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A Systematic Review of Mood Disorders and the Working Alliance in Latino Populations

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A SYSTEMATIC REVIEW OF MOOD DISORDERS AND THE WORKING ALLIANCE IN LATINO POPULATIONS

A Thesis

by

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ABSTRACT

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The working alliance and mood disorders in Latin populations has received scant attention. To remedy this deficit, this analysis completed a systematic review of this subject. This initial systematic review may aid to acquire a greater understanding of general and specific factors impacting this population. The Mixed Methods Appraisal Tool (MMAT), Version 2018 will be utilized in study appraisal, as will PRISMA guidelines. Study inclusion consists of studies involving adult Latino subjects with working alliance results as related to symptomology or discussion of working alliance effects on the population. A total of 11 studies met criteria; limitations consisted of the variable nature of studies included and the impact of inconsistent cultural adaptations in the studies. Nonetheless, this review may fill research gaps regarding working alliance effects in ethnic minority groups generally and mood disordered Latino groups specifically, while being of practical clinical use and aiding future studies.

DEDICATION

I would like to thank my father, Jose Leocadio Contreras, and my mother, Estela Contreras, for all the support they have provided me over the years and their encouragement, not only in my studies, but also in providing guidance and unceasing assistance with the complexities of developing into a moral and responsible human being. Gracias, Ma y Pa.

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CHAPTER I

INTRODUCTION

This review will assess the relationship between clients and mental health workers social interactions and the effects on mood disorder (MD) symptoms. Specifically, relevant aspects of the working alliance (WA) will be explored as they affect mood disorders and client perceptions in Latino populations. Results of this investigation can hopefully provide direction in addressing the mental health needs of this group. Considering the growth of the Latino population, and that Latinos are projected to make up close to 25 percent of the population of the United States by 2050, studies that inform on the requirements, availability, and appropriateness of services to this population would be welcome additions to the literature (Alegría et al., 2007). There may be differences in etiology in Latino groups which correspondingly reflect dissimilar needs; for instance, this population has been shown to have differences in depressive disorder rates, as well as substance abuse and anxiety disorders, with these differences even being reflective of birth origin, i.e., nativity (Alegría et al., 2007; Almeida, Molnar, Kawachi, & Subramanian, 2009; Grant, Stinson, Hasin, Dawson, Chou, & Anderson, 2004). Relevant to this study, Breslau, Kendler, Su, Gaxiola-Aguilar, and Kessler (2005) found the prevalence of mood disorder persistence to be higher in Latinos compared to non-Latino Whites, providing added justification for a focus on MDs in Latin populations.

A related consideration, mentioned by Landale, Orpesa, & Bradatan (2006), involving Latinos (as cited in Almeida et al., 2009) is the existence of informal support sources, such as

large family networks, from which this group derives great amounts of social support. It is possible one of these social support sources, which stresses the relevance and primacy of kin, termed *familismo*, or familism, mentioned in studies by Franzini et al. (2001), Vega & Miranda (1985) (as cited in Almeida et al., 2009) and Mindel (1980), could affect the perception or type of desirability for other sources of social support. In fact, Almeida et al. (2009) have demonstrated that each ethnic minority group in their study reported lower perceptions of social support from friends in comparison to non-Latino whites, and, worthy of note, resulting strength levels of friend perceived support was mediated by the extent of Spanish language use prevalence at home or by the bilingualism of participants, but significantly lower perceived friend support was the case for each of the minority groups in the study nonetheless. Seemingly, there are factors which may variably impact the perception of support in Latinos and, by extension, these factors may similarly be impacting undiscovered aspects of the patient-therapist relationship. This review may aid in identifying factors which may be relevant to the patient-therapist relationship among Latino clients.

The positive aspects of *familismo* and its concomitant benefits might be a source of support which explains why mental health services, potentially available to Latinos, are underutilized by this group (Jimenez et al., 2015; Villatoro, et al., 2014). Less than one in 11 Latinos with psychological illnesses interact with mental health practitioners; less than one in five with health-related mental problems communicate with a primary health care specialist, as pointed out by the DHHS (2001; as cited in Villatoro et al., 2014). Additionally, studies by Golding and Wells (1990), Hansen and Aranda (2012), Miville and Constantine (2006), Pescosolido, Wright, Alegría, and Vera (1998), and Snowden (2007) indicate the stronger the social support networks of Latinos, the less likely this group may be to avail themselves of

services provided by mental health service providers. Furthermore, since studies by Alvidrez (1999), Cabassa (2007), Ramos-Sanchez and Atkinson (2009), and Sabogal, Marín, Otero-Sabogal, Marín, and Perez-Stable (1987) indicate *familismo* is not congruent with discussion of problems outside of the kin network, due to perceived shame it may incur on the family, when individuals of Latino background access mental health services it would seem they could require approaches and sensitivity suitable to the cultural circumstances from which they have emerged. *Familismo, marianismo, respeto*, and similar cultural factors may differentially influence etiological attitudes towards therapeutic interventions and support provided for Latinos.

A review summarizing suitability and factors which impact therapeutic relationship interactions related to mood disorders between client and mental health professionals, medical personnel, and significant health care intermediaries in Latino populations is needed to address this important issue. The present review may aid in determination of the factors affecting therapeutic approaches with respect to the Latino population and could be a preliminary step in aiding to fill this seeming dearth in the literature.

CHAPTER II

REVIEW OF LITERATURE

The review will focus on the impact of the working alliance on four of the mood disorders frequently clustered together as affective mental illnesses, Major depressive disorder (MDD), Persistent depressive disorder (PDD or dysthymia), Bipolar Disorder I and II (BD I, BD II), and Cyclothymia. Among foreign-born and US born Mexican-Americans, the lifetime prevalence of any mood disorder has been determined to be an aggregate 14.1% in this population. Mexican-Americans represent about 60% of Latinos in the United States (Grant et al., 2004). Prevalence of related disorders in this group will be noted below. Alegria et al. (2007) note differences in rates of psychiatric disorders between groups of Latino ethnic groups, i.e., Cuban, Mexican-American, and Puerto Rican), and while figures for Mexican-American groups may not be definitively indicative for other Latino ethnicities, the numbers may serve as a general indicator of mood disorder prevalence in related Latino groups. The impact of overall social support, friend/partner support, and familial support will be explained with respect to the afore-mentioned mood disorders to develop a parallel by which similar therapist effects may be envisaged, and then, the effects of therapist support in the working alliance will be addressed specifically.

Kessler et al. (2005) note the lifetime prevalence of individuals in the general population meeting the criteria for Major Depressive Disorder (MDD) in the United States as 16.6%. Also, Mathers and Loncar (2006) observe it is expected to be a leading worldwide disease encumbrance by 2030 in nations of high-income. Major depression has a total lifetime

prevalence of 10.9% in foreign and native-born Mexican Americans (Grant et al., 2004). There are many factors which affect depression; in therapy, the therapeutic relationship could be expected to affect depressive symptomology strongly. A study by Parker and Ritch (2001) indicates patients experiencing depression may even perceive support (i.e. therapeutic support) differentially depending on depressive sub-type (as cited in Gladstone et al., 2007).

Kessler et al. (2005) observe Persistent Depressive Disorder (PDD), noted in their study as dysthymia, to be present among the general population at a level of 2.5%, Among Mexican-Americans, PDD, or dysthymia, has a lifetime prevalence of 2.2% in foreign and native-born subjects (Grant et al., 2004). Akiskal (2001) observes that, like MDD, those afflicted with PDD demonstrate various levels of impairment in key areas of psychosocial functioning; some examples include high morbidity, difficulties in social-occupational domains, and areas of health dysfunctions. More relevantly, comparison with medically ill/normal controls demonstrated impairment in marital relations and perceived social support in individuals experiencing PDD. Regrettably, the areas of social support and marital adaptation are comparatively unstudied, as is the area of dysthymia generally (Subodh, Avasthi, & Chakrabarti, 2008). A study dealing with dysthymia found euthymic patients felt social support, self-understanding, and acquiring the ability for self-reasoning aided in remission (Svanborg, Bäärnhielm, Wistedt, & Lützen, 2008), and, as with MDD, individuals of the study felt constructive social support and significant relationships impacted their disorder positively. These authors imply the existence of perceived social support, which could logically include medical healthcare support, may be indicative of positive long-term results for these types of psychological disorders.

