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Reflections of Low Income, Second Generation Latinas about Experiences in Depression Therapy

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Abstract

Depression is higher among second generation Latinas compared to immigrants but mental health treatment is stigmatized. Therefore, second generation Latinas were interviewed after completing an eight-session depression treatment program to gain insight on what they found valuable about their therapy experiences. Constructivist Grounded Theory guided data collection and analysis which showed that women valued treatment more when they recognized their needs were being met, the therapist was a worthy co-pilot, and the program's structure had flexibility. Four processes were considered important to their work in therapy: understanding feelings about past events, seeing patterns, accepting self, and changing family patterns but still being "family". Post therapy, women valued their enhanced confidence and a "toolbelt" of techniques they gained for self-treatment. These findings have implications for designing future depression treatment programs that are more likely to be desirable and effective for the growing subgroup of underserved second generation Latinas in the U.S.

Keywords

depression; grounded theory; health seeking; Latino / Hispanic people; mental health and illness; women's health

Depression is the leading cause of disability worldwide (World Health Organization, 2012). Among Latinos, the largest ethnic minority group in the U.S. (U.S. Census, 2014), the prevalence of depression is 27% (Wasserthiel-Smoller et al., 2014) and rates among women are twice that of men (Vega, Sribney, Aguilar-Gaxiola, & Kolody, 2004), which is similar to rates for Americans of other ethnicities. However, U.S. Latinos receive less mental health care than white Americans (Cook, McGuire, & Miranda, 2007; Office of Minority Health, 2013) even if they have insurance (Lagomasino et al., 2005; Ojeda & McGuire, 2006). Many symptomatic women never receive a proper diagnosis; data from a national study that included 9,032 U.S. women aged 18–44 who met criteria for past year major depressive episode showed that 68% of Latina women in the sample went undiagnosed (Ko, Farr, Dietz, & Robbins, 2012). In a study with a sample of 15,762 U.S. adults from five major ethnic groups (52% female), 30% of Mexican American participants who met 12-month criteria for

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a major depressive episode received at least one psychotherapy visit in the last year but only 11% received four visits lasting at least 30 minutes each (Gonzalez et al., 2010).

Poverty and stressful life circumstances have been found to be related to depression among women (Siefert, Bowman, Heflin, Danziger, & Williams, 2000) which is especially concerning because more than a quarter of Latinos live in poverty in the U.S. (U.S. Census, 2013). U.S. Latinos report more psychological distress than white Americans (Office of Minority Health, 2013). In a study with 1,577 low income women who met criteria for depression (of whom, 40% were Latinas), women with stigma-related concerns about getting professional help for mental health were less likely to perceive they had a need for mental health care; stigma concerns included being embarrassed to talk about personal matters with another person, being afraid of what others might think, and fearing that family members would not approve of them getting care (Nadeem, Lange, & Miranda, 2009). Stigma and opposition to treatment, such as fear of being committed to a mental health institution, were two of the main barriers to mental health treatment for depressed women in a national representative sample (Ko et al., 2012). Latinos with higher levels of stigma have been found to be more likely to miss therapy appointments and less likely to be able to manage their depressive symptoms (Vega, Rodriguez, & Ang, 2010).

To help counter problems with access or entry to care and to boost retention in therapy among low income minority populations including Latinas, experts have called for alterations in the design of depression treatment programs to accommodate the unique needs of patients with financial difficulties. Support for such changes has come from studies like the randomized clinical trial (RCT) of Miranda and colleagues (2003), which included 267 impoverished, clinically depressed women; of them, 50% were Latinas. These investigators found that 83% of participants who had been referred to regular mental health care-as-usual did not engage in any therapy sessions at all but women who received intensive outreach through the treatment arms of the study (i.e., multiple phone calls and education sessions on the benefits of depression therapy, transportation funds, childcare) did much better. Approximately 36% of participants in the Cognitive Behavioral Therapy arm of the RCT successfully attended at least six treatment sessions and 75% of those referred to the RCT's medication intervention arm successfully received nine weeks of guideline-concordant antidepressant treatment. The latter included weekly medication management phone calls from a nurse practitioner (Miranda et al., 2003). In another depression treatment study, innovations that improved treatment attendance included pre-therapy engagement sessions guided by ethnographic and motivational interviewing techniques (Miller & Rollnick, 2002) aimed at building trust by prioritizing what women voiced as worries about practical matters or cultural concerns (Grote et al., 2009). In addition, treatment can be offered in community-based sites that are familiar to low income women but are deemed less stigmatized by women (Grote et al., 2009, Miranda et al., 2009). While these alterations in therapy programs are recommended by experts, qualitative insight from the perspectives of Latinas enrolled in such therapy programs is needed to understand what it is about these innovations that women do or do not value. Such insight could be used to help other untreated women overcome ambivalence and enter needed care.

However, inquiry into the views of Latinas post treatment needs to be pursued with cultural sensitivity. It is crucial not to stereotype Latinas in the U.S. as if they were a homogeneous group with no subgroup differences. In addition to variable income and education levels, cultural practices, and beliefs, Latinas in the U.S. differ in relation to acculturation or time spent in the U.S. Sensitivity to acculturation levels in research with Latinas has brought useful insight on key indicators related to mental health status. For example, by using place of birth, research has shown that Mexican Americans who were born in the U.S. report higher levels of depression than those who were born in Mexico (Alegria et al., 2008; Vega et al., 2004). By including place of childhood, other research showed that Latinas who spent most or all of their childhood before age 18 in the U.S. reported more depressive symptoms than women who did not come to the U.S. until after age 18 (Heilemann, Lee, & Kury, 2002). Furthermore, depressed second generation Latinas are less likely to desire treatment compared to U.S.-born whites (Nadeem et al., 2007). Nonetheless, no research to date has targeted second generation, U.S. Latinas living with low income in relation to how valuable, desirable, or useful treatment they received was from their perspectives. For this and other reasons, researchers have called for more inquiry into Latino patients' perspectives on particular attributes of treatment they find useful and why (Karasz & Watkins, 2006; Lorenzo-Blanco & Delva, 2012).

