), chistes (jokes), or concrete actions that verge on performance art. Chicana feminisms advocate the creation of
flexible, almost poetic discourses that allow the uncovering and documentation of the consciousness exhibited by many of my respondents, ‘a differential consciousness’ (p. 266).

Differential Consciousness, developed by Latina feminists, provides a way of understanding resistance and resilience against systems of oppression.

The connection of feminisms and Latina feminisms to mental health issues is clearly an area in need of further examination. The current mental health theories do not adequately address the intersecting roles of oppressions in the lives of Latina women dealing with mental health issues. However, Latina feminisms provide an avenue for understanding how women can build a new culture using strength, resilience and resistance. Gloria Anzaldua (1999) poetically writes:

So, don't give me your tenets and your laws. Don't give me your lukewarm gods. What I want is an accounting with all three cultures-white, Mexican, Indian. I want the freedom to carve and chisel my own face, to staunch the bleeding with ashes, to fashion my own gods out of my entrails. And if going home is denied me then I will have to stand and claim my space, making a new culture - una cultura mestiza - with my own lumber, my own bricks and mortar and my own feminist architecture." (p. 21-22)

These words inspire readers to form a new culture with a feminist architecture. We must work on building the strengths and resilience of the individual coping with mental health problems. We must also work to transform the environment to reflect a more socially just reality. We must work to develop agencies - like mental health agencies - that can participate in the process of resilience for Latina women dealing with mental health issues.

**Standpoint Theory**

In the words of bell hooks, "Feminism is a struggle to end sexist oppression" (hooks, 1984, p. 15). When developing research and considering research methods, feminist perspectives can help shape and influence a thesis to be socially just. Harding (2004) emphasizes that "Feminism has a long history of association with bourgeois Liberal rights movements, racially
and ethnically discriminatory projects, heteronormative understandings, and other theoretical 'luxuries' available to women from the dominant groups" (p. 9). This must be taken into consideration when thinking about feminist research. In response to hegemonic feminism, feminists of color have propounded the idea that sexist oppression is inextricably linked to other forms of oppression including oppression in hierarchies of race, class, sexuality, nation, religion and others. The understanding of intersecting forms of oppression has led feminists to fight alongside other efforts directed toward promoting justice and equality. This fight for justice occurs in many realms, including the realm of research.

Feminist research "seeks knowledge for emancipation" and is committed to producing knowledge that opposes gender injustice as well as injustices that are inseparable from gender divisions (Jaggar, 2008, p. ix). This purpose does not come without dilemmas. There are a variety of feminist dilemmas in research which have shifted and changed over time. One major dilemma includes the fear of replicating or re-creating unequal hierarchies and power relationships during and after the field research (Wolf, 1996). In addition to highlighting research dilemmas, feminist critiques have also greatly contributed to the field of research. Feminists have critiqued the idea of the objective knower, and claim that knowledge is always socially situated (Harding, 2004). Feminism enables people to recognize evidence others thought unimportant. It has also enabled people to question assumptions and sometimes to reframe research agendas in light of different questions (Jaggar, 2008). Jaggar (2008) writes that “feminist solidarity with those suffering from gender oppression enables them to dissociate critically from the accepted rationalizations of gender inequality" (p. 307).

Feminists may use a variety of research methodologies in their research. However, one research methodology developed and used by feminists is standpoint theory. Standpoint theory
came about in the 1970s and 1980s as a feminist critical theory which examined the relations between the production of knowledge and practices of power (Harding, 2004). Harding (2004) explains that standpoint theory consists of being an explanatory theory as well as a method or methodology to guide future feminist research. Standpoint theory claims that certain marginal social locations create a perspective or a standpoint that gives a certain epistemic advantage (Jaggar, 2008). This advantage occurs because of the insights that come with being an "outsider-within" or being on the "borderlands." Harding (2008) states that these positions may include "women, racial/ethnic minorities, the victims of imperialism and colonialism, and the poor" as being in the position of "'strangers' to the dominant culture…” (p. 336). The experience of living on the margin produces insights that those who dominate in the culture might not have. Wolf (1996) states, "In other words, one's position in the social hierarchy vis-a-vis other groups potentially 'limit's or broadens' one's understanding of others" (p. 13). There is also a crucial political component to standpoint theory. Jaggar (2008) states, "Feminist standpoint theorists assert that the standpoint of women is discovered through collective political struggle on behalf of women" (p. 305). This political struggle provides opportunity to test insights and work towards a system that does not value the dominant groups’ rights over the others.

Standpoint theory has come under a variety of attacks and criticisms, but, as Harding (2008) puts it, "the point of standpoint theory is to help move people toward liberatory standpoints, whether one is in a marginalized or dominant social location" (p. 338). The ideas in standpoint theory can give a marked contribution to social justice projects. Harding (2004) writes:

Standpoint theory's focus on the historical and social locatedness of knowledge projects and on the way collective political and intellectual work can transform a source of oppression into a source of knowledge and potential liberation, makes a distinctive
The knowledge that standpoint theory can transform a source of oppression into a source of knowledge and potential liberation is crucial for this study and for Latina women who are survivors of the mental health system.

In broadening our understanding of standpoint theory, it is important to recognize that standpoint theory is not as simple as an "us" and "them" or the "haves" and "have-nots." As Harding (2008) states, "power functions in far more complex ways" (p. 338). Common and shared positions due to race, class, gender, or nationality do not always, or do not necessarily, lead to common understandings (Wolf, 1996). Feminists, including Gloria Anzaldúa, Cherrie Moraga and Chela Sandoval, have paved ground for a more intricate understanding of the position of the "outsider-within." The "theory of the flesh" and drawing from women's lived experiences is a crucial starting point (Hurtado, 2003). Naples (2003) writes:

I found the work of Gloria Anzaldúa, and Cherrie Moraga especially helpful for broadening the intersectional framework of feminist standpoint epistemology. For example, in the preface to This Bridge Called My Back, Moraga passionately ties the political consciousness of women of color to the material experiences of their lives. This "politics of the flesh" (Moraga, 1981, p. xviii) does not privilege one dimension and artificially set it apart from the context in which it is lived, experienced, felt, and resisted." (p. 27)

Grounding standpoint theory in people's experiences provides an avenue away from essentializing the outsider-within. Standpoint theory has been presented as a way of empowering oppressed groups, of valuing their experiences, and of pointing a way to develop an "oppositional consciousness" (Harding, 2004, p. 2).

Alison Jaggar (2008) lays out several important points to standpoint theory that I want to emphasize here. (1) Standpoint theory gives us direction in selecting research projects, advising
us to begin with questions that are problematic for those on societies underside, people who are impoverished or otherwise marginalized; (2) Standpoint recommends questioning the categories of ruling elites and managing bureaucracies; (3) It advises us to award varying degrees of credibility to different knowers, depending on their social location and political engagement relative to particular subjects; (4) Standpoint requires that researchers approach their research reflexively, looking critically at their own social locations, interests, and commitments and critically assessing their own reliability as knowers.

Reflexivity, looking critically at our own social locations, interests and commitments, and critically assessing our own reliability as knowers is important when developing a research project. As researcher for this project, I must come to terms with many aspects of this research. As a Euro-American, college-educated woman, I have been afforded certain unearned privileges that I must contend with in my research. I must ask the question, how does my social position influence my research interests? Being a Euro-American, college-educated woman is not all that defines me. By growing up in a divorced family with a single mother working three jobs, my family struggled for money until my mother's remarriage. Also, I am a survivor of the mental health system and have been diagnosed with bipolar disorder. I worked for many years with Latina adolescent girls and adults diagnosed with mental illness. I am powerfully drawn to feminism and work on a daily basis in the struggle to end sexist oppression along with other intersecting oppressions. So, I must ask the following question: In what ways do these experiences influence my research interests and interpretations? Naples (2003) writes, "The goal of reflective practice is to avoid creating new orthodoxies that are exclusionary and reifying" (p. 32). In this thesis, I hope to infuse this project with social justice and refrain from creating new orthodoxies that are exclusionary and reifying.
In conclusion, standpoint theory holds a variety of strengths as theory for research but other research methods have strengths as well. In fact, several feminists argue that a phenomenological approach is preferable because it best reveals women’s standpoint (Farrell, 1992; Stanley & Wise, 1990; Langellier & Hall, 1989; Wolf, 1996). This study uses feminist standpoint theory as well as a combination of deductive and inductive research methods. In keeping with Padgett (2008), this study explores not only what the participants experience with Latina women in the mental health system, but also the situations and conditions of those experiences. Standpoint theory as a research method is similar to the phenomenological analysis (PA) in that both explore lived experiences. They differ in that PA explores the lived experience of a phenomenon (Padgett, 2008), where standpoint theory explores the lived experience of certain groups of marginalized people (Harding, 2008).

One critical piece to understanding Latina women’s resilience in their participation with the mental health system involves the mental health providers. The first person a woman comes into contact with is a mental health provider. Mental health providers’ perspectives of Latina women matter. Their perspective of Latina women’s culture, risk factors, resilience and strength all impact a Latina woman’s experience in the mental health system. This study seeks to understand how mental health providers perceive or understand Latina women as clients. I ask the questions:

1. *How do mental health system providers perceive or understand Latina women as clients?*
2. *What factors do mental health system service providers believe influence Latina women’s access to services?*
3. *What factors do mental health service providers believe influence Latina women to continue using services?*
(4) Does a mental health service provider’s positionality impact their perception of Latina women involved in the mental health system?

The answers to these questions fill a gap in the literature and help us to understand one piece of the puzzle when understanding Latina women mental health system survivors and their resilience on an environmental level.
Chapter 3: Methods

This thesis focuses on the current perceptions of mental health providers of Latina women involved in the mental health system and offers a new perspective – one of strengths and resilience. This research began as an investigation into the current models of mental health which include an overwhelming focus on biology and pathology. Feminist perspectives provide a new way of looking at women’s mental health by beginning with strengths and resilience. Resilience literature shows that the process of resilience occurs on three levels – the individual, familial, and environmental. The literature also shows that resilience through connection provides a new way of looking at resilience. This connection involves interaction with mental health service providers. The literature shows that a Latina woman’s cultural strengths and connectedness through relationships contributes to resilience. By looking at research questions through the theoretical perspective of feminist standpoint theory we can begin to see that Latina women who are mental health system survivors have key lived experiences. Part of that experience involves their interaction with mental health service providers. The perspectives of mental health system providers give only one piece of the puzzle about Latina women’s experience with the mental health system, but this is an important piece.

The research questions of this thesis are framed by feminist theory and are informed by previous research on resilience. The goal of this research is to determine how mental health service providers perceive these Latina women related to access to services and ongoing use of services. Do service providers perceive resilience as a factor that contributes to their access to services and their ongoing use of services? This may include resilience on individual, familial or environmental levels. Do providers view Latina women as resilient women who have the potential to thrive? What types of narratives do they spin about Latina women involved in the
mental health system? This study proceeds from the perspective of standpoint theory and seeks to understand a person’s subjectivity as it relates to gender, race, class, nationality, and others. Standpoint theory theorizes that positionality affects a person’s subjectivity. How does a mental health system provider’s positionality influence their perception of Latina women involved in the mental health system?

**Research Questions**

In light of the current research on resilience and framing research with feminist perspectives, this study examines four questions:

1. *How do mental health system providers perceive or understand Latina women as clients?*
2. *What factors do mental health system service providers believe influence Latina women’s access to services?*
3. *What factors do mental health service providers believe influence Latina women to continue using services?*
4. *Does a mental health service provider’s positionality impact their perception of Latina women involved in the mental health system?*

Informed by the literature review on resilience, I hypothesize that:

**Hypothesis 1:** Mental health service providers, due to the prevailing focus on pathology, will not perceive Latina women as resilient women who can thrive.

**Hypothesis 2:** Mental health service providers will attribute (a) culture, (b) gender, and (c) race as factors that affect Latina women’s access to services.

**Hypothesis 3:** Mental health service providers will attribute (a) culture, (b) gender, and (c) race as factors that affect Latina women’s continuing use of services.
Hypothesis 4: Latina women service providers will be more attuned to the nuances of (a) culture, (b) gender, and (c) race than other service providers.

To answer these questions, this study uses a phenomenological approach attempting to deconstruct the perceptions of mental health system providers. A better understanding of providers’ perceptions helps us understand one piece of the puzzle of the resilience of Latina women who are involved in the mental health system. However, before I begin to talk about the current research designed to answer these questions, I lay out information about the Latina Mental Health Needs Study (LMHN), which provided the data used to answer the research questions (Renfro et al., in press). The LMHN interviews provide an opportunity to answer the research questions. By examining interviews with mental health providers, I hope to understand how resilience connects with access to and ongoing use of services for Latina women.

Latina Mental Health Needs Study

The Latina Mental Health Needs Study (LMHN) interviewed service providers to examine three areas of interest: (1) the central mental health issues of Latina women in the Metropolitan Chicago area; (2) the services that are provided to Latina women; and (3) the barriers to accessing services that Latina women experience (Renfro et al., in press). This thesis reframes the investigation from a feminist perspective with a phenomenological approach and looks at Latina women's ability to be resilient in the area of mental health services. Service providers are in a key position to assess the factors that lead to access to services due to their experience in working with Latina women. This study seeks to contribute to a greater understanding of how mental health service providers can help Latina women in their process of resilience and show that Latina women mental health system survivors can be resilient and thrive.
**Sampling and Data Collection.** I use interviews taken from the Latina Mental Health Needs (LMHN) study. The LMHN team conducted the sampling, developed the interview protocol and completed the interviews, including transcribing and reviewing the transcriptions (Renfro et al., in press). Phenomenological analysis typically uses criterion-based sampling and long interviews for data collection (Heppner & Heppner, 2004). The LMHN team used criteria including knowledge and experience by finding the person at each agency that was the most knowledgeable about mental health and Latina women (Renfro et al., in press). The LMHN team also used a stratified sampling strategy to find the service providers for interviews (Renfro et al., in press). Stratified sampling is used for diversity in geographic areas and setting type (Singleton & Straits, 2004). The LMHN team sampled from a diverse range of areas in the Chicago Metropolitan area including the north, west, and south suburbs. They chose areas with a 150% increase in the Latino/a population in 1999-2000 and areas where Latinos made up at least 50% of the population (Renfro et al., in press). The regions sampled included Cook, DuPage, Kane, Lake, McHenry and Will Counties. Interview sites were selected for several reasons including whether they were known by the research team, through internet searches for mental health agencies, or based on referrals and personal contacts of members of the research team. Once a site was selected, a LMHN team member contacted the potential interview site and asked to speak to the person most knowledgeable about mental health and Latina women (Renfro et al., in press).

The LMHN team conducted in-depth interviews with twenty-two service providers to gain an understanding of their perspective of Latina women's mental health concerns, their access to services, and their ongoing use of services (Renfro et al., in press). There were sixteen female participants and six male participants. Eleven participants were Latino/a, eight were
Euro-American, two were African American and one was bicultural. Thirteen participants had a master's degree, five had doctoral or medical degrees, and four had a Bachelor's degree. Sixteen of the twenty-two participants conducted therapy in Spanish and many providers conducted therapy in both English and Spanish (Renfro et al., in press).

Table 1 shows the characteristics of the providers by race/ethnicity. The providers’ gender, language, and position are summarized in the table according to their race/ethnicity. In this study, race/ethnicity is broken into “Latino/a” and “Non-Latino/a.” However, this table breaks down race/ethnicity by “African-American,” “Bicultural,” “Euro-American,” and “Latino/a” to give a more detailed description of the client’s positionality. Table 1 shows that there are two African-American providers (9%), one male and one female, both monolingual in English, and that one is a social worker and one is a therapist. There is one bicultural provider (5%), she is a female, bilingual, supervisor. There are eight Euro-American providers (36%), five of whom are female, three of whom are male. Half of the Euro-American providers are bilingual in English and Spanish, and half monolingual in English. Five of the Euro-American providers are directors, two are supervisors and one is a therapist. There are eleven Latino/a providers (50%), nine of whom are female, two of whom are male. Ten of the Latino/a providers are bilingual in English and Spanish, one is monolingual in English. Three Latino/a providers are directors, one is a program coordinator, one is a psychiatrist, three are supervisors and three are therapists.
<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Total</th>
<th>African-American</th>
<th>Bicultural</th>
<th>Euro-American</th>
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<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
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<td></td>
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<td>Gender</td>
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</tr>
<tr>
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<td></td>
</tr>
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<td>Director</td>
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<td>0%</td>
<td>0</td>
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<td>5</td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
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<td>0%</td>
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</tr>
<tr>
<td>Psychiatrist</td>
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</tr>
<tr>
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<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
<td>0</td>
</tr>
<tr>
<td>Social Worker</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>5%</td>
<td>0</td>
<td>0%</td>
<td>0</td>
</tr>
<tr>
<td>Supervisor</td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0%</td>
<td>1</td>
<td>5%</td>
<td>2</td>
</tr>
<tr>
<td>Therapist</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>5%</td>
<td>0</td>
<td>0%</td>
<td>1</td>
</tr>
</tbody>
</table>

The LMHN team consisted of five researchers, most of whom are bilingual. These researchers conducted semi-structured, face to face, one-to-one in-depth interviews with the...
twenty-four service providers after obtaining a signed informed consent (Renfro et al., in press). Two of these interviews were conducted in Spanish. This study uses the twenty-two interviews conducted in English. Most of the interviews were conducted at the mental health agency; however, some were conducted in a restaurant or cafe. After the interview, participants were given a $15 Borders gift certificate. The interviews were audiotaped, transcribed and reviewed by the LMHN research team members (Renfro et al., in press). During this process, all names were removed to protect confidentiality.

The LMHN interview protocol consisted of four main sections, each related to the overall question of mental health needs for Latina women (Renfro et al., in press). In the first section, interviewers asked questions about the organization and the providers who work with Latina women. The second section consisted of questions about the mental health issues Latina women face. The third and fourth sections of the interview protocol are most important to this study. The third contained questions about access to services. And the final section consisted of questions about factors that contribute to ongoing mental health service use. After completing each interview, the interviewer then asked questions regarding demographics of the interviewee and the agency (Renfro et al., in press). See Appendix A for the interview protocol.

The Current Study

The purpose of this study is to establish the current perspective of mental health service providers and how they perceive Latina women involved in the mental health system. This study proposes that a focus on strengths and resilience provides a meaningful framework to understand Latina women who are mental health system survivors. This study seeks to answer questions about resilience as it relates to access to mental health services and ongoing use of services from mental health providers perspective. Feminist standpoint theory argues that certain groups of
people have an epistemic advantage over other groups of people based on their social location in the current hierarchical system of oppression and privilege. This study is grounded in feminist standpoint theory. This research uses a phenomenological approach with a combination of inductive and deductive methodological approaches to answer the research questions.

**Data Collection.** In the interview protocol developed by the Latina Mental Health Needs (LMHN) team, the third and fourth sections provide data relevant to this study (Renfro et al., in press). See Appendix A for the interview protocol. The third section pertains to access to services. These included questions like, "What factors do you think influence Latina women's access to mental health services?" The interview protocol gave prompts to dig further into this question by asking about which factors at the agency make it easier or more difficult to access services and what factors in the women's lives make it easier or more difficult to access services. The fourth section of the interview protocol pertains to ongoing use of services. The protocol asks, “What are the issues that influence whether or not Latina women continue receiving mental health services at your agency?” Prompts were given here as well. The protocol prompted interviewers to ask about factors at the agency that make it easier or harder to continue receiving services and factors in the women’s lives that make it easier or harder to continue receiving services (Renfro et al., in press). A phenomenological analysis grounded in feminist theories will be used to analyze the data taken from these interview questions. The data analysis provides the opportunity for the current study to answer the research questions.

**Data Analysis**

This thesis uses a feminist standpoint theory as a theoretical framework and a phenomenological analysis to analyze the transcribed interviews. Although researchers who use a phenomenological approach are often reluctant to describe specific analytic techniques because
they can be seen as rules and inflexible (Bloomberg & Volpe, 2008), I will lay out my analytic approach as clearly as possible. Padgett (2008) states, "Phenomenological studies fill an important niche by exploring the depths of human experience..." (p. 150). This thesis explores the depths of experience of mental health system providers in order to understand a piece of the puzzle of Latina women’s resilience on environmental levels. Phenomenological data analyses have a few common elements. This includes gaining an overall sense of the whole by giving a synopsis of each participant’s experience, examining the context and setting of these experiences, and summarizing the major themes associated with excerpts from the interviews (Padgett, 2008; Heppner & Heppner, 2004). During the analysis, I also explore my own personal experience with the phenomenon (Padgett, 2008).

I used the “roadmap for qualitative data analysis” developed by Bloomberg and Volpe (2008). This roadmap lays out the process used in this thesis to analyze the data. The roadmap describes first finding the “big ideas,” then suggests to re-read and examine the data, code the data, and place the codes into categories. The next step involves memo’s, data summary tables, and inter-rater reliability. The roadmap suggests revising coding scheme and adding codes. Next, Bloomberg and Volpe suggest reporting the findings including participant quotations. Finally, the roadmap suggests interpreting and synthesizing the findings. This study follows Bloomberg and Volpe’s suggested roadmap. I describe the process I used in my analysis following this roadmap.
The first step in my analytic approach included reading through the transcripts to identify the “big ideas” and the identification of recurring patterns and themes that “cut through the data” (Bloomberg & Volpe, 2008, p. 101). After I read through the transcripts, I summarized each transcript. Each summary includes (1) contextual information – the context and background of the interview, the organizational background, the history, structure, mission, and values of the organization, staff and site description, (2) demographic information – descriptive information
including the participants’ gender, ethnicity and discipline, and (3) perceptual information – participants descriptions and explanations of their experience as it relates to Latina women as clients (Bloomberg & Volpe, 2008). The summary of each interview will be included in the results section.

Next, I worked to dissect and classify the data and place sections of material into categories (Bloomberg and Volpe, 2008). I used both an inductive and deductive approach. Predetermined categories make the researcher run the risk of analyzing data by coding text units according to what you expect to find (Bloomberg & Volpe, 2008), therefore, I remained flexible and open to change throughout the entire analytic process. In my analysis, I found several major categories including “culture,” “gender,” and “race,” “individual,” “access” and “retention.” These categories correspond to each research question.

After I identified the big ideas and placed sections of material into categories, I began an open coding method where both single sentences as well as multiple paragraphs were used for coding. These codes attempted to get at what was going on in the research, as well as figuring out what the providers were saying. Bloomberg and Volpe (2008) write: “The reduction process includes questioning the data, identifying and noting common patterns in the data, creating codes that describe your data patterns, and assigning these coded pieces of information to the categories of your conceptual framework” (p. 102). I followed this description by questioning the data, noting common patterns, and creating codes that describe data patterns. This tied into categories of my conceptual framework including “race,” “gender,” “culture,” “individual,” “access,” and “retention.”

For the first research question, How do mental health system providers perceive or understand Latina women as clients? I developed new codes. These codes tied into categories of
the conceptual framework. Broad Codes of the providers’ perception were developed including “Gender,” “Race,” “Culture,” and “Individual.” Within each category, I developed codes that I used in analyzing the data – many of these codes were drawn from the participants’ words in the interviews. In the category of culture, providers discussed: their own cultural position, respect, acculturation, religion, stigma, family, traditional healing practices/curandismo, and language. In the category of gender, providers discussed: gender roles, domestic violence, acculturation, acculturating children, sexuality, secrecy, soft-spokenness, the family, relationships, and strength/resilience. In the category of race, providers discussed: derogatory terms, discrimination/prejudice, and racism, the difference between Latinas and other races, and viewing Latinas as individuals. Providers identified individual qualities that pertain to Latina women including: self-esteem, symptoms of mental illness, isolation, immigration issues, trauma, eagerness to learn, resources, and empowerment. I used these codes to examine themes found within the data.

For the second and third research questions, *What factors do mental health system service providers believe influence Latina women’s access to services?; What factors do mental health system providers believe influence Latina women to continue using services?* I used the Latina Mental Health Needs Study (LMHNS) codes “access” and “retention” (Renfro et al., in press). In the category of “access,” providers described: gendered access, awareness, cultural beliefs, internal factors, resources, social status, social support and stigma. In the category of “retention” the providers described: bond, improvement, internal factors, mental health, resources, and social support.

Bloomberg and Volpe (2008) recommend using a data summary table in qualitative data analysis. The data summary involves using pseudonyms and descriptors (which are like codes),
then calculating the number of times each descriptor occurs within an interview. I created data summary tables for each main category identified including “Culture,” “Gender,” “Race,” “Individual,” “Access” and “Retention.” Please see Appendix B for my data summary tables.

As Bloomberg and Volpe recommend, my data summary tables use descriptors and pseudonyms. The descriptors are words and themes taken from the interviews. I also developed a method for the pseudonyms to help clarify gender and race/ethnicity of each participant and to make reading the interviews easier. I have developed a system to organize the participants. Female names are given to the women and male names are given to the men. Names beginning with “A” are African-American providers. Names beginning with “B” are bicultural providers. Names beginning with “E” are Euro-American providers. Finally, names beginning with “L” are Latino/a providers.