Perceived social support appears relevant in the progress of MDD and PDD and seems to likewise be the case with Bipolar Disorder (BD) I and II. The general population experiences a

total prevalence of 3.9% of BD I and II (Kessler et al., 2005), while Bipolar Mania is represented in Mexican-American foreign and native-born individuals by a lifetime prevalence of 2.8% for mania and a 2.2% lifetime prevalence for hypomanic occurrences (Grant et al., 2004). As in MDD, there are many possible contributory and mitigating factors during BD I & II; perhaps unsurprisingly, psycho-social factors also play a role in these disorders. To be sure, BD relapse is tied to elements such as family troubles as shown in Koenders et al. (2014). Relapse is also affected by unfavorable life events in close relationships as studies by Miklowitz, Wisniewski, Miyahara, Otto, and Sachs (2005) and Yan, Hammen, Cohen, Daley, and Henry (2004) demonstrate. Furthermore, the progression of the disorder in BD patients experiencing supportive relationships is more favorable according to Greenberg, Rosenblum, McInnis, and Muzik (2014). Similarly, a study by Stefos, Bauwens, Staner, Pardoen, and Mendlewicz (1996) indicates affective episodes were more likely to reoccur if low support levels were experienced (as cited in Johnson. et al., 2003). It has been found that subjectively perceived support which is seen as obtainable, satisfactory, and sufficient influences physical and psychological results to a greater extent according to Helgeson (1993), Kaul & Lakey (2003) (as cited in Koenders et al., 2015) and Uchino (2009), in relation to BD, than enacted, objective support - which refers to actual obtained support in a particular time period (Barrera, 1986; Uchino, 2009). Therefore, unsatisfactory levels of perceived support have been considered as negatively impacting BD symptomology - as with MDD and PDD.

Cyclothymia, is thought of as involving long-lasting affective swings of a diminished intensity and a less disabling nature than BD, and, perhaps indicative of the rarity with which statistical data concerning this disorder is obtained, Kessler et al. (2005) did not provide a separate category for this disorder in their study – despite the fact data was obtained from a

national survey, i.e., the National Comorbidity Survey Replication. Grant et al. (2004), likewise, did not indicate a separate category for this disorder – despite being part of the National Epidemiologic Survey on Alcohol and Related Conditions. In fact, literature for cyclothymia and perceived support related to this disorder appears scarcer and more difficult to find than PDD. So much so that data related to the prevalence of cyclothymia in Latino groups appears to not be readily available; the DSM-5 did refer to a general population prevalence as high as approximately 1%, with its' lower limit at 0.4% (American Psychiatric Association, 2013), making it the least widespread disorder considered by this review in the United States. It is perhaps due to this fact that cyclothymia studies in general, and studies involving cyclothymia in Latino groups and the working alliance specifically, are difficult to obtain. Though strictly conjecture, it would seem likely that cyclothymic individuals might benefit similarly from perceived levels of support as individuals with BD. Since perceived social support and social networks would seem to play a role in moderating the impact of negative events and topographical manifestations of mood disorders, the manner this social support could impact Latino individuals is considered.

Perceptions of Mental Health Variables Among Latinos

There are differences in ethnic and racial methods of employing mental health services and, though financial barriers impact service utilization, other factors also play a role. Turner et al. (2016) have proposed a Model of Treatment Initiation (MTI) which includes four major areas which could impact treatment engagement by members of an ethnic enclave; these areas consider the accessibility, availability, appropriateness, and acceptability of treatment apropos for a given group. A better comprehension of racial/ethnic minorities' barriers to treatment access may improve the use of those systems of specialized care (Turner et al., 2016). We may utilize this

model to guide the forthcoming discussion regarding predilections, the effect of cultural values, and other related variables as they pertain to the impact on Latino attitudes towards mental-health help seeking actions.

Though Latino Americans fall under the umbrella term "Latinos," even a cursory look will reveal within and between group differences in this heterogeneous group of Caribbean, South American, Central American, and Mexican origin. For instance, there are differences in the use of mental health services between immigrant and native Latinos. A study by Ramos-Sanchez and Atkinson (2009) indicated more enculturated, i.e., adhering to the Latin culture, Mexican-Americans were more likely to perceive mental health services favorably, though other studies have shown documentation issues could result in decreased use of mental health services (Turner et al., 2016). Perceptions of mental health may vary further by age cohort. A qualitative study regarding mental health perceptions of older Latino adults, 65 and above, indicates the descriptors of anxiety, stress, and depression may not be encapsulated appropriately by current diagnostic categories, which could then affect providers efforts in aiding the Latino patient appropriately (Curtin et al., 2018). Hansen and Aranda (2012) found utilization of mental health services by older Latinos is less probable if language acculturation is poor and instrumental and emotional support is limited. Gender, along with age, can impact help-seeking orientations as well. Young men are more prone to express negative attitudes towards mental health approaches than women (Gonzalez, Alegria, & Prihoda, 2005, as cited in Cabassa, 2007) and are less inclined to seek out treatment for mental issues like depression (Addis & Mahalik, 2003; Leaf, Bruce, Tischler, & Holzer, 1987; O'Brien, Hunt, & Hart, 2005, as cited in Cabassa, 2007)

Some issues of accessibility for Latinos include finding available services, finding services in Spanish, and overcoming wariness and anxiety due to uncertain expectations (Cortes,

2005; Guarnaccia, Martinez, & Acosta, 2005, as cited in Turner et al. 2016). Once services are located, culturally suitable resources, e.g., language appropriate therapy in Spanish, is usually lacking. This likely results in Latinos not seeking suitable treatment locales or being able to express their concerns as facilities with appropriately trained individuals are lacking (DuBard & Gizice, 2008; Nielsen, Jones, & Tucker, 2015; Ortiz, 2003; Ryan, 2011, as cited in Turner et al., 2016). When services are encountered, if they are not linguistically or culturally suitable, service may consequently be discontinued by clients. Other issues of suitability include Spanish assessment tools of appropriate validity and knowledge of the effects of acculturation upon mental health seeking attitudes of adults with respect to their children (Antshel, 2002; Lê Cook, Brown, Loder, & Wissow, 2014; Lopez, Dewey-Bergen, & Painter, 2008; Organista, 2007, as cited in Turner et al., 2016).

Additionally, perceived appropriateness of a mental treatment can be impacted by religious or cultural views and appears to result in less optimal resources being sought out, i.e., a preacher or general practitioner, curanderos, or sobadores (Satcher, 2001; National Institute of Mental Health (US), 2001, as cited in Turner et al. 2016). Cultural beliefs such as *fatalismo,* which holds life is not under one's immediate control, and *familismo,* can, respectively, prompt a sense of resignation, as opposed to solution seeking, and result in denigrating one's health needs to promote family well-being (Caldwell, Couture, Nowotny, 2008; Falicoy, 2014, as cited in Turner et al. 2016). *Machismo,* the male obligation to care for and defend the family, and *marianismo,* the obligation of Latin women to consider the needs of the family prior to their own needs, may result in similar self-effacing action and choices (Caldwell et al., 2008; Falicov,2014, as cited in Turner et al., 2016). The cultural values noted above allude to the acceptability of accessing mental health care and is also applicable to stigma associated with actually receiving

mental health care in Latinos (Satcher, 2001, as cited in Turner et al., 2016). Acceptability of mental health service treatment can include a hesitancy in obtaining treatment due to *familismo* and the shame it may incur for the family, hesitancy in revealing private information regarding the family, and concerns of ethnicity, immigration status, or racial stigmatization (Caldwell et al., 2008; Guarnaccia, Martinez, Acosta, 2005, as cited in Turner et al., 2016) – among other issues.