Therefore, the purpose of this study was to gain insight from a sample of second generation, English speaking Latinas of low income who were born or raised in the U.S. who had received depression treatment that had been designed to accommodate challenges they faced as low income women. Our aim was to understand which attributes of the treatment program were and were not described by the women as valuable, desirable, or useful as they reflected on their experience three months after their last therapy session, as well as why they stayed in the program after initiation through the eighth session, and what they found helpful beyond the end of treatment. The design of the treatment study required measurement of the women's depression levels one and three months after the conclusion of treatment. It was not known how the women's depression levels would change by the one or three month point, but we scheduled the qualitative interview at the three month rather than the one month point because it would give women more time to reflect on their experience, for better or worse, and it would also allow for a qualitative discussion of their views in the context of the up's and down's of daily living and emotional coping during the three months after treatment rather than just one.

Methods

Treatment that the Participants Had Received Three Months Before the Interview

Clinically depressed Latinas who participated in this study had engaged in an eight-session treatment program that was carefully designed; all features of the program were described elsewhere in detail. Before treatment began, each woman participated in a diagnostic interview using the Structured Clinical Interview for DSM-IV Axis 1 Disorders (First, Spitzer, Gibbon, & Williams, 1997) which was immediately followed by an interactive assessment which was inspired by the work of Grote and colleagues (Grote et al, 2009; Zuckoff, Swartz, & Grote, 2008) and involved the use of Motivational Interviewing

techniques (Miller & Rollnick, 2002). The goal of the interactive assessment was to assess the women's motivation to enter therapy and to help them overcome ambivalence (Pieters & Heilemann, 2010). Motivational Interviewing allowed for a balancing of power within therapy sessions by respecting the patient's perspective at all times and by seeking to "roll with" any resistance the patient may have to engagement or treatment (Miller & Rollnick, 2002).

Following this interactive assessment, an eight-session therapy program ensued. It involved use of a third wave Cognitive Behavioral Therapy (Kahl, Winter, & Schweiger, 2012) called Schema Therapy (Young, Klosko, & Weishaar, 2003) which was chosen because of its focus on how present day coping is affected by schemas that develop early in life, often to help cope with stressful childhood environments. Schema Therapy holds that schemas continue to play out in adulthood even if the situations that fostered and sustained them no longer warrant them and is well suited for patients who are dealing with multiple, complex life stressors such as financial stress, in addition to mental health issues. While it grew out of the Cognitive Behavioral Therapy tradition (Beck, 1995), Schema Therapy offers a rich framework for treatment because of its focus on family dynamics in the past and present and because it also integrates elements of attachment theory, Gestalt, and constructivism into its treatment model (Young, Klosko, & Weishaar, 2003). With constructivism in psychotherapy, the self and identity are simultaneously seen as self-defined and influenced by family and society; therapy is seen as a process of co-creation bringing deeper understanding of one's life (Kellogg & Young, 2008).

A person's mental health status should not be assessed in relation to just deficits in coping but also in relation to the person's strengths. Similar to people of different ethnicities, resilience has been found to influence Latinas' experiences with mental health and coping (Heilemann et al., 2002; Heilemann & Copeland, 2005). Therefore, a deliberate focus on enhancing resilience was part of the intervention (see also Heilemann, Pieters, Kehoe, & Yang, 2011). Also, inspired by the successful intervention of nurse practitioners in the RCT with depressed women of low income, including Latinas, by Miranda and colleagues (Miranda et al., 2003), each of the eight treatment sessions was administered by a Nurse Therapist (NT) (Heilemann) who was trained in Cognitive Behavioral Therapy, Schema Therapy, and Motivational Interviewing. Another therapeutic element of importance was an interactive therapeutic technique that organically emerged through the interaction between the NT and participants during therapy that we named Collaborative Mapping (Heilemann et al., 2011). This occurred when the NT wrote down on a shared piece of paper the elements of importance that a woman described about her life during a therapy session. Simultaneously, the NT engaged the woman in dialogue about her memories, emotions, and cognitions and together they would create diagrams, schemas, or charts to illustrate visually what the woman said or felt or the dynamic of a pattern they were identifying.

The NT had over 20 years of experience working with first and second generation Latina patients in the U.S. and low income patients as a perinatal nurse in county hospitals and public clinics and also as a family health nurse, mental health nurse, and Public Health Nurse in low resource neighborhoods. She was bilingual in Spanish and English and had previous experience engaging in various clinical and collaborative work with other Latina

nurses in the U.S., Mexico, Guatemala, and Puerto Rico. The NT was not a Latina and not of low income, however she was committed to and received specialized training in cultural competence regarding the unique cultural experiences and expectations of second generation Latinas. She also had experience and specific training aimed at enhancing social sensitivity to difficulties encountered by women living on a low income in the U.S.

As recommended (Grote et al., 2009; Miranda et al., 2009), therapy tor the eight-session program was done in a private room in a childcare center because it was a non-traditional, non-stigmatized community site that was not a clinic of any sort. Other unique features of the program included that all treatment sessions lasted two hours rather than being comprised of eight standard one-hour sessions to mitigate participants' potential discomfort or frustration in having to stop dialogue just after finally opening up during a session; this was a concern for women who had never been in therapy before. Most of the sessions were done completely in English, but some involved dialogue in Spanish.

A total of nine women were in this sample; all self-identified as English speaking Latinas who were born in the U.S. or immigrated to the U.S. before age 18 and whose parents were born in Mexico, Guatemala, Nicaragua, El Salvador, Belize, Honduras, Panama, or Costa Rica. All women were diagnosed with depression at the time of the clinical diagnostic interview before treatment and entered therapy but only eight finished all eight sessions; they did so within 16 weeks of initiation. The woman who dropped out of the study did so after the second session because she reported her depression had diminished and she no longer needed treatment; IRB requirements did not allow for her to be invited to be interviewed for the current study. A multi-item depression symptom scale, the Beck Depression Inventory-II (BDI-II) (Beck, Steer, & Brown, 1996) was used before, during, and after treatment as an empirical measure of depression. As was reported elsewhere (Heilemann et al., 2011), all eight women had scores above the cutpoint of 14 or higher indicating risk for depression before treatment (mean score was 40.50 +2.89 Standard Error) but scores were below 14 both at the end of treatment and three months after treatment.