On top of this analysis, as suggested by Charmaz (2003), I also used the coding to examine how structure and context serve to support, maintain, impede or change their statements by looking at the positionality of the interviewees. This addressed the fourth research question: *Does a mental health service providers positionality impact their perception of Latina women involved in the mental health system?* To determine the nuances of the Latino/a and non-Latino/a providers, I used the data summary tables. In these tables, I counted how many times a code was developed for Latino/a and non-Latino/a providers. I calculated the number of times codes were used for each provider. I then added the number of codes among Latino/a and non-Latino/a providers. Because the interviews were half Latino/a and half non-Latino/a, I was able to compare this number to see which group had more incidents of codes. The number of codes made for each aggregate group showed how much the Latino/a and non-Latino/a groups had to say in their descriptions of Latina women. I also examined the silences – or gaps – that I
identified in many of the interviews with non-Latino/a participants. As I read through, sorted, and coded the data, I also wrote memos to help guide my analytic process.

In summary, my data analysis attempts to determine the perception of mental health system providers of Latina women. To do this, I use standpoint theory as a theoretical framework and phenomenological analysis to analyze the data. After identifying the big ideas, summarizing each transcript, and placing the information into categories, I used an open coding method. After creating and using codes developed for each conceptual category, I created data summary tables for each main category. This process worked to answer the first three research questions. For the fourth research question, I calculated the number of codes made for Latino/a and non-Latino/a providers and compared the numbers to determine if one group had more to say in their responses than the other. Analyzing the data created results with a wealth of information. This information will be displayed in Chapter 4: Results.

Relevance, Impact, Outcomes

This project is important for many reasons. Women’s and Gender Studies will be advanced because there is a gap in feminist literature on mental health. The field of Women’s and Gender Studies will be advanced through this research because there will be more research on resilience and the transformation of pathologizing language. There is also a gap in the literature in psychology around Latina mental health concerns, particularly as they relate to strengths and resilience. Focusing on resilience – on individual, familial, and environmental levels – helps to identify more effective preventive measures in treating women with mental health needs. There is also a gap in social work literature on using the strengths perspective with Latina women in the mental health system. By looking at resilience, we may come to see Latina women as dynamic players in social context. This research seeks to understand Latina women's
access to services and ongoing use of services. Obtaining an understanding of the perception of mental health service providers of Latina women gives us one piece to the larger picture of the resilience of Latina women mental health system survivors. This research is relevant to people interested in feminist perspectives as well as to psychologists, social workers, and those interested in the mental health of Latina women. Ultimately, this research will impact the lives of Latina women receiving mental health services. As Aurora Levins Morales has said: we seek integrity and grow toward creative and just solutions, sometimes by crooked paths, but always reaching. Although the women examined in this study have sought integrity through paths that led them to the mental health system, this research hopes to gain a new, more socially just perspective of their situation. This research looks at women who are mental health system survivors not as ill and pathological, but as women with strengths and resilience who have the potential to thrive.
Chapter 4: Results

This chapter lays out the results of this study. The chapter begins with a review of the purpose of this study. There is a lengthy summary of the twenty-two interviews in alphabetical order. Following the interviews, the findings are described in detail. Finally, the chapter concludes with a summary of the findings.

The purpose of this study is to establish the current point of view of mental health service providers and how they perceive Latina women in the mental health system. This study proposes that a focus on strengths and resilience provides a meaningful framework to understand Latina women involved in the mental health system. This study uses standpoint theory as a theoretical framework for the methodology. In light of the current research on mental health and framing research with feminist perspectives, this thesis examines four questions:

1. *How do mental health system providers perceive or understand Latina women as clients?*
2. *What factors do mental health system service providers believe influence Latina women’s access to services?*
3. *What factors do mental health service providers believe influence Latina women to continue using services?*
4. *Does a mental health service provider’s positionality impact their perception of Latina women involved in the mental health system?*

Informed by the literature review on resilience, I hypothesize that:

*Hypothesis 1: Mental health service providers, due to the prevailing focus on pathology, will not perceive Latina women as resilient women who can thrive.*

*Hypothesis 2: Mental health service providers will attribute (a) culture, (b) gender, and (c) race as factors that affect Latina women’s access to services.*
Hypothesis 3: Mental health service providers will attribute (a) culture, (b) gender, and (c) race as factors that affect Latina women’s continuing use of services.

Hypothesis 4: Latina women service providers will be more attuned to the nuances of (a) culture, (b) gender, and (c) race than other service providers.

Ultimately, I suggest an approach to treatment of Latina women that comes from resilience and strengths-based perspectives which give a more holistic understanding of the women and provides for better outcomes. This chapter presents key findings from 22 in-depth interviews. I will first include a summary of each of the interviews. I will then discuss the findings from each coded section.

The findings from this study on mental health system providers’ perspective of Latina women prove to be informative. Four major findings emerged from this study:

1. The majority (20 of 22 [91%]) of mental health providers did not see Latina women as resilient. Two of the providers (9%) identified their clients as resilient and used a strengths based/empowerment model with their clients. The providers identified a variety of cultural, gender, racial and individual factors to describe their clients.

2. The providers perceived the following as affecting access to services: gender, awareness, culture, internal factors, resources, social status, social support, and stigma.

3. The providers perceived the following as affecting retention and ongoing use of services: resources, social support, bond, and improvement.

4. Of a total of 686 coded responses, 402 (59%) were from Latina providers, 284 (41%) were from non-Latina providers. This implies that Latina providers had a more to say about Latina women than non-Latina providers as half of the interviews were with Latino/a providers and half were with non-Latino/a providers.
Summary of Interviews

Organization of Pseudonyms. I have developed a system to organize the participants’ responses using pseudonyms. Female participants are given female names and male participants are given male names. Names beginning with “A” are African-American clients. These include the names: Aaron and Amanda. Names beginning with “B” are bicultural clients. This includes the name Betsy. Names beginning with “E” are Euro-American participants. These include the names: Edward, Eli, Elisa, Elizabeth, Ellen, Emily, Erin, and Ethan. Finally, names beginning with “L” are Latino/a clients. These include the names: Lacy, Laura, Lauren, Laurence, Laurie, Leslie, Lily, Linda, Lindsey, Loretta, and Luis. I also organize them alphabetically. I use pseudonyms to make reading the responses easier. This particular system using the clients race/ethnicity was developed because I use standpoint theory and the positionality of the participants is important when considering the responses.

Characteristics. The following table gives the name and characteristics of each provider. This table breaks down the providers’ characteristics by gender, race, language and position. The chart shows the following: Aaron is a male, African-American, monolingual, social worker. Amanda is a female, African-American, monolingual, therapist. Betsy is a female, bicultural, bilingual supervisor. Edward is a male, Euro-American, bilingual, medical director. Eli is a male, Euro-American, monolingual, director. Elisa is a female, Euro-American, monolingual, director. Elizabeth is a female, Euro-American, bilingual, social worker/director. Ellen is a female, Euro-American, monolingual, case manager supervisor. Emily is a female, Euro-American, bilingual, therapist. Erin is a female, Euro-American, monolingual supervisor/team leader. Ethan is a male, Euro-American, bilingual, director. Lacy is a female, Latina, bilingual, program coordinator. Laura is a female, Latina, bilingual, supervisor/manager. Lauren is a female, Latina, bilingual,
psychiatrist. Laurence is a male, Latino, bilingual, therapist. Laurie is a female, Latina, bilingual, program director. Leslie is a female, Latina, bilingual director. Lily is a female, Latina, monolingual, director. Linda is a female, Latina, bilingual, supervisor. Lindsey is a female, Latina, bilingual, supervisor. Loretta is a female, Latina, bilingual, therapist/intake coordinator. Finally, Luis is a male, Latino, bilingual, therapist.

Table 2. Description of Providers’ Pseudonyms by Gender, Race, Language and Position

<table>
<thead>
<tr>
<th>PSEUDONYM</th>
<th>GENDER</th>
<th>RACE</th>
<th>LANGUAGE</th>
<th>POSITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aaron</td>
<td>Male</td>
<td>African-American</td>
<td>Monolingual (English)</td>
<td>Social Worker</td>
</tr>
<tr>
<td>Amanda</td>
<td>Female</td>
<td>African-American</td>
<td>Monolingual (English)</td>
<td>Therapist</td>
</tr>
<tr>
<td>Betsy</td>
<td>Female</td>
<td>Bicultural</td>
<td>Bilingual (Spanish/English)</td>
<td>Supervisor</td>
</tr>
<tr>
<td>Edward</td>
<td>Male</td>
<td>Euro-American</td>
<td>Bilingual (Spanish/English)</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Eli</td>
<td>Male</td>
<td>Euro-American</td>
<td>Monolingual (English)</td>
<td>Director</td>
</tr>
<tr>
<td>Elisa</td>
<td>Female</td>
<td>Euro-American</td>
<td>Monolingual (English)</td>
<td>Director</td>
</tr>
<tr>
<td>Elizabeth</td>
<td>Female</td>
<td>Euro-American</td>
<td>Bilingual (Spanish/English)</td>
<td>Social Worker/Designer</td>
</tr>
<tr>
<td>Ellen</td>
<td>Female</td>
<td>Euro-American</td>
<td>Monolingual (English)</td>
<td>Case Manager/Supervisor</td>
</tr>
<tr>
<td>Emily</td>
<td>Female</td>
<td>Euro-American</td>
<td>Bilingual (Spanish/English)</td>
<td>Therapist</td>
</tr>
<tr>
<td>Erin</td>
<td>Female</td>
<td>Euro-American</td>
<td>Monolingual (English)</td>
<td>Supervisor/Team Leader</td>
</tr>
<tr>
<td>Ethan</td>
<td>Male</td>
<td>Euro-American</td>
<td>Bilingual (Spanish/English)</td>
<td>Director</td>
</tr>
<tr>
<td>Lacy</td>
<td>Female</td>
<td>Latino/a</td>
<td>Bilingual (Spanish/English)</td>
<td>Program Coordinator</td>
</tr>
<tr>
<td>Laura</td>
<td>Female</td>
<td>Latino/a</td>
<td>Bilingual (Spanish/English)</td>
<td>Supervisor/Manager</td>
</tr>
<tr>
<td>Lauren</td>
<td>Female</td>
<td>Latino/a</td>
<td>Bilingual (Spanish/English)</td>
<td>Psychiatrist</td>
</tr>
<tr>
<td>Laurence</td>
<td>Male</td>
<td>Latino/a</td>
<td>Bilingual (Spanish/English)</td>
<td>Therapist</td>
</tr>
<tr>
<td>Laurie</td>
<td>Female</td>
<td>Latino/a</td>
<td>Bilingual (Spanish/English)</td>
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</tr>
<tr>
<td>Leslie</td>
<td>Female</td>
<td>Latino/a</td>
<td>Bilingual (Spanish/English)</td>
<td>Director</td>
</tr>
<tr>
<td>Lily</td>
<td>Female</td>
<td>Latino/a</td>
<td>Monolingual (English)</td>
<td>Director</td>
</tr>
<tr>
<td>Linda</td>
<td>Female</td>
<td>Latino/a</td>
<td>Bilingual (Spanish/English)</td>
<td>Supervisor</td>
</tr>
<tr>
<td>Lindsey</td>
<td>Female</td>
<td>Latino/a</td>
<td>Bilingual (Spanish/English)</td>
<td>Supervisor</td>
</tr>
<tr>
<td>Loretta</td>
<td>Female</td>
<td>Latino/a</td>
<td>Bilingual (Spanish/English)</td>
<td>Therapist/Intake Coordinator</td>
</tr>
<tr>
<td>Luis</td>
<td>Male</td>
<td>Latino/a</td>
<td>Bilingual (Spanish/English)</td>
<td>Therapist</td>
</tr>
</tbody>
</table>
In the next section, I will summarize the 22 interviews. They are placed in alphabetical order by pseudonym. Each summary includes (1) context and background of the interview, the organizational background, the history, structure, mission, and values of the organization, staff and site description, (2) demographic information – descriptive information including the participants’ gender, ethnicity and discipline, and (3) perceptual information – participants descriptions and explanations of their experience as it relates to Latina women as clients (Bloomberg & Volpe, 2008).

1. AARON – African-American, Monolingual (English), Social Worker:

Aaron is an African-American, male, social worker. The mission of the hospital is to “provide care and the treatment for mentally ill adults and to improve their lives and return back to the community.” He states, “Latinos are generally more family oriented, religious oriented, and probably were skeptic about coming. That was a stigma, but I think that since the word’s gotten out in the community that yeah we can go there, we have many of us here and its gets out.” He states that they don’t have many bilingual staff members. They don’t have any Spanish speakers in house, but some that come from the outside. He said they lost two social workers who were bilingual. He states: “I do believe that a person should be able to have that knowledge of the field. You can interpret, but you have to know what you are interpreting for. Yeah, culturally, yeah, you understand, but you have to be knowing what the services are and what they should be doing…” He says in the past year, he’s probably worked with about twelve Latina women. Aaron spoke about how there are certain agencies that serve Latina women but that the segregation is a problem. He thinks it would be better to bring someone who speaks Spanish and incorporate them into the unit, rather than isolating Latina women to one agency. Most of the
women he serves are from Mexico, from 18-60 y/o, from varied SES, with sixth grade education on average, usually second generation, and usually come in for depression.

Aaron identifies factors that influence mental health of Latina women. He identifies economics, the family structure, and male-female relationships on the individual level. “I find more problems with the male dominator. Male dominated structures in the family, where the women really are selfish versus too permissive.” On the level of the couple, Aaron identifies physical or sexual abuse, or cheating husbands as problems that affect mental health. On the level of the family, Aaron states that, “Family stuff with other members is pretty good. I mean in terms of housing, how females talk to sisters, mothers, brothers, husbands, that’s generally good.” He states that the neighborhood is not generally a stress on Latina women. He also does not identify political factors that affect mental health. He states, “I haven’t heard much anything about the political factor. I don’t know if it is because they don’t hold much political actions. Uh it’s probably not a whole lot at all. I haven’t seen that.”

Aaron discusses factors that make it easier and harder to access services which includes a discussion of stigma as well. Aaron states that the language barrier is a problem for access to services. But, he states, “That shouldn’t be the case because before we discharge any of the clients we should be able to get an interpreter and bring them in to say this is what we want to do. This is how we want to connect through here.” He states that stigma outside the hospital prevents Latina women from coming in, but he believes that stigma is a barrier that has been broken down. He states, “But generally that hasn’t been an issue anymore because that’s kind of that barrier has been kind of broken down. Because if the new generation of the Hispanic clients out there who generally are accepting help, you don’t have this old condition no more.” He identifies family as a factor from individuals’ lives that make it easier to access services. Factors
that make it harder to access services include old traditions. He states, “If that woman clings to 
old values. Old traditions that their thinking ‘Oh well you don’t need this. You need this. This 
will cure this.’ You know that thinking.” Once people do access services, Aaron states that 
stigma goes away. He says, “I think they are curious to understand something that they really did 
not think it could have been, but they accept it once they find out because they’re here and 
medications[…]. They’re usually accepting of treatment.”

He discusses factors that make it easier and harder to continue receiving services as well. 
He identifies familiarity with the language as important for ongoing use of services. He also says 
it depends on the therapist. He states, “But it depends on the therapist. I really do believe I made 
a good great connection to many of the women that I’ve worked with. Some with whatever little 
Spanish I speak. I mean it was appreciated. I think I didn’t have any problem at all with that with 
that aspect.” He identifies language as the primary problem. He states, “not necessarily someone 
who is Hispanic, but someone who can communicate with them.” Aaron mentions that if there 
are family members who have gone through mental health services helps continuing services. He 
feels that some Latina women fear what social workers are going to do with the information, like 
for example, that the government may use their information against them. He identifies language 
and the ability to communicate as the most crucial element for quality mental health services that 
help with ongoing use of services.

2. AMANDA – African-American, Monolingual (English), Therapist:

Amanda is an African-American, woman, therapist. The hospitals mission is to get 
individuals who are suffering from acute psychiatric illnesses and to stabilize their illness and 
then transition to outpatient services. Their agency has no bilingual staff members and no 
Latino/a staff members. She has one Latina client at the time of the interview. She has noticed an
increase in Latina women who come in for service, but language is a problem. In a given month, Amanda probably sees 10 max Latina women. Most of the Latina women come from Mexico. Most of the women she sees are young (early 20’s), half are employed, most with seven years of education, and almost all are immigrants and are low-income. The women come in because they are the only hospital who doesn’t turn anyone away. Amanda states that her work with Latina women differs from her work with people from other racial/ethnic groups. She states that language is the first difference because she needs an interpreter. She says, “I think it creates a barrier for interacting with that person…” but “in terms of treatment I mean it’s like how I treat everyone, you know, as individuals. You know, I don’t treat one group I know this is the group I treat the group this way even diagnosis I treat all depressed individuals this way or bipolar individuals this way. It’s by individuals.” The most common reason Latina women come to see her is for depression. She also sees some who are pregnant and depressed. She had one with schizophrenia and auditory hallucinations.

Amanda discusses factors that affect mental health on several levels. On the individual level, Amanda states that self-esteem is a big issue. This stems from abuse the women may have experienced as a child – sexual, physical or emotional abuse – or from abuse in marriage. She says that she tries to empower the women that come see her and she encourages them to talk about what is on their mind. She says, “Because a lot of the time the females tend to be a little bit more quiet and can be shy, soft spoken kind of thing.” The dynamics of the couple affect mental health because, she says, “it is pretty uh patriarchal in which the male is kind of the ruler of the home…Marital discord is usually related to the upkeep of the home, the care of the children or infidelity on either part really.” She states that dynamics in the family – like isolation – can affect Latina women’s health. On the environmental level with the community or neighborhood,
Amanda identified language and immigration issues are the primary issues that affect mental health. As far as cultural beliefs, Amanda states: “Well, I think that, you know, the message seems to be that the man is the head of the household and you know kind of like men are heard over the female, and I think that can be depressing in and of itself.” She states that some of the women are stay at home moms and they want to go out and work, make more friends. As far as political or societal factors that affect mental health, Amanda discusses her own experience with Latinos coming to the area. She states, “Well yeah…for a person who has kind of grown up in the area it can be kind of cultural shock because we had this mass influx of Hispanics come into the area. […] So, yeah, I grew up in the area and its been like this mass influx of individuals and uh so you know prejudices and stereotypes and all those types of things are revisited, of course you know, on both parts.” She states that people in the area have not reacted pleasantly to Latinos coming to the area. There have been protests and police may be targeting Hispanic drivers for insurance and drivers licenses. She says, “So there has been a lot of protests and a lot of issues that are community related so I think that it’s a shock for everyone and adjustment for everyone sort of like this hospital I think the area itself is going through an adjustment phase.”

Amanda is asked about factors that affect access to services. She identifies the language barrier as making access to services more difficult. She cannot identify any other things in Latina women’s lives that might make it harder or easier for them to access services. She says, “No, like I said, we service everyone whether you have insurance whether you don’t have insurance […] we service everyone. I think the biggest thing is the language.” Stigma also affects access to services. Amanda states that when she worked with a program for children, the mothers wouldn’t want the fathers to know about the services. She says, “The father, the males in the home, didn’t believe in mental health services and uh didn’t feel like their family, personal lives shouldn’t be
When asked about what Latina women’s beliefs about mental health are, Amanda states: “Well, I don’t know, the ones who come in here I guess are ok with it! (laughing) I mean the ones that come in you know… I have heard them say that different family members saying that you know they don’t believe in mental health treatment and that things should be handled in the home stuff like that…” Amanda identifies that some husbands don’t want their wives taking psychotropic medications but that others are supportive especially as time goes on. Amanda identifies that whether it is a Latino person or a person in general that there are a lot of myths and uncertainty about receiving mental health treatment – especially upon one’s first admission. Some of those “myths” include stigma. She says, “Well you know the whole labeling thing, ‘I’m crazy’ you know if I come to the psychiatric ward I’ll never get out of here and um I have to be in a psych ward forever. The biggest thing is I’m crazy and I don’t want to be crazy. I’ll have to take medication all my life, you know, that sort of thing. My family will disown me if I uh receive mental health treatment. Those sort of things kind of uh common things that we hear, yeah.”

Amanda discusses factors that make it more harder or easier to continue receiving services. She mentions language as the main reason why someone might continue or not continue services. She also mentions education about mental health care. As far as quality mental health services for Latina women, Amanda mentions language again. She says, “I think that the hospital in general needs to start promoting looking for recruiting Spanish speaking psychiatrists, nurses, workers for everything or at the very least provide training so that you know both of us who don’t know or cannot speak Spanish or only speak a little Spanish can have at least the minimum ability to interact with the patients that we have.”
3. BETSY – Bicultural, Bilingual (Spanish and English), Supervisor:

Betsy is a bicultural, bilingual, woman who is a supervisor of an agency designed to prevent child abuse and neglect. Betsy was identified as Euro-American in the Latina Mental Health Needs Study (Renfro et al., in press), but self-identified in the interviews as bicultural. Therefore, I have labeled her as bicultural. At Betsy’s agency, there are 10 people on staff, plus the director, all of whom are bicultural and bilingual. They currently serve over 100 Latina women, about 95% Mexican, one Colombian. Their clients are of low SES, low education levels, and most first generation. The women typically deal with depression and low self-esteem.

Betsy discussed factors that affect mental health in Latina women. She identifies depression, low self-esteem and isolation on the individual level. On the relationship level, she identifies domestic violence and sexual, physical and psychological abuse. On the family level, she discusses language and isolation. She states, “The fact that they don’t speak the language. The fact that most of them they don’t have real family.” Plus, she mentions difficulty finding a job and with transportation. On the cultural level, Betsy discusses traditional gender roles. She states, “I think that their husbands get to do whatever they want. They can be rude or domestic violence. It’s okay these kind of things.” She identifies immigration as the primary influence of mental health on the political/societal level.

Betsy discusses factors that make it easier and harder to access services. She identifies transportation, language, cost, and childcare as the primary factors that affect access to services. Stigma is also discussed as affecting access. Betsy agrees that Latina women find mental illness stigmatizing. She says that they don’t tell their friends or members of the family about it. She states, “I think that unless they are desperate, they are not gonna go. Some of them are open. Like some they see the need or the benefit that they will receive.” Betsy thinks that higher
acculturation makes some women more open to therapy. She tells her clients that “Post-partum depression is caused biologically and there’s nothing, you know, there’s nothing wrong with that. You don’t have to feel guilty about that.”

Betsy also discusses factors that make it easier or harder to continue receiving services. She states that if they see progress and if they have the support of their family they will continue services. She states that sometimes women stop services because they get two jobs and their financial situation causes them to stop. Betsy discusses quality mental health services that could help with retention. She mentions language and bicultural services. She states, “That they would be in Spanish. That would be also bicultural, meaning that they can understand some of the issues that they go through. Free would be fantastic.” Plus, she mentions transportation and childcare and therapists that can go to their houses.

4. EDWARD – Euro-American, Bilingual (Spanish and English), Medical Director:

Edward is a Euro-American, bilingual, male, medical director of a hospital which has inpatient and outpatient psychiatric treatment and programs for children, adolescents and adults with three hospitals; one for Hispanics, another for Polish, and another for English speaking patients. Of the staff, he states that about 50% speak Spanish in the mental health center. Out of 600 patients about 1/3 of them are Latina women. The majority of the women are Puerto Rican and Mexican with some coming from Central America, Nicaragua, Honduras and a minority coming from Guatemala and Costa Rica. The women are mostly 18-80 y/o, lower and lower-middle-class, with grammar school and high school maximum education, some with college education, and most are first or second generation.

Edward states that his work with Latina women differs from work with women from other racial/ethnic groups because of his experience with working with a diverse range of Latina
women from different Latin countries. He also discusses the difference between rural women and women from the capital. He states, “So there is a tremendous variation so it is impossible to talk about Latina women.” When asked how his treatment of a Latina woman might differ from, say, an African-American client, he answers, “You do things according to how do they perceive themselves.” Edward states that most of the issues Latina women come dealing with are anxiety, loneliness, issues of being in a marriage that they don’t want to leave because of economic reasons, issues of marital abuse, issues with children who are disrespectful because they don’t speak English. He states there are many issues but the main ones are depression, anxiety, and marital problems.

Edward describes individual, relationship, community and political factors that influence mental health. The individual level factors that influence mental health of Latina women, in Edward’s opinion, include dependency, “being at the mercy of their husbands,” and “in a certain sector, and I think that the population that I see, the women are considered like property and people that are for those types of tasks; cleaning, taking care of the children, cooking…” Within the couple, Edward states that many of the husbands bring their wives to help them, but when they get better and more opinionated the husbands don’t want them coming back “because they are becoming too independent or coming with new ideas.” He states that generally he encourages them to become more independent and some husbands don’t like that. Family dynamics affect mental health because generally women are taking care of many children and serve their husbands. He states, “There are very few that can tolerate such amount of pressure. […] So sometimes eh when the violent man or the husband who is authoritative and has high expectations and also doesn’t value the work that women do at home the situation can become unbearable for these patients and many of them attempt to commit suicide.” In the
neighborhood/community context, Edward states: “I think that in many of the neighborhoods that are surrounding the hospital there is a climate of instability.” He identifies high crime rates and drugs as problems that affect mental health. For cultural beliefs that affect mental health, Edward states that there is more openness about receiving mental health services. There are political/societal factors affect mental health as well. He states: “The synthesis of everything that is happening in society. I think that the poor habitants people living in home where there are two or three families would increase promiscuity, lack of comfort, lack of space.” He also states that lack of education, poverty, medical illness, poor eating habits, and exposure to alcohol and drugs are all factors that influence mental health on a political/societal level.