Though various cultural values were mentioned above, the cultural value of *familismo* is perhaps especially noteworthy in its effects on Latino mental health help-seeking intentions; in a study by Villatoro, Morales, and Mays (2014) a particular facet of *familismo* represented by the level of perceived family support, or behavioral familismo, was studied for its effects on Latino utilization of mental health services. Results indicated high levels of perceived family support predicted use of alternative sources for mental health care, e,g,, religious. The converse is also true, as a study by Miville and Constantine (2006) demonstrates: lower perceived familial social support contributes to increased mental health services help-seeking attitudes and behavior. The latter may reflect a negative family environment which creates an increased need for mental health care (Villatoro et al., 2014) and a perception of inadequate familial support. The former condition, in which the individual feels supported, may reflect levels of enculturation in which not only *familismo* is strong but accompanying cultural values as well and likely results in benefits such as decreased stress and increased self-validation. Social support generally and family support provide Latinos benefits which are widely recognized and noted below.

Effects of perceived social support on individuals

Social support can imbue persons with self-worth by validation which potentially protects against illness, provides a haven for recovery, and helps preserve physical and psychological well-being through the social ties maintained. Social networks vary in breadth, but findings

indicate large social networks do not necessarily provide greater protection against stressful events (Roy, 2011). This study also found that those who obtained support from a smaller social network composed of close family members and spouses experienced a smaller number of stressful events. Considering these results, the behavior of those in a close social relationship with an individual would seem to be of importance in maximally affecting aspects of their behavior, and, having noted the above studies, it would seem likely this would be of relevance when it involves individuals experiencing mood disorders as well. Therefore, the impact of one to one relation acquires additional import.

However, proffered support is not sufficient, it is the perception of offered support which oftentimes is necessary to aid individuals in various ways. Regarding perceived support, for instance, a study of HIV women by Serovich, Kimberly, Mosack, and Lewis (2001) indicated a greater significance in positive mental health results when perceived social support is believed to be the case as opposed to the actual availability of social support. Results in McDowell and Serovich (2007) also suggest perceived familial social support foretold depressive symptoms, as did familial and friend social support when considering recent (past few days) and extended loneliness (past few years). The study implied overall dissimilarities in the relationship for mental health between perceived and actual social support. This research involved an HIV-positive population, but it would seem reasonable to consider similar roles of perceived and actual support with Latinos on mood disorder symptomology.

The Working Alliance

As mentioned, social networks can positively affect psychological states, and smaller social networks may provide more protection from stressful events. A vital ingredient of an individual's immediate inner social network, and source of support for individuals dealing with

mood disorders, would seem to be the relationship between a client and therapist - or a similar mental health/health figure - known as the working alliance; this is also referred to as the helping alliance or the therapeutic alliance. The working alliance (WA), commonly thought of as a working partnership between client and therapist, is widely believed to predict therapeutic outcome. The WA is a component of a tripartite conceptual construct: the therapeutic relationship. This relationship is commonly considered to be made up of three components: the working alliance, transference and countertransference, and the real relationship (Bhatia & Gelso, 2018). Transference and countertransference, respectively, refer to the displacement of an emotion felt by the client for one individual onto the therapist while countertransference refers to the analyst's responses to the patient with respect to the therapist's own historical, experiential context (Bhatia & Gelso, 2018). The real relationship is defined by Gelso (2011) as "the personal relationship existing between two or more persons as reflected in the degree to which each is genuine with the other and perceives the other in ways that befit the other (pp.12-13)", (as cited in Kivlighan Jr., Gelso, Ain, Hummel, & Markin, 2015). For purposes of this discussion, elaboration will deal with the WA proper. It is thought the working alliance is one of the more, and possibly the most, important feature in patient recoveries (Havens & Ghaemia, 2005), and it is specified by Hatcher and Barends (2006) as concordance in activities and goals of therapy between client and therapist with an emotional tie uniting them. The strength of an alliance reflects the appropriateness of compatibility between the therapist and patient and the thoroughness with which the components which compose the WA, agreement on goals, bond development, and task assignment are carried out (Bordin, 1979). While other aspects of a client's life may be impacted, a most visible and measurable aspect of an intervention's or construct's suitability would be outcome, or changes in symptom severity.

A meta-analysis involving 11 studies by Sharf, Primavera, and Diener (2011) reported a positive and relevant association between likelihood of treatment dropout and the WA (as cited in Cooper et al., 2016), which would impact outcome. Relatedly, in another meta-analysis carried out by Horvath and Symonds (1991), the analysis of 24 studies indicated a reliable relation of moderate strength between the WA and treatment results. The authors reported a cumulative effect size of .26, which is in a range reported for similarly relevant psychotherapeutic factors. Though type of disorder was unreported, a table review indicated some studies utilized measures of depression exclusively, i.e., *The Beck Depression Inventory* and *Hamilton Rating Scale for Depression*, with those studies reporting approximately similar effect sizes, .25 and .22 respectively, of the overall meta-analysis which they composed. A study by Weiss et al. (1997) indicates depression is positively impacted by the WA through its effect on pharmacotherapy adherence (as cited in Berk, Berk, & Castle 2004), perhaps particularly through the relation of interpersonal elements and social support. Geerts, Bouhuys, and Van den Hoofdakker (1996) note social support, as defined by a clinician's attunement (non-verbal acts of recognition) with a patient, likewise has prognostic value for improvement of depression in unipolar and bipolar patients (as cited in Berks et al., 2004). These studies lend support to the WA as beneficial to therapeutic outcome generally and seemingly impacts depressive and bipolar disorders similarly.

In fact, Havens and Ghaemi (2005) describe the WA as a possible mood stabilizer for bipolar disorder, and the relationship of the bipolar disordered individual with their therapist may relevantly impact the evolution of the disorder. Berk et al. (2004) also indicate the WA may positively impact outcome in bipolar disordered patients through increased adherence to psychotropic medications. Gaudiano and Miller (2006), and Sajatovic et al. (2005) have likewise shown an association between outcomes such as symptom betterment and maximization of

psychotherapy interventions resulting from therapist-patient relationships. Strauss and Johnson (2005) conducted a study involving Bipolar I subjects which similarly concludes manic symptoms may be positively impacted by a strong WA, with negative attitudes towards psychopharmacology decreasing as well. Zeber et al. (2007) found patient's perceptions regarding provider support has also been shown to impact observance of medication regimens (as cited in Perron et al. 2009) and that firm alliances can aid with patient's attitudes regarding BD interventions is also supported by Berk et al. (2004), and Schou (1997). Bipolar disorder is impacted by WA strength and, since patients spend the majority of the illness in a depressive state (Judd et al., 2002; Miller, Uebelacker, Ketner, Ryan, & Solomon, 2004, as cited in Gaudiano & Miller, 2006; Havens & Ghaemi, 2005), a strong WA, as indicated above, should likewise tend to reduce the severity of depressive symptomology.

That the WA is beneficial to outcome is widely supported (Bachelor, 2013; Berk et al., 2004; Horvath & Symonds, 1991) However, a pre-condition for a strong WA is an appropriate fit for the tasks at hand. Besides the difference in type of working alliance generated by the requirements of a psychotherapeutic approach, i.e., the demands/procedure required of the participants, the goodness of fit of the personal characteristics of the participants involved, in relation to the therapeutic approach, impacts the results and efficacy of the technique employed. Factors of concern for ideal compatibility in alliances generally could include characteristics such as client intelligence, which is demonstrated as a strong predictor of therapy dropout, and a psychological orientation to the therapeutic approach employed and tasks required is also necessary. This could, not necessarily broadly, be interpreted to include a cultural orientation, psychological sophistication, and social economic standing (Bordin, 1979). Type of client disturbance or diagnosis could differentially impact therapeutic outcome with the patient

engaging in more cognitive errors as a result of mood disturbance. For instance, Beck's universality hypothesis posits all mood disorder subtypes result in cognitive errors as related to reality interpretation, with manic disordered and depressive disordered individuals more prone to overly positive and negative cognitions, respectively, and these errors in turn may negatively impact the WA (Kramer, Bodenmann, & Drapeau, 2009). Forgas, Bower, and Krantz (1984) likewise indicate a present mood state can impact the interpretation of occurring events, and even the recall of previous social events can be impacted in a manner concordant with the current mood being experienced.

