

Medical Family Therapy: A Model for Addressing Mental Health Disparities Among Latinos

ELAINE WILLERTON
MARY E. DANKOSKI
JAVIER F. SEVILLA MARTIR

The Latino population in the United States is growing at an exponential rate. As a medically underserved population, Latinos experience many health disparities, including those related to mental health. Current research suggests that Latinos in the United States are at high risk for problems such as anxiety, depression, somatization disorders, and substance abuse, yet, often these health needs go unmet. This article suggests that an effective method of reaching and treating more Latinos is through medical family therapy. Because Latinos may be more likely to seek help from a physician for mental health complaints, and because marriage and family therapists may be most culturally congruent in their orientation to therapy, collaboration between health care providers and medical family therapists is logical.

Keywords: medical family therapy, Latinos, health disparities

The Latino population is the fastest growing and largest minority group in the United States (U.S. Census Bureau, 2000). Most Latinos come to the United States to seek better economic and educational opportunities (Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002). Many who began as migrant workers, spending long and laborious days on a job for substandard wages, have settled here permanently and have brought their families to the United States with them. However, with immigration comes increased pressure to acculturate and assimilate, as well as stress from the hardship and poverty that often accompany these difficult transitions, particularly in the current politicized and unfriendly immigration environment (Alegria et al., 2002; Kouyoumdjian, Zamboanga, & Hansen, 2003; Organista, 2000). Because of this, Latinos may be especially vulnerable to marital distress, family problems, depression, and anxiety (Kanel, 2002; Organista, 2000). Yet Latinos remain largely a medically underserved population, with many mental health problems left untreated.

It is important to first note that Latinos are not a homogeneous group. The term Latino refers to persons of Latin America cultural origin (Falicov, 1998). Each Latino cultural group has its own unique history, sociopolitical background, and migration

Elaine Willerton, MS, Department of Child Development and Family Studies, Purdue University, West Lafayette, Indiana; Mary E. Dankoski, PhD, and Javier F. Sevilla Martir, MD, Department of Family Medicine, Indiana University, Indianapolis, Indiana.

Correspondence concerning this article should be addressed to Elaine Willerton, MS, Fowler Memorial House, 1200 W. State St., West Lafayette, IN 47907. E-mail: cwillert@purdue.edu

patterns (Lopez, 2003; Romero, 2000; Santiago-Rivera et al., 2002). Wide variations among Latino groups exist, depending on issues such as country of origin, socioeconomic status, education, religion, gender, and generation. Therefore, it is not safe to assume that recommendations for working with Latinos are a "one size fits all" recipe. Rather, comments in this article should be read as broad generalizations about values and characteristics that are often shared among Latinos, but with the understanding that multiple individual differences exist. These recommendations must be seen as what providers should be prepared to do, rather than a set of rules they are obligated to use with every Latino family (Bean, Perry, & Bedell, 2001).

HEALTH DISPARITIES AMONG THE LATINO POPULATION

Latinos may be at higher risk for mental health problems compared with the general population. Research indicates that Latinos are not only more likely to have psychiatric disorders than their Caucasian and African American counterparts, but are least likely to receive care (Alegria et al., 2002). Results from the National Comorbidity Survey (NCS) indicated that compared to non-Latino Whites and African Americans, Latinos had a significantly higher prevalence of diagnosable affective disorders as well as comorbid conditions (Kessler et al., 1994). For example, one study of Latino patients presenting for behavioral health treatment determined that they were more likely to be diagnosed with major depression than other ethnic groups (Minsky, Vega, Miskimen, Gara, & Escobar, 2003). While the prevalence rates may be higher, studies also show that minority clients receive lesser and poorer quality care, increasing the burden of disability from mental health problems (U.S. Public Health Service Office of the Surgeon General, 2001; Institute of Medicine, 2002).