Edward discusses access to mental health services. He states that the fact that more that 50% of their therapists are Latina, from the community, who know the culture, the barrio or the neighborhood helps with Latina women coming in for services. He states, “Ideally Latino is very typical that they don’t want to see, in general, professionals from other ethnic groups.” Transportation is a barrier to access to services. Edward also states that when there are other members in the family that are seeking mental health professionals makes it easier for them. He states that Latina women don’t want to come in when they are dealing with issues of sexuality. He states, “Especially younger women that are lesbian or bisexual they have more problems in coming to our service because of the fear of being rejected or labeled or anything like that.”

In regards to stigma, Edward states that stigma is less of an issue now than it was in the 90’s. “The advertising of mental health issues in channel 44 and 66 and other Latino channels has been very helpful.” Edward states that the women who come in are willing to do what is necessary to improve their situation. He describes women who discover that they can demand respect from their husband or their boyfriend. Edward describes this as very rewarding and
gratifying. He states, “They were women that were abused, they have very low self-esteem, they never fight for their right, and now you know I am sometimes you know I am sometimes amazed to see the changes – 180 degrees stimulated by us.” Edward discusses ongoing use of services. He states that sometimes the fear that the husband will tell them not to come anymore is an issue for ongoing services. He also states that sometimes there is someone in the family telling them not to follow the suggestions. He gives an example of a young woman with severe bipolar disorder. The mother told her daughter to abandon the medication and to take different kinds of teas. He states, “And this patient has had three hospitalizations and finally she is convinced that the mother had good intentions but the mother has helped her get into a lot of trouble because she stopped the medication based on the mother’s advice.” Edward gave another example of a woman who gained weight on her medications and the husband wanted her to stop the medications because of that and she got very, very sick again. Another issue Edward identified is transportation and finances for medications.

He states that quality or effective mental health services for Latina women includes an empathic therapist who “understands the patients language and their patients culture, that is aware of the economic hardships that many of these patients are going through, that knows eh sociologically all the issues that surround the patient of the social class where the patient comes from, that they are aware also of the machismo in the Latino culture, and what they suffer through those types of association with those male types.” Edward also sees that issues of marital abuse has to be a priority. He states, “I think that many of these women have suffered sexual abuse at an early age.” Prevention is a major way to improve Latina mental health. He also mentioned abortion and prevention of pregnancy because children are difficult when you can’t take care of them.
5. ELI – Euro-American, Monolingual (English), Director:

Eli is a Euro-American, male, director. He does therapy and outreach services with Latino/a clients. They serve about 10 Latina women out of around 300 clients. The Latina women they serve come mostly from Mexico and some from Ecuador and one from Columbia, mostly first generation, some second generation. Most of the women they serve are from lower socioeconomic class and many are undocumented with difficulty finding jobs. He states that in graduate school he studied the Latino/a community in Chicago so that reaching out and becoming familiar with the Latino/a community has become a part of his professional work. Eli also states that he is from a small immigrant community – the Polish community. He says, “I felt that I was very ethnocentric in that way, even though it was not from a, what would be considered a minority group.” He also explains that he was in the Peace Corp in Western Samoa and this experience shaped his perspectives. He says, “I think it makes me very sensitive to the fact that where we come from and our ethnic backgrounds are very important.” His work with Latina women differs from work with women from other racial/ethnic groups in several ways.

Language is a major difference. He describes the importance of making the client feel comfortable. He says, “For example, even when I have an African-American intern or if I have a European staff or intern working with an African-American client. I talk with them about the fact that at some point the issue of the comfort level of dealing with someone from a different ethnic group or racial background is really important.”

Eli describes factors that affect Latina women’s mental health. Latina women facing marriage problems with abusive husbands and difficulty with mental illness are described as affecting access. He states “What I have found is that in a traditional Latino…uh society…what’s the term I want…the extended family is so important but then when families
come to the United States for one, they lose a lot of that support...” Eli also talks about natural healing practices. He states: “A lot of our families, Latina families, especially the women I think turn to...um what would be the term...more native approaches to...folk healing...Or they’ll go to faith healers and get herbal medications and things like that. But, this isn’t often talked about because especially if you don’t have a Latino therapist because I think there is a sense that we wouldn’t...Anglos wouldn’t accept or understand that.” Eli identified neighborhood/community factors that affect mental health. He states that stigma is a problem in the community, as well as children joining gangs, drug and alcohol problems. On the political level, Eli states that the community is in transition. He states, “When I first started here minority families were not really welcomed.” Eli states that the village was under court order to try to hire more minorities. But, “Now, that is not the case as much now. We have more minorities, still a small percentage, but more minority people working for the village, we have more minority people living in the village, and we actually have a diversity group that meets...So there is more openness I think.”

Eli discusses factors that make access to services and ongoing use of services easier or harder. He talks about how different it is in his community compared to other communities that have more Latino/a people. He says that he thinks that over the next 10-20 years there will be a change with more “bilingual services are available in stores or that there will be more 2nd and 3rd generation Hispanic families who will be more comfortable in English and be able to access services.” He states that even though many at the agency don’t speak Spanish they are still sensitive because of the kinds of discussion they have and their training approach to counseling. Eli describes churches in the community as an important part of helping Latina women access services. He focuses on the language barrier. He says, “I think that as a society we are kind of schizophrenic, in that we are supposed to, you know we have as a big image the Statue of Liberty
in that is welcoming to everybody and yet we still have people who want to make English as the official language in the state or the city.” Stigma affects access to services as well. Eli describes stigma in Latina women’s families and a preference for natural remedies. “I think that’s part of traditional ideas that Hispanic families come with, in that there is a stigma in seeing a psychologist or social worker, and that’s why I think that more native remedies would be the first choice.” Eli explains that they treat Latina clients the same as they treat all the clients in terms of their counseling approach. He also states that some Latina women have a difficult time talking about their private family business to a stranger. Eli spoke at length about a specific family where the mother protected the abusive husband. The daughters in this family told Eli that their father was abusive, but the mother would keep it hidden and deny it. Eli states: “And I think part of the dynamic is that often times, the Latina wife or mother has to protect the father or protect the family and keep all that quiet.”

To keep Latina women coming for services, quality mental health services are discussed. Eli explains, “So good mental health with cultural sensitivity and bilingual ability is what I would say would be good services to Latina women.” When asked what is culturally sensitive, Eli responds, that you can’t operate from assumptions, and that you have to listen to what the client is saying, and come up with the language that is meaningful to both of you.

6. ELISA – Euro-American, Monolingual (English), Director:

Elisa is a Euro-American, woman who is director of the women’s mental health program at a hospital. The mission of the program is to provide evidence-based cutting edge care for women with psychiatric symptoms that relate to gender or to reproductive cycle of a woman. Elisa states that the clinic is very diverse, but is unsure about how many Latina women they serve. Their agency has three psychiatrists, two psychologists, several social workers as well as
nursing and occupational therapy staff. None of whom are Latina or Bilingual. Some of the nurses do the translating. She states, “I should add, by the way, you didn’t specifically ask but I think it’s worth noting that we have a program here specifically to try and recruit and retain faculty members who are Spanish-speaking and Hispanic…but it didn’t work. So, it’s not easy.” Elisa created the program, designed it, implemented it, oversees it and continues to maintain and grow it. She provides direct care to outpatients and sometimes is on call for the inpatients and she supervises trainees. When asked specifically what types of Latina women the agency sees, Elisa responds: “It’s pretty diverse.” She states, “Well in a sense services have to be tailored to each individual person. In other words, we have found that we can’t really make generalizations saying treating all Hispanic patients x way or y way.”

She also describes taking into account cultural background. She states, “Nevertheless, we very much have to take cultural background into account in figuring out how people will understand and conceptualize and articulate their inner experiences. What we might regard as a symptom, somebody else might regard as not a symptom but as perhaps a religious experience, perhaps something that was a consequence of their behaviors in some culturally understood way.” Elisa also describes the influence of family members, degree of acculturation and other factors that influence use of services. She states, “We see a very diverse population of Hispanic women, so depending on exactly what subculture a person is from, somebody from Peru might have a very different conceptualization from somebody say, Mexico, and even within Peru there might be a very poor person from Peru, a very wealthy person from Peru…all of that matters.” Elisa states that they usually service Hispanic women indirectly through consulting with their primary care sites. She describes stigma, stating, “We find there is widespread fear of being identified as a patient with psychiatric problems, that sometimes the fear is in the woman herself,
very often the fear is in her family members, could be her husband, could be her parents. There is a fear of disclosing to family members in many cases…” which can lead to transportation problems. Elisa states that most of the women come seeking help for interpersonal difficulties, “especially with their partners and with their gender roles” which strongly influence their symptoms and vulnerability to depression and anxiety.

Elisa describes factors that influence mental health on the individual level, relationship level, familial level, community level and political level. On the individual level, she states, “What we know about that to the extent that we understand is that many people start out with genetic vulnerabilities and genetic resiliencies and that early on life experiences especially severe early life stress, that’s sexual abuse or physical abuse, plays a profound role in what happens to those genetic vulnerabilities and resiliencies.” She also states that you can’t separate individual factors from contextual factors. She states, “They are constantly in an interplay with one another.” Elisa informs us that a high percentage of women have been abused. She states that acculturation rates differ between women and men, that women acculturate faster. She says, “But, if the acculturation rates differ and the man is more interested in some respects, especially with respect to gender roles being more traditional, that can be a source of conflict.” Elisa identifies different levels of acculturation or different value systems between generations, “which is the case for probably many families but is intensified by immigration and moving to a very new and different culture.” She also identifies a lack of social support because of immigration. In the neighborhood, there are factors that influence mental health. Elisa states, “If a neighborhood seems organized, safe, reliable versus dangerous, chaotic, unpredictable it safely creates a very different level of either chronic stress or general feelings of safety and security.”
Elisa identifies cultural issues that influence mental health as well. She shows that there is a link between religious beliefs and cultural beliefs. She states, “In Latino cultures it is often difficult to separate out religion from culture in that respect.” Elisa also identifies that internal and external factors make it easier and harder to access services. She states that money, transportation and language are factors. She states that citizenship is a factor. She also identifies some obstacles that lie “within the woman” citing “stigma against mental illness or fear of stigma, again it is an interaction between the woman and her surrounding culture or in her family members, even if she acknowledges that she has a problem and would like to seek psychiatric care she might not be able to because of family opposition.” Elisa states that bringing in key family members helps with retention. Retention is also influenced by cultural beliefs. She describes a situation where a woman is experiencing a side effect and doesn’t want to voice any opposition to the medication because of deep respect for the physician. Quality and effective mental health services for Latina women are described as: “Services that are based on the latest research data and yet also take into account the more ineffable influence of culture and life circumstances.”

7. ELIZABETH – Euro-American, Bilingual (Spanish and English), Social Worker:

Elizabeth is a Euro-American, bilingual, woman who is lived in Peru for a long time and is a social worker/director of a Spanish speaking post-partum mood and anxiety disorder program. She sees about thirty Latina clients, about 90% are Mexican, 1% Puerto Rican, and then some South and Central American women from Venezuela, Guatemala, and Honduras. The women are “childbearing age” anywhere from 12-46 y/o, of low SES, 90% undocumented, 90% first generation, with mostly grade school education. When asked how her work with Latina women differs from her work with women from other racial/ethnic groups, she states that when
she covers for a colleague it’s much easier to find resources for English speaking clients. The service needs for her clients are complicated. She states, “Also there’s quite a bit of domestic violence. And racism and being exploited. So I deal with those issues as well.” She works with women who deal with depression, anxiety, some schizophrenia, very little substance abuse and a lot of domestic violence. She states that with the English speaking program, they ask if a person hears voices, but not with their Latina ladies “because there are a lot of women that if they don’t hear voices, a lot of them have magical thinking. So, they kind of were raised with belief system like if you hear a noise that that’s something that they’re spirit...” Elizabeth states that she doesn’t believe that some ethnic groups are more susceptible to post-partum than others.

However, she has seen research that says lower socioeconomic groups tend to have more and that it is higher among Spanish speaking. “But, what I see is not that it hasn’t been post partum depression it’s just been a lot of problems that are depressing. There’s an incredible amount of infidelity...So they have a reason to be depressed. I always say my English women don’t have a reason to be depressed my Spanish people they actually have a reason to be depressed.” Elizabeth describes the reasons Latina women come in for services, and it’s usually not for mental health treatment. She says that they joke in the hospital that almost never will a Latina woman ask about social services, but white women are constantly asking, “What do you have. What can you send me?” “Not our Hispanics, they do not ask.” Elizabeth says, “You know what people always saying there’s this big stigma – there’s not. When people are desperate and you’re gonna make calls for them and help them with their concrete needs […] You know, they’re excited.” She states that stigma does not affect Latina women, but then mentions that with medication it’s different, that women don’t want to take medication at first.
Factors that affect mental health are identified on the individual, couple, familial, community and political levels. On the individual level, Elizabeth identifies sexual abuse, rape, and harassment. She states, “Sexual abuse is prevalent in a lot of the rural patients that had a rural upbringing. Things like that…and usually there is more than one perpetrator – you know two or three is more common than not. And there is some rape on the job. Supervisors that take advantage – that kind of thing. There’s sexual harassment…” On the level of the couple, Elizabeth identifies in-law issues where the woman has conflict with the mother-in-law. Elizabeth also states, “The women are much more interested in helping their children than helping themselves.” She states that the majority of the women have little to no support from others. On the community/neighborhood level, Elizabeth doesn’t see much of a local community for Latina women. She states, “They still seem really isolated to me. You know they don’t know their neighbors often or a lot of time they are mostly English speakers around so the language really prohibits that development.”

When asked about cultural beliefs, Elizabeth says, “Yes, women not being heard; women not deserving to be heard; not having a voice – I mean I think it is very significant for my women need more help than some of the English speaking women and ask for it. I don’t think there’s…you know…the women’s lib movement has not affected my clients. In fact, it’s just the opposite where they see themselves as submissive and you know not entitled.” Elizabeth also states that Latina women take a lot more abuse because of the finances and can’t speak English. Learning to speak English is identified as an “ego booster.” Documentation and language are identified as political factors that affect mental health. When asked, “Do you think they internalize the marginalization at all?” Elizabeth responds, “Sure, sure. They don’t call the police
if they are being beaten. Because they are afraid of being deported – they won’t go to a lot of the service I recommend because they are afraid they will be asked for papers.

Factors that make it easier or harder to access services was discussed during this interview. Elizabeth believes that being a therapist helps the women to access services. She says, “A lot of times the people they come in contact with are rude to them or you know just treat them unfairly.” She also states that many of the Latina women have grown up in large families and did not receive a lot of attention, so when they come to therapy they engage really well. She states, “They just get really excited they’re so grateful to be have someone be advocating for them and helping them supporting them and wanting to give to them.” Elizabeth states that her agency doesn’t accept public aid which makes accessing services harder.

Factors that make it easier or harder to continue receiving services were also discussed. When the women get better and see the improvement, they continue. Some have problems with transportation, child care, and spouses who don’t want them to leave the house or aren’t supportive of the program. Elizabeth states that Latina women don’t ask to get their needs met, but their program teaches them to get their needs met. With regards to stigma affecting access to or ongoing use of services, she states, “It’s more the Anglo people that think that the Hispanics have a stigma. That’s much a bigger barrier than the actual stigma.” Quality services that would help Latina women are identified simply as “free, bilingual, and in the community.”

8. ELLEN – Euro-American, Monolingual (English), Case Manager Supervisor:

Ellen is a Euro-American, woman who is a case manager supervisor. Her agency is an outpatient agency that serves all adults with serious and persistent mental illness. There are about eight bilingual staff at the agency out of over 15 staff members. They use interpreters for their clients. She does assessments with Latina clients and has anywhere from 15-20 Latina women on
her caseload. Most of the women come from Mexico, are between 20 and 30 y/o, “poor and indigent,” with high school the highest level of education, and mostly second generation. Ellen states that there is a heightened increase in eating disorders among the Latino/a population. She states: “I don’t think we do any different [with the Latino population compared to others] but I think that it’s important to be culturally attuned to, you know, whose going to be making decisions in this family, to take a look at the fact that how is it that we can build up the strengths within the family.” They mostly come in for psychosis, anxiety and depression, and abuse. When asked what the women say they are coming in for services, Ellen states: “With the staff that can speak their language, they will open up about those things right.”

Ellen identifies factors that affect Latina women’s mental health on several levels. She says that on the relationship/couple level that mental health issues are seen as a weakness. She says, “They keep, maybe they keep the problems within the family longer and it [is] seen that it might be a sign of weakness to take medication and come for treatment so that can be more of a hurdle for the Hispanic client or the Latino client versus our traditional clients.” On the neighborhood/community level, Ellen says that there are limitations to how many services and resources are available. When discussing cultural beliefs, Ellen describes stigma around medications. But, she also says that her bilingual staff understand cultural issues better than others and that “the rest of us may need more sensitivity to the fact those things be considered.”

On the political/social level, immigration is identified as the primary issue that effects mental health. She explains, “Immigration, people are scared and they’re fearful and those kinds of things coupled with the kind of psychiatric problem a person can have, they aren’t so totally sure they can trust people, so along with general sensitive truest that psychiatric clients can have which seems to be even more heightened.”
When asked about factors in women’s lives that make it easier to access services, there is a silence. She states, “Well, I don’t know that there are any.” However, she does have factors that make it harder, describing undereducation, lack of skills with the computer, and stigma. She describes that stigma causes women to wait longer to get services until it becomes a crisis and they need to be hospitalized. Ellen also states that the stigma makes it harder for women to take medication.

For continuing services, Ellen identifies a lack of bilingual staff as a problem for retaining Latina women. She also says that all the psychiatrists are female which makes it harder for men to receive services. She also describes that sometimes clients start getting better and so then they don’t think they need medication or treatment any more. They try to “write to them in their language” and do outreach to get them back. Quality mental health services that can help with access and retention include several factors. She says, “That we are culturally sensitive- the other thing is that we- our approach is to be individualized based on what their needs are and that we come from a strength perspective so we build on what they got going through.”

9. EMILY - Euro-American, Bilingual (Spanish and English), Therapist:

Emily is a Euro-American, bilingual, female, therapist. She works at the agency but also consults one morning a week in the obstetrics and gynecology clinic in the hospital. The mission of her agency is to “serve all of the patients within the catchment area.” Her job is staff psychologist which means she sees “a whole variety of clients of all different age ranges, couples therapy, group therapy, and individual, family” and she supervises students. Fifty percent (50%) of her caseload is Latina but sometimes it’s closer to 75 or 80%. She sees Latinas from Puerto Rico, Uruguay, Cuba, Chile, and majority Mexican women. Emily states that she is “really aware of cultural issues, of issues around immigration, acculturation, economic issues.” She also states
that she is “well aware of what it means to come to this country, to miss family on the home
country, and how that impacts the diagnosis, how it impacts the treatment.” When asked how she
is more aware, she states that this comes from experience, a lot of research, living in other
cultures and through personal relationships. She states that Latina women don’t usually come
asking for help with their immigration issues, but more for help to deal with anxiety, depression
or relationship problems. When asked if she treats Latina women differently than, say white
women, when they are dealing with depression, she states that it is different. She takes into
account “how happy is this person in this country, how much did they want to come or how
disappointed are they now that they’ve immigrated here and what life is like here…Does it live
up to what they were hoping for?”

On the individual level, Emily feels that certain factors influence Latina mental health.
Factors like family history, history of mental illness, history of substance abuse in the family,
history of symptoms, how much social support, how much education, their financial situation,
living situation and certain kinds of physical and sexual abuse all influence mental health. In
relationships, certain factors like “women who are with alcoholic men,” poor communication,
lack of intimacy and domestic violence all influence mental health. Also, issues with their kids,
like if a kid has ADHD, effects their mental health. Emily Identified cultural issues that affect
mental health as well. These include “issues around confianza [trust] and respect…trust and
building therapeutic relationships.” Emily states that she has to be aware of her position and if
they can trust her or not. She states, “I’m aware of a lot of values around gender and things like
that and gender role that might be different from my own values in some of the women I treat.
You know, what it means to be a mother, what it means to be a wife.” She states that some
women don’t believe in divorce, for example, even when the husband has been abusive
throughout their whole relationship. Emily identifies political and society issues that influence mental health as well. She states, “I’m aware of kind of racial issues and sometimes, especially in the women’s group when they’re making kind of comments about themselves and how they view themselves in a negative way about themselves or their cultures or their backgrounds, using derogatory terms even about themselves sometimes.” She then states that it is really rare for Latina women to talk negatively about themselves, “I’d say once every five months.” She then says that women say things like, “I should really learn English,” or refer to coming to the country illegally. Emily states that a lot of the women feel very isolated from other women because they are home all day with their husbands and kids. She states that during therapy, the younger women can get advice from the older women and that they support each other.

Emily discusses factors that make access to services easier or harder. She identifies attitude of the woman, husband or family. She says, “I think part of [the influences of access to services] is attitude about it to begin with. So how accepting is the husband or family of the idea of coming to therapy…I have someone who she’s like I can’t come today because my husband is home and he doesn’t want me to go to therapy, you know, I can’t leave the house.” She also states that money, transportation, insurance, and documentation are all issues with access to services. There are also class differences that affect access to services. She says that about half are educated with at least a high school degree. Emily says that some women received a lot of education in Mexico but here they are cleaning houses. She says, “It’s like Maslows hierarchy of needs, if I have a woman who is worried if she’s going to be able to pay the rent or buy food for her children, it’s really hard to get into the depth of look at childhood history…” Location also affects access to services. Emily states, “I think we could physically go to more places where Latinas hang out.” That going out into the community is better. She states that education about
therapy helps with access to services. She says, “So [a] really good assessment of motivation and stuff from the very beginning and a lot of education around what it means. I think that helps a lot and some attention to the environmental issues of what makes it hard to get here and trying to work with them around [time].”

Emily discusses factors that affect continuing services. She again discusses the family or husband’s attitude. She says, “If there’s a lot of odds against it like the husband doesn’t want her here or the parents really think it means she’s crazy or her work schedule changes every single week…” These things can affect ongoing use of services. She describes quality mental health services that could affect access to and ongoing use of services. She describes a situation where the staff speaks Spanish but has no cultural understanding. She says, “Unfortunately, what I’ve seen in other locations is like, you know sometimes people without as much training, without maybe a Ph.D. or a masters or something might be pulled in to do the work because they speak Spanish but yet they don’t have the therapy background to actually do the work. She also describes comprehensive services and access to bilingual staff and documents written in Spanish.

10. ERIN – Euro-American, Monolingual (English), Team Leader:

Erin is a Euro-American, woman, supervisor or team leader for the child and adolescent unit. She doesn’t work with Latina women directly but the agency provides a variety of mental health services for adults and children that Latina women access. She states that depression is the biggest reason why a Latina woman might come to receive services. Family problems are another. She states that their agency is very aware of cultural differences and “the impact of your own cultural history of who you are and how you developed in your context and so then that context we really do provide bilingual and bicultural services. It isn’t just staff that speaks
Spanish, it’s staff that also has an understanding of the culture. So in that sense yes it is different and as I would hope that it would be unique to each person.”

Factors that affect mental health were discussed. Erin states that the cultural context in which a woman was raised affects mental health issues, including what part of Mexico they came from. She states that there is a huge difference depending if you come from, say, Mexico City or from rural Mexico. She says, “You know, mental health services aren’t that popular in Mexico and there is great stigma, just as there still is here, but greater still in Mexico, there is an assumption that you’re crazy if you get services or if you get mental health services.” Erin also describes the belief that the women have to carry their cross. She states, “I think that, or a belief that you have to ‘cargar tu cruz’ [carry your cross] you just have to carry it.” She also identifies language as a factor that affects treatment. She says, “Who wants to get treatment in a language not your own?” Erin also describes the couple’s affect on mental health. She states that it’s really no different than any other couple, however, “If you are coming from a stereotypically traditional Mexican family then the husband or the male partner is going to have the power and the decision-making control and depending on how he chooses to use that, you know, will have a tremendous impact on how the woman perceives herself and perceives her ability to get help.”

Family Dynamics also affect mental health. Erin describes her experience with the Latino/a community, stating that in general, children are raised by an extended network of family. But, when the women come to the U.S. they lose that extended network. She says, “So, that can have a real detrimental effect ‘cause that is how we know how to raise our children. If you are first generation and your children are born here and are growing up here you get into these huge gaps of understanding…And if you’re not feeling like you’re doing a great job as a parent then that absolutely contributes to you feeling very badly about yourself.” In the
community/neighborhood, Erin identifies factors that affect mental health including not enough resources, gang ridden areas, and stress levels. Immigration is identified as the political factor that affects mental health for Latina women.

Factors that make services easier or harder to access services were discussed. Erin identifies language, knowledge and awareness, and education are all issues that affect access to services. She states, “In general, I think the population in general is not that well educated on mental health services but I think Latinos even more so.” Erin states that having bilingual and bicultural staff make access to services easier. Lack of resources, especially financial resources, is a huge barrier to receiving services. The question is asked, “Are there factors in Latina women’s lives that you think make it easier for them to access mental health services?” She states: “Things about them? I don’t know, that’s a good question, I’ve never thought about it. I think that mostly the same as for everybody else. I can’t think of anything that would be different, specifically.” She thinks that stigma, cultural issues can be barriers to access to services. She states: “It can work both ways. I have seen first generation Latina women from rural Mexico be persistent and advocate for themselves and get services for themselves and for their children.”