While these difficulties could be applicable to working alliances in general, a therapeutic dyad made up of participants of differing cultural origins has additional difficulties to consider. To be sure, a meta-analysis by Flückiger et al. (2013) notes subject ethnicity moderates outcome in relation to the WA (as cited in Zilcha-Mano & Errázuriz, 2015) As previously noted, WA strength is impacted by the suitability of the patient to the tasks at hand, so perhaps patients of varying ethnicities may logically be expected to benefit from varying approaches based upon their particular circumstances or upbringing; also, these approaches and pre-existing conditions could moderate the alliance relationship outcome. Conversely, therapist abilities may also affect therapeutic results; for instance, type of therapeutic approach and accumulated experience may impact consequences (Zilcha-Mano & Errázuriz, 2015). Another therapist ability of importance could include therapist multicultural competency (TMC) which Fuertes et al. (2006) note to be of relevance in the WA. They include three areas of competency as defined by Sue et al. (1998): practitioners beliefs and attitudes, ability, and beliefs/knowledge (as cited in Fuertes et al., 2006). TMC would appear to be relevant as studies by Constantine (2002) and Fuertes and Brobst (2002) point to TMC affecting patient satisfaction more than general practitioner competence

would allude (as cited in Fuertes et al., 2006); Fuertes et al.'s (2006) study also notes WA ratings are associated with TMC ratings, and a greater sense of a working relationship with the therapist. Appropriate skill development in TMC could impact the WA positively as it may be a prognosticator of client satisfaction and their sense of being understood. Furthermore, a lack of TMC could result in unintended negative interactions, such as microaggressions, which have been shown to negatively impact WA ratings in a minority group study involving white therapists and African Americans (Owen et al., 2011). Also, Thompson and Jenal (1994) observe minority clients experience discontent with their therapist, irrespective of therapist ethnicity, if subjects of culture are not broached (as cited in Owen et al., 2011). Not addressing subjects of culture might even be construed as a type of microaggression by the patient, and microaggressions have been demonstrated to impact therapy results and course (Owens at al., 2011).

Imel et al. (2011) and Owen, Imel, Adelson, and Rodolfa (2012) support the observation that client racial/ethnic minority status impacts therapist effectiveness, beyond general competence (as cited in Morales et al., 2018) so that varying levels of competency in this area and its impact on outcome could be considered an effect of the therapists' skill (Morales, et al., 2018) and reflect greater or lesser development in this area. However, appropriate development in this zone would appear to be beneficial not only for strengthening the WA but also allowing therapists', and therapy's, continued development, as a clinician low in TMC tends to be involved in a greater number of cases resolving in a client's unilateral premature ending of treatment (Anderson, Bautista, & Hope, 2019). Since membership in ethnic minorities is affiliated with increased premature termination, TMC could aid in retention of ethnic/minority clients so that this population might then wholly benefit from planned therapeutic interventions.

Anderson et al. (2019) produced results demonstrating increased instances of therapy completion related to TMC. A greater understanding of minority or ethnic concerns and predilections, as reflected by TMC, would appear to potentially maximize positive outcome.

Among minority/ethnic groups which could benefit from TMC are mood disordered Latino minorities. A study by Grant et al. (2004) finds approximately comparative rates of lifetime prevalence of any mood disorder to exist between U.S. Born Mexican-Americans (19.3%) and US Born Non-Latino Whites (20.9%), but Breslau et al. (2005) conclude Latinos with mood disorders to be at greater risk for persistence of their affective illness. Given the above-mentioned similarity of social support effects, it may be reasonable to hypothesize affective disorders, as part of a WA, are generally affected in a similar fashion – less special considerations of minority membership. In this manner, a positive alliance might aid in betterment of psychological outcomes (Zeber et al., 2008) by incorporating TMC in alliances built. Understanding the factors which impact the working relationship in Latino populations would aid in improving outcome by possibly increasing TMC. A study by Tonigan (2003) showed that minority groups of African-American and Latino patients seem to place a greater premium on close therapeutic relationships as compared to white counterparts. It is hoped a greater affinity and ability to empathize with Latino minorities by synthesizing information gathered through this analysis and then applying it to increase TMC to strengthen the WA may be one of the positive results of this review.

CHAPTER III

METHODOLOGY AND RESULTS

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) checklist (Moher, Liberati, Tetzlaff, & Altman, 2009) was employed in development of this review. A literature search was conducted on six databases: Cochrane Library, EBSCOhost, Pub Med, Sage Online, Scopus, and Web of Science; publication dates selected were inclusive of the dates January 1, 1960 to August 30, 2019. Limiters of English language studies consisting of human adults was employed. Studies to be included were selected by using variations of these keywords.

- In identifying studies including the first term of relevance, the search terms employed consisted of therapeutic relationship, working alliance, therapeutic alliance, and helping alliance. To maximize the number of studies obtained, the Boolean search term "or" was inserted between the four preceding search terms.
- In identifying studies including the second term of relevance, the search terms employed consisted of Latin, Latino, minority, Mexico, Mexican, Puerto Rico. Puerto Rican, Cuba, Cuban, Latin American, Central American, South American, Spanish, multicultural, cross-cultural, ethnic, diverse population. To maximize the number of studies obtained, the Boolean search term "or" was inserted between the preceding 17 search terms.
- In identifying studies including the third term of relevance, the search terms employed consisted of depression, depressive, bipolar disorder, cyclothymia, dysthymia, persistent

depressive disorder, major depressive disorder, mood disorder, affective disorder. To maximize the number of studies obtained, the Boolean search term "or" was inserted between the preceding nine search terms.

- The three search terms were utilized in various combinations with the Boolean operator "AND."

Inclusion criteria

For review inclusion, studies needed to meet the following criteria.

(1) The study was required to have classification as a randomized control trial (RCT), Open Label Trial (OLT), have originated from such studies, or be a qualitative study involving aspects of the working alliance and mood-disordered Latinos.

(2) Study samples were required to be composed of Latinos exclusively or the Latino group needed to be part of a quantitative or qualitative analysis which determined or evaluated the impact of the working alliance on Latinos.

(3) Studies were to be selected from peer-reviewed journals.

(4) The focusses of the study, or a result of the study, was an observation of the interaction of the mood disordered state with the working alliance as related to therapy outcome, symptom severity, and/or appropriateness for Latino populations.

(5) The studies needed to be conducted in one of the 50 United States or United States territories.

(6) The studies needed to be made up of samples of adult individuals 18 or above.

Exclusion criteria

(1) Studies making general mention of working alliance impact on minorities but not specifying the impact on Latinos specifically.

(2) Studies mentioning the impact of the working alliance on minorities but not providing a quantitative measure or qualitative commentary regarding the type of therapeutic alliance effects.

(3) Studies not referring to measurable quantitative or outlined qualitative change in mood symptomology resulting from working alliance effects.

Data Collection and Extraction

Upon review of study titles and perusal of the abstracts for related study terms, the seemingly appropriate articles from the preliminary group of studies was selected for further consideration. Of the initially selected articles, those meeting any of the exclusion criteria or articles which failed to meet all the inclusion criteria were eliminated. Selected articles were then read in total for further determination of suitability in the review. After final selection by the main author, article suitability was further assessed by committee members.

Study Quality Assessment

PRISMA guidelines were applied to the systematic review, and the quality of the studies assessed as per recommendations consistent with the Mixed Methods Appraisal Tool (MMAT), Version 2018 (Hong, et al., 2018) which aided in determining, accounting for, and assaying the impact on systematic review results of any deficiencies in methodological quality in the review of studies deemed suitable for this paper.