The Qualitative Interview Done Three Months After Treatment Conclusion

This study was approved by the UCLA Institutional Review Board. Only Latinas who had completed the eight-session treatment program were eligible for this study. Therefore each of the eight women who completed the treatment program were asked on their last session by the NT if they would agree to be contacted by another researcher (Dornig), a skilled qualitative researcher and therapist who was previously unknown to the participants, about possibly taking part in a private interview three months after their last therapy session. All eight women agreed, signed informed consent, and were informed that they would be contacted by telephone three months later by the researcher who would do the interview. When the researcher called the women three months later, according to the IRB requirement, each woman was given the option to choose/not choose to participate in the interview at that time. Each of the eight women agreed. The interviews were conducted in a private room behind a closed door at a community-based childcare center. Following the methodological guidelines of constructivist grounded theory (CGT) amply described by Charmaz (2006), intensive interviewing was used to gain an in-depth understanding of the women's views and

experiences. The interviews were guided by open-ended, semi-structured questions (see Table 1). Special attention was given to build trust and respect the participant's comfort level. Each interview lasted 1–2 hours. Each participant received a $20 cash incentive at the interview's end.

Analysis of interview data was guided by CGT which emphasizes an inductive and comparative analytic approach to qualitative research, not unlike the tradition of classic grounded theory (Glaser & Strauss, 1967; Glaser, 1978). However, CGT is influenced by the philosophical underpinnings of social constructionism, informed by the work of Berger and Luckmann (1966). Constructivism states up-front that any interpretation of the studied phenomenon made by a researcher is itself a construction (Charmaz, 2014). Compared to classic grounded theory or Glaserian grounded theory (Cutcliffe, 2005) which is also described as objectivist grounded theory (Breckenridge, Jones, Elliott, & Nicol, 2012; Charmaz, 2003; Taghipour, 2014), CGT does not assume the researcher is a neutral observer who discovers data; rather, data is mutually created by the researcher and the participant. With a strong emphasis on methodological rigor, CGT is to a greater extent aligned with the interpretive tradition and emphasizes understanding more than explanation (Appleton & King, 1997; Guba & Lincoln, 2007). The interpretive work of the constructivist does not involve *discovery* of what's "out there" to know and it does not provide a *revelation* of what participants' experiences mean. Rather, it results in a construction of meaning that is one interpretation among many possible interpretations (Schwandt, 1994). The CGT researcher enters into the phenomenon of study as best they can, recognizing that any one person's social reality is framed by their assumptions about institutions and society even if they are not cognizant of these assumptions (Bergman & Luckmann, 1966). Thus, the constructivist recognizes that in the research process, the researcher plays a powerful role in that they are the ones making crucial analytic decisions as they analyze the data. Due to the difficulty in ever fully understanding all the complex and private influences in a participant's world (including deeply held values, beliefs, ideologies, and tacit meanings), any attempt of the researcher to identify causality will always be incomplete and indeterminate (Charmaz, 2003).

Applying constructivism to grounded theory in this study kept us aware that the data, our analyses of the data, and our interpretations were all social constructions (Bryant & Charmaz, 2007). We accepted that in data collection, the researcher is a co-constructor of meaning with participants as they generate data (Mills, Chapman, Bonner, & Francis, 2007). Each time the researcher takes part in the process of engaging with data, they are actively constructing their understandings as they read, code, analyze, reflect on, and interact with the data; this is influenced by contextual factors such as their gender, income, privilege or the lack thereof, and many other attributes as well as prior knowledge and presuppositions. Therefore, intentional acts of reflexivity were crucial elements for us as researchers to identify, scrutinize, and reduce the effect of our own personal assumptions on the research. All three researchers wrote memos and participated in rigorous dialogue together as we engaged in the process of studying how and why participants constructed meanings and took action in their lives (Charmaz, 2008; Corbin & Strauss, 2015).

Conceptually, our inquiry was framed by the theoretical perspective of Symbolic Interactionism which holds that humans act dynamically on others and themselves while simultaneously and continuously redefining their sense of self (Blumer 1969; Charon, 2007; Corbin & Strauss, 2015; Strauss, 1959). Human beings are social persons who are constantly interacting socially with others and with themselves (via the ongoing inner dialogue of thinking). This social interaction leads people to do what they do based on what is happening to them in their current situation and based on definitions they have/make about their world (Charon, 2007). By focusing on interaction, Symbolic Interactionism provided theoretical depth to our focus on the women in our study. The claims of Symbolic Interactionism and constructivism are compatible; both contend that meaning is derived from social interaction and continuous interpretation (Blumer, 1969; Charmaz, 2006; Corbin & Strauss, 2015; Schwandt, 1994). In our study, women's reflections on and engagement in therapy with the NT were conceptualized as rooted in interactions the women had with themselves (via self-talk or thinking) and with others. We sought to understand women's experiences in the context of a sense of self that was dynamic (not static), emerging, and understood through interpretation, accessed through the interview.

Interviews were tape recorded with permission of participants, transcribed verbatim, checked for accuracy, and then independently coded by three researchers. This started with the identification of initial codes based on each line of data. To do this, we used gerunds in short phrases to emphasize the action in the line of data, staying close to the data and minimizing interpretation. Then, we identified the most significant or the most frequently occurring initial codes and compared data to data to create focused codes. By using these focused codes, we sifted through large amounts of data to create groups of data based on focused codes; these were then discussed by the research team (Charmaz, 2006). Charts were used to organize focus codes that were particularly rich and robust in order to develop them into categories. One type of chart, for example, featured rows of codes or quotes from individual participants organized in columns that allowed us to see the range of experiences or viewpoints from various women based on a particular focused code. This helped to refine our analysis to form a category or to go deeper into a category to articulate particular properties within a category. Diagrams were more free-form; they were created to articulate schematically the relationships between properties of a category and to illustrate dynamics within the data. Often such diagrams were more like stepping stones that we used to move closer to a more cogent understanding of the processes experienced by women in the data, rather than a final snapshot that we all agreed fit the data.