Stigma can affect access to services. Erin describes the belief that mental illness doesn’t exist. She says, “I think the basic belief that there is no such thing as mental illness, that it is controllable, that it is a will, you have the willpower to overcome it. So I you can’t then it must mean you are essentially flawed and so who wants to acknowledge that?” Elisa states that Latina women’s beliefs about mental illness involve fixing it yourself. She says, “I think there is a belief it’s your fault and you should be able to fix it and if you just try hard enough you will stop
feeling depressed. I think that is a belief.” Elisa also states that when basic needs are not met, mental illness is not high on the priority list.

Factors that affect continuing services include primarily language. She states, “Language is a huge issue.” Scheduling, cost, and factors in the home environment also affect continuing services. Erin states, “Latinos are very relational. And so once a good relationship is developed, there tends to be a commitment to it.” Getting them in the door is probably harder “but I don’t know,” she says.

11. ETHAN – Euro-American, Bilingual (Spanish and English), Director:

Ethan is a Euro-American, bilingual, man who is a director, clinical director, and administrative director. His agency is a mental health center in Chicago that serves people with severe mental illness. He states that of the 16 employers about 10-12 are bilingual, and about 5 are bicultural. About 50% of their clients are Latina women. Most are from Mexico, second most are from Puerto Rico, but they also have women from Guatemala, El Salvador, Columbia, and Peru. The women are from 18-70’s y/o, working class, low and just above that, most with primary education, some high school and few college, most are “newly arrived.” They typically come to the agency with depression, distress within the family.

His work with Latina women differs from his work with women from other racial/ethnic groups. He states, “That’s a multi-level question.” He gives details about how the “vast, vast, vast, vast majority of Latinas have arrived in this country without having their papers in order,” and that the harrowing experience of crossing “la frontera [the border]” is traumatizing. He states there is posttraumatic stress disorder and that the experience of coming over his “harrowing” and that the “rug could be pulled out at any time” makes for challenges. He says, “This is the solid foundation, quote unquote solid – sort of like a river of ice that is broken up in the spring time
and they have a chunk of ice. That is about the best of a foundation as people have.” He also mentions a history of a pattern of abuse from childhood. “This pattern includes physical, psychological, sexual abuse that has been prolonged over the years from childhood and every week we have services with I would say 60 people and of those who are […] They break your heart, these stories of intense and continued physical and sexual abuse.” He states that besides immigration, and childhood abuse, domestic violence is a third issue and a bimodal distribution of being homemakers is the fourth issue and finally, that the “women who have the responsibility to negotiate their way and their families way in this society.” And all these factors are compounded with issues of mental illness including anxiety disorder, panic, posttraumatic stress disorder, major depression recurrent without treatment, bipolar disorder, and psychosis. He states, “What’s interesting and challenging is that among the Latina women many have never received services in Mexico…” He describes an occasional visit to the doctor with some herbal remedies and that mental health treatment was often done by families. Being monolingual and also living in poverty are also issues that affect mental health.

Ethan describes “cultural archetypes” about how in Mexico there’s been poverty and persecution consistently since the arrival of Europeans and that “Mexicans over the centuries have learned to adapt and contain many of their real emotions and feelings in order to survive in a structural society that was placed on them.” He describes a natural rage that people should experience over childhood abuse but what he sees is depression, anxiety, psychosis. “We rarely hear women express appropriately the rage and the anger of these situations” He discusses cultural beliefs that affect mental health. He states that these include “Cultural beliefs about social roles, sex roles, socialization, who’s in charge of the household. And among Latinas to their credit they don’t really buy into that. However, their husbands are of the opposite mindset
and there are no cultural supports or very few for women to be viewed as equal.” Ethan describes how women work to support the family and also raise the children. He states that husbands don’t see childcare as their role. Ethan also mentions isolation and cultural beliefs about what cause mental illness. He says, “People have tried working with a pastor or tried going to a curandero and they continue to do all of that while here too but I think people see a clinic […] they made a decision that all of the other ways are not working.” Ethan states cultural beliefs include “mal ojo, that somebody has cast a spell. That it is their role in life to be like this, this is what it means to be a woman, to suffer. The paucity of services and access to services in Latin American countries is low.” In the neighborhood/community, Ethan identifies factors that affect mental health. He states, “I think in one sense people experience community as ‘we’re all going through the same stuff.’ And I think people gather around churches and some other organizations.” Grief and loss, not only of family members, but also of culture and values are issues that Latina women face. Ethan states, “So, women feel isolated. They are neither connected to the generations prior or with those coming up.” Ethan is also one of the few providers who discusses resiliency. He states that resiliency is another internal factor that influences mental health issues. He states, “Yes. It’s resiliency…No woman ever received this message to go, cross the frontier, make a new life, fight discrimination, bias, lack of access to health care, be isolated as a homemaker, take every that tradition we know about family, multigenerational; no woman who is here has ever heard that there is this seed inside that just comes to birth and there is this hope and tenacity and deep roots and it’s that resiliency, drive, hope and aspiration that does create the possibility of healing.”

In regards to access to services, Ethan identifies discrimination and bias in society as affecting access. He states that people can’t vote and impoverishment affects access to services.
He discusses healthcare in that when a woman is pregnant she has Medicaid services available. Good reputation also helps. Some factors he identified as making it more difficult to access services include finding time, transportation, and childcare. He states: “In general women are so caught up with childcare and they dynamics of family life, the effects of depression, anxiety, PTSD, as well as just working hard, so finding time.” He discusses that this is a neighborhood with gang violence on the streets as well. When asked about stigma, Ethan states, “I can’t speak for Latinas. Among those who are arrived and come through the door and are referred here, no people want help for themselves and many will not share that they are in a mental health program so that’s where the stigma comes in. It’s true in our society people are blamed for having a mental illness.”

Ethan identifies poverty and transportation that have an effect on Latina women’s ongoing use of services. He states: “It really takes cultural adaptation to be able to walk through this door. Oh here’s the big thing. Any of our clients, women, are telling the deepest parts of their lives to a stranger, this is not culturally sanctioned, maybe a person would go to a priest about it, go to confession but that’s a different experience.” Quality mental health services also effect ongoing use of services for Latina women. Ethan states that there needs to be culturally sensitive providers, an understanding of the family, the dynamic of crossing the “frontera [border]”, being an immigrant, dynamics of being in a new city, isolation, opportunity, the pain and separation of loss. Awareness of all these issues will help Latina women to receive quality mental health services.

12. LACY – Latina, Bilingual (Spanish and English), Program Coordinator:

Lacy is a Latina, bilingual, woman who is a program coordinator. She works with Latina women directly, some individually, some in a group and also through coordinating the program.
The program mission is to educate Latino/a families to have or enhance the communication. Lacy describes the difficulties that parents have raising their children that belong to two different cultures. She states that the language can be difficult when the children speak both English and Spanish but the parent speaks only Spanish. Lacy says, “What was okay to do in Mexico, in un pueblito, is different from what is okay for kids in the US.” Lacy states that most of the Latina women come for issues of domestic violence. They have about 40 staff members, all of whom are bilingual and bicultural. They serve over 200 families, most of whom are Latino/a – about 85-90% Latino/a. Most of the clients are from Mexico, one from Columbia, and some from Puerto Rico. The agency provides mental health services for problems with communication with the client’s children, acculturation stress, depression, feelings of isolation, and anxiety. Lacy’s work with African-American and Euro-American families is different from Latino/a families in that African-Americans and Euro-Americans are more knowledgeable about the system. For example, the concept of visitation is too foreign for some Latinos.

The main mental health problems include anxiety and depression because of isolation. She states, “When you’re talking about the acculturation, children, or when they come to a different country, different language, and we talk about this, they lose everything. They lose their extended family, they…you know so I think it’s normal that depression hits them.” Lacy also states that there is a lot of stigma among Latina women and the providers need to educate them. She says, “When you’re talking about mental illness…there is a lot of you know myths of it…estoy loca, it’s for crazy people, so the stigma of carrying this. A lot of times we have to explain that, educate them.” Lacy describes situation when Latina women come to the agency – usually because they are having trouble with their kids growing up in a different culture and because of domestic violence. She describes traditional gender roles, stating, “And also role’s,
the traditional role of a female and the male. You know a lot of times they’ll say ‘you’re going to [Agency], you better not stop dusting’ you know. So historically in the, I hate to generalize that role of a submissive wife, you know.” Factors in Neighborhood/Community that affect mental health include fear of gangs and of their children getting involved in the wrong crowd. But, Lacy also describes that a major issue is lack of support and isolation. “We’re talking about families that lost their extended family, a lot of them they don’t have family here. This is so important for us to have them have a family to connect with them.”

Lacy describes access to Services citing language and culture as the first issue. She says, “We talk about even though you’re bilingual but sometimes you know the language of your feelings or your heart […] I think there’s not enough professionals that are sensitive to their culture.” In Latina women’s lives, Lacy mentions that there is an eagerness to learn which helps with treatment. She also states, “I don’t find much of what we call resistance. Although I have trouble with the term saying that the clients resist…I tend to blame the professional.” Lacy also states that follow up helps with continuing services. Also, jobs and transportation can affect continuing use of services. She describes quality mental health services as including being open to the clients, learning from them, giving them respect… “And I think you also [need] to provide professionals that are bicultural and bilingual. And I think we need to have more in our field. You cannot adapt a model that works for the mainstream. It won’t work for Latinas […] I don’t believe in providing services with an interpreter.” Lacy says you lose a lot in translation.

13. LAURA – Latina, Bilingual (Spanish and English), Supervisor:

Laura is a Latina, bilingual, woman who is a supervisor/manager. The agency’s mission is to strengthen families, diverse families in their communities. The agency evolved from doing charity work to being a social service agency. She states that of 50 employees at her agency
about 5 are bilingual and bicultural. She works with Latinas in group therapy. Over 50% of their clients are Latina. They usually find out about services through word-of-mouth. Most of the women are Mexican with some Guatemalan, Honduran, and South American clients. The women are mostly in their twenties to early forties, most are working poor, low education level with some who completed college, and most first generation. She states, “Its low acculturation meaning they’ve been here for a number of years but they still predominantly speak Spanish, very isolated, they usually do not work, and are, depend on their partners for income. They usually own – they often own a home I shouldn’t say usually – often own a home […] and are usually first generation.” She states that they found out early on that Latinas hold on to services longer than the English speaking clients. She states, “The English speaking Latina and the speaking domestic violence victim, specifically African-American and Euro-American, would be much more goal-oriented naturally. They would come, they would want to get what they needed to get and leave. The Latina hangs on and hangs on so it presents a different kind of challenge…” Laura states that her work with Latina women differs from her work with the English speaking community. She says, “I think with African-American and Euro-American, it tends to be more kind of business-like, you know, they come get a service, they know – they seem to be more educated about the process of counseling and the service, you know, what they are supposed to do with how they’re supposed to act.” However, she describes the lower acculturated, monolingual Latina as being unfamiliar with services and that they need to be “socialized” into what mental health services entail.

Laura identifies mental health issues that Latina women deal with on many different levels. She identifies domestic violence and problems parenting as the main issues. On the individual level, she states, “Women tend to acculturate quicker than men because, and this is my
speculation, they are getting exposed to a whole different value system and a different way of a
different mindset for women that a lot of them aren’t used to […] I’m talking about the one who come from very traditional backgrounds, maybe rural areas, and they get exposed to so many differences here and they start changing and that creates conflict in the relationship…” In the neighborhood/community she states that she hasn’t seen that to be much of an issue. When describing cultural beliefs that affect mental health, Laura states, “There is a lot of magical thinking.” and “you get into this external locus of control and internal locus of control, I think that people come from a mindset that they’re going to come and they are going to somehow be transformed but they are not seeing themselves as part of that process so that’s part of the education that needs to occur.” Laura states that mental health services are viewed in terms of whether they are helpful or not. She also discusses stigma, especially around medication and psychiatrists. She says, “The medication is just huge in terms of the prejudice so bias against it. […] a lot of fear of dependency which keeps them from either taking the medication properly or they’ll get off without telling their doctors. […] There is a lot of stigma attached to going to a psychiatrist.”

With regards to access to services, Laura identifies bilingual services and agencies that represent the community are important. She states, “Well, having people that are bilingual really helps. I mean people really feel that if they don’t speak English that that’s okay.” Laura states that having an agency that represents the community is important. For example, she says, “So if you’re working with African-Americans you better have a lot of African-Americans on the staff because it’s a reflection of who you are serving. And so here, the diversity is important and we have some of it.” Laura identifies lack of knowledge as making it harder for people to come to the agency. She also states that for the domestic violence victim “desperation,” “isolation,” and
“feeling terribly about their situation” makes them seek relief. She also describes cases where the domestic violence survivor will have to “sneak” in for services, and this makes accessing services more difficult.

With regards to stigma, Laura states that they aren’t seen as a specifically mental health agency. They call it counseling which maybe makes it easier. Laura blames the aldermen for not getting more involved with the Latino/a population. She discusses political issues and states: “People are coming from Mexico and they are used to not making a lot of wage and just want to make a living and get ahead with their families. They are not going to go get involved in all this stuff about politics and all of them are undocumented so they don’t even vote or anything so their voices are not heard and I think that might explain why after so many years of growth of Latinos in this community we still see [lack of services].”

Laura discusses what makes it easier or harder to receive services. She states that the agency helps Latina women feel that they got what they needed “and sometimes they don’t know what they need all they want is to feel connected and so by having different options for them to stay connected…” Laura identifies transportation, safety, money, and insurance as things that affect receiving services. She states that some people who don’t receive services “either don’t know about the services that we offer here, or they’re afraid that we might charge, or they are assuming it might not be helpful, or they just don’t know about counseling in general. I’m reallyspeculating because I don’t know.” Laura also identifies engagement as key in providing quality services to Latina women.

14. LAUREN – Latina, Bilingual (Spanish and English), Psychiatrist:

Lauren is a Latina, bilingual, woman who is a psychiatrist for two affiliated outpatient clinics. The mission of the program is to provide services to the neediest and to meet their
demands in behavioral health whether it be child or adolescent or adult depression, schizophrenia, bipolar, or anxiety. They make it a priority to meet the need of Latina women in the community. In commenting on the agency, she states that she could teach her organization cultural sensitivity implying that there is a lack of cultural sensitivity among some of the providers. In addition to therapy, Lauren states that she works to empower Latina women. She states, “Well, in addition to therapy, I try to find ways to empower the Latina women. In many situations, it’s unfortunate that they find themselves depending on relationships that are very abusive, at least the ones that I see. And they have no sense of empowerment.” Lauren serves at least 75 Latina patients. They are from Chile, Brazil, Argentina, Ecuador, Cuba, and most from Mexico and Puerto Rico. Many of the women come to the agency because of depression, anxiety, and are overburdened with the work of the children. Lauren states, “They’re also dealing with teenagers who are acculturating, and therefore assimilating into the predominant society. And then there is what we call this culture clash…” Lauren describes Latina mothers who are “traditional in trying to keep the family afloat and the family boundaries afloat.” She states that the Hispanic male experiences “severe discrimination especially in this era of anti-immigration laws” and that the man internalizes the abuse and “in a counter transference, or a transference, will bring it home, take it out on the wife who then takes it out on the child, who then…it becomes a vicious cycle.” Lauren states that Hispanic males are “the last person to go get help at a mental health clinic” and will self medicate with drugs and alcohol. Lauren states that in Mexican society they don’t have many therapists. She gives the example of San Potosio which is grossly impoverished with lack of resources as the only state that has resources for the mentally ill. “So, stigma is very much alive, and it keeps most of the Latino population outside my office.” Lauren cites the difference between Mexican women and Puerto Rican women, in that Puerto
Rico is much more acculturated, but there is still a lack of quality mental health services. The women they serve come from a variety of educational, SES, and generation statuses.

Her work with Latina women differs from women of other racial/ethnic groups in many ways. She states that first you need to create a friendly environment who can relate to a woman in crisis. “You have to respect, and give them at least some respect.” She states that there are some Latina women who don’t want to be spoken to in Spanish and find that offensive, however, she states, “At the same token, there’s the other Latina, that if you proceed in English will think that, have preconceived notions of who or what you are all about a may not cross that cultural divide and open up to you if she thinks that you are part of the dominant culture.” Lauren uses her knowledge about Mexican and Puerto Rican culture and shares that with them. She says, “And so cultural sensitivity is very, very important as is the social status and is the family support because if you do not acknowledge family in the realm of one to one therapy, you can lose the patient too.” She summarizes her opinion, stating, “So, it’s really very important to be culturally sensitive and be able to share with them in the language that they are most comfortable, in an environment that is welcoming and not foreign.” Lauren states that she sees patients with depression, anxiety, domestic violence, and also patients with psychosis who don’t want to let on that they are dealing with it. She also sees dementia, women suffering from panic attacks, eating disorders and substance abuse. The women who come to the agency say they come for help for many reasons. Lauren states, “Oh, you know I hear everything from ‘ay, no me siento bien [I don’t feel well] or ya no puedo cocinar [I can’t cook anymore]…or I just can’t do what I used to do before. I’m the matriarch, I’m supposed to provide for my husband, provide for my kids. I just don’t have it anymore to do. And people are calling me lazy, people are calling
me Buena para nada [good for nothing], etc. etc. and my husband’s unfaithful to me, he’s looking outside the family. So all these reasons are reasons people come in.”

Lauren identifies factors that affect mental health on the individual, relationship, familial, community and political levels. On the individual level, she identifies stress as being linked with disease. She also identifies discrimination and post-traumatic stress disorder as affecting Latina women on the individual level. Lauren states that the husband or children using substances affects mental health. She states, “In addition to providing for the home, she now has to deal with the emotional upheavals of her husband who may be confronted with stress outside the family, of her children who are really having cultural clash, uh between the outside pressure of assimilating, and the inside cultural demands.” On the level of the couple, Lauren identifies that everyone has different conceptions about how a marriage will work, but as the Latina women becomes more empowered, there is a clash in traditional marriages. With regards to family, Lauren states, “Oh the family is key. The family is core, and in the Latino community, in the traditional Latino community, there is a grandmother and grandfather, aunt, uncle, and all these other people that factor into the equation as to whether or not to go seek help, or not seek help.” She also identifies that some families say the women don’t need medication, just motivation. On the neighborhood/community level, Lauren states that they can be very positive and helpful. She gives one example of a bright social worker who was linked to a church. She and the priest became good friends and the priest recommended her to see a psychiatrist. “So they can be extremely supportive. And then you have your curanderos and espiritistas, which a lot of people seem to turn to. […] So, you have to ask them well, you cannot dispute the fact that they’re going to see these people.” Lauren states that you have to let them see which approach is most effective.
When discussing the effect of cultural beliefs on mental health, Lauren states “Oh they’re substantial. They are substantial.” She gives an example of a client who was hospitalized and became so afraid that it would be forever that he started to peel off the medal from the door and so they called the police who ended up shooting him fatally. Another example she gives is a patient who is hospitalized and the family is so vehement to get her out of the hospital and in one instance they went to the politicians and local news channels. The intervention was from a priest, she says, “because the priest is very revered in the community.” Once the priest validated what the hospital was doing the family calmed down. Lauren states, “So culture plays a huge factor, and again it’s something that a skilled therapist, a skilled psychiatrist needs to be knowledgeable about, educated about, if they’re going to deal with this population.” Political and societal factors are also identified as affecting mental health. Lauren states that, “Politically, this is a country that is becoming, everyday, a little more diverse. […] So the fact that we are becoming a multicultural society, it means that you can no longer stand back and say I won’t get involved I won’t learn about them, but you must just become much more educated about others and in order to be able to cross that bridge when a patient comes to your office.”

When asked about what makes it easier or harder for Latina women to access services, Lauren identifies the front staff as key. She states, “I cannot emphasize enough that your front staff, your receptionist, must be very adept, almost intuitive about the needs of the person calling you. […] If you have someone that’s friendly, that’s culturally sensitive, that can speak their language, you’re more than likely to get those people through the door.” Lauren also identifies education about symptoms and treatment is important. She states, “Education is key. Educating them about their symptoms, their positive outcome from being receiving the treatments is crucial.” Finances, transportation, and building rapport with culturally sensitive providers all
affect access to services. In the Latina women’s lives, Lauren states “I think a very supportive family is always a plus. Education is always a plus. And the Latina woman is a very strong woman. And they are very skilled, I think, in this country they’re becoming much more skilled as generations go by.” Lauren identifies stigma as a factor in the women’s lives that makes it harder to access services. She states, “The stigma, and that’s not only my Hispanics, but also the general population at large. It is still very much a stigma to come see a psychiatrist.” She discusses stigma further citing soap operas and movies as exemplifying the stigma in society. She states, “Well, in our culture, and all you have to do is look at the soap operas, the Latina soap operas, to know that going to see a psychiatrist is not a good thing.” She mentions ‘One Flew Over the Coo Coo’s Nest as well. She also describes instances where a man takes a woman to the emergency room and she is admitted based solely on what the man says: “There’s still the devilish man that is too easily ready to put that poor woman in the crazy ward, saying treat her, she’s crazy.”

For continuing to receive services, Lauren identifies factors that make it easier or harder for Latina women. In Latina women’s lives, she identifies respect as very important for ongoing use of services. Lauren also states that with the more traditional Latina women there is an eagerness to learn. She states, “So, they’re very eager to learn, very eager and enthusiastic to seek out and receive help that’s going to potentially empower them to become more independent.” Dysfunction in the family is identified as a factor that make it harder to continue receiving services. She states, “The dysfunction in the family sometimes can be a red flag. If you have someone who’s physically abusing the female, they’ll be less likely to feel empowered to even make the phone call, let alone drag themselves to the clinic.” Childcare and substance abuse are also issues that affect continuing use of services. Quality mental health services are identified
to help Latina women continue using services. She states that a comfortable atmosphere, and awareness of the language and culture are important for Latina women. She states, “We each come with our own backgrounds, our own baggage, our own racial, ethnic, socioeconomic status, and so you have to acknowledge those in treatment…”

15. LAURENCE – Latino, Bilingual (Spanish and English), Therapist:

Laurence is a Latino (Columbian), bilingual, man, who is a therapist. His agency’s mission is to serve the uninsured and underinsured population in McHenry County with regards to healthcare. The clinic also has a Latino family therapy program. All the support staff and the nurse are bilingual and bicultural. Laurence states, “I’m a strong believer in the use of self in treatment. Um, I think very frequently what a lot of my treatment involves is trying and trying to validate these women that are coming in. They are facing a variety of different pressures.” He also discusses being a male therapist and how that effects therapy. He says that being male has been helpful for the most part, but, he says, “There has been occasions where [being male] has caused problems between the patient’s partner. You know, it is an intimate relationship, obviously it is not sexual, but it is an intimate relationship and very frequently causes a conflict...” Laurence states that he is a very strong believer in the systems approach. He sees about 10 women, 7 of whom are Latina. Most of the women are from rural Mexico, some from Central America. Ages range from 8-67 y/o, with at or below poverty line, with a wide range of education levels, usually first generation. He states that he sees “interfamily culture clash” “where the parents were born and raised and kind of learned their parenting in Mexico, under a Mexican cultural hierarchy with their norms, and values and beliefs. But their kids either having, either whether if they were born here or came here when they very young, are really being raised in American society, you know…” He states that the parents have a difficult time coping with
the interfamily culture clash. He states, “And the parents just have no frame of reference on how to um, how to cope and how to handle it some of those pressures.” When asked how his treatment with Latina women differs from his treatment with women of other racial/ethnic groups, Laurence states that focusing on family is the primary difference. He works to try to bridge the gap between their upbringing and the situation they are in here. He describes situations where a woman will have been in the U.S. for a while and start to adapt to the culture. But, he says,

“When they’re told, ‘That’s not Mexicana.’ That quote is not your role, that is not your place. Um, but then they start struggling with ‘where do I go, what do I do? You know, I’ve got my family telling me, you know, keep your traditional female role within the family, but I’ve got all of this information saying that women have power, that women should be empowered, that women should have some independence within their family. Um, it just tears them up.”

He describes Latina women dealing with depression, anxiety, and little insight into their feelings. He states: “One of the things…I’ve come to really notice and this is especially with the women that have come from the very rural, um, areas of Mexico; they have very little insight into their feelings.” Later he states: “Very frequently, you know, they feel empowered just being able to describe what they’re feeling.

Laurence discusses factors that affect Latina women’s mental health on many different levels. He explains on the individual level that they must reconcile their upbringing with their current situation. He states that when they grew up dirt poor and now have a house and nice things they don’t understand why they feel isolated and their kids are giving them problems, and they don’t understand why they feel so bad. On the level of the couple, the biggest struggle identified is domestic violence. He says, “Very frequently a lot of what I see is more, not; there’s no violence, but there is definitely issues of power and control and emotional manipulation, um,
by the partner.” He later states, “You know economically, and religiously, and culturally, you’re not a single mother in Mexico, is my understanding. You know, you put up and shut up.” On the family level, Laurence describes a fear that Latina women have for their children. He says, “So, you know, I try and find a way to, you know, explain some of the societal norms. But I also try to explain, ok, let’s at least entertain the possibility that this could help.” On the neighborhood level, he describes a segregation – that Latinos self-segregate in the community. But, after a while, they start to feel isolated so they move around Euro-Americans. He explains that then he notices they feel unhappy in their new neighborhood. He explains, “You know, that’s probably one of the biggest challenges that I face.” A lot of what he does is to try to get them to build their horizons and build some of their own social support networks. He states, “You know, church for a lot of the families I work with is very important. “ Laurence discusses cultural beliefs, and explains that, in his opinion, cultural beliefs add to their depression. He says, “You know, just because a lot of their cultural beliefs are being challenged once they get here. You know, cultural beliefs with regards to what’s appropriate raising your children, what’s appropriate in terms of a partnership, what’s appropriate in terms of their, their role as a Latina within the family. You know, it’s being challenged almost daily.” On the political level, like many of the other interviewers, Laurence also identifies immigration as one of the biggest factors. He tries to get his clients politically involved by even just writing a letter. He states: “It’s been very, very empowering at a more county, community level. You know, um, to see, you know, we voiced our opinion, we did something public and guess what we’re still here.” He discusses the immigration rallies and states:

“Overall it’s a very positive impact on the community. And I think that they’ve really gotten engaged. I’ve met so many people; they never watched the new before in their life, now they’re watching
Laurence discusses access to services and describes factors that make it easier or harder for Latina women to access services. He believes that community involvement is crucial for social workers. He says, “Word of mouth is gold up here.” Some of the challenges include childcare, conflicts with work, and transportation. He also thinks that the cultural definition that if there is a problem it’s the Latina women’s fault, that this definition helps get Latina women through the door. He also states that stigma makes it harder for Latinas to access services. That there is a belief that if someone receives mental health services they must be crazy, and he has to work to dismantle that.