Results

Search criteria and reference review resulted in 1542 titles being produced. After initial review, 1478 articles were excluded leaving 64 articles. The first round of articles was omitted due to lack of title relevance, duplicate status, or being printed in a foreign language. Of the 64 retained, upon abstract review 20 did not mention Latinos, 9 were studies outside of the specified U.S. area, 8 were unrelated to mood, and 15 were unrelated to working alliance. This left 12 articles which were suitable for inclusion in the review, but one article was deemed unsuitable

for inclusion by committee review. Therefore, the total number of articles for review was 11; The flowchart for inclusion is demonstrated in Figure 1.

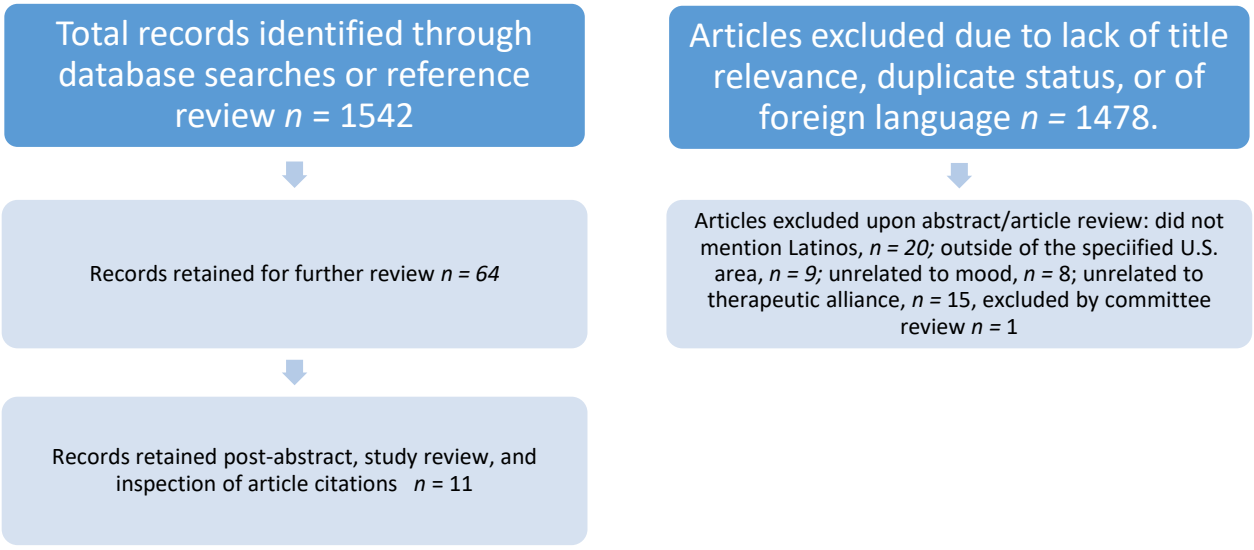

Figure 1. Flowchart of Selected Studies

Adapted Modalities

The 11 studies selected indicate the impact of the working alliance on mood disorder severity in Latino populations or provide commentary on the interaction of the working alliance with mood disorders. The studies were published between 1998-2019. Eight of the articles involve depression and, of the remainder, one of the studies involved dysthymia. This was a qualitative study by Wells, Palinkas, Sha-Lai, and Ell (2015) in which 48% of the Latino/a subjects were reporting dysthymia consistent symptomology. The remaining two studies noted 33.8% of participants (94.1% Latino) experienced a depressive disorder (Villalobos et al., 2016), and the Latino participants in Fortuna, Alegria, and Gao's study (2010), met DSM-IV criteria for dysthymia, subthreshold depression, or full criteria for major depressive disorder. The summary table is presented below.

Table 1.
Summary Table

A SYSTEMATIC REVIEW OF MOOD DISORDERS AND THE WORKING ALLIANCE IN LATINO POPULATIONS						
In-text citation	**Title**	**Sample**	**Measure(s)**	**Summary of key findings**	**Reference**	**Comments**
Bernal et al., 1998	Factors associated to outcome in psychotherapy: An effectiveness study in Puerto Rico	Puerto Rican population of seventy-nine individuals who received psychotherapy in Puerto Rico.	Demographics questionnaire follow up questionnaire, and questionnaire investigating psychotherapy results and outcome; Beck's Depression Inventory scores; Symptom Checklist-36 scores; 8-item Satisfaction Questionnaire (SQ-8); Integrative Psychotherapy Alliance Scale (IPAS)	The authors concluded symptomatic severity, age, number of sessions, and the therapeutic alliance are associated with therapy effectiveness, with the alliance explaining 45% of the effectiveness variance.	Bernal, G., Bonilla, J., Padilla-Cotto, L., & Perez-Prado, E. M. (1998). Factors associated to outcome in psychotherapy: An effectiveness study in Puerto Rico. *Journal of Clinical Psychology*, *54*(3), 329–342.	The working alliance deserves further exploration in clinical training and psychotherapy research.
Caplan & Whittemore, 2013	Barriers to treatment engagement for depression among Latinas.	12 Latina participants fit criteria. Six were Puerto Rican, one Dominican, one Mexican, and four United States born women identified as Puerto Rican (3) and Columbian.	A qualitative descriptive approach was employed to acquire understanding as it relates to treatment engagement among depressed Latinas. 12 Latina participants fit criteria. Participants were interviewed in their home in their preferred language. The Stressful Life Events Questionnaire was employed to guide structured interview questions regarding traumas. Topics of interest lay in four areas of open-ended questioning: Self-recognition of depression, previous depression treatment, family, cultural, and religious influences, and treatment engagement. NVivo, a qualitative data management software, was used to store interview transcriptions and significant statements were coded employing appropriate terms. Codes were theme grouped into themes	Gender-based violence (GBV) and negative experiences as a child affected the support perceived in seeking care and treatment engagement, with treatment effectiveness perception, cultural values, religiosity, and personal values affected by GBV and negative childhood experiences. Treatment engagement was also affected by negative experiences in therapy, denying severity of illness, and medication fears.	Caplan, S., & Whittemore, R. (2013). Barriers to treatment engagement for depression among Latinas. *Issues in Mental Health Nursing*, *34*(6), 412–424. https://doi.org/10.3109/01612840.2012.762958	Insufficient response from family members and religious figures along with the impact of cultural values create barriers to treatment engagement when there is a historical context of GBV and childhood adversity. Screening should be employed for these events to determine a suitable intervention with patients.
Chong & Moreno, 2012	Feasibility and acceptability of clinic-based telepsychiatry for low-income Hispanic primary care patients	Latino patients with major depression (*n* = 167) were assigned to telepsychiatry (80, WEB) or treatment as usual (87, TAU) and procured from a community health center.	The Personal Health Questionnaire 9 (PHQ-9); The Mini International Neuropsychiatric Interview (MINI); The Acculturation Rating Scale for Mexican Americans (ARSMA-II); Demographic, treatment, and health service utilization information. Sheehan's Disability Scale (SDS); Visit Specific Satisfaction Questionnaire (VSQ-9); The Working Alliance Inventory Short Form, and a 6-month follow up questionnaire.	Groups did not differ in completed proportion of appointments, but WEB patients rated their working alliance satisfaction significantly stronger than TAU participants. The use of antidepressants by WEB was significantly higher than TAU; depression dropped more quickly in in WEB than TAU but final depression score difference was not significant. Number of unproductive days did not differ between groups. Twice as many WEB patients were willing to pay for services than TAU.	Chong, J., & Moreno, F. (2012). Feasibility and acceptability of clinic-based telepsychiatry for low-income Hispanic primary care patients. *Telemedicine Journal And E-Health: The Official Journal of The American Telemedicine Association*, *18*(4), 297–304. https://doi-org.ezhost.utrgv.edu/10.1089/tmj.2011.0126	Telepsychiatry is acceptable for depressed low-income Latinos but has questionable feasibility. Telepsychiatry can improve accessibility for patients and decrease travel time for mental health professionals.