Several explanations exist for the underutilization of mental health services by Latinos. In a recent survey conducted in a Midwestern Latino community, participants indicated the following barriers to utilizing health care: cost of services (52.4%); lack of health insurance (44%); language (37.7%); fear of system (27.8%); transportation (7.9%); lack of knowledge of available services (5.2%); and other (4.1%). Almost half (43.5%) the participants reported that they were diagnosed with a chronic illness and of those, 11.8% had been diagnosed with depression (Sevilla Martir, et al., 2007). This survey shows the dilemma of both a high need for care and the many barriers that impede services.

As early as 1982, the President's Commission on Mental Health found four major reasons for ethnic minority underutilization of mental health services: lack of availability, accessibility, acceptability, and accountability (Parron, 1982). Over the past several decades the mental health field has advanced in developing more culturally sensitive therapy; however, these four issues remain major barriers today. More recently, the issue was reaffirmed in the President's New Freedom Commission on Mental Health (2003) when the elimination of disparities in mental health services was included as a core goal. In the final report of this New Freedom Commission, it states, "the mental health system has not kept pace with the diverse needs of racial and ethnic minorities, often underserving or inappropriately serving them" (2003, p. 49).

With Latinos, the availability barrier refers to the inadequate number of culturally competent and bilingual services available. While more acculturated Latinos may not speak Spanish or may be bilingual, not all family members may have equal proficiency in English (Bean et al., 2001). Clients with limited English proficiency are unlikely to pursue care without access to a bilingual provider (Alegria et al., 2002). The use of interpreters may be an option

and is state-mandated in most hospital systems; however, interpretation services may not be readily available to physicians or psychotherapists in small or private practices. Moreover, the presence of an interpreter can change the dynamics in the room, can impact the sense of confidentiality and safety of the client, and can ultimately negatively impact the provider–client relationship. Some have been tempted to use a bilingual family member as an interpreter. However, in addition to changing the power balance in the family, this places the patient and family member at risk of triangulation and could prevent a client from disclosing all of their concerns candidly, making such a practice inappropriate.

The best situation is for treatment to be provided by bilingual health care providers. Studies of ethnic and/or language matching have shown that bilingual psychotherapists (regardless of ethnicity) are more culturally sensitive with Latino clients (Lu, Organista, Manzo, Wong, & Phung, 2001). A lower dropout rate and increased length of mental health treatment is also more likely with Latino clients when there is a language match (Sue, Fujino, Hu, Takeuchi, & Zane, 1991; O'Sullivan & Lasso, 1992). Unfortunately, there is a severe shortage of Latino or bilingual physicians and mental health providers across the fields of psychology, psychiatry, marriage and family therapy (MFT), counseling, and social work (Preciado, 1999). Such providers are in short supply and high demand.

In addition, the health care system in the United States is vastly different from those in Latin American countries. Latinos wanting mental health care may feel unsure about how to seek and use mental health services (Kanel, 2002). New immigrants in particular, face significant hurdles to accessing basic medical care, let alone mental health services. Many do not understand how the U.S. health care system functions, and if in the country ille-

gally, may fear deportation (Clark, 2002). One study of Mexican Americans found that simply knowing where to find a provider increased the likelihood of using mental health services (Vega, Kolody, & Aguilar-Gaxiola, 2001). Collectively these findings underscore the importance of cultural sensitivity and savvy when conducting family therapy with an immigrant family. Falicov (1997) indicates that older children in an immigrant family may find themselves in the position of translator for their parents and mediator of family clashes over acculturation. While important, the older child may resent this responsibility and may actually disempower younger siblings or create distance between family subsystems. In addition, parents in the immigrant family may misplace their fears and frustrations over finances or illness onto more minor problems such as difficulty with the children. Falicov emphasizes respecting the family's preference to focus on their presenting problem while creating openings to discuss the matters that the therapist recognizes as impacting the family system.