Laurence also discusses factors that make continuing services easier or harder. He describes the work of the therapist as key to retention. He says, “I think that one of the things that I really make sure that I do is that I validate their own perspective.” Laurence states that if their schedule changes or finances change then they stop receiving services or if they can’t get daycare they will stop coming. Also, sometimes the clients don’t see fast results or maybe their symptoms get worse and so they stop coming. On the same note, some women start to see changes and they get support from the family and they continue and it goes very well. “If it’s the partner taking care of the kids, or the grandmother, you know, helping with transportation, um, that makes a big world of difference in terms of making sure that they still, um, that they continue receiving services.”

16. LAURIE – Latina, Bilingual (Spanish and English), Program Director:

Laurie is a Latina, bilingual, woman, program director for adult outpatient services in an agency that offers “quality, comprehensive services tailored to the cultural and economic
diversity of its consumers.” She is the one in charge of arranging service appropriate to the Latino/a population. She also supervises cases and facilitates group therapy. Her services are conducted in Spanish. Most of her clients are Mexican and some Puerto Ricans. Some come from Honduras, Ecuador, South American countries, etc. The women are between 18 and 65 years old, low income, half on Medicaid, with high school education or less. Her work with Latina women differs from work with groups of other racial/ethnic identities in several ways. She states that, “it’s a different culture and you have many many, many cultural differences in general the Latino population engages faster in treatment.” She explains that Latina women are more open to closer interaction than other cultures. She states, “They engage really fast.” Laurie states that Latina women are “just more prompt to participate and trust the clinician faster.” She also mentions isolation and history of trauma as influencing their willingness to engage in a healthy relationship with the therapist. Laurie states that Latina women usually come with diagnosis of mood disorders, depression, anxiety, and PTSD. The women themselves use terms like nervios [anxiety] and ataques de nervios [attack of nerves] and diprimido [depression].

Laurie identifies factors that affect mental health issues of Latina women on the individual, relationship, and community levels. On the individual level, she identifies past history, trauma and abuse (sexual, emotional, and physical). She states that she sees about 80-90% women who have experienced some sort of trauma. In relationships, she sees a repetition of the abuse. She also states that support varies. She says, “Some are totally opposed. Some women come in secrecy without them knowing you know when they work when they don’t check on them. And some are being supportive and everything in between.” Laurie also states that as they become more acculturated, they become more accepting. When asked if there is any reason why Latino partners wouldn’t be supportive in the woman seeking services, Laurie states: “Why
because I think they are in very controlling relationships and they want to control everything in their lives.” In the community/neighborhood context, she states that living in a poor community with less resources and no language, no jobs, etc. affects mental health. Laurie is asked, “How about cultural beliefs that you think affect mental health on the Latina women?” She answers, “No.” For political/societal factors, she states that discrimination affects mental health. She says, “That they have less opportunities than other people because of many reasons – language, lack of education, or level of education. Sometimes, they’re very poor, they live in communities where they don’t even go out from those communities so they have less opportunities to find jobs or—and if they find jobs they’re really underpaid and no benefits so they have no insurance, no benefits, all that for sure.”

Laurie identifies factors that make it easier to access services include language and an understanding of Latino/a culture. This primarily includes good clinicians that understand the Latino/a culture. She identifies factors in Latina women’s lives that affect access to services which include the Latino/a culture being a “more open culture in general,” education, and that stigma has diminished. She states, “And then there—as I said at the beginning – they’re really open and engaged in services so that part makes it easy. What makes it difficult maybe some of them are in certain relationships or households where it’s still taboo and not acceptable so they wouldn’t come.” She states that stigma is much less now because in the past only people with very severe mental illness would come in for services. Now, because of exposure to TV and the ways of the United States, Laurie states that it’s easier for Latina women to receive services.

In regards to continuing services, Laurie states, “I think what makes it easy is that everything is provided in Spanish.” In Latina women’s lives factors that influence continuing use of services include family support, and if they see improvement and progress. It makes it harder
if they have no family support. She also states that if a clinician has really good engagement skills, a Latina woman recognizes that and makes them more committed as well. Laurie is asked, “Do you think your familiarity with Latina culture makes it easier or do you think the good engagement transcends that?” She responds: “I think it makes it easier. I think the relation—sitting with someone that, for a client, sitting with a clinician that understands the culture and is immersed in that culture even though they don’t have to know everything but, I think that makes it much easier. It helps a lot.” Laurie also states, “I mean for an agency to be really culturally fit, they should be Latinos at all levels…Spanish-speakers mainly.” She also identifies the importance of group therapy and how effective group therapy is and if she could choose one service for a Latina woman it would be group therapy.

17. LESLIE – Latina, Bilingual (Spanish and English), Director:

Leslie is a Latina, bilingual woman who is director of senior and community services. Her agency focuses on ethnocentric care and meeting the needs of Latinos in the Chicago area. They offer services including housing programs for women and children and families that are at-risk for homelessness which includes women who are fleeing domestic violence situations or are homeless for economic reasons. They have a Head-Start program. They serve primarily Puerto Rican and Mexican families and some Cuban who are low-income and a mix of first, second and third generations. When asked how work with Latina women differs from work with women from other racial or ethnic groups, she says, “Interesting…well, I think that first of all, services are offered in the client’s language. I think we bring 52 year history of the experience of working with the Latino culture, and what you would call Latino-centric dynamics or factors.” She also states: “We would deal with a Latina woman differently if we feel she is fearful because of lack
of documentation and fear that she is going to be reported versus an African-American or Anglo woman who that is not a fear issue.”

Leslie identifies factors that affect mental health. She states that the cultures collectiveness view, gender stereotyping, misogyny and dynamics of the family affect Latina women. She states, “I think for the most part, the Latina women who arrive here are struggling with one the trauma, literally its trauma of migration, and the demands of acculturation, the acculturation issues that affect the family system and the children start to become Americanized, and the value systems seems to be affected.” She also describes a very male dominated hierarchy in the Latino/a family and that this affects a woman’s ability to access services. She also identifies immigration status and poverty as huge barriers. For newly immigrated families, she states, “If you mention trabajadores social o psychologo ellos it is that it’s pathologized. So I think in our culture seeking out mental health services is labeled as pathology. I think our culture also proposes or postulates that we should be handling those within extended family or through the church and not so much talking to service providers.” Stigma is also identified as affecting mental health. She states, “I think the fact that we are Latinos serving Latinos, automatically, naturally, innately takes away the stigma in many ways. So that is not them coming to the dominant culture for help, it’s them coming to another Latino, or Latino organization.” Political Factors that affect mental health primarily include the lack of mental health funding. She states that this “leaves the lowest income families like Latinos and the African-Americans to having to go to mental health clinics where their history has now changed. I think the waiting lists are long, sometimes the people practicing and servicing there are not going to provide services in an ethnocentric manner.” She states that some factors like language, staff make-up that is Latino/a, ethnicity, location, history, and reputation all help to make access easier for Latina women.
Leslie also states that childcare issues, transportation, and isolation are factors in individual lives that affect access to mental health services. She is also one of the few providers who talk about empowerment. She states, “I think it comes from a real sense of their own desire to become empowered and to improve their life situation.”

Leslie describes stigma and larger social factors as affecting mental health. She states, “I think the very stigma makes them think it’s an interpsychic or intrapsychic problem of theirs so that it’s a deficiency in their character or in their quality…I don’t think they see the larger society factors of why their situation is the way they are at, or why they’re the children don’t have the education their getting, or they don’t have the employment they’re looking for, or they’re not able to access user friendly services where they’re at.” She also discusses acculturation level. She states that the women believe if they’re deprimida [depressed], or nerviosa [anxiety] that they can get over it on their own.

Leslie states that their agency feels comfortable advocating for Latinos and that their advocacy starts at the top – “Our president is a social worker by profession and she is a Latina, so you know. I think that makes a huge difference.” She gives an example of a woman who deals with Anglo attorneys and confronts socioeconomic issues, issues of discrimination and of prejudice, not of abuse. “So, I mean, it’s that kind of empowerment, feminist, I mean I don’t even know how many words to use, but I think we definitely use an ethnocentric, empowerment, feminist approach in all of our services we provide our Latina women.”

With regards to continuing services, Leslie believes that the workers at her agency exhibit the core values that have been studied again and again with Latino/a families. She states, “So, when you talk about the Latino/a core values that people are studying now, familismo, personalismo, respect, all the things that they’re saying is…affects a person’s health seeking
behavior.” She describes this as influencing ongoing use of services. She states, “So here I think that has always been our focus, so I think because our staff structure and our agency structure is inherently Latino from top to bottom, I think that’s what makes it easier for them to continue here. They feel a sense of family.” Leslie describes mental health services that incorporate a Latino-centric understanding with an empowerment aspect, advocacy aspect, and a psycho-educational aspect all influence ongoing use of services.

18. LILY – Latina, Monolingual (English), Director:

Lily is a Latina, woman who is the mental health division director of an agency that provides affordable mental health services to the community which also includes substance abuse, HIV/AIDS, and adolescent/youth services. Most of her clients are referred to the agency by word-of-mouth or referrals from the state hospital. Most of her clients are from Mexico with some Puerto Rican and Guatemalan clients. Her work with Latina women differs from work with women from other racial and ethnic groups in that many of the women come with different needs like needing papers, having limited resources, and experiencing domestic violence. Lily states that she believes the cycle of domestic violence is the same among women of all races/ethnicities, but that the stressors are different for Latina women. She states that these stressors include “documentation, the family, shame and guilt.” She also states that Latina women relate their self worth to the man and that leaving the husband is not an option.

Mental health issues on individual, familial, community, and political levels are identified by Lily. She states that mental health issues include parenting issues, relationship type issues, support system needs, loneliness, grief and loss from losing their families from moving here, bereavement issues, some Axis II borderline, depression and anxiety or nervios. She states that Mexican Americans who have been raised in the States can identify as being depressed, but those
raised in Mexico say, “I have nervios, No me dan ganas de hacer nada…” On the individual level, Lily identifies pregnancy, child rearing, gang affiliation of their children, being a good mother, a good wife, the sole glue of their family, and alcoholism. She also identifies post-traumatic stress, mood swings, and depression as well. Lily discusses relationship issues between men and women. She states: “We brought in Men are from Mars, Women are from Venus for the men’s group, they weren’t ready for that, and the women were not ready for that yet, they don’t want it right now.” Lily also states that raising the children is different among men and women. She states, “For example, gender issues in raising their children is different where the men get more freedom and the woman are more sheltered and kept at home, so, those issues even play out in fashions as the Mexican American women have those experiences more than the women who end up being raised in Mexico…”

Relationship factors that influence mental health include couples that come in together have a difficult time when one individual has mental illness and the other can’t relate to what they’re going through. Lily also describes problems with communication and support. She states that marital issues, financial issues, parenting issues, and alcoholism can be a strain. She also discusses genetic predisposition and describes situations where an uncle may have MI but the family just describes him as kooky. Lily discusses husbands who are unsupportive of their wives and husbands who are supportive. She states that the ones who are supportive tend to bring their wives in for services or contact Lily when they aren’t doing well. But, she states, “those tend to be very few, especially if they come from Mexico straight over here. Those that are Mexican American tend to be a little more open to the possibilities of mental illnesses. They can have genetic predisposition and treatment is not just the pill and tend to support.”
When asked about family factors that influence mental health, she states, “There is a lot. I think the responsibility the stress of usually Latina women are seen as the glue, like I said. They are the ones that keep the family together and I think it’s the pressure of letting the family down, it’s the pressure of not fulfilling her role as the glue of their family.” Lily also states that they have the responsibility of taking care of the finances, the children, and the household. She states that they try to use an analogy of diabetes because “Latino culture itself is more easily ready with the diabetes than they are [with mental illness].”

She describes community/neighborhood and political issues that affect mental health. She identifies stigma as number one on the community level. She also states, “I think a lot of them use religion, they can see prayer as a necessity, we tell them oh it’s like meditation when you do a rosary…” When discussing political issues that affect mental health, Lily states, “I don’t know if they are aware, but I think their lack of awareness on political issues and how they impact their mental health services.” Lily states that the vote is one political issue that is a big deal but isn’t seen as very important. She tries to get the people involved, to feel as though they have a voice with the government, even if they were born in Mexico. She describes Latina women as soft spoken and timid, stating, “For those Latinas that have been here a while and that have, I guess, assimilated or acculturated to the society, the more open and willing to go and they’re more vocal where the others are more quiet—like I told you, the first time they tend to whisper, speak very softly, be very timid and that in itself is a barrier on all levels, to let them know, speak up, speak up.”

Lily discusses access to service and ongoing use of services. In regards to access to services, she states that the family support and childcare issues are important. Also, bicultural and bilingual makes access to services much better. She states, “I think the fact that we identify
all the cultural needs that that helps as well, it makes it feel a little... whenever we do outings or socialization we try to get food that compliments them and their culture.” The cost, documentation, and few resources make access to services more difficult. Gender issues matter as well in the case of male workers when a wife or daughter is receiving services. Daycare, childcare also affects access to services. In regards to continuing use of services, Lily first identifies the support of the family as crucial to ongoing use of services. She states that the language and the culture can also be barriers, because bilingual workers are not always culturally aware. Lily also identifies stigma, lack of insight, and difficulty understanding mental health terminology. Lily states that it’s a “another whole bowl of wax with Latinas” because they “internalize relationships” and there are cultural issues there as well.

19. LINDA – Latina, Bilingual (Spanish and English), Supervisor:

Linda is a Latina, bilingual, woman supervisor for an agency that believes all people have the right to a violence free life. Many of their clients deal with mental health issues like depression, stress, suicidal ideations because of the domestic violence. She states that she worked really hard to get more bilingual, bicultural staff and now their agency is two-thirds bilingual and bicultural. 99% of her clientele is Latino/a, Spanish-speaking only. Word of mouth is their biggest promoter. About 80% of her clients are Mexican, but some are from Honduras, Columbia, Guatemala. She has seen all age ranges. In regards to education, she states, “I have had women that are very...the majority of them have a low education because of the way our culture is. A lot the macho mentality or the dads or whatever. They don’t think that the women should have a higher education.” The women are of varied generational status. She states that the she has a support group that deals with a variety of issues: “Some it’s the issues that we’re going
through whether it be depression, whether it be the stress, whether it be the orders of protection and why women stay, you know the Latino culture.”

When asked how her work with Latina women differs from work with women from other racial/ethnic groups, Linda describes her own upbringing in Mexico City. She states, “The experience that I have had is the self-esteem for the Latina women is low because of what is instilled in us. I’m…I was born in Mexico City and I went through a lot of what they’re going through. We are…being the women we don’t have as many rights.” She states that women from the States have their own mindset and know that education is good for you. They get jobs, have a car, can get a license, go to the movies, go to the club…but, Latina women can’t do that. She states that it was instilled in Latina women as young girls by their parents. When a Latina woman comes into her office, the first thing she does is to try to make them feel comfortable by speaking Spanish. They connect on where they are from, etc. When an Anglo woman comes in they get started right away, but for a Latina woman she tries to make it a comfortable environment first. She says, “And that’s what I’ve noticed in the difference between Anglo women and Latino women. They are so dependent on somebody else deciding for them that they’ll ask me, ‘what should I do? Tell me what to do.’ Where the Anglo woman you will give them an option and she goes ‘Ok. I’ll do this.’ So there is a difference.” Education is different between boys and girls.

Linda discusses factors that affect Latina women’s mental health. She explains that 80% of Mexico is Catholic and this affects women’s marriages that they cannot leave abusive husbands. She states that she works to try to instill independence in her clients but for them to understand that is very hard. She says, “That’s something that’s not acceptable in our culture because they have to be lower than you. They have to be the ones that are obeying, submissive, and not tell you what to do. So in trying to change that in a male to see…” Linda explains that
men come here and have to cook and clean for themselves and face discrimination and so they turn to drugs and alcohol. She also states, “Because that’s another thing you have to be, a virgin. If you’re not a virgin, oh my god. You are a whore, you are bitch, whatever. A lot of the complaints that some of my women have too,” that the husbands are always suspicious and inflict mental psychological abuse. She discusses dynamics in the family that affect mental health. She tries to get her clients to see how they are raising their girls in the way that they were raised. Linda asks her clients, “Do you want your daughter to go through this? Do you want your son to treat his wife…And they come in here and they’re so embarrassed about it because they put a stop to it from the father now, but they’re allowing the kid, son or the daughter. But one of the things that plays a role in that is when we come to the United States we lose part of the family.” She explains the difficulty in disciplining their children because many Latina women are afraid of the government. In the neighborhood/community she describes a tragic situation. She describes the community being together and not stopping a husband from beating up his wife. She says that they call the men “mandilones” if their relationship is equal with their woman or if the wife is in charge. So there is a lot of peer pressure from other men. As far as cultural beliefs that affect mental health, she cites stigma as an influencing factor. She says, “A psychiatrist or mental health is for crazy people. And what they don’t understand is coming for the counseling is not getting psychiatric help. You’re not going to a psychiatrist, but they still see it as you’re the crazy one if you go.” Linda did not have much to say about political/societal factors that affect mental health. She identifies language as a big barrier for receiving services. She says, “There’s not a Spanish speaking psychiatrist in town…Translation is different and it’s gonna be hard for someone to come in and have a translator there and tell them to open up freely.
So it’s a barrier, it’s a barrier not having someone to understand first of all the language and then the culture. So it’s very difficult.”

Linda discusses factors that make access to services easier and harder. She says that word of mouth is the best way to get people in to the clinic. She says, “word of mouth will be the easiest…Once you get them to keep going in there it’ll start spreading like wildfire.” Stigma also impacts access to services. She says stigma is instilled in the women. She says, “It’s something that’s instilled in us and we’re supposed to know it by heart and we’re not supposed to go out of what is being taught to us and instilled in us…” She explains that stigma exists in her own family. They believe that she is too independent and fair. She states that women believe mental illness to be stigmatizing, like it’s something you got from somewhere. Latina women believe that mental illness is only for crazy people “Only crazy people in bed.” She states that she doesn’t try to normalize it for them, she just gives them the referrals of where to go.

For continuing services, factors that make it easier or harder are discussed. It helps that they provide free services and that they have bilingual and bicultural staff available 24/7. Linda states that many women are hiding from their husbands. She says,

We have a bad reputation out there in society. In the…one of the bad reputations we have is that we break up marriages. We break up relationships. We’re here to separate the husband from the wife. And the other one is we’re lesbians and want the women for ourselves. We’re a bunch of angry lesbians, who hate the men, so we want the women for ourselves. So…what a reputation, huh?

Some factors that make continuing services harder include language, finances, their schedule, and cultural understanding. She says, “In hiding, transportation…the language is a barrier. Affording them is a barrier. The availability of the schedule is…And even beyond that not understanding the culture.”
20. LINDSEY – Latina, Bilingual (Spanish and English), Supervisor:

Lindsey is a Latina, bilingual, woman who is a supervisor of the different counseling programs the agency has. Her agency provides an array of services to the community to help people to be able to help themselves. About 90% of the staff are bilingual. She provides clinical supervision for women that are of Hispanic backgrounds. Many of the Latina women come to the agency through word of mouth and referrals from the DCFS system. She serves Latina women mostly from Mexico and Puerto Rico, some Dominican and Cuban. Most of the women she sees are from way below the poverty line and have low education. The agency provides counseling, family counseling, case management, group intervention, emergency classes, etc. She believes that her work with Latina women differs from her work with women from other racial groups in several ways. She states, “We always take into consideration their culture, we take into consideration whether they are documented or not…You know we may do more family counseling cause we know that that seems to be a little more effective with people who are of Hispanic origin. I think that culture is something we always have in mind and that we take into consideration as we are developing strategies.” The main symptoms she sees include depression, anxiety, and abusive relationships. There is also some posttraumatic stress disorder. She also states, “Sometimes they just come in because they need…how to find food.”

Lindsey discusses factors that affect mental health issues of Latina women. She states, “I think a lot of times social isolation, especially immigrants, who are used to having family and extended family…then they move here and they are alone and they feel alone…” She also identifies relationships, abuse in relationships, domestic violence, problems with children and other psychiatric conditions including clinical depression and being anxious as influencing mental health. On an individual level, Lindsey sees navigating the system and abuse at home. In
family dynamics, Lindsey states: “I think our Latina ladies they are involved in family and if the family is not OK, however they define OK, they get worried, they get upset, they need help…Family is a value and when the family is not OK they’re not OK.” On the community level, she identifies gangs, social isolation and documentation as affecting mental health. In regards to political dynamics, Lindsey states: “the documentation issue, it’s a political thing, that definitely affects as a stressor as a big stressor. It affects the ability of people to get their basic needs met and that definitely affects mental health.”

Lindsey discusses access to services. She identifies barriers to services which include legal status, the lack of Spanish-speaking and bicultural providers in their community, lack of knowledge for new immigrants, and fear. She states, “In cases of domestic violence you may not see these ladies until they end up in the hospital or something really bad happens.” Being a one-stop shop agency helps Latina women receive services for them and their families. She states that stigma is a big barrier. She states that a lot of women probably don’t come in for services because of stigma. Lindsey states that Latina women use a different vocabulary when talking about mental illness. The most common word they hear is “nervios.” Lindsey also states, “We hear really often people getting sobados. People drinking certain teas…And oftentimes it’s done in combination with therapy, or case management, or whatever the service may be that we provide for them.”

Lindsey also discusses continuing services. She identifies language, incorporating value system like family, flexibility with time, an emergency line in Spanish all as ways that help women continue receiving services. Also, home-based, community-based, and case management services are provided which help. She states, “We believe that people have to have their basic
needs met before we can approach any mental health issues.” She states that abusive relationships and drug addiction make ongoing use of services harder for women.

21. LORETTA – Latina, Bilingual (Spanish and English), Therapist/Intake Coordinator:

Loretta is a Latina, bilingual, woman, who is a therapist and intake coordinator for a non-profit family counseling center whose mission is to provide counseling, psychotherapy, and community education services centering strength, family life, fostering healthy personality development, enabling clients to establish a sense of control over their lives so they can live responsibly and compassionately. She is the only one at the agency who is bilingual and bicultural. The main reason that her clients come to receive help are for PTSD, depression, and sexual abuse. Her clients are primarily Mexican, poor, recent immigrants and undocumented. She states that “it’s amazing…I’ve been doing this, I didn’t realize how much Latina women suffer from depression and sexual abuse issues and it’s amazing to see that more are coming out…it’s just sad that there just not enough resources for them.” She believes that education and the media are encouraging people to come forward. Her work with Latina women differs from work with women from other racial groups first and foremost the language barrier. She explains, “There isn’t such a taboo with African-American or Anglo-Saxons you know, that’s something very common where with Hispanics they are so secretive. Oh I don’t, you know, my husband doesn’t want me to come because only crazy people go to counseling so just that taboo, the language barrier is a very big difference.” Loretta identifies depression, crying all the time, arguing with the kids all the time as reasons for seeking help.

Loretta discusses factors that affect mental health. For individual factors discusses the traditional roles that Latina women are expected to conform to. She states, “They come from Mexico where their parents or grandparents very traditional and their way of thinking is very
different from what America teaches our women.” Loretta states that there is a secretiveness and a fear that their information is going to be talked about. She says it takes 1-2 sessions to explain the roles. It takes a long time for Latina women to let things out. “For example,” she explains, “I just, I’ve been seeing a client for almost over a year and just in the last 2 sessions she disclosed how her ex-husband raped her 5 or 6 times and so those are the kind of things that you can tell they hold back, they are just not too sure what they can share.” She states that Latina women are afraid of being judged and told to leave their husband. The interviewer asks if being Latina makes it more difficult or easier for them to share because of cultural issues. She replies, “You know what, I believe that’s a double-edged sword. Some of them will find it easier because they feel I can relate with them. And some of them will see me as oh here she has an education, what does she know about suffering, what does she know about this and that, and so it’s a double-edged sword.”