In-text citation	Title	Sample	Measure(s)	Summary of key findings	Reference	Comments
Collado et al., 2016	The Efficacy of Behavioral Activation Treatment Among Depressed Spanish-Speaking Latinos	A randomized control trial involving *N* = 46 Spanish speaking Latinos comparing Behavioral Activation Treatment for Depression (BATD) to supportive counseling (SC)	Beck Depression Inventory – II, Spanish Version; Structured Clinical Interview for DSM-IV-TR (SCID-IV); Of the Behavioral Activation for Depression Scale (BADS) scales, The BADS Total Activation Scale and the BADS Activation Scale were employed. The Reward Probability Index; The Therapeutic Alliance with Clinician Questionnaire (TAC), Spanish Version and satisfaction questionnaire. Adherence was measured by calculation of session number completed, homework completion ratio to assigned homework, and attrition latency.	BATD had greater remission of depression symptoms in time as compared to SC and also demonstrated greater remission of MDD when treatment ended. BATD also demonstrated greater levels of activity and environmental reward as compared to SC. Treatment satisfaction, therapeutic alliance, and treatment adherence was not different between groups	Collado, A., MacPherson, L., Lejuez, C., & Calderón, M. (2016). The Efficacy of Behavioral Activation Treatment Among Depressed Spanish-Speaking Latinos. *Journal of Consulting & Clinical Psychology*, *84*(7), 651–657. https://doi-org.ezhost.utrgv.edu/10.1037/ccp0000103	BATD appears to increase environmental reward, activity level, and depression reduction in Spanish-speaking Latinos.
Collado et al., 2019	Mental health stigma in depressed Latinos over the course of therapy: Results from a randomized controlled trial	A randomized control trial involving *N* = 46 Spanish speaking Latinos comparing Behavioral Activation Treatment for Depression (BATD) to supportive counseling (SC)	Data produced from a randomized clinical trial comparing efficacy of BATD and SC among Latinos was employed (*N* = 46)	Over time, mental health stigma (MHS) decreased, with greater decreases observed in SC MHS had positive associations with therapeutic alliance and depression symptomology over time but not treatment attrition vis a vis pre-treatment MHS levels	Collado, A., Zvolensky, M., Lejuez, C., & MacPherson, L. (2019). Mental health stigma in depressed Latinos over the course of therapy: Results from a randomized controlled trial. *Journal of Clinical Psychology*, *75*(7), 1179–1187. https://doi-org.ezhost.utrgv.edu/10.1002/jclp.22777	At least some level of MHS was attested to by participants (83%) indicating relevancy in this population but results indicate simply receiving treatment is sufficient in reducing MHS levels.
D'Angelo et al., 2009	Adaptation of the preventive intervention program for depression for use with predominantly low-income Latino families.	Parents with serious depressive disorders during the past 3 months were sought and 9 Latino females met criteria.	Spanish translated versions of the Hamilton Depression Rating Scale (HDRS); Child Behavior Checklist (CBCL); Global Assessment Scale (GAS); Semi-structured Interviews concerning the intervention (for quantitative and qualitative data); Impact of the Project Rating Scale, Modified Concerns Scale; Recent Life Changes Questionnaire; The Integrative Psychotherapy Alliance Scales; Therapist Fidelity Rating Form.	The adaptation was seen as helpful by families and not stressful; effects were comparable to the original intervention and fidelity to the revised manual was achievable by preventionists. The working alliance was strong according to participant perception's	D'Angelo EJ, Llerena-Quinn R, Shapiro R, Colon F, Rodriguez P, Gallagher K, & Beardslee WR. (2009). Adaptation of the preventive intervention program for depression for use with predominantly low-income Latino families. *Family Process*, *48*(2), 269–291. Retrieved from http://ezhost.utrgv.edu:2048/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=rzh&AN=105543712&site=ehost-live.	A strength-based focus is thought necessary for use of this protocol, with families welcoming it. The role of preventionists can be one of advocacy as well

In-text citation	Title	Sample	Measure(s)	Summary of key findings	Reference	Comments
Fortuna et al. 2010	Retention in depression treatment among ethnic and racial minority groups in the United States.	*N* = 564 Non- Latino Whites, African Americans, Latinos, and Asians who have received depression treatment within the prior 12 months.	Data was used from the Collaborative Psychiatric Epidemiology Surveys to determine correlations and differences between ethnicities in depression treatment in the prior year.	Treatment by a health generalist results in decreased levels of retention in treatment as opposed to treatment by a mental health specialist; having received medication, likewise, is also a correlate for increased retention for all study participants as well.	Fortuna, L. R., Alegria, M., & Gao, S. (2010). Retention in depression treatment among ethnic and racial minority groups in the United States. *Depression and Anxiety*, *27*(5), 485–494. https://doi.org/10.1002/da.20685Fuertes, J. N., Stracuzzi, T. I., Bennett, J., Scheinholtz, J., Mislowack, A., Hersh, M., & Cheng, D. (2006). Therapist multicultural competency: A study of therapy dyads. *Psychotherapy : Theory, Research, Practice, Training*, *43*(4), 480–490. https://doi.org/10.1037/0033-3204.43.4.480	Increasing the availability mental health care specialists, or similar services in primary care may aid in improving levels of retention in treatment.
Interian et al., 2010	Adaptation of a motivational interviewing (MI) intervention to improve antidepressant adherence among Latinos.	*N* = 30 Latinos were included in six focus groups for the adaptation process to elicit their perspectives. N = 7 were test cases of the applied intervention and *N* = 5 were solicited for feedback on intervention improvements.	The authors employed a qualitative methodological framework and used an 11-question discussion guide. All study procedures were executed in Spanish and participants completed a demographics questionnaire. Focus group duration was from 90-120 minutes and were audio recorded for analysis, with the recording transcribed into text, analyzed by employing a grounded theory approach and stored in a qualitative analysis software program, ATLAS.ti. Analysis of fidelity to MI techniques was conducted by a Latina MI consultant.	Adaptations developed consisted of reframing adherence of medications as a method of *luchando* (struggling) against their issues, improvements on methods to disseminate information on antidepressants, feedback on *persoalismo* in therapy, and promoting an increase in motivation to combat depression.	Interian, A., Martinez, I., Rios, L. I., Krejci, J., & Guarnaccia, P. J. (2010). Adaptation of a motivational interviewing intervention to improve antidepressant adherence among Latinos. *Cultural Diversity and Ethnic Minority Psychology*, *16*(2), 215–225. https://doi-org.ezhost.utrgv.edu/10.1037/a0016072	Issues concerning Latinos regarding antidepressant use were clarified and considerations in the use of MI techniques with Latinos improved.