Another barrier is poor accessibility. A major problem contributing to health disparities (across the United States, for Latinos and all others) is lack of health insurance and not being able to afford basic health care services. This is a major U.S. health care problem, with current estimates showing that 15.6%, over 45 million Americans, are uninsured (U.S. Census Bureau, 2003). In the same year, the uninsured rate for Latinos was double the national average at 32.7%, compared to 19.5% of African Americans, 18.7% of Asians, and 11.1% of non-Hispanic Whites (U.S. Census Bureau, 2003). A study of Mexican Americans found that having private insurance increased the use of mental health providers (Vega et al., 2001), yet Latinos may be less likely to have either public or private sector insurance (Zuvekas & Taliaferro, 2003). Furthermore, Latinos often lack time to use mental health services due

to work and family obligations (Kanel, 2002; Miranda & Cooper, 2004; Zuvekas & Taliaferro, 2003). Transportation can also be a contributing factor to accessibility problems if services are distant (Organista, 2000) or not in the neighborhood (Alegria et al., 2002). Community-based services, while most effective in reaching underserved populations, are not always readily available.

Yet, even with access to services, those services may be of poorer quality, and/or may be of a discriminatory or racist nature (U.S. Public Health Office of the Surgeon General, 2001). Such discrimination compounds the stigma already attached to mental health problems, making the lack of acceptability an especially relevant barrier for Latinos, potentially exacerbating distrust of the system. Too few services exist that are consistent with the cultural needs and expectations of minority clients (Alegria et al., 2002; Organista, 2000). Despite differences within Latino ethnic groups, studies show that certain shared contextual and cultural values may predispose Latinos to use natural support systems when coping with problems (Kanel, 2002; Vega et al., 2001). For example, family unity and honor tends to be highly valued among Latinos, extending beyond marital or biological ties to include relationships such as *compadres* (godparents) (Garcia Preto, 2005). This is a source of social support, yet could potentially prevent or delay treatment-seeking through lack of recognition that professional help is needed (Alegria et al., 2002). It is frequently a last resort to look outside the family for help (Garcia Preto, 2005). Compared with non-Hispanic Whites, Latino clients are likely to have different cultural ideas about illnesses and health, differences in help-seeking behaviors, and differences in language, communication, and interaction patterns. The respect for authority that tends to be highly valued among Latinos, for example, can be misinterpreted as deferential or unassertive to

others. In addition, beliefs and practices regarding "folk medicine" are important to understand. It is not uncommon for some Latinos to believe in Santeria or Espiritismo or to consult with *curanderos* (folk healers) or *yerberos* (herbalists) in regard to physical or emotional symptoms (Baez & Hernandez, 2001; Bean et al., 2001; Dobkin de Rios, 2002; Falicov, 1998; Santiago-Rivera et al., 2002). Many physicians and therapists lack training in cultural competence, and may "pathologize" such characteristics and practices of Latino clients. Furthermore, health care providers often experience greater clinical uncertainty with minority clients, which may cause them to rely on stereotypical beliefs and biases, especially under time-pressured situations (Institute of Medicine, 2002).

At the institutional level, mental health agencies have also historically neglected to provide culturally sensitive services for minority clients (Organista, 2000). The mental health research on Latinos has not changed significantly in the last 25 + years (Vega et al., 2001), and in fact, minorities are significantly underrepresented in mental health research (U.S. Public Health Service Office of the Surgeon General, 2001). The epidemiology of mental illness for Latinos and the related barriers to services have remained relatively constant, indicating that improvements in mental health services have not kept up with the growing Latino population and their needs (Vega et al., 2001). One factor may be a shortage, traditionally, of Latinos in key positions to effect change (Preciado, 1999). However, this tide is changing with recent national attention paid to the uninsured crisis and health disparities across racial and ethnic groups, and with the advent of organizations such as the National Hispanic Medical Association (founded in 1994) and the National Latino Behavioral Health Association (founded in 2000).

A promising direction that could likely narrow the mental health disparities gap is collaborative, integrative services between

mental health and other health care providers. A growing development in the field of MFT and among other systemically oriented psychotherapy practitioners has been medical family therapy, the active collaboration between psychotherapy clinicians and physicians and other health care providers. Regardless of field (MFT, psychology, social work, psychiatry) a qualified family therapist should have training and supervision in systemic thinking and therapy in order to integrate contextual issues such as culture and relational dynamics into treatment. It is our position that medical family therapists may be uniquely well suited to serving the needs of Latino patients in such an integrated model.