Memos were written by each individual researcher and shared to explore and analyze particular focused codes that held promise for becoming a category (Charmaz, 2006). Reading each other's memos allowed us to see how we each had constructed our own understanding of a specific category through engagement with the data. This facilitated our ability to recognize individual perspectives but also to check one another and avoid a tendency to over focus on any one participant's experience or any one researcher's interpretation of one particular case in deference to the range of experiences reported in the data (Corbin & Strauss, 2015). Overall, the process of discussing each others' memos deepened our analysis and strengthened our ability as a team to recognize each woman's view but also to see it in the context of the views of all participants on a particular topic.

Analytic strategies were used to move back and forth from the abstract to the concrete as we deliberately asked questions of the data, made comparisons within and across cases, looked for relationships, and identified patterns that could facilitate understanding of our data. This allowed us to identify properties within a developing category as well as the range of women's experiences of properties across cases (Corbin & Strauss, 2008). All three researchers were committed to cultural sensitivity and ethical standards for qualitative research. We openly discussed our positionality (Charmaz, 2008; Rosaldo, 1993) as white American women with doctorates who were gainfully employed, licensed in nursing (Heilemann, Pieters) or psychology (Dornig), and living in America but not of low income. Each wrote memos to enhance reflexivity in relation to interpretations that developed within analytic discussions of the data and, as previously noted, to interrogate assumptions or biases that might have threatened the integrity of the work.

The benefit of three analysts brought a rich and rigorous search for underlying processes within the data for the women across cases and a rejection of stereotyping. While we often agreed on interpretations that we constructed together during analysis, sometimes disagreements arose. At these times, we would go back to the original data to carefully examine the participants' words in context. As constructivists, we accepted that we were emergently, actively co-constructing meaning while engaging with data collected in the past but analyzed now, in the present moment. Thus, disagreements about interpretations were taken seriously as part of the constructivist process. It was here, through dialogue, that we would draw upon Symbolic Interaction to ground ourselves in the theoretical assumptions that the women were always engaged in various kinds of social interaction with themselves and others which gave definition to their sense of self and world, that their definitions of the world contributed to what they did and how they coped, and that their sense of self was dynamic and emergent, not set in stone. With these theoretical precepts in mind, we would then re-engage with the data and work through the disagreements until resolution; we found that the strategy of constant comparison was the most helpful to resolving disagreements, guided by the goal to gain an understanding of a range of women's experiences of any one particular phenomenon.

Demographics

The average annual income of this English speaking Latina sample was $15,080 ± 927 (Standard Error) and the range was from $4,272 annually for a family of four to $33,996 annually for a family of five. All participants had an income that was less than 1.25 times the poverty threshold (i.e., the threshold set by the U.S. government that identifies those living in poverty based on income and number of people living on that income) (Hokayem & Heggeness, 2014). All participants met criteria to receive no cost social services in the County of Los Angeles. Participants were on average 31 years old, seven had completed high school, and seven were employed full or part time. Five participants were single, two were separated and one was divorced. Six women were mothers (range 1–4 children). Additional demographic information about the sample and analysis of quantitative data collected three months after treatment completion has been reported elsewhere (see Heilemann et al., 2011).

Results

Three months after completion of depression treatment, the Latinas of this sample explained that three things about the therapy program helped them to engage in the treatment (engagement enhancers) including feeling early on that their needs were being met, seeing the therapist as a worthy "co-pilot", and recognizing that the program had a flexible structure. Although the NT used a variety of different therapeutic activities, it was the women's progress in therapy that caused them to stay in therapy rather than to drop out; their progress is reflected in four related but somewhat distinct processes (valuable processes of therapy). These included understanding feelings about past things that happened, seeing patterns and gaining perspective, accepting myself and my life now, and changing family patterns but still being "family". The four processes were not mutually exclusive and did not necessarily happen in succession. Post therapy, women valued two elements they carried with them after treatment (useful take-away's) which included an enhanced sense of confidence and a "toolbelt" of techniques for continued self-treatment. See Figure 1.

Engagement Enhancers

Engagement due to feeling her needs were met early on—Women in this sample were aware that they had been diagnosed with clinical depression when they started coming to sessions. When reflecting on their distress, women remembered feeling that their needs for help started being met from the time of the diagnostic interview and they reported that this was very gratifying. As one participant said, "Since day one, right way, I felt a big sigh of relief, [I said] "This is great!" This is exactly what I was looking for." Women admitted that they confided things in the NT that they never had shared with anyone else which felt good and indicated to women that therapy was the right path. Another woman experienced a positive shift that came like a tangible feeling after the first session.

> From the first time that I spoke with her I felt [like] when you start taking - I felt like I was walking around with a bunch of bricks on my back, so I took one brick off, you could say. Yeah. From the first meeting, I felt one brick off.

This positive shift was surprising to some who didn't imagine that therapy would be so effective so early in the process. One participant admitted, "I thought it was just going to be talking and then, how would you say it? I got help!" Another noted that she went into the first session thinking, "I'll just talk and cry and just let it all out" but, to her surprise, the NT used methods and tactics that were unexpected and useful. Participants reported they realized how important it was to be heard by another person. Because they had a good first session, they found themselves looking forward to the next.

Engagement due to seeing the therapist as a worthy and capable "co-pilot"—Participants explained that the NT related to them from the beginning in a way that was desirable. One woman explained that the NT did not tell her what to do or how to live her life but she listened carefully and offered her expert opinion. Another said that expressing her inner feelings with the NT was "like talking to a mirror" or like sharing so that someone could witness the authenticity of her feelings or "co-sign it." But for this to happen, women felt that being able to trust the NT was an important early step,

> My first couple meetings, it was kinda, not scary but like, how can I put this? You know, when you have to tell all these personal things to somebody you really don't know but yet you know that they can help you? It's kinda like scary in a way, but at the same time a relief because you know that they can help you.

Things that mattered about therapy included what the NT talked about and even the way she spoke. As a participant said, "She gave me that confidence, professional confidence, and the words, the vocabulary she used, and everything, helped me to open up with my situation." The NT's interaction with them was seen as unusual in that she asked questions no one had ever asked before, she knew what to say in response, and she had ideas about what steps the woman should take next. They valued the professionalism and confidentiality of the NT. Women compared this to the behavior of their family or friends who they said were critical or quick to judge them without asking questions or listening to the answers. One woman explained that her mom wants her to open up to her but when she does, her mom just criticizes her. She liked that the NT would listen and give choices. Another highlighted how the NT asked questions:

> [The NT asked] "How did you feel? How did that make you feel? What did you think about that?" And usually, you know, if I mention THAT to my cousin or to a friend of mine, they'll just be like, you know, "Oh, that's messed up," and things like that; but it's not a "How were you feeling?" kind-of-deal.