Loretta discusses couples dynamics that affect mental health. She describes traditional roles again, stating that Latino/a men have specific ideas of how a woman should be. She states that they come in with “macho attitudes” and have a difficult time with intimacy. Loretta states that she sees both supportive and unsupportive husbands. She states that some husbands are open-minded and some are unsupportive (about 60% supportive/40% unsupportive). She states that some husbands are “afraid that their [wives] empowerment is going to come back and change their system, there is no support there.” Family dynamics also affect mental health. Loretta identifies cultural issues comparing the U.S. vs. the Hispanic culture. She states, “I think that the culture, you know, the American culture, we put so much emphasis on individuality and independence where the Hispanic culture, they are more towards the family and you work for the family…” She describes how important it is that therapists understand the clashing of cultures,
particularly when children of immigrant women are being raised in the U.S. Loretta states that when a therapist tries to impose individualistic values on a family, they decide not to come back because, they say, “she’s just going to pollute my daughter or my son and they are going to leave the familia…” She states there is not an emphasis on furthering education and the clash can cause some children to get into gangs. This affects Latina women’s health because “Latina women in this case they feel a sense of responsibility towards the husband and they want to keep the husband happy that sometimes they forget to defend the children…”

Loretta also discusses the neighborhood and community affects on mental health, stating, “There isn’t many neighborhoods or agencies that can provide parenting classes, that can work on communication skills. A lot of these families, because of the language barrier, they’re on their own, they’re on their own. They’ll access church I mean I think that’s about the only positive thing…[but] the church can only do so much.” She also states that Latina women are not comfortable seeking services. She says, “I think that the Latino population is not trusting yet of these neighborhood agencies to where they are comfortable in going out and seeking it.” Loretta also states that gangs are a big problem in their area. This affects Latina women’s mental health because it causes guilt and helplessness. Also, fear of being deported is a big issue. “And so they feel helpless and they don’t see a lot of options and sometimes when you sit back and listening to their story, you’re like you’re right, what options do you have? So poverty is a big issue and not enough support.”

There are also cultural belief and political factors that affect Latina women’s mental health. Loretta describes some alternative forms of healing, stating that they hurt Latina women’s health. She states, “Their beliefs in brujeria, which is witchcraft. Their, what else…belief in witchcraft, their religious beliefs…hurt [them].” Loretta states that sometimes a priest will tell
their congregation that those who are seeing a counselor are not relying enough on God and that can hurt a woman who experiences guilt and shame. With regards to political issues, Loretta states that there are not enough politicians representing the Hispanic population, “and then the Hispanic population is not rising to the occasion and saying, listen you are not representing us very well. I mean not many Latinos are willing to go there but there is a growth.” Loretta also describes a fear that Latina women have around immigration. She says, “They are so afraid of being deported, they are so afraid of what others are going to think of them, they don’t like to cause chaos, they are very quiet and submissive…” Loretta also states that politicians don’t see that mental health is a very big issue especially with new immigrants.

Loretta talks about the problems of accessing psychiatric services in her location. She mentions stigma related to receiving psychiatric care. She says, “I mean they already come and see you as—seen a counselor and they already think that they’re crazy because I’m seeing you and now you want to say psiquiatra [psychiatrist], oh then you really think I’m crazy, so getting them to buy into the idea of why I’m recommending that you see you psychiatrist, the walls go up and you can see it and I’ve lost clients because of that, I’ve lost many clients because of that.” Loretta also states that there are stereotypes about medications and the roles of women. She says, “You know, the Hispanic culture, the women are taught to be very resilient and you do it, you don’t need the support of a counselor, you don’t need medication, you can do it. And so when they’re faced with the idea of maybe taking medication, it’s a weakness for them and a lot of them are not willing to accept that.” Loretta mentions that Latina women typically believe that mental illness doesn’t exist and their experience of sexual abuse, domestic violence, is normal and happens to everybody. “Introducing them to a new way of thinking…to what a healthy relationship and that you could be assertive and you do have a voice, they don’t buy much into
it.” She also states that she gets asked if she is married to a Hispanic and when she says yes they are surprised when she says he doesn’t beat her or cheat on her. She states, “They think all Hispanic men are alcoholics and they abuse their wives or the infidelity, oh my goodness, they think infidelity is normal and that their choices are few, few choices, and so they just bear with it.”

Loretta describes a barrier with language, for example, trying to explain flashbacks and PTSD in Spanish can be difficult when your education has been in English. Loretta tries to empathize with issues of stigma. She explains that they are in a new culture and talks to them about empowering their lives. She says that their views of mental illness do change over time. She encourages them to share their experience with a comadre or aunt to spread the word about how counseling can help.

Loretta states that education and neighbors are encouraging people to seek help more is making it easier for Latina women to access mental health services. She says, “The teachers, the doctors, the nurses, they’re taking more time to really listen to Latina women and finding out what’s really going on and then saying to them, this isn’t normal it sounds like you really need to go to talk someone...” Lack of support from significant others and lack of access to transportation, child care, and economics are all barriers to access to services.

For continuing services, Loretta identifies factors that make it easier and harder to continue services. One factor that makes continuing services easier is when they see positive changes. For example, Loretta states, “They see the positive changes and they want to continue coming in because they see the doors opening and they’re empowered – they feel empowered and so, it makes it easy for them to come in.” Quality mental health services also help to retain Latina women in services. Loretta describes quality mental health services as culturally sensitive,
in Spanish, and not concerned with documentation. She states, “I think it’s when you’re culturally sensitive. Most of all when you speak the language and that don’t ask about residency, if you’re illegal or not and that you’re not judgmental and that you’re not going to shove your ideology and your beliefs down their throat but are willing to accept them for who they are and work with them where they are at. If that means they want to stay with this abusive husband, then you work with that.”

22. LUIS – Latino, Bilingual (Spanish and English), Therapist:

Luis is a Latino, bilingual, man who does intakes, assessments, and individual and group therapy. He currently serves about 80% Latino/a clients and 85% of them are female. Most of his clients are from Mexico, some from Puerto Rico, a few from Central America, and one from Cuba. He states that his Mexican clients primarily come to the agency for mood symptoms, depression, anxiety, and family relational issues. They are mostly between 25-45 years old, low socioeconomic status, half and half undocumented, with high school education and some with college degrees, about 80% are new immigrants, and about 80% are taking medication. His work with Latina women differs from work with other racial/ethnic groups because Latina women “don’t have the support system that other groups will have. They might not even know how to access those few services in the communities so I might be a little bit more paternalistic in the sense of let’s try to call this list, kind of making the phone call to other providers instead of saying to her just call...” Luis also states that acculturation and trauma affect mental health. He states, “The other think that I think it would be more into the discussion of themes such as acculturationalization or issues regarding leaving family members in another country, those are—the immigration journey, how’s it for them, the potential trauma or what was the experience, were they pulled or pushed from their country—I think that plays a significant role into the assessment
and treatment.” Luis states that women usually come in for physical help and then are referred for mental health treatment.

Factors that affect mental health issues of Latina women on several levels are discussed. On the individual level, Luis identifies isolation and loss. He states, “I think one of the factors is isolation, they feel quite isolated, they don’t have a support system and that takes a toll in their ability to manage stress around them. They used to dealing with issues such as losses, coming from their country or most who are here are not having the support system just exacerbate that…So those are some of the individual factors.” As couple, he states that around 80% of the women he works with deal with domestic violence or any kind of emotional abuse. He states, “Another factor of relationship is the issues such as power and control from the husband, which the woman in a way start becoming acculturated here so yeah I’m bringing the money but you still treat me like I cannot do so that will take a toll—can exacerbate some of the exposing factors for domestic violence and things like that.” He also states that the kids are in a process of acculturation and that they acculturate faster than the parents. He says, “Now the parents are running out of ways to manage their kids because now they become smarter than them and that takes a significant role…I really believe if I provide the parents with the information and accessing to the resources in the community, it empowers them to keep that line of authority in a more effective way…” Luis discusses neighborhood and community factors affect mental health. He discusses stigma in the community. He says, “Well, first of all the idea of coming to ‘loquero’ cause that’s how some people call or name mental health services is as scary for many Latinas to think that many of them they will come only when they seem to have exacerbated to the point that intervention is required.” Luis states that it is different in multicultural Chicago than it is in Waukegan. He says, “There is a lot of struggle between the community and the
Latinos. There is a lot of isolation," Overall he states that racism and prejudice – structural – may affect mental health concerns. He gives the example of Latinos driving and getting pulled over and having their car impounded because they don’t have ID. He says, “They did a stop a couple of weeks ago and they took about I hear it was about 120 people took it to deported, people right now are like oh my god!” There are problems with the police and that causes extreme anxiety for the women.

Luis discusses cultural beliefs as a strength and a weakness. Because of this, the provider needs to create a balance in treatment. He states, “So you need to balance out how I can help this person become more independent in a community that require in order to function but at the same time knowing that becoming too independent is kind of neglecting some of the family ties that will help her to cope better with her kids and her husband.” He also mentions dealing with second language is hard and that there is stigma in the community. He describes stigma as: “Well, they see it as you have to be crazy in order to get the mental health services. That’s the main thing, you go there because you’re going to go to the Loquero and you’re going to be talking to someone that—you go there it means you are at the very edge of losing everything, but that’s what prevents a lot of people to come. They might be more willing to go to church or to the pastor—that’s another issue because the church leaders are not well informed about mental health issues.” He identifies immigration and lack of knowledge about how the system works as political and societal factors that affect mental health. Another factor he identifies is difficulties when the services are not bicultural.

Luis discusses access to services. There are factors that make access easier and harder. Luis states that the agency is close to the medical doctors “because the doctors are part of the family” He also mentions that they work with public aid and that they don’t need papers helps
with access to services. He states that the lack of personnel can affect access to services. When staff is focusing on translating it gets in the way of “really addressing what you need to.” Finances are also a barrier. In Latina women’s lives, transportation is a big barrier to receiving services.

Factors that make continuing services easier or harder are also discussed. He states, “I think the fact that I am bicultural, I think the fact that I have knowledge of community-based organizations so when they are dealing with an issue I can refer here, I can be like a case manager, if that’s what they need, I can be a therapist when that’s what need.” Luis also states that he feel that Latina women are really committed to improve their life situation and when they see something that is beneficial to them, they really stick to it as much as they can. He says, “I think if you can tap into how coming here is going to translate in improving their life situation at home, with their kids, they would do that. I guess that’s part of the marianismo.”

Effective MH services also help with access and retention. Luis identifies what he thinks quality mental health services are. He says, “I consider those services that will tap into the reality that they are dealing. If you provide services that will address the here and now.” Luis identifies group therapy as very effective for Latina women. He states that when they can hear about the experiences of other women like them, who for example might take medications, it can be really effective. He mentions kids that get into gangs and discusses the history of the Waukegan area.

These summaries of the interviews provide an in depth look into each participant’s response. Each summary included (1) contextual information – the context and background of the interview, the organizational background, the history, structure, mission, and values of the organization, staff and site description, (2) demographic information – descriptive information including the participants’ gender, ethnicity and discipline, and (3) perceptual information –
participants descriptions and explanations of their experience as it relates to Latina women as clients (Bloomberg & Volpe, 2008). Next, I will examine the findings and include quotes from the different interviews that exemplify responses from the majority of the participants.

**Summary of Major Findings**

In this section of the results, I will discuss the four major findings in detail. The findings are organized according to the codes from the most often cited to the least often cited in each finding. I will be describing the number of times each participant discussed the code under analysis. There are a total of 22 interviews, 11 of which are of Latino/a providers (names starting with “L”) and 11 of which are non-Latino/a providers (names starting with “A,” “B,” and “E”).

In the discussion of the findings, I use quotes from interviews that most aptly represent the discussion from the majority of the providers. Refer to Appendix B for tables of race/ethnicity and pseudonyms by comment codes.

**Finding 1: The majority (20 of 22 [91%]) of mental health providers did not see Latina women as resilient woman who can thrive.** Two of the providers (9%) identified their clients as resilient and used a strengths based/empowerment model with their clients. The providers identified a variety factors to describe their clients including:

- resilience
- culture
- gender
- race
- additional findings

See Appendix B, Table’s 4, 5, 6, and 7.

**Resilience.** Two (9%) of the providers described Latina women as resilient and used a strengths based/empowerment model. Here are two responses. Leslie stated:

So, I mean, it’s that kind of empowerment, feminist, I mean I don’t even know how many words to use, but I think we definitely use
an ethnocentric, empowerment, feminist approach in all of our services we provide our Latina women. And I think it’s really unique, because I think our leadership at [AGENCY] brings that. I think that your main leaders at [AGENCY] are women and are Latina women and we have been acclimated to the concepts of feminist theory and empowerment theory and ethnocentric theory, and so I think we have made a conscious effort to have made a conscious effort to have that trickle down and incorporate that really at the practice level which is hard to do.

Ethan stated,

Yes. It’s resiliency. I had trouble moving from one part of the north side of Chicago to the other and the amount of energy and the belief in themselves and their families and their destiny carries women over beyond what anybody could have ever scripted for them. No woman ever received this message to go, cross the frontier, make a new life, fight discrimination, bias, lack of access to health care, be isolated as a homemaker, take every tradition we know about family, multigenerational; no woman who is here has ever heard that there is this seed inside that just comes to birth and there is this hope and tenacity and deep roots and it’s that resiliency, drive, hope and aspiration that does create the possibility of healing.

These statements reflect the providers’ views of strengths, resilience, and empowerment. Besides the two interviews quoted above, none of the other providers discussed empowerment and resilience and were more likely to describe Latina women according to their symptoms, cultural norms and gender roles. Some of the providers discussed contradictions and acculturation that Latina women experience related to empowerment. For example, Luis stated:

I think one of the things that a lot of Latinas that I’ve seen struggle with, the ones that have been here, um, for a number of years, that they also start to, um, adapt to and to try and differentiate themselves within the family, um, and when they’re told, ‘That’s not Mexicana.’ That quote is not your role, that is not your place. Um, but then they start struggling with ‘where do I go, what do I do? You know, I’ve got my family telling me, you know, keep your traditional female role within the family, but I’ve got all of this information saying that women have power, that women should be empowered, that women should have some independence within their family. Um, it just tears them up.
Still others viewed Latina women as submissive and un-empowered. Elizabeth stated: “I don’t think there’s…you know…the women’s lib movement has not affected my clients. In fact, it’s just the opposite where they see themselves as submissive and you know not entitled.” Lauren, a psychiatrist, states that she works to empower Latina women, but that they have no sense of empowerment. She states: “Well, in addition to therapy, I try to find ways to empower the Latina women. In many situations, it’s unfortunate that they find themselves depending on relationships that are very abusive, at least the ones that I see. And they have no sense of empowerment.”

Culture. In this section, I will first give a summary of the findings related to culture – see Appendix B, Table 4. Then, I will use samples of quotes from the interviews for each category. The overwhelming majority of providers (21 of 22 [95%]) discussed stigma as a barrier to receiving and continuing mental health services. The good majority of providers (20 of 22 [90%]) discussed their own culture and position related to the Latina women they serve. In these discussions, they described the importance of having providers who not only speak the language but also know about the culture of Latina women. An overwhelming majority (21 of 22 [95%]) mentioned language in their interviews. A majority of the providers (14 of 22 [63%]) described religion as being important for Latina women’s lives. Just under half of the providers discussed issues of acculturation (10 of 22 [45%]) and acculturating children (10 of 22 [45%]). Respect was discussed as being an important cultural quality for Latina women by some of the providers (5 of 22 [22%]).

Stigma. The overwhelming majority discussed stigma. Four of the providers state that stigma is not as much of a problem as it used to be. Three of these were non-Latino/a providers. Laurie, a program director, stated: “You know, it’s good to use [mental health workers] and that all this stigma that only if you’re crazy you go is, you know, has really
diminished a lot, it’s still a little bit there but not even close to what it used to be.” Elizabeth, a director, states: “It’s more the Anglo people that think Hispanics have a stigma. That’s a much bigger barrier than the actual stigma.”

Most of the providers, however, describe stigma as having a major effect on Latina women receiving and continuing services. The providers distinguished between first generation Latinos and those recently migrated from those who have lived in the states for a long time, stating that the first generation Latinos saw seeing a social worker or a psychiatrist as pathology. Leslie, a director, stated:

The cultural beliefs that affect mental health is, I think, traditionally there is a lack of understanding among the first generational Latinos and recently migrated…immigrated families that mental health services if you mention trabajadores social o psicologo ellos it is that it’s pathologized. So I think in our culture seeking out mental health services is labeled as pathology. I think our culture also proposes or postulates that we should be handling those within extended family or through the church and not so much talking to service providers.

Many providers used the term “crazy” to describe the stigma that women have about mental illness. They described the women as viewing anyone who received mental health services as crazy. This was seen as preventing the women from receiving or accessing services. For example, Luis said:

Well, they see it as you have to be crazy in order to get the mental health services. That’s the main thing, you go there because you’re going to go to the Loquero and you’re going to be talking to someone that—you go there it means you are at the very edge of losing everything, but that’s what prevents a lot of people to come.

Another common discussion when talking about stigma was stigma of medications. For example, Laura, a supervisor, said:

The medication is just huge in terms of the prejudice so bias against it. […] a lot of fear of dependency which keeps them from
either taking the medication properly or they’ll get off without
telling their doctors. [...] There is a lot of stigma attached to going
to a psychiatrist.

Stigma is a major theme in the literature and will be discussed further in the discussion of access
to services.

**Providers Own Culture.** A good majority of the providers (20 of 22 [90%]) discussed
the importance of their own culture and position related to the women they serve. In their
discussion, they described the importance of having providers not only speak the language but
also know about the culture of Latina women. Emily, a therapist, stated:

> Unfortunately, what I’ve seen in other locations is like, you know
> sometimes people without as much training, without maybe a
> Ph.D. or a masters or something might be pulled in to do the work
> because they speak Spanish but yet they don’t have the therapy
> background to actually do the work…The language, the training of
> the therapist, the understanding that the therapist has of the cultural
> issues that are involved for each particular – you know, not making
> stereotypes of all Latinas that are like this but having some
> understanding of what it means to be a Latina or to be from this
> specific country.

An interviewer asked Loretta, a therapist, if being Latina makes it more difficult or easier for the
clients to share because of cultural issues. She stated that just being Latina doesn’t necessarily
mean Latina women will share more. Loretta said:

> You know what, I believe that’s a double-edged sword. Some of
> them will find it easier because they feel I can relate with them.
> And some of them will see me as oh here she has an education,
> what does she know about suffering, what does she know about
> this and that, and so it’s a double-edged sword.

**Language.** An overwhelming majority mentioned language in their interviews. Some
of the providers discussed using translators, however, the majority of the providers are bilingual.

Linda, a supervisor, stated:
Translation is different and it’s gonna be hard for someone to come in and have a translator there and tell them to open up freely. So it’s a barrier, it’s a barrier not having someone to understand first of all the language and then the culture. So it’s very difficult.

As shown in the interviews quoted above, cultural awareness and ability to speak the language appeared to be important in the providers discussion of their own position related to the Latina women they serve.

**Religion.** Some of the providers perceived religion as having a major impact on Latina women’s lives. The providers perceived Latina women as being more comfortable to talk to a priest or pastor than a therapist. Laurence, a therapist, stated: “You know, church for a lot of the families I work with is very important.” Leslie, a director, stated: “I think our culture also proposes or postulates that we should be handling those within extended family or through the church and not so much talking to service providers.” And Ethan stated:

> It really takes cultural adaptation to be able to walk through this door. Oh here’s the big thing. Any of our clients, women, are telling the deepest parts of their lives to a stranger, this is not culturally sanctioned, maybe a person would go to a priest about it, go to confession but that’s a different experience.

A few providers saw church and religious beliefs as negative. Loretta, a therapist and intake coordinator, states: “Their beliefs in brujeria, which is witchcraft. Their, what else…belief in witchcraft, their religious beliefs…hurt [them].” Loretta also states that sometimes a priest will tell their congregation that those who are seeing a counselor are not relying enough on God and that can hurt a woman who experiences guilt and shame. Yet, other providers saw the church as positive and helpful. Lauren states, “They can be very positive and very helpful.” She gives one example of a client who was a bright social worker and who was linked to a church. She and the priest became good friends and the priest recommended her to see a psychiatrist.
Acculturation and Acculturating Children. Many of the providers identified that the women have difficulty with acculturation and acculturating children. Issues of acculturation overlapped with issues of gender roles, stigma, isolation, and soft-spokenness. Some providers, like Erin, perceived Latina women as acculturating faster than their male partners. Many providers described Latina women who have not assimilated to the U.S. culture as soft-spoken. There was also a discussion that the Latino culture teaches women that assertiveness is not a positive quality. For example, Lily, a director, said:

For those Latinas that have been here a while and that have, I guess, assimilated or acculturated to the society, the more open and willing to go and they’re more vocal where the others are more quiet—like I told you, the first time they tend to whisper, speak very softly, be very timid and that in itself is a barrier on all levels, to let them know, speak up, speak up. And those that have been longer, oh they’re very vocal, very assertive because even assertiveness is a quality is not seen as a positive quality either by the male within the family or within society itself and that could be a Latina slash women issue, there, combined.

The culture clash between parents and children was perceived as a problem that Latina women face. Many providers described Latina women as having different cultural values than those that their children develop growing up in the U.S. The providers used terms like “interfamily culture clash” and explained that Latina women have to deal with children growing up with U.S. cultural values. For example, Loretta said:

I think that the culture, you know, the American culture, we put so much emphasis on individuality and independence where the Hispanic culture, they are more towards the family and you work for the family and when there is children involved and they are growing up here, they’re wanting to pursue that individuality, that independence and that’s when they are clashing a lot and I believe that a lot of our therapists need to be more culturally sensitive to that.
Gender. In this section, I will first summarize the findings related to gender – see Appendix B, Table 5. I will then give quotes from providers who exemplify the findings in each category of gender. An overwhelming majority of providers described Latina women as being victims of domestic violence or abuse (16 of 22 [72%]). A majority of providers viewed Latina women as being family oriented (15 of 22 [68%]). Also, a majority of providers saw Latina women as fitting into traditional gender roles (14 of 22 [63%]). Finally, half of the providers discussed the relationship Latina women have with their husbands (11 of 22 [50%]).

Domestic Violence. Domestic violence was a major theme throughout the interviews. An overwhelming majority mentioned domestic violence as an issue that their Latina women deal with. Many providers stated that a high percentage of their Latina women deal with domestic violence issues. Considering the high rate of domestic violence against women - one in four women will experience domestic violence at a given point in her lifetime (Tjaden & Thoennes, 2000) – it is important to understand that domestic violence is not just an issue that Latina women deal with. Also, in the interviews, domestic violence was often integrated with other issues like mental health symptoms, immigration and childhood abuse. Elisa, a director, mentioned the connection between mental health and abuse. She stated:

What we know about that to the extent that we understand is that many people start out with genetic vulnerabilities and genetic resiliencies and that early on life experiences especially severe early life stress, that’s sexual abuse or physical abuse, plays a profound role in what happens to those genetic vulnerabilities and resiliencies. Subsequent life stress, such as if that person was raped or suffered domestic violence, also plays a significant role. And the rest of it gets into other contexts, so you really can’t separate out, I don’t think, individual factors from contextual factors. They are constantly in an interplay with one another.

Other providers stated that many Latina women think that domestic violence is normal or should be tolerated. Loretta, a therapist, stated:
It’s amazing…in the 10 years that I’ve been doing this, I didn’t realize how much Latina women suffer from depression and sexual abuse issues and it’s amazing to see that more are coming out…They think all Hispanic men are alcoholics and they abuse their wives or the infidelity, oh my goodness, they think infidelity is normal and that their choices are few, few choices, and so they just bare with it.

**Family.** Family issues are discussed at length amongst the providers as being a major part of the Latino/a culture, and important to Latina women’s lives. The providers perceived that their Latina women are very family oriented and used words like “the core” or “the glue” that holds the family together to describe their role in the family. Ethan, a director, stated, “I really believe that the goals, or one of the goal, is that want their family to get better.” Family is discussed at length in a number of interviews. Here are two quotes from providers that exemplify how the providers view family as key to Latina women getting better:

> Oh the family is key. The family is core, and in the Latino community, in the traditional Latino community, there is a grandmother and grandfather, aunt, uncle, and all these other people that factor into the equation as to whether or not to go seek help, or not seek help. (Lauren, a psychiatrist)

> I think our Latina ladies they are involved in family and if the family is not OK, however they define OK, they get worried, they get upset, they need help…Family is a value and when the family is not OK they’re not OK. (Lindsey, a supervisor)

Besides stating how core the family is to Latina women, several providers connected the value of family with isolation. Some stated that when Latina women come to the U.S. they become more isolated and removed from the family.

**Traditional Gender Roles.** Traditional gender roles were discussed by a majority of the providers. There are many dynamics within gender roles that were discussed. As mentioned above, domestic violence was talked about a lot. The providers often perceived Latina women as fitting into traditional gender roles which keeps them from getting out of abusive situation. Here
is one example from the interviews about women sticking with abusive relationships because of traditional gender roles:

[Leaving the husband] is not an option, financially, it’s not an option. Secondly, they were married for life and that’s their cross, and they’re going to work it through, we’re like okay. So I think it’s the way they were raised and a lot of them are raised as this is the man you marry, good or bad, you stick with it, and they stick with it. So, I think in that sense, culturally, it is different. (Lily, a director)

Another theme within traditional gender roles was the relationship with the husband and the changes therapy has on their relationships. The providers saw the Latina women as not wanting to come to services because their husbands were opposed to treatment. Emily’s response is one example that is representative of other interviews as well:

I think part of [the influences of access to services] is attitude about it to begin with. So how accepting is the husband or family of the idea of coming to therapy…I have someone who she’s like I can’t come today because my husband is home and he doesn’t want me to go to therapy, you know, I can’t leave the house. (Emily, a therapist)

A few providers even said that once husbands see their wives becoming more independent, they want them to stop therapy. Edward, a director, stated, “In certain sector, and I think that the population that I see, the women are considered like property and people that are for those types of tasks; cleaning, taking care of the children, cooking…” Edward stated that many of the husbands bring their wives to help them, but when they get better and more opinionated the husbands don’t want them coming back “because they are becoming too independent or coming with new ideas.”