COLLABORATIVE HEALTH CARE: A PATHWAY TO REACHING THE LATINO POPULATION

The concept of medical family therapy was first introduced in the early 1990s (McDaniel, Hepworth, & Doherty, 1992) as a biopsychosocial systems model, in which all problems are conceptualized as biological, psychological, and social in nature (Engel, 1977). In this model, effective treatment addresses each component systemically. Many physicians have historically been trained to emphasize the biological while minimizing the psychological and social components of health, and family therapists have historically been trained in the opposite manner (McDaniel et al., 1992). Medical family therapy is an attempt to better integrate the components of the biopsychosocial model in the delivery of mental health services through active collaboration of family therapists as members of health care teams. For example, family therapists may conduct therapy with clients in medical settings, consult with health care teams in the care of patients, and may provide education for medical students and resident physicians, particularly in the specialty of family medicine. Despite this trend, there is currently a lack of literature

addressing the use of medical family therapy with Latinos.

A collaborative arrangement provides additional treatment options which are more easily available and accessible to physicians and patients. Latinos are likely to receive their first intervention for mental illness through a physician (Diaz-Martinez & Escobar, 2002). One study showed that both immigrant and U.S.-born Mexican Americans disproportionately used general medical providers for treating mental health problems (Vega et al., 2001). Like many clients, symptoms of underlying emotional problems are often expressed through somatization in the Latino population (Kouyoumdjian et al., 2003), especially in women, older individuals, those from developing nations, and those with lower income and education (Falicov, 1998). This issue makes intervention through a medical setting important. In the case of depression, the physical nature of some symptoms such as weight loss or fatigue may naturally prompt a visit to a physician (Diaz-Martinez & Escobar, 2002), and it is fairly common for symptoms of depression or anxiety in Latinos to manifest as physical ailments (Kanel, 2002).

In addition, there are some important culturally specific cues to which a provider must attend closely. One particular issue among many Latinos is known as *ataque de nervios* (panic). The symptoms of *ataque de nervios* include trembling, heart palpitations, numbness, loss of consciousness, difficulty breathing, and a transient hyperkinetic state (Falicov, 1998; Rivera-Arzola & Ramos-Grenier, 1997; Romero, 2000). *Ataque de nervios*, which is most common among Puerto Ricans and women, is a culturally accepted manner through which to seek help or react to a stressful situation (Falicov, 1998; Rivera-Alzola & Ramos-Grenier, 1997; Romero, 2000). Depending on the amount of experience a physician has with Latinos, with somatization, or with integrated care, such symptoms may

or may not indicate to the physician that there is a psychological component involved. The best approach for somatization (regardless of a patient's ethnicity) is an integrated biopsychosocial approach, yet many physicians misinterpret symptoms and try to use a purely biomedical framework (McDaniel et al., 1992). Having a culturally competent medical family therapist on the treatment team could increase the likelihood that such symptoms be recognized as involving an emotional basis.

While Latino persons are likely to seek help through primary care, primary care providers alone are not equipped to serve all mental health needs, nor are providers always culturally competent. A primary care physician may prescribe medication, recommend and refer for counseling, or provide brief office-based primary care counseling him or herself. However, given reimbursement issues and time constraints (with the average visit lasting 15 minutes), the structure of primary care does not generally lend itself well to effective talk therapy-based mental health intervention. Furthermore, psychopharmacologic treatment and referral many not fit well with many Latino patients. In a cross-sectional study of the identification and treatment of depression among diverse primary care patients, Miranda and Cooper (2004) found that although primary care providers recommended depression treatment for Latino patients as frequently as for African American and Caucasian patients, Latino patients were least likely to take antidepressant medication or follow up on referrals to specialty mental health care. A study of Latinos in Southern California found that the majority of those interviewed did not believe medication could help them (Kanel, 2002). This evidence suggests that Latinos may prefer to receive psychotherapy for their problems rather than take psychotropic medication.