Women described feeling a sense of collaboration with the NT. They referred to the work as something they did together. A participant remembered the NT saying from the beginning, "let me help you help yourself." Because the NT seemed to respect their priorities and responsibilities as mothers, spouses, daughters, and workers, the women felt they were in dialogue with a partner. One woman described the NT as her "co-pilot;" she saw the NT as managing all the technical aspects of the work so that she (the participant) could be the one directing where to go. Describing this, she said, "...so she's driving, but I'm navigating and that's what we did."

Engagement due to flexible structure of therapy sessions—The women had busy lives with many demands due to the needs of their children and/or extended families, which is why they valued what they perceived as a flexible structure to the program. They described having a say in the start and stop time of sessions and the dates when sessions were scheduled and rescheduled. This made them feel that their own particular needs mattered and that it was possible for them to fit the sessions into their demanding weeks.

Women valued that there seemed to be both an agenda of activities to do each week but also a flexibility to change the agenda based on emotional needs on that particular day. Being able to be honest with the NT about how something in therapy did/did not work for them deepened participants' ability to be spontaneous and honest about their feelings. For example, a participant described how she bought a journal she intended to use for homework assigned by the NT, but then instead of using it, she only thought about writing in it during her homework time between sessions. The NT was fine with the decision and the woman said she learned from both dialogue with the NT and dialogue with herself about it even though she never did the actual assignment.

The participants valued the written notes and diagrams that the NT drew on paper during sessions based on the things the women said. One woman said that knowing that the NT was writing down things she said allowed her to actually hear her own voice. For her, it was freeing to know that the NT was simultaneously listening and writing while she was saying what she felt. Another participant expressed how this process revealed things to her about herself:

> …she [the NT] always repeated what I said to make sure that, like, I knew this was coming from me. It was nothing she was putting, like words, in my mouth or none of that stuff. And so, I'd be like, "Wow! I say all these things?"

Women appreciated being able to physically see their own words transcribed on paper and how they could take the paper with them at the end of the session. One woman explained how, during sessions, she would build on the diagram or words written on the paper to help express how she felt. She spoke of a particularly helpful diagram that she co-created with the NT that she called "my circle" because it included a visual representation of everything she cared the most about in life; she liked it because all of these elements were depicted in one circle on one piece of paper.

Sometimes a quote from the woman or a note from the NT would be written on a small card, which one woman called, "little ones to keep on my dashboard." Women explained these notes were most helpful if they put them in conspicuous places in their homes or cars to help remember something important from the session. A participant shared that her cards included quotes like, "I don't have to make everyone happy" and "It's ok to just be happy with yourself." All women reported that they still had the copies of notes and diagrams from their sessions.

Valuable Processes of Therapy

Therapy process 1: Understanding feelings about past things that happened

—The women described how powerful experiences happened within the work of therapy when they gained new insight about "why" their feelings were so strong and painful. They explained that past events were traumatic and thus brought pain. This included past physical or sexual abuse, emotional rejection from parents, thoughts of suicide, drug use, and episodes of being abandoned. Women reported that it was useful to talk about these issues because they gained insight into their past. One woman stated:

> One thing that I will never ever forget is that she helped me trace back to where my depression started. I never thought about it . . . She helped me trace it back and pinpoint it. And, that was the most emotional day. I cried for days I think, for like, yeah I cried for a few days after that.

She went on to say how her tears changed to relief through this process of understanding why her feelings were so painful. While women had different ways of expressing that they valued the work of reflecting on their past, each pointed out that therapy allowed them to see possible reasons why painful things happened, even if they wish these events had never happened. This process gave what Elena described as a kind of fuel or "gasoline" to go further and to see how to deal with it in the future.

Therapy Process 2: Seeing patterns and gaining perspective—Although each woman spoke about different experiences and different relationships, all the women described how the work in therapy showed them patterns that gave them a much larger perspective on their situation, their relationships, and themselves. A participant said that therapy "helped me get to the root of it, that there were reasons for why I was feeling this way." Women explained that the sessions helped show how the patterns from childhood were still setting them up for misery in their relationships today. One woman said,

> Just going back and just thinking about a lot of things and just making a lot of connections on things as I grew up, too, and then, as I got older, and it made sense to me. It just started making more sense to me why, why I made the decisions I made, why I was drawn to certain things.

The women valued their ability to see patterns because it showed them how the past was related to the present, but in a way that was practical and understandable so they were able to change. A participant said, "Because if you know why you're doing what you're doing, then it's easier to not do it." Women confided that even if it meant they had to traverse distressing terrain in their memories, therapy was worth it because understanding the patterns brought explanations that were coherent in their lives now. In addition, it was valued because it allowed women to open emotional doors that had been shut, which meant that valuable feelings were hiding or held in secret. One woman explained that this did not make sense to her until she did the work of therapy:

> It actually helps you, somewhat, open this, like, treasure that you have inside your body. I guess you would say, metaphorically speaking, that therapy helps you open that and helps you understand why you kept so many things inside of you. It's like you keep everything bottled up and then… I feel so relieved. I feel like I got this huge weight off my shoulders.

Therapy process 3: Accepting myself and my life now—As a result of being in therapy, the women explained that they accepted themselves and their lives now in a way they had not done before. By doing the activities guided by the NT in sessions, one woman pointed out that she realized, "I'm not crazy, this is what I have lived." Another came to recognize that both now and in the past, her emotional reactions were reasonable reactions to difficult problems; she knowingly reflected, "I'm just human and have emotions because of what I've been through." Women were appreciative that their new ability to accept themselves and their past freed them to engage in their life today with greater tolerance and perspective. A participant said, "I feel more accepting of me, I feel relieved and refreshed, it's like getting back into my own shoes. It's like freedom."