Race. The providers were asked how their work with Latina women differed from their work with women of other racial/ethnic groups. During the interviews, the providers discussed
race, discrimination, segregation, and differences between races – see Appendix B, Table 6. Of the providers, over half discussed the issue of the difference in their treatment of Latina women (12 of 22 [54%]). Some of the providers described the Latina women as dealing with discrimination and prejudice (6 of 22 [27%])

**Difference Between Racial/Ethnic Groups.** The providers were asked how their work with Latina women differs from their work with other racial/ethnic groups. Of the providers, over half responded to this question, primarily citing language and immigration as issues as the difference. Leslie, a director, stated:

> I think when we work with the Latina woman, we are taking into account the Latina-centric factors or issues that she may be experiencing, that an African American woman wouldn’t be (i.e.) for example immigration status. We would deal with a Latina woman differently if we feel she is fearful because of lack of documentation and fear that she is going to be reported versus an African-American or Anglo woman who that is not a fear issue.

Other providers perceived that Latina women were different from Euro-American or African American clients in the way they perceive or approach treatment. Laura, a supervisor, described Latina women as being less goal directed than African-American and Euro-American clients. She stated,

> The English speaking Latina and the speaking domestic violence victim, specifically African American and Caucasian, would be much more goal-oriented naturally. They would come, they would want to get what they needed to get and leave. The Latina hangs on and hangs on so it presents a different kind of challenge.

Loretta, a therapist and intake coordinator, described Latina women as being more secretive and having more stigma around mental health issues. She stated,

> There isn’t such a taboo with African American or Anglo-Saxons you know, that’s something very common where with Hispanics they are so secretive. Oh I don’t, you know, my husband doesn’t
want me to come because only crazy people go to counseling so just that taboo, the language barrier is a very big difference.

Other providers saw that Latina women deal with different issues than Euro-American or African-American clients. Some of those issues include immigration, language, and a lack of awareness about services. For example, Elizabeth, a director, stated, “I always say my English women don’t have a reason to be depressed my Spanish people they actually have a reason to be depressed.” Elizabeth said that they joke in the hospital that almost never will a Latina woman ask about social services, but white women are constantly asking, “What do you have. What can you send me?” Elizabeth said, “Not our Hispanics, they do not ask.” The providers therefore seemed to perceive Latina women as having different issues or approaching treatment in ways that are different from Euro-American or African-American clients.

**Additional Findings.** In addition to culture, gender, and racial factors when describing Latina women, providers also described individual characteristics – see Appendix B, Table 7. These findings made up less than half of the providers: Respect was described as a very important quality for Latina women (11 of 22 [22%]). They were also described as soft-spoken (4 of 22 [18%]) and secretive (4 of 22 [18%]). Some of the providers described Latina women as eager to learn (2 of 22 [9%]). Less than 10% of the providers described sexuality, resilience, isolation, grief and loss, and the difference between rural and urban women from Mexico.

In summary, the majority of the providers did not see Latina women as resilient and able to thrive, though two mentioned resilience and empowerment. The providers primarily perceived Latina women as being victims of domestic violence, as being family oriented, fitting into traditional gender roles, religiously oriented, with issues that are different from Euro-American or African-American clients, and dealing with acculturation and acculturating children. These findings are important when seeking to understand providers’ perception of Latina women.
Finding 2: The providers perceived the following as affecting Latina women’s access to services:

- gender
- awareness
- culture
- internal factors
- resources
- social status
- social support
- stigma

See Appendix B, Table 8.

The providers were asked: *What factors do you think influence Latina women’s access to mental health services?* The providers perceived the following:

**Gender.** Half of the providers (11 of 22 providers [50%]) perceived that gender affected access to services. They described childcare, documentation, housework, domestic violence and bilingual/bicultural staff as factors within this category. For example, Lindsey, a supervisor, identified legal status, language, and fear of domestic violence as affecting Latina women’s access to services. She said:

> Legal status, definitely; the lack of Spanish-speaking and bicultural providers in their community; for new immigrants lack of knowledge of how to even begin; fear, in cases of domestic violence you may not see these ladies until they end up in the hospital or something really bad happens.

Similar to many of the providers, Lily, a director, discussed childcare as a barrier to accessing services:

> Another issue, I’m trying to think, daycare, childcare. We don’t have formal, say childcare services, where we can say okay this is our childcare worker to take care of the kids as they come. We don’t have that so it makes it very hard for our agency to provide Latinas who have children.
Some providers discussed the importance of having female workers on staff because of the perception that Latina women’s partners might have of a male worker. Other providers said that having women on staff helped Latina women be more open to receiving services. Ultimately, many of the providers perceived gender as an influencing factor for access to services.

**Awareness.** Awareness was another area that providers perceived as influencing Latina women’s access to services. A majority of providers (15 of 22 [68%]) described themes of awareness. Within the category of awareness, providers described immigration, cultural and gendered reasons for awareness or lack of awareness of services. Some described problems with access due to immigration issues and language. For example, Erin, a supervisor/team leader, stated:

> I think language is a huge issue and I think a lack of knowledge, a lack of awareness about what is out there and what it means and how it works. In general I think the population in general is not that well educated on mental health services but I think Latinos even more so.

Some providers also stated that there is an increasing awareness of services thanks to the media.

**Cultural Factors.** In addition to gendered access and awareness, providers perceived cultural factors as affecting access to services. More than half of the providers (13 of 22 [59%]) described cultural issues that affect access to services. These included discussions about traditional healing practices, family, stigma in the culture, and language. Leslie, a director, discussed many of these cultural dynamics. She stated:

> The cultural beliefs that affect mental health is I think traditionally there is a lack of understanding among first generation Latinos and recently migrated...Immigrated families that mental health services if you mention trabajadores social [social workers], o psicologo ellos [their psychiatrist] it is that it’s pathologized. So I think in our culture seeking out mental services is labeled as pathology. I think our culture also proposes or postulates that we should be handling those within extended family or through the
church and not so much talking to service providers.

**Internal Factors.** Internal factors of the woman that influenced their access to services were defined as personal characteristics of the woman, such as how open she is about seeking mental health services. Other factors were considered as well, such as eagerness to learn, confidence in navigating the system or neighborhood so she can get services, how persistent is she at finding services, her mental health and how that may impede her ability to seek services, desperation level, fear of violence in the community, and fear of deportation because of being undocumented. A majority of the providers (13 of 22 [59%]) perceived these internal factors as influencing access to services. Ethan, a director, put it:

> In general women are so caught up with childcare and the dynamics of family life, the effects of depression, anxiety, PTSD, as well as just working hard, so finding time. This is a neighborhood, like many others, where there are gangs and there is a high incidence of violence in the streets. Every one of our clients has witnessed violence on the streets.

Providers also discussed eagerness to learn and Latina women’s desire to become empowered as internal factors. One provider, Leslie, a director, stated, “We’re still on access, well, I think it comes from a real sense of their own desire to become empowered and to improve their life situation.” Leslie also stated: “I think they really need the, they’re eager to learn. I don’t find it once they walk through the doors, I don’t find much of what we call resistance. I have trouble with the term saying the clients resist***, I tend to blame the professional.” Other providers described Latina women as overcoming many obstacles. For example, Lauren, a psychiatrist, stated: “And the Latina woman is a very strong woman. She has overcome many obstacles, much like the African American woman.” These are just a few representative examples of individual factors that influence access to services.

**Resources.** Resources were another area that providers perceived influenced Latina
women’s access to services (12 of 22 [55%]). Latina women were described as having difficulty with access to resources which then influenced their access to mental health services. Resources including finances, childcare, transportation, papers, and insurance were all identified as impacting access to services. Emily, a therapist, stated:

How much control does she have of the money to get here and to feel that she can negotiation the train system, the bus system, if she’s driving this or that. So there are some financial issues, there are patients that I provide like with bus passes and things like that so that they can come and go and don’t have to worry about that. There’s the insurance issue.

A few providers talked about camaraderie among the women as a resource to help them access the services. For example, Elizabeth, a director, stated:

They can really… they support each other, they help each other and they give each other rides. They really develop a camaraderie and many of the women only do the support group even though it is recommended that they do all three. But they don't just have motivation or the resources aren't available or they can't get there - whatever the limitations are. And so they just come to the support group and it's so helpful; that in it of itself is very helpful.

The Latina women’s schedule (considered here as a resource) was perceived as another barrier that affected their access to services. The providers felt that providing services during different times of the day and week would help Latina women access services more easily. Linda, a supervisor, identified a number of resources, including schedule, that prevented Latina women from accessing their services. She stated:

The outreach is one of the things that is helpful, but if we don’t have the services offered in this area we’re stuck. So some of the factors will be money, the fees, transportation, the understanding of the culture, the education that they have…The language is a barrier. Affording them is a barrier. The availability of the schedule…

Social Status. The providers also perceived social status as influencing Latina women’s
access to services. The majority of the providers (15 of 22 [68%]) perceived social status as influencing access to services. Social status involves factors like if the woman is pregnant then she can get public aid which will allow her to access mental health services; immigration status may prevent woman from receiving services; sexual orientation may impact seeking services because woman may fear being labeled or rejected; discrimination, etc. The providers mentioned that Latina women can receive free services while they are pregnant, according to Illinois State law. Emily described social status related to pregnancy succinctly when she stated: “Well that's the amazing thing about that ob-gyne clinic, for the nine months that they're pregnant, they get that public aid card, so often it's like the only time in this country, when they're pregnant, that they can actually afford to come to therapy.” Social status related to sexuality was discussed by one provider as affecting Latina women’s access to services. Edward, a medical director, stated:

I think that eh generally the Latina women that are that is just something that is less and less. Latina women don't want to come when they have issues of sexual, sexual issues. Especially younger women that are lesbian or bisexual they have more problems in coming to our service because of the fear of being rejected or labeled or anything like that. I think that we don't have a special program in that area but we are open to any kind of issue. The people are coming for those services are minority and generally because they have been recommended by another person that has been having those issues and they have felt comfortable.

Social Support. In addition to social status, social support was found to affect access to services. More than half of the providers (13 of 22 [59%]) perceived social support – including dependency in a relationship and of knowing someone who has received services – as a factor in accessing services. Word of mouth was a huge source that helped Latina women access services. For example, Edward, a medical director, describes mother-in-laws, aunts, and sisters as influencing Latina women to access services. He stated:
I think that when there are other members in the family that are seeing a mental health professional it is easier for them. Generally, those members are in general, I'm not saying all the time, but they calling them by phone and asking where they are going and what kind of therapist they have obtained and the relative has been successful or has been partially successful they are coming and saying you know my mother-in-law, my aunt, my sister has been coming here. She told me that you provide services and she's very happy about it.

Social supports can also negatively impact access to services. The providers perceived the women to be in unsupportive relationships. For example, Loretta, a therapist/intake coordinator, stated:

They have very, very poor support systems in terms of coming in for counseling. And the secretiveness, just even when they come in to see me, their first concern is, are you going to share this with Fulana or Fulano and reassuring them.

Social support can affect access to services in both negative and positive ways. The providers discussed both the positive and negative ways social support can influence Latina women.

**Stigma.** As mentioned above, stigma was discussed in an overwhelming majority of the interviews. The providers discussed stigma specifically related to access to services as well. A majority of the providers (19 of 22 [86%]) discussed stigma when referring to access to services. Stigma was defined as the belief that being labeled as having a mental illness is bad makes it difficult to seek services. This clearly would have an impact on access to services. Three providers gave succinct examples that represent the discussion around stigma. Laurie, a program director, stated: “I think their self-esteem, as it is, it’s very low and when someone tells them that mental health services are for crazy people, I think they believe it.” Lily, a director, stated: “I think the stigma is number one on the community level and it does impact Latinas.” And Lauren, a psychiatrist, stated: “So, stigma is very much alive and it keeps most of the Latino population outside of my office.” Some providers saw stigma as an issue not just in the Latino population.
Again, Lauren’s comments aptly represent opinions of the other providers. She stated, “The stigma, and that’s not only my Hispanics, but also the general population at large. It still is very much a stigma to come see a psychiatrist.”

In summary, the providers perceived gender dynamics, cultural factors, individual factors, and resources as affecting a Latina woman’s access to services. In some cases, these factors helped the women to access services and, in other cases, these factors impaired women from accessing services. Once Latina women access services, retention or ongoing use of services becomes very important. In the next section, the providers discuss retention and ongoing use of services.

**Finding 3: The providers perceived the following as affecting Latina women’s retention and ongoing use of services:**

- **resources**
- **social support**
- **bond**
- **improvement**

See Appendix B, Table 9.

Each provider was asked the question: *What do you think makes it harder or easier for clients to continue receiving services?* The providers perceived the following:

**Resources.** A majority of providers (16 of 22 [73%]) perceived a Latina woman’s resources as contributing to ongoing use of services. Resources were defined as money, time available, transportation, and childcare. Many of the providers cited each of these as factors that affect ongoing use of services. Schedule was mentioned in a variety of examples. Here is an example from Emily. She said:

> But I think sometimes, if there's a lot of odds against it like the husband really doesn't want her here or the parents really think that means she's crazy or her work schedule changes every single week
and she can't keep that three o'clock if it's an appointment. I think some of those things can affect it.

Transportation and childcare were also mentioned in a variety of examples. Elizabeth, a social worker/director, describes transportation and child care as huge issues that prevent women from continuing services. Elizabeth engaged in outreach but saw resources as affecting ongoing use of services. She stated:

Well you know it's like planting seeds. I'll call them periodically. I'll joke with them - don't you like me; you won’t come see me; or you know I cajole them you know or whatever but a lot of times it can be that they're too depressed to reach out initially at least. You know have to work with that. Transportation is a huge issue; child care is a huge issue. There's a significant number that the spouses don't want them to leave the house to go anywhere let alone this. And he is not supportive of the program.

Social Support. A majority of providers (14 of 22 [64%]) mentioned social support. Social support, whether a woman has support from others including her spouse and family members, can affect whether or not a woman continues receiving services. Many of the providers perceived supportive or unsupportive husbands as affecting ongoing use of services. Loretta, a therapist/intake coordinator, stated that 60% of the husbands are supportive and 40% are unsupportive. Family and spouse support can affect retention by making ongoing use easier or harder. For example, Laurie, a program director, discussed how retention is harder with no family support. She stated, “[It] makes it harder if they have no family support.” Many of the providers mentioned that the women have to hide their use of services from their family and spouses. Linda, a supervisor, explained the type of reputation mental health service providers have in society. This reputation affects women from telling their partners or families about receiving services. Linda stated:

Some of the women come in hiding from the husbands. So a lot of the husbands do not know that they are in counseling. We have a
bad reputation out there in society. In the...one of the bad reputations we have is that we break up marriages. We break up relationships. We're here to separate the husband from the wife. And the other one is we're lesbians and want the women for ourselves. We're a bunch of angry lesbian women, who hate the men, so we want the women for ourselves. So... what a reputation huh.

**Bond.** One of the major themes of continuing services that the providers perceived involves the bond of the client with the provider. Half of the providers (11 of 22 [50%]) perceived the connection that Latina women feel to the agency as affecting ongoing use of services. This was defined as the bond – the feeling of connection to the agency, what the woman perceives the agency can provide or do for her, and the commitment felt once the relationship is built. One example from Laurie, a program director, highlights the perception of engaging with services that was mentioned by many providers. Laurie stated,

> I think they are more open to closer interaction than other cultures that maintain themselves more distant when it comes to relationships or check it out longer, I think the Latino population, not all of them, but as a culture a majority would be really open to engaging in services. They engage really fast. Of course you need a good clinician with good engagement skills but if you have them as soon as the Latino feels, you know, someone is caring for them and they are here to help, they would just totally engage.

Erin, a supervisor/team leader, describes Latina women as “very relational” and stated that once they access services, retention is much easier. Erin said: “I think once you are here and you are getting services then there is a commitment in general. Latinos are very relational. And so once a good relationship is developed, there tends to be a commitment to it.”

**Improvement.** Finally, if a woman sees improvement, she was perceived as more likely to continue receiving services. Many of the providers (9 of 22 [41%]) perceived improvement as impacting ongoing use of services. For example, Laurie, a program director, responded: “Easier in their lives I guess if they have, if they see number one if they see improvement and progress
coming to treatment...” Luis stated: “I think they really are committed to improve their lives situation and when they see something that is beneficial to them, they really stick to it as much as they can.” Another example of this phenomenon can be exemplified by Loretta’s response:

I think what makes it easy for them to continue is that they see, they see the positive changes and they want to continue coming in because they see the doors opening and their empowered-they feel empowered and so, it makes it easy for them to come in. And yet when they come in they're - now they are wanting to bring their partner or now they're wanting to include the kids because now they are empowered enough to say okay, this is not healthy and we need to work in it, we need to work.

In summary, the providers did not see culture, gender, and race as impacting ongoing use of services. They saw more interpersonal factors and resources as contributing to retention. These findings are important when trying to understand how providers perceive Latina women and their reasons for continuing to receive services.

**Finding 4: Half of the providers were Latino/a and half were non-Latino/a.** Of a total of 686 coded responses, 402 (59%) were from Latina providers, 284 (41%) were from non-Latina providers. This implies that Latina providers had more to say about Latina women than non-Latina providers.

Understanding the positionality of a provider is complex. The providers’ life experience, perceptions, racial/ethnic identity, and familiarity with other cultures all impact their positionality. Many providers discussed their own identity during the interviews. As discussed above, a majority (20 of 22 [90%]) discussed the importance of the cultural understanding of the provider. Also, there were certain silences in some of the interviews with non-Latinos, which suggests a less than nuanced understanding of Latina women’s lives. At the same time, some non-Latino/a providers showed that they are very aware of the language and cultural issues. Some Latino/a providers seemed to have stereotypical responses about Latina women. Despite
these differences between Latino/a and non-Latino/a providers, the evidence shows that the Latino/a providers were coded 18% more often than non-Latino/a providers. This implies that Latinos have more to say about Latina women’s lives. Ultimately, the majority of the providers agree that a person should have familiarity with both the language and the culture when serving Latina women. In the following section, I will describe in brief detail the providers’ discussion of their positionality as it relates to Latina women.

Emily is a Euro-American, bilingual, female therapist. She states that she is “really aware of cultural issues, of issues around immigration, acculturation, economic issues.” She also states that she is “well aware of what it means to come home to this country, to miss the family on the home country, and how that impacts diagnosis, how it impacts the treatment.” When asked how she is more aware, she states that this comes from experience, a lot of research, living in other cultures, and through personal relationships. She states that she has to be aware of her position and if the clients can trust her or not.

Laurie is a Latina, bilingual woman program director. She is asked, “Do you think your familiarity with Latina culture makes it easier or do you think the good engagement transcends that?” She responds: “I think it makes it easier. I think the relation—sitting with someone that, for a client, sitting with a clinician that understands the culture and is immersed in that culture even though they don’t have to know everything but, I think that makes it much easier. It helps a lot.” Laurie also states, “I mean for an agency to be really culturally fit, they should be Latinos at all levels…Spanish-speakers mainly.”

Edward is a Euro-American, bilingual, male director of a hospital. He states that he knows about the Latino culture through so many years of working with women from different countries. He states, “subtle differences where do they come from in the case the Mexican
women they are coming from the capital or they are coming from provinces with part of the South or North of Mexico. There are subtle differences even though people want to include everybody in the same category you know there are differences.” He also states that he doesn’t treat Latina women differently than women from other racial/ethnic groups, he states: “You do things according to how do they perceive themselves.”

Some of the providers discussed how being Latino/a naturally makes providing service to Latina women easier. Lindsey is a Latina, bilingual, woman supervisor. She states that it can be difficult to even verbalize because “most of us are bicultural so it comes, it’s just something that we deal with day in and day out and it’s natural to a large extent…” Leslie is a Latina bilingual woman director. She states: “I think the fact that we are Latinos serving Latinos, automatically, naturally, innately takes away the stigma in many ways. So that is not them coming to the dominant culture for help, it’s them coming to another Latino, or Latino organization…So, I think our reputation and our history in the community helps people to let go of the stigma and the embarrassment of coming seeking help.”

Lauren is a Latina, bilingual, psychiatrist. She states that she uses her knowledge about Mexican and Puerto Rican culture and shares that with them. “And so cultural sensitivity is very, very important as is the social status and is the family support because if you do not acknowledge family in the realm of one to one therapy, you can lose the patient too.[…] So, it’s really very important to be culturally sensitive and be able to share with them in the language that they are most comfortable, in an environment that is welcoming and not foreign.”

Eli is a Euro-American, male, director. He states that he is from a small immigrant community – the Polish community – and that he is fluent in Polish. “I felt that I was very ethnocentric in that way, even though it was not from a, what would be considered a minority
group.” He also states that he was in the Peace Corp in Western Samoa and this experience shapes his perspective. “I think it makes me very sensitive to the fact that where we come from and our ethnic backgrounds are very important.”

Loretta is a Latina, bilingual, woman who is a therapist and intake coordinator. She states that she gets asked if she is married to a Hispanic and when she says yes they are surprised when she says he doesn’t beat her or cheat on her. She states that, “They think all Hispanic men are alcoholics and they abuse their wives or the infidelity, oh my goodness, they think infidelity is normal and that their choices are few, few choices, and so they just bare with it.”

Amanda is an African-American, woman therapist. Her agency has no bilingual staff and no Latino/a staff members. She states, “In terms of treatment, I mean it’s like how I treat everyone, you know, as individuals.” She also discusses the culture shock due to immigration. “Well yeah…for a person who has kind of grown up in the area it can be kind of cultural shock because we had this mass influx of Hispanics come into the area. […] So, yeah, I grew up in the area and it’s been like this mass influx of individuals and uh so you know prejudices and stereotypes and all those types of things are revisited, of course you know, on both parts.” She states that people in the area have not reacted pleasantly to Latinos coming to the area. There have been protests and police may be targeting Hispanic drivers for insurance and drivers licenses. “So there has been a lot of protests and a lot of issues that are community related so I think that it’s a shock for everyone and adjustment for everyone sort of like this hospital I think the area itself is going through an adjustment phase.” She says the biggest problem with Latina women is language, but does not identify other factors that make accessing services easier or more difficult.
Luis is a Latino male therapist states, “I think the fact that I am bicultural, I think the fact that I have knowledge of community-based organizations so when they are dealing with an issue I can refer here, I can be like a case manager, if that’s what they need, I can be a therapist when that’s what need […] I am the only one who speaks Spanish here as a therapist, so if I go on vacation…” Luis fades off when discussing what happens when he goes on vacation, thus implying that his familiarity with the culture and the language is important when serving Latina women.

Ellen is a Euro-American, woman, case manager supervisor. She states that their agency uses interpreters for their clients. When she is asked what the women say why they are coming in for services, she states: “With the staff that can speak their language, they will open up about those things right.” When she is asked what factors in women’s lives make it easier to access services, she states: “Well, I don’t know that there are any.” These silences stand out in some of the interviews showing that there is a less than nuanced understanding of Latina women’s lives in some of the non-Latino/a providers.

**Summary and Conclusions of Results**

As described at the beginning of this chapter, four major findings emerged from this study:

1. The majority (20 of 22 [91%]) of mental health providers did not see Latina women as resilient. Two of the providers (9%) identified their clients as resilient and used a strengths based/empowerment model with their clients. The providers identified a variety of cultural, gender, racial and individual factors to describe their clients.

2. The providers perceived the following as affecting access to services: gender, awareness, culture, internal factors, resources, social status, social support, and stigma.
3. The providers perceived the following as affecting retention and ongoing use of services: resources, social support, bond, and improvement.

4. Of a total of 686 coded responses, 402 (59%) were from Latina providers, 284 (41%) were from non-Latina providers. This implies that Latina providers had more to say about Latina women than non-Latina providers as half of the interviews were with Latino/a providers and half were with non-Latino/a providers.

Table 3 summarizes four findings or coded descriptors that were discussed in more than 70% of the interviews. I decided that those areas discussed in more than 70% of the time should be included as major findings. This includes the culture of the provider which was discussed in 90% of the interviews. Within this category, Latino/a providers were coded (discussed) 26 times, whereas non-Latino/a providers were coded 18 times. In the category of access to services, stigma was discussed in 86% of the interviews, with 26 codes for Latino/a providers, and 19 codes for non-Latino/a providers. Domestic Violence and Abuse was discussed in 72% of the interviews. In this category, Latino/a providers were coded 13 times, whereas non-Latino/a providers were coded 10 times. In retention and ongoing use of services, 73% discussed resources as affecting use of services. In this category, 12 codes were given to the Latino/a providers, and 11 were given to the non-Latino/a providers. This table highlights the major findings discussed in the interviews as well as showing how Latino/a providers were coded more times than non-Latino/a providers.
Table 3. Coded Descriptors Discussed in more than 70% of Interviews

The providers discussed in this thesis are the therapists, directors, supervisors, psychiatrists, and social workers for agencies that provide services to Latina women. These are the people in positions of power. Their opinions and perceptions of Latina women impact how Latina women are treated and what kinds of services they might receive. Rather than examining...
the Latina women who receive mental health services, this thesis examines the providers’ perspectives of Latina women. I hope to understand the biases of the providers.