Since Latinos are more apt to seek and receive medical treatment than mental health services, by integrating psychother-

apy services with medical services many barriers to receiving mental health care could be addressed. Physically conducting therapy in the same practice in which a Latino patient sees his or her physician addresses accessibility problems. In addition, presenting a family therapist as a regular member of an interdisciplinary health care team both increases treatment availability and the likelihood that a Latino patient may enter and remain in treatment. Receiving therapeutic services within such a context could also reduce fear and stigma, since this arrangement presents therapy as a normal part of comprehensive and integrated health care. It is especially important to implement such integrated and culturally competent services at Federally Qualified Health Centers (FQHCs). Such health centers are located in community neighborhoods and receive federal funding to provide care for uninsured and underinsured patients. Since lack of insurance is a problem for many Latinos, making integrated medical family therapy services available at such centers may greatly improve access.

Moreover, compared to other mental health providers, family therapists may be best equipped to work with Latino families within a medical context for several reasons. By training, medical family therapists have a systemic orientation, and many family physicians, who provide a large portion of primary care in the United States, are also trained to think systemically (Doherty & Baird, 1983). Thus, collaboration between the two fields is a natural partnership. A systemically trained medical family therapist can consider the complex system in its entirety, including the patient and his or her cultural context, family, employers, schools, medical providers, therapists, insurance companies and the larger health care system (McDaniel et al., 1992).

The perspective of medical family therapists may also be the most culturally congruent approach to working with Latino

clients because, in Latino culture, *la familia* (the family) is a central part of life and a framework for understanding the world. Typically, Latinos keep a close bond with their families of origin, using them as a major source of support and problem solving (Falicov, 1998; Santiago-Rivera et al., 2002). In contrast to an ideal of rugged individualism perpetuated in U.S. dominant culture, Latino persons are more likely to favor a collectivist mentality, thinking about what is good for the family as a whole rather than for themselves (Kaniasty & Norris, 2000; Kouyoumdjian et al., 2003; Romero, 2000). Kanel (2002) found that over half the Latino respondents in her study mentioned family issues (such as marital strain and problems with children) as current difficulties they would prefer to address in therapy. Thus, both a systemic orientation and involving the family in therapy are important and necessary components to effectively address a Latino patient's problems (Miranda & Cooper, 2004). Santiago-Rivera and colleagues (2002, p. 149) state that "inevitably, counseling Latinos requires systemic expertise as well as sensitivity and understanding of the cultural variants embedded in *la familia*." Marriage and family therapists are the only one of the five core mental health professions designated by the Health Resources Services Administration (HRSA) to have mandatory, supervised clinical experience in the modality of family therapy. Family therapy has thus been considered the most culturally relevant and favored approach for working with Latino clients (Bean et al., 2001; Gelman, 2004).

PRACTICAL ISSUES AND CASE EXAMPLES

Collaborative patient care between family therapist's and physicians can take many forms. The authors have all worked in family medicine residency programs where medical and psychotherapy services were available in the same clinical office. Behavioral science, a required curriculum

in family medicine residency training, is often taught by family therapists and other mental health clinicians, so many residency programs have therapy available on site. However, such integration is far more rare in clinical practices that are not teaching sites. A therapist could arrange to rent office space in a physician's practice, but otherwise finding monies for such a position is often a problem. One author (EW) completed her doctoral internship in a family medicine clinic where salary was paid by a grant, so that therapy services could be offered for free. Another author (JM) worked as a physician in a federally qualified community health center (FQHC) that employed one therapist who split her practice among five such centers, visiting each of the FQHC sites on different days of the week.

Working from the same office brings many advantages for the therapist, physician and patient. Physicians are more likely to think of referring to a therapist whom they know and see in the office on a regular basis, and may more readily consider therapy as a treatment option instead of or in addition to psychopharmacology. When it is possible for the physician to introduce the therapist to the patient during a medical visit, the possibility that the patient will schedule the first appointment and follow through is greatly increased. Physicians and therapists can also more easily discuss patient care and needs. For instance, a patient referred for therapy was thought by the therapist to need an adjustment of her antidepressants. The physician was consulted immediately and the three were able to discuss and make the appropriate adjustments before the patient left the building.