Being able to accept life now was partly due to an ability to let go of blaming themselves. Women described how the talking, writing, listening, and interaction of therapy gave them a greater ability to stop wishing for things that were unrealistic and to start dealing with the realities of their situation in the present. Because of this, one woman expressed:

> Every day I accept myself more and more . . . So it's just a way of life now . . . you just gotta like, appreciate yourself, and value yourself, and respect yourself, and then everything will just, you know, go along and if it doesn't, then it's okay.

As a result of this process in therapy, women valued how differently they felt. Instead of being devoted to pleasing others, a participant explained that she changed: “I’m not concerned about if you like what I’m doing or not, you know? I’m more concerned about – do I like it? Is it working for me? Am I comfortable?” Another said that she had always tried to please her family members even if her actions did not reflect how she truly felt; now she said she realized that failing to be authentic with them had its costs: “they’re not really liking YOU, if this is not who you [really] are.” This led her, like other participants, to see that breaking some family patterns would be necessary.

Therapy process 4: Changing family patterns but still being “family”—Through the interactive work of understanding why things happened in the past, seeing patterns, and becoming more accepting of themselves, participants realized they had options for different ways of dealing with their families that they never saw before. Women expressed how important it was to be able to change old patterns that hurt them, but to do so without completely rejecting their families. The ability to make such changes was valuable because it opened up the possibility that they could choose to be emotionally healthy without having to completely abandon cultural values for prioritizing the family unit. Secure that they could stay close and honor their family ties even if they saw unhealthy patterns, women valued how therapy gave them the opportunity to seek the best ways to relate to their families. One woman described this as when the NT showed her options through potential scenarios of how she could deal with a family problem without leaving the web of family relationships. Another talked about learning that it was ok to have privacy from her family when she previously didn’t think that was acceptable.

The work of therapy helped women evaluate family patterns including gender roles and expectations enacted by their parents. They saw dynamics that were hurtful and valued the chance to discuss traditional cultural and social expectations their parents had for male-female relationships. A participant said, “. . . us Latinas, you know, you’re supposed to like please your man 100%! But it’s like, “No, you can’t do it all the time.”” Another woman felt an urgency to break the role based patterns she saw in her parents’ discordant and occasionally abusive relationship:

> I don’t want that same behavior in my own family and I know that because I was in that environment. I am more inclined to take certain roles whether I want to or not. They’ll creep up! So I wanna work on that right now.

Women spoke specifically about how their parents’ interactions influenced their own gender identity and expectations within intimate relationships, both hetero- and homosexual. For example, one participant explained she “was having a hard time, now, with just interacting with the opposite, you know, sex” so she wanted to change things in her life even if it was difficult. She felt her problems were influenced by the way her father acted towards her but she had learned it was important to accept her parents even though she did not agree with her dad’s behavior because she had her own life to live. She said, “They lead different lives and I lead a different life, and I’m a separate individual. Yes, I am their daughter, but I am a separate individual.”

Women talked about how expectations for family members were not fulfilled on various occasions and although that was disappointing, it helped create some distance. One woman had assumed family members "were supposed to be there through thick and thin" but she realized they weren't in real life. Like other participants, she said she learned that the change would need to come from her rather than from them. Women admitted they wished some relatives had been more mature, responsible, or protective of them. For example, a participant explained that her aunt was not there when she needed her, so she learned she had to focus on her own life, rather than the needs or expectations of her extended family if things were going to change for the better. She said, "I'm not here to change a thousand people, I'm here to change me."

Useful Take-Away's

Enhanced sense of confidence—While some women reported that they would have preferred that therapy could last longer than eight sessions, all women talked about how they gained more confidence as well as skill with new therapeutic techniques they continued to use after their last session. In relation to confidence, the women realized positive things about themselves. Women cited mottos that expressed their new attitude towards themselves; for one woman it was "I'm ok" and for another it was "I'm intelligent." The building sense of confidence grew over time as one woman explained,

> It was healing to me. So every time I came in and I walked out of here from seeing her, I just felt, you know, like a rooster with its, you know, with the feathers all (motioning with her hands), I just felt like, "Yeah! I'm good and I can do this" and I just felt so much confidence in me.

The women reported their perspective had widened which helped them gain a sense of self worth after what they described as a long period of feeling worthless. This was strengthened by the ability to recognize their emotions and that, rather than staying the same forever, negative feelings do pass. This gave them a valuable sense of hope and assurance.

> I'm more confident about who I am. I can actually get up and recognize when I don't feel okay, when I am starting to feel that way, that it's a feeling that is gonna pass, it's the momentary thing and I know it's just me getting caught up emotionally again in that feeling but it's not a bad thing. I actually feel better about who I am and I'm more confident about my decisions and my future. I'm not feeling so bad that it's gonna continue.

Toolbelt of techniques for self-treatment—The second benefit that women gained from therapy was skill and knowledge about tactics and therapeutic tools they could use on their own to help themselves emotionally. One woman referred to this as a "toolbelt" of techniques that she developed during treatment. Many women described a "stop and think" tool they used to identify their feelings before acting on them. Women reported using this tool whenever they found themselves thinking, feeling, or saying something emotional: "As soon as I started feeling something, I had to stop and think, "OK. Why am I feeling like this?" and that overall, that helped me out! Until this day, it still helps me out." By identifying what was triggering her feelings, one woman explained she was able to stop

herself from automatically becoming angry or shutting down and turning away from everyone by secluding herself.

Another tactic that was valued by the women was to make a list of pro's and con's when trying to make a decision. A participant said that after learning to do this technique with the NT, she found it so useful that she started referring to herself as a "pro-and-con person." Even though she conceptually knew that pros and cons existed all the time in the past, the actual experience of writing out the pro's and con's with the NT on paper brought it to life. Now, she said she uses the skill on her own and even with her friends.

Another woman explained that she had created a notebook where she wrote down various things from her therapy sessions, and she continues to use the notes today. She said that whenever she struggles with decision-making, she goes back to the notebook and chooses a technique from her notes to help herself.