In light of the providers’ discussion about Latina women, it is clear that they do not perceive Latina women with a strengths based perspective, or as resilient women who have the ability to thrive. I hope to infuse a strengths-based perspective and more in-depth cultural understanding (that it’s not just about language) into the dominant cultures perspective of Latina women who are mental health system survivors. A change of mentality is needed in the minds of those with power, not a reform in the minds and culture of the Latina women.
Chapter 5: Discussion

*We draw our strength from the very despair in which we have been forced to live. We shall endure.* – Cesar Chavez

The purpose of this study is to establish the current point of view of mental health service providers and how they perceive Latina women in the mental health system. This study proposes that a focus on strengths and resilience provides a meaningful framework to understand Latina women involved in the mental health system. This study uses standpoint theory as a theoretical framework and phenomenological analysis. In light of the current research on mental health and framing the research with feminist perspectives, this thesis seeks to understand how providers perceive or understand Latina women as clients. This thesis also seeks to understand what factors providers believe influence Latina women’s access to and ongoing use of services. Finally, this thesis examines the positionality of the providers to determine if Latino/a providers had a greater understanding of Latina women’s lives than non-Latino/a providers. Based on the literature review, I developed four hypotheses. I thought that the providers would not see Latina women as resilient. I also thought that they would attribute culture, gender, and race as affecting both access to services and continuing use of services. I also predicted that Latino/a providers would have a more nuanced understanding of Latina women’s experience than non-Latino/a providers.

**Major Findings and Conclusions**

*We can never judge the lives of others, because each person knows only their own pain and renunciation. It's one thing to feel that you are on the right path, but it's another to think that yours is the only path.* - Paulo Coelho

This study used interviews which investigated the perspective of service providers about Latina women. Researchers asked these service providers to share about their lives and their experiences working with Latina women. Their perspective matters because these are the
therapists, directors, supervisors, psychiatrists, and social workers who are in positions of power to change lives. These interviews provide one piece of the puzzle of the experience of Latina women mental health system survivors. This study leaves the door open for examining Latina women’s resilience by interviewing the Latina women themselves. However, this study focuses just on the providers perceptions. In this section, I discuss the results of this study, conclusions drawn from the findings, and recommendations for future research.

In the twenty-two interviews, two providers viewed Latina women as resilient. The prevailing focus on biology and pathology in U.S. culture makes these finding unsurprising (Ballou & Brown, 2002). However, in light of the literature review and the overwhelming evidence of resilience and strength in the Latino/a culture, these findings are disappointing. The providers’ perspectives of Latina women overlapped in many ways. To give a crude summary, the providers perceived Latina women as timid, secretive, soft-spoken, married, and dealing with domestic violence and acculturating children. The Latina women were seen as fitting into traditional gender roles. Religion and family were seen as central to their lives. They were described as seeing mental health treatment as only for the very ill or the “crazy” people and as preferring natural healing practices instead of mental health services (Renfro et. al., in press).

As predicted, the providers perceived culture and gender as contributing to Latina women’s access to services. However, the providers did not perceive race as contributing to access to services. In addition to culture and gender, the providers also attributed awareness, internal factors, social status, resources and stigma as affecting access to services. Awareness, gendered access, social status, and resources make a lot of sense when thinking about a person’s ability to access services. If a person does not have an awareness of what is available, or resources for transportation, childcare, or payment, or is dealing with domestic violence, then it
makes sense that they could not easily access services. On the other hand, culture, internal factors, and stigma are more abstract. Attributing these factors to Latina women’s ability to access services takes the responsibility off the providers and puts it onto the women themselves. When providers perceive Latina women as unable or unwilling to access services because they don’t believe in mental illness or are uneducated, this makes fixing the problem of access to services much more difficult.

On an environmental level, focusing on improving resources, ending gender discrimination, and improving public education and awareness can be effectively done by providers and agencies to improve access to services. Once these are no longer barriers, I believe that the culture, internal factors, and stigma will not be as big of a barrier for Latina women. Despite this opinion, studies of resilience show that factors on the individual, familial, and environmental levels all contribute to resilience (Garza et al., 2004; Garmezy, 1991; Jordan & Hartling, 2002). When looking at an environmental level like mental health services and deciding how to improve access, we must look at all three areas – individual factors, familial/support factors, and environmental factors.

An unexpected finding was that providers did not perceive culture, gender or race as affecting continuing use of services. The providers perceived bond, improvement, resources, and social support as contributing to retention and ongoing use of services. These findings show that once Latina women access services, the providers’ ability to provide meaningful and effective services becomes crucial. By creating a meaningful connection, effective services, and assistance with resources, agencies providing services to Latina women can improve the ongoing use of services. Improving social supports may be more difficult for a provider to do, especially in cases of domestic violence and immigration away from family and friends. However, as studies
of resilience show, developing a meaningful connection with a person or people in the
community contributes to resilience (Jordan & Hartling, 2002).

The results indicate that Latino/a providers have a more to say and possibly a more
nuanced understanding of Latina women’s lives than do non-Latino/a providers. This is not the
case across the board, of course. Some Latino/a providers had a less than nuanced understanding,
while some non-Latino/a providers appeared to have a very nuanced understanding of Latina
women’s lives. Also, it is important to apply an intersectional analysis to these findings. There is
not an easy dichotomy of insider/outsider with Latino/a and non-Latino/a participants. Instead
this dynamic is complicated. The participants are a diverse group of people in race, ethnicity,
gender, age, class, and nationality (Renfro et. al., in press). Latinos in general are also a very
diverse group and so one cannot conclude that simply having a Latino/a provider will
automatically have a more nuanced understanding of Latina women. In light of the findings,
however, it appears that an understanding of both language and culture is crucial when providing
services for Latina women. To improve services for Latina women, agencies should work to hire
and keep people who are both fluent in Spanish and who have an understanding of the culture.

**Relationship of the Results to Previous Research**

*Once social change begins, it cannot be reversed. You cannot uneducate the person who has learned to read. You cannot
humiliate the person who feels pride. You cannot oppress the people who are not afraid anymore. We have seen the future, and
the future is ours.* - Cesar Chavez

Times are changing. The work of feminist psychologists, resilience researchers, experts
on Latino/a culture and others connects to the results of this study in a variety of ways. Previous
research combined with the findings of this study point us to a better future. The previous
research can be divided into five sections. First, there must be a move away from pathology and
into studies of resilience. Second, the experience of mental health system survivors must be woven into feminist politics and analysis. Third, studies of resilience provide important implications for the results of this study. Fourth, Latina women’s resilience must be understood through understanding specific risk factors and the cultural, spiritual, and individual resilience of Latina women. Finally, previous research using standpoint theory and phenomenology is important to consider in light of the use of standpoint theory and phenomenology in this thesis.

Feminist psychologists and others have called for a move in the mental health field away from pathology and into resilience and strengths (Ballou & Brown, 2002; Brown, 1994; Espin, 1997; Worell, 2001). The results show that the past focus on pathology affects providers to this day. The overwhelming majority of the providers did not discuss Latina women as resilient. However, the few that did show that providers can examine Latina women involved in the mental health system by looking at not only the problems they come to the agency with, but also at their strengths and their ability to be resilient. If we theorize women’s strengths first, some of the barriers identified for access to and ongoing use of services can be broken down. As a mental health system survivor, I believe that it is crucial to understand people who are diagnosed with mental illness not as “crazy,” pathological or ill, but as survivors who can overcome obstacles and be resilient. Starting from this point of view can break down stigma and improve not only self-esteem, but also relationships with family members and mental health service providers.

Previous research shows that there is a gap in the literature around feminist analysis of mental health issues. The experience of mental health system survivors must be woven into feminist politics, analysis, and critique. Latina women mental health system survivors, particularly those women discussed in this thesis that have emigrated to the U.S. and are poor, deal with intersecting systems of oppression. These systems include facing sexism, racism, able-
ism, classism, nationalism, and others. This recalls a poignant statement by one provider who said, “My Latina women have a reason to be depressed” (Renfro et. al., in press). Feminists have tapped into sources of resistance, resilience, and empowerment. When considering the results and findings of this study, that the providers perceive Latina women as facing a vast number of barriers and difficulties when accessing and continuing services, these sources of resistance, resilience and empowerment are crucial.

Previous studies of resilience have shown that resilience occurs on three levels – the individual, familial, and environmental levels (Garza et. al., 2004; Garmezy, 1991; Jordan & Hartling, 2002). The providers in this study identified factors on the individual, familial, and environmental level that the Latina women they work with face. This study considers service providers as a crucial piece to understanding Latina women’s lives on an environmental level. Examining the factors that affect access to services and continuing use of services is important in understanding whether or not Latina women will have this community source of resilience in their lives. The providers identified factors for access to and ongoing use of services that connect to the previous research on resilience – factors on the individual level such as awareness, internal factors, improvement and stigma; factors on the familial level such as social support and bond; and factors on the environmental level such as gender, culture, social status, and resources (Renfro et. al., in press).

Some of the barriers to care specific for Latina women were discussed in the literature review. These included the belief that mental health services are only for the extremely ill, cultural beliefs about the enduring suffering of the woman, and a lack of awareness (Landrine, 1995). These three barriers were found in this study as well. Even though there was an overwhelming emphasis on the barriers and problems in Latina women’s lives, the providers did
show awareness of the areas of resilience and strength found by previous research. The areas of resilience identified in previous research include spirituality, family connection, a differential consciousness, and language (Garza et. al, 2004; Sandoval, 2000; Trueba, 1999). The providers did discuss these qualities in their interviews as factors that help Latina women access and continue receiving services.

Lastly, the previous research on standpoint theory and phenomenological analysis is important for this study which used standpoint theory as a theoretical framework and phenomenological analysis as the methodology. The research on standpoint theory shows that peoples’ positionality impacts their credibility as knowers (Harding, 2004; Jaggar, 2008). Whether a person is in a dominant position in society or a marginalized position, standpoint theory emphasizes liberatory standpoints (Harding, 2008). The providers in this study were all in dominant positions in society due to their jobs as providers. However, the providers all had individual experiences related to class, race, gender, or sexuality that places them in different positions of marginalization. The positionality of the providers’ race/ethnicity proved, in this study, to be an important factor when considering Latina women’s lives. The Latino/a providers appeared to have more to say about Latina women, as discussed in the results chapter. This fits with previous standpoint theory research which shows that the positionality of a person matters (Harding, 2008). Finally, looking at the interviews with a phenomenological analysis proved to be effective. The phenomenon of the experience of working as a provider with Latina women is important to examine because this experience shapes policy and practice.

This thesis works to continue the social change that the researchers discussed in the literature review chapter have already begun. As the providers share in their interviews, once Latina women see improvements and changes, they do not go back (Renfro et. al., in press). The
previous research connects to the findings of this thesis. We can move towards a better future by looking at Latina mental health system survivors from a strengths perspective and understanding resilience as it relates to access to and ongoing use of services. We can improve services to Latina women by providing services in Spanish from providers who have a good understanding of Latino/a culture.

**Implications for Theory and Practice**

*My feminism is humanism, with the weakest being those who I represent, and that includes many beings and life forms, including some men.* – Sandra Cisneros

Feminism is not just for women and resilience is not just for the strong. Feminism and resilience are important for all people, particularly the weakest and most vulnerable. This thesis also holds implications for theory in the field of Women’s and Gender Studies as well as psychology. This thesis also holds implications for practice, not just for Latina women involved in the mental health system, but for all people who are mental health system survivors.

**Implications for theory.** This thesis holds implications for theory in the fields of Women’s and Gender Studies and psychology. Feminists have already begun to transform pathologizing research projects into more liberatory projects. This is another such study. There is also a gap in feminist literature on mental health. This study fills a gap in the literature by giving a feminist analysis of mental health system providers’ perspectives of Latina women. There is also a gap in the literature in psychology around Latina mental health concerns, particularly as they relate to strengths and resilience. Focusing on resilience – on individual, familial, and environmental levels – helps to identify more effective preventive measures in treating women with mental health needs. By looking at resilience, we may come to see Latina women as
dynamic players in social context. This provides new information and research for both the field of Women’s and Gender Studies and for psychology.

**Implications for practice.** Aurora Levins Morales (1999) uses the term “mental health system survivors,” which is how this thesis has viewed and referred to Latina women who are involved in the mental health system. This thesis holds implications for practice with mental health system survivors. By viewing Latina women who receive mental health services as survivors, we begin to transform pathologizing language. This thesis found that providers did not view Latina women as resilient or from strengths based perspectives. This causes one to wonder how providers view all people who receive mental health services. A key component to defining resilience is that a person has experienced adversity. People who are involved in the mental health system have experienced adversity in their lives, if only from their experience dealing with mental health difficulties. This implies the importance of understanding resilience as it relates to mental health system survivors. On an environmental level, agencies that provide mental health services are a key component to people’s resilience. Therefore, examining access to services and ongoing use of services becomes crucial. This research looks at mental health system survivors not as ill and pathological, but as people with strengths and resilience who have the potential to thrive.

**Limitations of this Study**

“This is to assuage our conscience, darling” she would explain to Blanca. “But it doesn't help the poor. They don't need charity; they need justice.” – Isabel Allende

The purpose of this research project is to understand the perspective of service providers and to understand how they perceive Latina women mental health system survivors. I hope this study will help Latina women, however, it only provides a small piece of the puzzle to
understanding their experience and ability to be resilient with the service provided to them. In all research projects, there lie limitations. There are limitations to this study, the main one being that I did not interview the Latina women themselves to examine their resilience. In the next section, I will discuss several identified limitations to this study.

This study uses standpoint theory which argues that certain people have a position of epistemic privilege, born through struggle, which gives them a more accurate view of the subject being studied (Harding, 2004). From this theoretical framework, one could conclude that Latina women mental health system survivors, as a marginalized group, have an epistemic privilege over others about their mental health and resilience. Therefore, the fact that I did not interview Latina women themselves proves to be one major limitation to this study. During this process, I struggled with examining resilience from the perspective of the providers. The providers are in a position of privilege and cannot tell all there is to tell about Latina women’s resilience. After much thought, I decided to examine the positionality of the providers about Latina women in keeping with standpoint theory.

This thesis used interviews from the Latina Mental Health Needs Study (Renfro et al., in press). Although a stratified sampling method was used in the Chicago area, this sample cannot be described as a representative sample of all providers of mental health services. The questions asked in the interview protocol (see Appendix A) did not ask about resilience specifically. It is difficult to enter into domains of resilience due to the nature of the questions asked. This could mean that some providers who use resilience perspectives did not get a chance to share this perspective. Also, I used twenty-two interviews, and using more interviews would have made the results stronger. As discussed in the literature review, longitudinal studies of resilience are
important (Rutter, 2006), and this study only gets at the perspectives of providers at only one point in time.

Another limitation of this study is the self-report nature of the responses. Due to this approach, it is difficult to know how truthfully and thoroughly the providers answered the questions. Social desirability may have had an influence on their answers. Another limitation was that the providers were not asked about resilience directly. The providers were asked to identify factors that they perceived affected mental health, access to services, and ongoing use of services but were not asked their opinions about resilience directly. This may have elicited more strengths based views, and should be done in future studies attempting to understand this phenomenon.

A methodological limitation involves the exploratory technique of phenomenology which only gets at an initial snapshot of the phenomenon of resilience and the experience working with Latina women involved in the mental health system. This study also gave summaries of the interviews and used heavy quoting from the interviews in the results section. This was meant to provide a wealth of information for the reader so that research interpretation could be lessened. However, this is also a limitation where the reader may feel as though they are expected to interpret the data themselves.

Finally, this study attempts to get at the providers perspectives of their Latina clients, not their perception of Latina women in general. It is important to note that the population the providers are discussing is not about Latina women in general and is a skewed population. The Latina women that the providers discussed are Latina women involved in the mental health system and therefore deal with specific issues that are not representative of Latina women in general.
Directions for Future Research

...I am participating in the creation of yet another culture, a new story to explain the world and our participation in it, a new value system with images and symbols that connect us to each other and to the planet. – Gloria Anzaldúa

Certain kinds of research are an act of participation in the creation of a new culture. If we engage in certain kinds of liberatory research we can create new value systems with images and symbols that connect us to each other and the planet. This study uses standpoint theory as a theoretical framework for methodology and phenomenological analysis as method for analyzing the data. There are not many studies related to resilience or related to the perspective of those in power (namely, the providers of mental health services) that use this approach. This thesis fills a gap in the literature by examining the positionality of mental health service providers and their views of Latina women with a standpoint theory framework and a phenomenological analysis of the data. Future studies could use this approach to determine the nuanced perspectives of providers.

This study opens up gaps in the research. There are very few studies about mental health providers’ perspectives of Latina women. Most studies are done examining the patient or consumer. There are also very few studies about mental health providers perspectives of individuals of other racial/ethnic groups who are involved in the mental health system. Future studies should be done to see if the positionality of the providers impacts their perception of the population they serve. Also, understanding how the providers’ perception of Latina women impacts Latina women’s lives would be good to know. Future studies examining how providers’ perceptions impact women’s lives could give implications for good interventions in the future.

I recommend a study in which the providers would be asked about resilience and strengths specifically. There may be more awareness about resilience among the providers that
was left undiscovered by the types of questions asked. Also, most of the providers served Latina women in areas that had large Latino/a populations or a recent increase in Latino/a population. If this study were to be completed in other areas in the country, there may be even less of an understanding of Latina women than what was discovered in this study.

Gaps opened up by this research could be addressed by new approaches to this topic. Standpoint theory could be used to study Latina women about resilience by interviewing Latina women themselves. This approach could be used to study other groups of women as well including, for example, African-American, Native American, Indian, Arab-American or Asian women. Quantitative data analysis could be done in examining resilience among Latina women mental health system survivors. This would address some of the limitations of qualitative research. A cross sectional study could be done, as well as surveys of Latina women and mental health providers. Longitudinal studies on resilience are important and could be done with Latina women mental health system survivors.

Final Summary and Conclusions

We can no longer blame you, nor disown the white parts, the male parts, the pathological parts, the queer parts, the vulnerable parts.  
– Gloria Anzaldua

In this study, the therapists, directors, supervisors, psychiatrists, and social workers who are providers of services to Latina women primarily discussed Latina women who are poor, Spanish speaking immigrants from Mexico. As Anzaldua (1999) states, the U.S.-Mexican border is “an open wound” and the lifeblood of the two worlds merging together forms third country – “a border culture” (p. 25). This study examines the providers’ perspectives of the lives of Latina women who live in this border culture and who receive mental health services. Their lives are fraught with trials and adversity which points to the importance of understanding resilience.
Based on the preceding discussion of the results, this study comes to several conclusions. This study found that the majority of the providers do not perceive Latina women from strengths perspectives or as resilient. They identified a variety of cultural, gendered, racial, and individual factors that they saw as describing Latina women’s lives. This finding supported the first hypothesis. This finding is important when understanding how strengths and resilience perspectives can transform the current mental health culture that focuses on pathology and illness.

This study also hypothesized that the providers would attribute culture, gender and race as affecting access to services and ongoing use of services. This study found that the providers did attribute culture and gender as affecting access to services, but found that there are other factors (awareness, internal factors, resources, social status, social support, and stigma) that affected access to services as well. Surprisingly, the providers did not attribute culture, gender or race to continuing use of services. They attributed bond, improvement, resources, and social support as contributing to retention. These findings were supported by previous research.

This study holds important implications for mental health system survivors – particularly Latina women. It also holds implications for future research in the field of Women’s and Gender Studies as well as psychology because of its focus on feminist principles of liberation and resilience. The use of standpoint theory and phenomenological analysis holds implications for future studies hoping to replicate these findings.

As stated in the very beginning of this thesis, Aurora Levins Morales (1999) writes: "Human beings seek integrity like water seeks its level, grow toward creative and just solutions like plants grow toward sunlight, sometimes by crooked paths, but always reaching" (p. 130). This thesis works to understand a piece of the puzzle of Latina women mental health system
survivors’ lives through the perspective of mental health system providers. This thesis works towards building the integrity of people involved in the mental health system as well as those people who are in positions of service. Like a plant growing toward the sunlight, the conclusions of this study help us to seek integrity through creative and just solutions.
References


New York: NYU Press.


APPENDIX A

Interview Protocol
Latina Women’s Mental Health Needs
Interview Protocol

Date: ____________________________  Interviewer: ________________

Time Interview Began: _______________  Participant ID#: _____________

Time Interview Ended: _______________  Location: ________________

1. Please describe your organization.
   a. What is the mission of your organization or program? *(Ask about the mission of the program with which interviewee is involved.)*
   b. How long has your organization been around?
   c. How many years has your organization been serving the Latino community?
   d. How many years has your organization been serving Latina women specifically?
   e. Please tell me the number of staff members at your organization/program.
      Number of bilingual (English/Spanish) staff members? Number of bicultural staff members?

2. Please describe your role at this organization.
   a. How long have you been working at this organization?
   b. What are your job responsibilities?

3. Please describe in what capacity you work with adult Latina clients (e.g., one-on-one counseling, group therapy, program director).
   a. About how many Latina women do you currently serve in your job?
   b. How do these women typically find out about your services?
   c. What are the countries of origin of the Latina women who come to your agency?
      Why do you think (name of ethnic group/country of origin) women in particular come to your agency?
      *(Make sure you ask about each ethnic group that is identified.)*
   d. What is the age range of the Latina women you serve?
   e. What is the socioeconomic status of the Latina women you serve?
   f. What is the educational level of the Latina women you serve?
9. What is the generational status of the Latina women you serve?

4. What mental health services or interventions are provided to Latina women at your agency? Please describe.

5. How does the work at your agency with Latina women differ from your work with women from other racial or ethnic groups?

6. Overall, what are the main mental health issues that Latina women have when they initially come to your agency?
   a. What do these women say are the reasons why they are seeking mental health services?
   b. Can you describe the different factors that affect the mental health issues of Latina women? Can you begin by describing the individual level factors you believe may affect the mental health of Latinas?
      • How do dynamics within the couple affect mental health?
      • How do family dynamics affect mental health?
      • How does the neighborhood/community context affect mental health?
      • How do cultural beliefs affect mental health?
      • How do political or societal factors affect mental health?

7. What factors do you think influence Latina women's access to mental health services?
   a. What factors at your agency do you think make it easier for Latina women to access mental health services?
   b. What factors at your agency do you think make it harder for Latina women to access mental health services?
   c. Are there factors from Latina women's lives that make it easier for them to access mental health services?
   d. Are there factors from Latina women's lives that make it harder for them to access mental health services?

8. What are the issues that influence whether or not Latina women continue receiving mental health services at your agency?
   a. What factors at your agency do you think make it easier for Latina women to continue receiving mental health services?
b. What factors at your agency do you think make it harder for Latina women to continue receiving mental health services?

c. Are there factors from Latina women's lives that make it easier for them to continue receiving mental health services?

d. Are there factors from Latina women's lives that make it harder for them to continue receiving mental health services?

9. Please describe what you consider quality or effective mental health services for Latina women. Elaborate.

10. If you had unlimited resources, what changes or services do you think would greatly improve Latina women's mental health?

11. Those are all the questions I have for you about Latina women's mental health needs. Is there anything that we didn't have the chance to talk about that you think is important to discuss?

TURN OFF AUDIOTAPE

We would like to know a little bit about who you are and your background. I'm required to ask you all of the questions in this part of the interview.

1. What is your gender? ________________

2. What is your age? ________________

3. What is your race/ethnicity? (Check all that apply)

   □ African-American/Black  □ Asian/Asian-American/Pacific Islander
   □ Caucasian/White        □ Native American/American Indian
   □ Latino/a (please specify) ____________________ □ Other (please specify) - ________________

4. What is your highest educational degree completed?

   □ No formal degree          □ High school diploma     □ Other:
   ____________________
   □ Associates degree / Technical degree □ B.S. / B.A.
   □ M.S. / M.A. / MSW / MC      □ Ph.D. / Psy.D. / M.D.
5. What is your license or certificate held?

☐ LPC / LCPC  ☐ LMFT  ☐ LCSW/LSW
☐ Psychologist  ☐ Psychiatrist  ☐ Other (please specify)

6. What languages do you speak fluently? (Check all that apply)

☐ English  ☐ Spanish  ☐ Other (please specify)

7. In what languages do you conduct therapy/counseling with your clients? (Check all that apply)

☐ English  ☐ Spanish  ☐ Other (please specify)

8. Please describe the type of agency in which you work:

☐ Private practice  ☐ Medical setting  ☐ Community mental health center
☐ Community-based service organization  ☐ Other (please specify)

9. In what manner do clients typically pay for the services at your agency? (Check all that apply)

☐ Private insurance  ☐ Medicaid or Public Assistance  ☐ Services are free
☐ Sliding fee (please state the minimum and maximum range of fee at your agency): min- ____ max- ____
☐ Other (please specify): ____________________

10. Please estimate the number of adult Latina clients served at your agency in the past year: ____

11. What are your agency’s typical days and hours of operation?

Days: ___________________________  Hours: ___________________________

12. Please indicate where your agency is located (check one):

☐ Chicago  ☐ Chicago suburb (please specify) ____________________

175
☐ Collar county (please specify town and county) _____________________________

13. What is the zip code where your agency is located? _____________________

INTERVIEWER NOTES
Things to consider:
   a. nonverbal behavior
   b. overall tone of interview
   c. general themes (in case audiotape breaks)
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Table 5. Race/Ethnicity and Pseudonyms by Comments Regarding Gender Codes

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Table 8. Race/Ethnicity and Pseudonyms by Comments Regarding Access to Services Codes

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