Patients may find it less stigmatizing to enter a medical clinic, and can more easily request time away from work to go to the doctor's office. Many patients also simply find it easier to come for therapy to the same place where they receive medical care. In one example where this was a big

issue, a physician suspected that her Latina patient who came in complaining of abdominal pain was a victim of domestic violence. The patient, Carmona, met the therapist (EW) briefly during the medical visit and accepted the physician's recommendation to come back for a therapy session because it was in the same building and she did not drive. Carmona was an immigrant from Guatemala who had been living in a large city in the Midwest for 20 years. During the initial brief meeting she appeared comfortable speaking English with the therapist, although her physician was bilingual. When Carmona returned for the first therapy session it was evident that speaking in English about personal issues was not comfortable or helpful for her. The therapist immediately located the clinic's Child Development Specialist who came in to translate. The Child Development Specialist, a native of Colombia, collaborated with the therapist to obtain a thorough history. Carmona admitted a long history of physical and emotional abuse from her alcoholic husband who was currently not working, leaving her to support the family on her own. She also reported that her 18-year-old son was also receiving counseling through a community agency after being charged with illegal activity. She felt her son's counseling was helping him mature and develop a better self image, but he had also begun stepping in front of his father when he tried to abuse Carmona and was getting into physical confrontations with him. The combination of these stressors was a likely cause of her physical symptoms. She did not realize, until speaking with the therapist and Child Development Specialist, that she did not need her husband's permission to seek separation or divorce.

Carmona began coming regularly for therapy sessions, which usually included the Child Development Specialist as a translator. The therapist contacted and collaborated with her son's counselor and arranged some family therapy sessions with

mother and son. Carmona continued to see her physician who, with the therapist, actively collaborated on her care. Carmona's physical symptoms gradually subsided as she progressed in therapy and made changes in her life.

CONCLUSION

Family therapists wishing to work with Latinos in a medical setting must be competent in two cultures: (a) Latino culture and (b) the culture of medicine. Much has been written about providing culturally competent therapy with Latinos, and there are also some excellent references for working in medical settings. A comprehensive review is outside the scope of this article.

The need for mental health providers competent to work with Latino patients cannot be overstated. The Latino population is growing in America and with it, the critical need for more culturally acceptable and accessible mental health care. The cost of untreated mental health problems is in the billions annually in both direct and indirect costs, and in reduced quality of life (U.S. Surgeon General's Report on Mental Health, 1999). Latinos face many barriers in accessing and receiving culturally appropriate, affordable, effective, high quality mental health care. One answer that provides a great possibility for reducing the disparities for Latinos is a bridge between medical care and family therapy. There are four main reasons why the presence of medical family therapists in medical settings could increase and improve mental health care for Latinos: (a) their physical presence integrated into a medical practice would reduce access and availability barriers for Latino patients; (b) family therapists, because of their family systems approach, may most culturally congruent for working with Latinos and their families; (c) they can assist physicians in assessing a patients' need for mental health intervention; and (d) if well trained and culturally competent, they could potentially train physicians and other health professionals

how to best serve Latino clients in a culturally competent manner, through understanding some of the systemic and contextual issues that impact Latino clients.

A medical family therapy approach is directly aligned with national recommendations. The Institute of Medicine (2006) recently published recommendations to improve the quality of mental health and substance use disorders in their influential "Quality Chasm" series. One of the recommendations (Recommendation 5-2) explicitly states that better integration of primary health care and mental health care must occur, including integrated practice arrangements in which mental health professionals practice in the same clinical practice as primary care physicians. Such an approach would help make mental health treatment more accessible, acceptable, available, and accountable for Latinos and clients of all racial and ethnic backgrounds.

Moreover, all health professions educational institutions, including marriage and family therapy training programs, must recruit and train more Latino providers to better meet the needs of the growing population. Latinos are grossly underrepresented among mental health provider groups, and multiple strategies exist to meet this goal (Institute of Medicine, 2004). Ultimately, we must ensure that the diversity within the mental health workforce mirrors the diversity of the population being served. Both integrated care in modalities such as medical family therapy, and recruiting more underrepresented minorities in the field such as Latinos, are critical components of the solution to meeting unmet mental health care needs.