The technique of planning and doing an experiment in daily life wherein participants tried out a change involving other people was also reported as useful. Women explained that they would choose an action in relation to some problem with another person, do the action, and then step back to observe or learn from what happened. Several women described how they were continuing to do experiments; one woman said she does them even with her family members because it helps her determine who she can and cannot count on in a bad situation. She said this tool gave her enhanced confidence despite the uncertainty of particular situations in her life. Others reported that the use of experiments had a calming effect on them because it reduced confused thoughts, clarified the cause of angry/sad feelings, and helped them discover what they could do in response.

Discussion

The reflections of our sample of eight second generation Latinas of low income who previously completed an eight-session depression treatment program three months prior to the interview, revealed how interactional experiences in treatment were valued because they enhanced engagement, enriched the processes of therapy, and led to benefits that were useful after treatment ended. Other researchers have found that the prominent reason why Latinos discontinue depression treatment after starting is because they do not find the benefits they initially sought (Karasz & Watkins, 2006; Lorenzo-Blanco & Delva, 2012). For patients of various minority groups in the U.S., engagement in, adherence to, and reception of treatment itself is linked to having the sense that that treatment is worth it and that the therapist can be trusted (Dixon et al., 2011). In line with this, our participants highlighted the immediate relief they felt when it became clear to them that their needs were being met early on by a therapist who was professional, capable, and trustworthy. Their engagement strengthened when they realized the structure of the program was flexible and would work for their busy lives. However, Caplan and Whittemore (2013) found that Latinas with a past history of gender based violence or adversity in childhood may experience a diminishing ability to engage in depression treatment if their family does not support their quest to get treatment or if cultural values require women to hide problems to protect the reputation of the family. Furthermore, if gendered expectations call for Latinas who are mothers to endure emotional

difficulties and remain silent, they may put off treatment. Such threats to Latinas' abilities to engage in therapy reinforce the importance of examining and articulating why our sample entered and stayed in the eight-session program.

The perspective of Symbolic Interactionism is useful to exploring our participants' views about therapy and understanding what worked and why. Symbolic Interactionism holds that reality is made meaningful by interpretation which is a result of ongoing social interaction and self-reflection or thinking (Blumer, 1969; Charon, 2007). For our sample, therapy was itself a space for social interaction with the therapist as well as meaningful self-reflection. Symbolic Interactionism purports that it is this interactive process that leads human beings to define the situation in terms of its social and personal meaning for them in ways that influence what they do (Blumer, 1969; Charon, 2007). In particular, each person acts self-reflexively much of the time, taking into account not only herself, but also the imagined selves (point of view) of others.

A Symbolic Interactionist lens suggests that, for our sample, therapy was effective because the women felt their particular concerns were heard, verbalized, and normalized by the NT through meaningful interaction experienced in therapy sessions. As such, through interaction with the NT and through her perspective and attitudes, it seems women were able to experience themselves through their own eyes (self-reflection) and through the eyes of the therapist which allowed them to take the point-of-view of the "other" (Coser, 1977). Within this process, it is likely the women experienced a particularly effective type of respect that was mutual and reciprocal, compatible with the Latino cultural value of "respeto" (Garza & Watts, 2010; Juckett, 2013). That is, they found themselves in dialogue with someone who paid attention to them with concern and personal regard, as is expected with the Latino value of "personalismo" (Aguilar-Gaxiola et al., 2012; Warda, 2000), but also someone they realized they could partner with, rather than just defer to. This mutuality was not insignificant. Rather, our data showed it was experienced as a valuable aspect of their interactions with the NT; furthermore, it strengthened their sense of self in a memorable way that they still appreciated three months after the experience.

It is noteworthy that a participant described her work with the NT as being like looking at herself in a mirror, something most of us do every day in order to get 'a read' on reality. This echoes the notion of the "looking glass self" described by Symbolic Interactionist, Charles Horton Cooley (Reynolds, 2003, p.60) in that the therapist provided a way for the woman to perceive the responses of an "other" towards her. Through this looking glass, participants could reflect on, explore, and revise feelings and attitudes towards their sense of self, in the presence of an "other" self, the NT (Kinch, 1978; Turner, 1991). Interactions with the NT, who considered the women's perceptions and opinions within the interaction experience itself to be important, led them to feel endorsed by someone with the status of a "cosigner" or a witness. This suggests participation in a social exchange they valued, a back and forth communication that was generative to their sense of self and helped to enhance confidence. With this, Symbolic Interactionism spurs an interpretation of the therapeutic interaction as a process that allowed for a re-visioning of the women's experiences, contexts, and feelings. In turn, therapy, as a space of interactive meaning making, helped shape women's views of

reality (their self, family and social contexts) and ultimately expanded the range of behavioral responses they perceived as possible for them to implement in their daily life.

From the vantage point three months after treatment conclusion, women spoke of their own growth during therapy, and in so doing, that which stood out to them was the sense of autonomy they experienced within the therapeutic relationship. They explained that the NT was present in therapy sessions, willing to provide technical support, share strategies, and offer tactics but she did not take away their ability to "navigate" the ship of their lives. The NT did not judge the way the women engaged in homework; it was acceptable to the NT even if the women just thought about doing homework but actually did not do any assignments. Other models of therapy may have made homework completion an "issue," or urged clinical interpretations about problematic noncompliance with homework.

The NT's style of interaction was unique to the women; her ability to really listen to them was described as "freeing" perhaps because it too fostered autonomy. Rather than listening in order to take control, the women felt that the NT listened to put the focus on what they said, what they felt, and what they identified as their needs. This in turn seemed to open up the possibility for them to be able to hear themselves, to notice their own words and thoughts, and to gain insight. Being listened to in this way was not ordinary and it was greatly prized by the women. As has been noted by many researchers, listening is crucial to quality nurse-patient relationships of many kinds with all kinds of patients (Bhui et al., 2015; Stickley & Freshwater, 2006). Also, a therapist's ability to be empathic, engaged, and interested in patients is considered key to a strong therapeutic alliance in a variety of therapeutic approaches (McEnvoy, Baker, Plant, Hylton, & Mansell, 2013). Specifically in this study, however, participants valued how the NT would listen and then verbally repeat back what they said so they could hear it and how she would simultaneously document it on paper in an open and collaborative way. When describing this activity, the women seemed to be referring to the innovative and emergent approach of Collaborative Mapping that developed organically during the eight therapeutic sessions (Heilemann et al., 2011). The women attached value to the way the NT listened and openly documented what they said. The women's reflections imply a sense of balanced power in that the NT did not take secret notes; rather, she was learning and exploring alongside the women in a transparent and highly collaborative interaction. The co-creation of diagrams and charts plus the sharing of notes was valued and potent as collaborative work in therapy that brought results that mattered to the women.