In-text citation	Title	Sample	Measure(s)	Summary of key findings	Reference	Comments
Ishikawa et al., 2014	Uptake of depression treatment recommendations among Latino primary care patients.	*N* = 90 Primary care patients of Latino descent were selected from the Cambridge, Maryland area	Patient Health Questionnaire (PHQ-9) and an attached form requesting phone contact consent; the Physician-Patient Working Alliance Scale (PPWA); the Physician Multicultural Competence Scale (PMCS); Brief Acculturation Scale for Hispanics (BASH); Depression Self-Stigma Scale (DSSS); Attitudes Toward Seeking Professional Psychological Help – Short Form (ATSPPH-SF); Basic demographic information, language preference with primary care provider was also obtained.	23% uptake of recommendations by patients at Time 1 and 53% uptake of recommendations at Time 2. Medication recommendations had greater levels of follow through than psychotherapy recommendations. Working Alliance strength affected the intent of following up on treatment recommendations and was a mediator of the relationship for intention of follow up and cultural competence.	Ishikawa, R. Z., Cardemil, E. V., Alegría, M., Schuman, C. C., Joseph, R. C., & Bauer, A. M. (2014). Uptake of depression treatment recommendations among Latino primary care patients. *Psychological Services*, *11*(4), 421–432. https://doi-org.ezhost.utrgv.edu/10.1037/a0035716	Intention to follow PCP treatment recommendations regarding depression is impacted by the patient-PCP alliance; improvement of uptake of depression treatment recommendations may be increased by a greater understanding of this relationship.
Villalobos et al., 2016	Effects of language concordance and interpreter use on therapeutic alliance Effects of language concordance and interpreter use on therapeutic alliance in Spanish-speaking integrated behavioral health care patients.	*N* = 458 Spanish-speaking patients attending two primary care clinics for behavioral health services were recruited for the study in northwest Arkansas. 94.1% of the sample were Latino and 33.8% of the sample presented for depression symptoms.	Demographic and medical data was obtained from patient electronic records; The Collaborative Outcomes Resource Network (ACORN) questionnaire; the therapeutic alliance was measured via the inclusion of four working alliance questions in the ACORN; qualitative interviews were made with behavioral health-care providers, medical assistant interpreters, and Spanish-speaking patients by the authors.	Therapeutic alliance was not related to interpreter use regardless of demographic variables. Benefits and disadvantages of interpreter use emerged, with bilingual providers seen as providing more accurate communications, greater trust promoted, and greater privacy afforded. Nonetheless, interpreters were seen as aiding in provision of much needed behavioral health needs of this population.	Villalobos, B. T., Bridges, A. J., Anastasia, E. A., Ojeda, C. A., Hernandez Rodriguez, J., & Gomez D. (2016). Effects of language concordance and interpreter use on therapeutic alliance in Spanish-speaking integrated behavioral health care patients. *Psychological Services*, *13*(1), 49–59. https://doi-org.ezhost.utrgv.edu/10.1037/ser0000051	The enhancement of linguistic and cultural adequacy may be enhanced through the development of a strong collaborative relationship with interpreters and the emphasis of interpreter training.
Wells et al., 2015	Retaining Low-Income Minority Cancer Patients in a Depression Treatment Intervention Trial: Lessons Learned.	The majority of patients in the original study *(n* = 446) were Spanish-speaking, foreign born, Latino, female, and were living in the United States over 40 years. 48% reported dysthymic symptoms.	This study was a sub-study of the Alleviating Depression among Patients with Cancer (ADAPt-C). The authors employed grounded theory and Meichenbaum's and Turk's adherence theory was used for provider interviews. Questions were oriented towards the five dimensions for treatment retention proposed by Meichenbaum and Turk. Nine behavioral health providers conducted interviews in person (n = 6), by telephone (n = 2) or in writing (n = 1).	Telephone and therapeutic alliance promotes retention in depression treatment and communication among members of a collaborative care team in oncology care.	Wells, A., Palinkas, L., Williams, S.-L., & Ell, K. (2015). Retaining Low-Income Minority Cancer Patients in a Depression Treatment Intervention Trial: Lessons Learned. *Community Mental Health Journal*, *51*(6), 715–722. https://doi-org.ezhost.utrgv.edu/10.1007/s10597-014-9819-3	Strategies proposed stress provider/patient dialogue.

Study subjects consisted of Latino/a ethnicity, with representation at 100% in 8 studies, 94.1% in one study (Villalobos et al., 2015), and, in another study, Latino subjects comprised 86% and 91% of participants in intervention and control conditions, respectively (Wells, et al., 2015). 9.6% of Latino(a) subjects made up the study by Fortuna, Alegria, and Gao (2010).

Of the 11 studies the review produced, three were qualitative studies – two were grounded theory studies, and one presented as a qualitative study. Wells et al. (2015) and Interian, Martinez, Rios, Krejci, and Guarnaccia, (2010), respectively, assessed best approaches towards promoting depression treatment in Latino cancer patients and determined adaptations for a motivational interviewing intervention geared towards better antidepressant adherence. Lastly, Caplan and Whittemore's (2013) qualitative approach explored how gender-based violence and childhood adversity affects treatment engagement. There was one sequential exploratory mixed-methods study design and seven quantitative studies. Of these, three RCT studies were produced, and four quantitative descriptive studies were also part of the review. The RCT studies investigated the impact, acceptability, and feasibility of clinic based telepsychiatry on a Latino population (Chong & Moreno, 2012), the benefits of behavioral activation as a form of treatment (Collado, MacPherson, Lejuez, & Calderón, 2016a) and the third RCT, which utilized data from the immediately aforementioned RCT, determined the factors impacting mental health stigma in that same Latino population (Collado, Zvolensky, Lejuez, & MacPherson, 2019). Of the four quantitative descriptive studies, one was an effectiveness study in which Bernal, Bonilla, Padilla-Cotto, and Perez-Prado's study (2010) determined the factors associated with outcome in psychotherapy and another was an OLT study dealing with depression prevention (D'Angelo et al., 2009). Ishikawa et al.'s study (2014) involved uptake of primary care providers treatment recommendations by patients, and, lastly, analysis of formerly obtained survey data measured

retention rates of Latinos in depression treatment in a representative sample (Fortuna et al., 2010). The latter study determined the impact of ethnic membership on outcome.

Cultural Adaptations

Attempts to address client needs particular to the Latino population will be noted and referenced as cultural adaptations (Collado, Lim, & MacPherson, 2016b) and could include elements as disparate as assessment forms in Spanish, bicultural/bilingual therapists, or an understanding of cultural norms. Any observed relevance of noted adaptations regarding the working alliance, mood disordered individuals, and the target Latino population will be assessed for their respective impact. Cultural adaptations can serve to enhance patient buy-in and promote the development of the working alliance via a patient's greater sense of being understood and an increased ease of relatability to the mental health/health specialist who is interacting with the Latino client. The nature of the adaptations employed could be judged by various extant frameworks but the one selected is based upon a study by Bernal and Saez-Santiago (2006). These authors propose a framework by which cultural adaptations may be analyzed, and the applicability of their eight-pronged system will be utilized in this review. Table 2 provides example of their proposed system and study characteristics.

Bernal et al. (1998) conducted a study with a Puerto Rican population of former clients of the University of Puerto Rico, Rio Pedras Campus' University Center for Psychological Services and Research. Cultural adaptations included adaptation and back translation of certain items of the 8-item *Satisfaction Questionnaire (SQ-8*) (Roberts, Attkinson, and Mendias, 1984) and back translation of various questionnaires. Additionally, some items of the Demographic Questionnaire were piloted and constructed for the study and instructions modified in questionnaires. Caplan and Whittemore's (2013) adaptations involved interviews executed in the

language of client preference, with the investigator being fluent in Spanish and experienced in interviewing low-income populations and monolingual immigrants. Additionally, the investigators have an awareness and take consideration of various cultural values in their analysis of the study results as pertaining to treatment engagement. Chong and Moreno's (2012) employed adaptations included the use of a male and a female Mexican American psychiatrist, with both fluent in English and Spanish, and questionnaires previously translated into Spanish for other studies, clinical trials, or the instrument developers utilized. Additionally, as the subjects were part of a low-income group, patients were not required to pay for telepsychiatry or mental health care provided. Collado et al. (2016a) and Collado et al. (2019) utilized study adaptations which included a Spanish version of the *Behavioral Activation Treatment for Depression* manual*,* staff with Spanish language fluency, and research assistant adherence to Spanish administration of the Structured Clinical Interview for DSM-IV-TR. Additionally, the Spanish translation of the Supportive Counseling Manual was utilized as a comparative condition. Both manuals were translated and back translated by several psychologists of Spanish speaking nativity. Also, the Beck Depression Inventory II was employed, Spanish version, and Collado et al. (2016a) also utilized a translated/back translated versions of two questionnaires. D'Angelo et al. (2009) included adaptations such as conducting the interview in English or Spanish, utilizing a family-oriented and strength-based approached, and considering the context of the Latino family experience. Multiethnic researchers, along with bicultural and bilingual preventionists, adapted the program for use with low-income, urban family units while integrating cultural context and values, utilizing same ethnicity/race, language fluent, professionals to promote a sense of clinician empathy for the client and designing the interventions to fit with client life demands while considering the resources accessible to the