REFERENCES

- Alegria, M., Canino, G., Rios, R., Vera, M., Calderon, J., Rusch, D., et al. (2002). Inequalities in the use of specialty mental health services among Latinos, African Americans and non-Latino Whites. *Psychiatric Services, 53*, 1547-1555.
- Baez, A., & Hernandez, D. (2001). Complementary spiritual beliefs in the Latino community: The interface with psychotherapy. *American Journal of Orthopsychiatry, 71*, 408-415.
- Bean, R. A., Perry, B. J., & Bedell, T. M. (2001). Developing culturally competent marriage and family therapists: Guidelines for working with Hispanic families. *Journal of Marital and Family Therapy, 27*, 43-54.
- Clark, L. (2002). Mexican-origin mothers' experiences using children's health care services. *Western Journal of Nursing Research, 24*, 159-179.
- Diaz-Martinez, A. M., & Escobar, J. I. (2002). Assessing and treating depressed Latino patients in primary care. *New Jersey Medicine, 99*, 37-39.
- Dobkin de Rios, M. What we can learn from shamanic healing: Brief psychotherapy with Latino immigrant clients. *American Journal of Public Health, 92*, 1576-1578.
- Doherty, W. J., & Baird, M. A. (1983). *Family therapy and family medicine*. New York: Guilford Press.
- Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science, 196*, 129-136.
- Falicov, C. J. (1997). "So that they don't need me anymore": Weaving migration, illness, and coping. In S. H. McDaniel, J. Hepworth, & W. Doherty (Eds.), *The shared experience of illness* (pp. 48-57). New York: Basic Books.
- Falicov, C. J. (1998). *Latino families in therapy: A guide to multicultural practice*. New York: Guilford Press.
- Garcia Preto, N. (2005). Latino families: An overview. In M. McGoldrick, J. Giordano, & N. Garcia Preto (Eds.), *Ethnicity and family therapy* (3rd ed., pp. 153-165). New York: Guilford Press.
- Gelman, C. R. (2004). Toward a better understanding of the use of psychodynamically-informed treatment with Latinos: Findings from clinical experience. *Clinical Social Work Journal, 32*, 61-77.
- Health Services Resource Administration, Public Health Service Act (42 CFR Pt. 5).
- Institute of Medicine (2002). *Unequal treatment: Understanding racial and ethnic disparities in health care*. Washington, DC: National Academies Press.
- Institute of Medicine (2004). *In the nation's compelling interest: Ensuring diversity in the health-care workforce*. Washington, DC: National Academies Press.
- Institute of Medicine (2006). *Improving the quality of health care for mental and sub-*