As is common with people of other ethnicities, our data indicate that family relationships had an important influence on the Latina participants' experiences of depression. Other researchers have focused on this and found that family cultural conflict increases the risk of depression for Latinos and that family support has the opposite effect (Lorenzo-Blanco & Delva, 2012). Nonetheless, the strong Latino cultural value of 'familismo' (importance of loyalty to and cohesion within the family) (Garza & Watts, 2010; Jones, 2014; Juckett, 2013; Ishikawa, Cardemil, & Falmagne, 2010) has been identified as a barrier to help seeking related to mental health. Within Latino communities, familism has been found to make the disclosure of mental health problems very difficult (Aguilar-Gaxiola et al, 2012). Although the topic of family relationships and expectations may be taboo for Latinas, the women of

our sample indicated that a focus on identifying and changing family patterns was crucial to the success of their treatment, even if painful, private memories of repeated family occurrences were the focus. Such work can only proceed if there is respect for family ties, values, and relationships so that disclosure can go unhindered within the process of treatment (see also Heilemann et al., 2011). A respect for the complexity of family relationships and the associated schemas that developed in childhood to help a woman cope but that still operate in adulthood are emphasized in Schema Therapy (Young et al., 2003) which is likely to have increased the value of the therapy sessions to the women. Perhaps this contributed to personal sense of confidence women described. The delicate balance of honoring the Latino value of familism and the importance of family relationships seems to have been a crucial element in therapy. As Latinas engage in what is sometimes a painful exploration of family based and historical issues while doing ongoing therapeutic work, significant attention needs to be given each woman's experience of familism, especially when dealing with something as stigmatized and problematic as seeking, engaging in, and staying enrolled in mental health treatment (Aguilar-Gaxiola et al., 2012).

Limitations

Our work is unique in our aim to explore Latinas' experiences of being in therapy. However participation in this study was limited to the eight women who completed one particular treatment program (see Heilemann et al., 2011). In addition, based on the design of our study, interview data were intentionally collected only at one time point approximately three months after treatment completion. All women were interviewed by a researcher who was not the NT however some women asked and were informed that the interview transcripts would be analyzed by the entire research team which would include the NT. Therefore, it is possible that this may have had an effect on the data. Because Latina women outside this program were not recruited and because multiple interviews were not done with each participant, the amount of data collected was limited. Nonetheless, data from this sample of a subsection of second generation Latinas in the U.S. can help deepen understanding about elements that this group found helpful to their ability to engage and persevere in the therapeutic process across eight sessions of therapy, yielding the beneficial results of enhanced confidence and expansion of skills for future mental health self-care.

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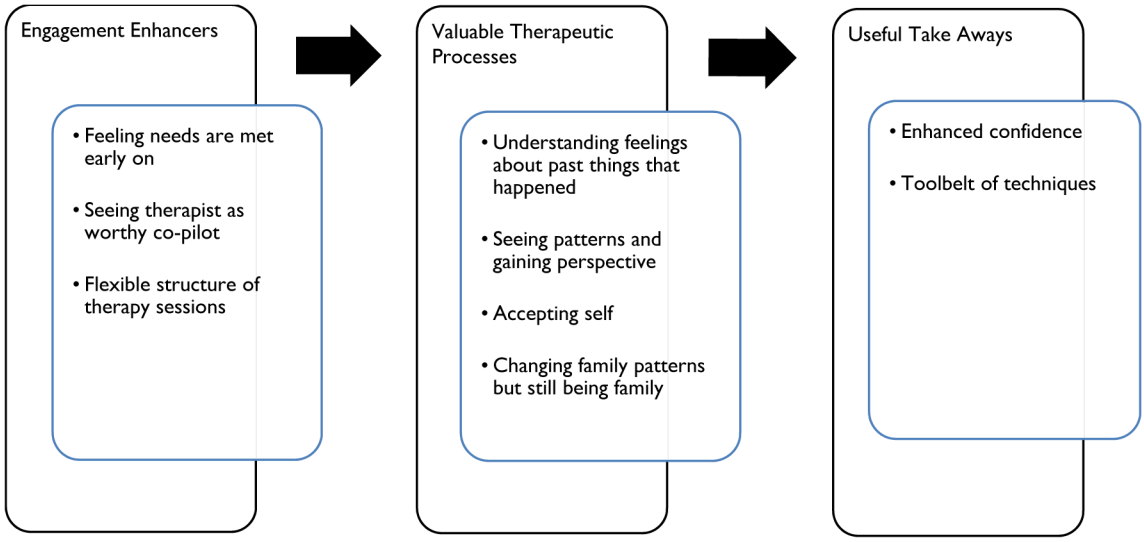

Figure 1.
Latinas' reflections on therapy.

Table 1

Interview Questions and Probes for the Interview Three Months Post Treatment

What did you think therapy would be like before you started the program? • What was it like to make the call in the beginning? Tell me what it was like at the first session of therapy. • What made it that way? (based on whatever she says, such as, what made it uncomfortable, comfortable, difficult, easy, etc.). What did you do during therapy sessions? • Which of those was/was not helpful and why? • Which of those were/were not valuable to you and why? • What was/was not useful about the therapy and why? • If she names activities, tactics, or techniques, ask: What it was like for you to try the (activity, tactic, or technique) in therapy? What did you think of the way the therapy program was organized? (such as, the way the NT led the sessions from start to finish, coming for 2 hours for each session, the location, etc.). What helped you decide to continue coming to therapy week to week? • If there was a time when you just wanted to skip a session due to your busy schedule, please tell me about that. Now that it is three months after your last session, looking back: Tell me about what effect, if any, the therapy has had on your life now. • What most stands out to you about the work that you did in therapy? What do you do now to help you with your mood during times when you feel low? Tell me about anything else we missed or that you want to add.