- stance-use conditions: Quality chasm series.* Washington, DC: National Academies Press.
- Kanel, K. (2002). Mental health needs of Spanish-speaking Latinos in southern California. *Hispanic Journal of Behavioral Health, 24*, 74–91.
- Kaniasty, K., & Norris, F. H. (2000). Help-seeking comfort and receiving social support: The role of ethnicity and context of need. *American Journal of Community Psychology, 28*, 545–581.
- Kessler, R. C., McGonagle, K. A., Zhao, S., Nelson, C. B., Hughes, M., Eshelman, S. et al. (1994). Lifetime prevalence of DSM-III-R psychiatric disorders in the United States: Results from the National Comorbidity Survey. *Archives of General Psychiatry, 151*, 979–986.
- Kouyoumdjian, H., Zamboanga, B. L., & Hansen, D. J. (2003). Barriers to community mental health services for Latinos: Treatment considerations. *Clinical Psychology: Science and Practice, 10*, 394–422.
- Lopez, S. R. (2003). Reflections on the surgeon general's report on mental health, culture, race and ethnicity. *Culture, Medicine, and Psychiatry, 27*, 419–434.
- Lu, E. L., Organista, K. C., Manzo, S., Wong, L., & Phung, J. (2001). Exploring dimensions of culturally sensitive clinical styles with Latinos. *Journal of Ethnic & Cultural Diversity in Social Work, 10*, 45–66.
- McDaniel, S. H., Hepworth, J., & Doherty, W. J. (1992). *Medical family therapy: A biopsychosocial approach to families with health problems.* New York: Basic Books.
- Minsky, S., Vega, W., Miskimen, T., Gara, M., & Escobar, J. (2003). Diagnostic patterns in Latino, African American, and European American psychiatric patients. *Archives of General Psychiatry, 60*, 637–644.
- Miranda, J., & Cooper, L. A. (2004). Disparities in care for depression among primary care patients. *Journal of General Internal Medicine, 19*, 120–126.
- New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming Mental Health Care in America. Final Report.* DHHS Pub. No. SMA-03-3832. Rockville, MD. Retrieved January 21, 2006, from www.mentalhealthcommission.gov
- Organista, K. C. (2000). Latinos. In J. R. White & A. S. Freeman (Eds.), *Cognitive-behavioral group therapy for specific problems and populations* (pp. 281–303). Washington, DC: American Psychological Association.
- O'Sullivan, M. J., & Lasso, B. (1992). Community mental health services for Hispanics: A test of the culture compatibility hypothesis. *Hispanic Journal of Behavioral Sciences, 14* (4), 455–468.
- Parron, D. L. (1982). An overview of minority group mental health needs and issues as presented to the President's Commission on Mental Health. In F. V. Munoz & R. Endo (Eds.), *Perspectives on minority group mental health* (pp. 3–22). Washington, DC: University Press of America.
- Preciado, J. (1999). Behavior therapy's commitment to cultural diversity: The case of Hispanics. *The Behavior Therapist, 22*(10), 199–200, 207.
- Rivera-Arzola, M., & Ramos-Grenier, J. (1997). Anger, ataques de nervios, and la mujer Puertorriquena: Sociocultural considerations and treatment implications. In J. Garcia & M. Zea (Eds.), *Psychological interventions and research with Latino population* (pp. 125–141). Boston: Allyn & Bacon.
- Romero, A. J. (2000). Assessing and treating Latinos: Overview of research. In I. Cuellar & F. A. Paniagua (Eds.), *Handbook of multicultural mental health: Assessment and treatment of diverse populations* (pp. 209–223). San Diego, CA: Academic Press.
- Santiago-Rivera, A. L., Arredondo, P., & Gallardo-Cooper, M. (2002). *Counseling Latinos and la familia.* Thousand Oaks, CA: Sage.
- Sevilla Martir, J. F., Saywell, R. M., Zollinger, T. W., Przybylski, M. P., Zoppi, K. A., & Hirth, J. (2007). *Barriers to healthcare access faced by the Hispanic community in Indianapolis.* Manuscript submitted for publication.
- Sue, S., Fujino, D. C., Hu, L. T., Takeuchi, D. T., & Zane, N. W. S. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consulting and Clinical Psychology, 59*, 533–540.
- U.S. Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General—Executive Summary.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.
- U.S. Census Bureau. (2000). *Projections of the Resident Populations by Race, Hispanic Origin, and Nativity: Middle Series, 2050 to 2070 (NP-T5G).* Retrieved March 4, 2006, from www.census.gov/population/projections/nation/summary/np-t5-g.txt
- U.S. Census Bureau. (2003). *Income, poverty, and health insurance coverage in the United*

- States: 2003*. Retrieved March 4, 2006, from www.census.gov/hhes/www/income.html
- U.S. Public Health Service Office of the Surgeon General. (2001). *Mental health: Culture, race, and ethnicity: A supplement to mental health: A report of the Surgeon General*. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service.
- Vega, W. A., Kolody, B., & Aguilar-Gaxiola, S. (2001). Help seeking for mental health problems among Mexican Americans. *Journal of Immigrant Health, 3*, 133–140.
- Zuvekas, S. H., & Taliaferr, G. S. (2003). Pathways to access: Health insurance, the health care delivery system, and racial/ethnic disparities, 1996–1999. *Health Affairs, 22*, 139–153.