client. Literature detailing risk and resiliency in Latino families and review of focus group and private experience regarding Latinos families was swotted. Research approaches most beneficial for Latinos and data obtained from a previous pilot test was incorporated into the adaptation. Alliance building by obtaining *confianza* (confidence) and conveying *respeto* (respect), as mentioned by the authors, was a focus due to studies indicating minority distrust of health care providers. Opportunities to talk openly were provided within the context of family discussion and acculturation and generational differences were addressed as they applied to the family. Measures were selected considering life stressors and acculturative stresses experienced by Latino members. Spanish versions of the Child Behavioral Checklist and the Hamilton Depressive Rating Scale were employed. Remaining semi-structured interview measures and self-report measures were translated into Spanish and revised as needed by three bicultural/bilingual clinicians. The option of English or Spanish version administration was provided to participants. Fortuna et al. (2010) used data obtained from the Collaborative Psychiatric Epidemiology Surveys (CPES) to obtain their results; as the Fortuna et al.'s study (2010) was not executed with Latino considerations in mind, adaptations were not considered in the study design, though the original CPES components did allow for interviews in the Spanish language. Ishikawa et al. (2014) promoted adaptations which included the primary author, a fluent Spanish speaker, conducting all interviews. Visits were conducted in Spanish with primary care providers (PCP), via interpreter, or by being carried out in English or a combination of both languages. Scheduled follow up calls were executed in language of preference and eight questionnaires were provided in English or Spanish. The questionnaires were translated by a native Spanish speaker and professional translator. Villalobos et al. (2016) implemented adaptations which consisted of interpreter use in a primary care setting or, alternatively, the use

of a bilingual behavioral health consultant (BHC). Wells et al. (2015) carried out a sub-study of the Alleviating Depression among Patients with Cancer (ADAPt-C) parent study (Ell et al., 2007). Cultural adaptations for the original study involved providing material facilitation in the form of bus transport, low literacy level educative bilingual material, free childcare, and language concordant providers. Table 2 summarizes included cultural adaptations by study. Special observations/conditions of each study are provided below Table 2 with regard to specific elements of cultural consideration in particular studies.

Study Quality Assessment

The MMAT has five categories of general study designs with all types screened by questions S1 and S2 to determine suitability for further consideration. Under "study type" the number denotes category, e.g., "1" denotes a qualitative study, "2" denotes a quantitative randomized controlled trial, and so forth. Further clarifying information is provided under study type and studies are grouped together by category. MMAT responses include "Yes, No, or Can't tell", with auxiliary commentary permitted in the evaluation. All categories consist of 5 queries which will be presented as .1, .2, .3, .4, and .5 in the column heading, with the appropriate response provided. Questions for each study type are presented below as worded in the actual MMAT appraisal tool. To the screening questions S1, "Are there clear research questions?" and S2, "Do the collected data allow to address the research questions?" all studies met criteria except Interian et al., (2010), Villalobos et al., (2016) and Wells et al. (2015) not meeting criteria for S1 but all meeting criteria for S2 in the sense that the purpose of the study's general goal appears to have been met. This review included four of the five category types, and the criteria fulfillment appropriate to each are noted in Table 3 below

Table 2.
Elements of cultural consideration in articles selected

Author, Year	Language	Therapist Matching	Inclusion of Cultural Symbols and Sayings	Inclusion of Cultural Knowledge in treatment content	Treatment Conceptualization	Treatment Goals	Treatment Methods	Treatment Context
Bernal et al., 1998	+	+	+	+	+	Not Specified	Not Specified	+
Caplan & Whittemore, 2013*	+	+	+	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Chong & Moreno, 2012	+	+	-	+	Not Specified	Not Specified	Not Specified	+
Collado et al., 2016	+	+	-	+	+	+	+	+
Collado et al., 2019	+	+	-	+	+	+	+	+
D'Angelo et al., 2009	+	+	+	+	+	+	+	+
Fortuna et al. 2010**	+	–	–	–	–	–	–	–
Interian et al., 2010^^	Not Specified	+	+	+	+	+	+	+
Ishikawa et al., 2014~	+	+	+	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Villalobos et al., 2016	+	+	+	Not Specified	Not Specified	Not Specified	Not Specified	Not Specified
Wells et al., 2015	+	+	Not Specified	Not Specified	Not Specified	Not Specified	+	+

*Caplan & Whitemore's (2013) study involved a qualitative descriptive method exploring Latina treatment engagement and did not involve treatment as such.

**Fortuna et al. (2010) utilized data from a prior study to establish correlates of interest but cultural considerations were not a priority in this study.

^^Regarding Interian et al.'s study (2010), Interian is a Latino surname and the author is likely Latino, but this was not specified.

~ Ishikawa et al.'s (2014) investigation concerned uptake of primary care providers' recommendations of depression treatment (in lieu of therapists) but not of the treatment itself.

Interian et al. (2010), Villalobos et al. (2016), and Wells et al. (2015) were exploratory studies and, for that reason, did not utilize interventions or propose direction of effects in their respective studies. However, the three studies met all criteria of their particular study type, and generated data which can be utilized in the discussion and summary sections and were, therefore, not excluded from the review.

Bernal et al. (1998), Caplan and Whittemore, (2013), D'Angelo et al., 2009, Fortuna et al. (2010), and Ishikawa et al., (2014) met screening question criteria and all five criteria of their respective study requirements. Additionally, while not meeting screening question criterion S1, Interian et al., (2010), Villalobos et al. (2016), and Wells et al. (2015) met all requirements of their study type. The remaining four studies did not meet all aspects of the five criteria. The requirements for qualitative studies are presented below:

1.1. Is the qualitative approach appropriate to answer the research question?

1.2. Are the qualitative data collection methods adequate to address the research question?

1.3. Are the findings adequately derived from the data?

1.4. Is the interpretation of results sufficiently substantiated by data?

1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?

Surprisingly, the RCT studies failed to meet criteria of their study type requirements as well. Chong and Moreno's study (2012) may have been impacted by differential auxiliary treatments with the WEB group of a patients receiving additional administrations of the *Visit Specific Satisfaction Questionnaire* (VSQ-9) and the *Working Alliance Inventory Short Form* (WAI). It would seem the best suited categorization of this possible flaw would fall under .1 of the study protocol – since, otherwise, the groups were comparable at baseline.

Table 3.
Summary of Study Appraisals

Authors	Study Type	.1	.2	.3	.4	.5
Caplan & Whittemore, 2013	1 Qualitative Descriptive Methodology	Yes	Yes	Yes	Yes	Yes
Interian et al., 2010	1 Qualitative grounded theory	Yes	Yes	Yes	Yes	Yes
Wells et al.; 2015	1 Qualitative grounded theory	Yes	Yes	Yes	Yes	Yes
Chong & Moreno, 2012	2 Quantitative RCT	No	Yes	Yes	Yes	Yes
Collado et al., 2016	2 Quantitative RCT	Yes	Yes	Yes	Can't Tell	Yes
Collado et al., 2019	2 Quantitative RCT	Yes	Yes	Can't Tell	Can't Tell	Yes
D'Angelo et al., 2009	4 Quantitative Descriptive	Yes	Yes	Yes	Yes	Yes
Ishikawa et al., 2014	4 Quantitative Descriptive Ecological	Yes	Yes	Yes	Yes	Yes
Bernal et al., 1998	4 Quantitative Descriptive Effectiveness Study	Yes	Yes	Yes	Yes	Yes
Fortuna et al. 2010	4 Quantitative Descriptive Survey	Yes	Yes	Yes	Yes	Yes
Villalobos et al., 2016	5 Mixed methods Exploratory study	Yes	Yes	Yes	Yes	Yes

It is uncertain if this differential application of assessments, ostensibly measuring characteristics of treatment which conveys a measure of concern in the satisfaction and sentiment of the patients, might impact the results of the study by resulting in an inflated level of positive sentiment for those involved in the intervention and a greater appreciation of the intervention thereby being the result.

In Collado et al. (2016a), it is unclear as to whether the study meets criterion 2.4; there is uncertainty regarding whether outcome assessors are blinded to the intervention provided and the category therefore is labelled "Can't Tell." Additionally, Collado et al. (2019) measure mental health stigma utilizing the *Stigma Checklist Questionnaire* (SCQ); however, the Cronbach's alphas obtained were in the range of 0.66 to 0.70, and, at least in some cases, the α might be considered unacceptably low. It is unclear if this might impact results in an overly unacceptable manner. This concern, if relevant to researchers who consider an α less than 0.70 unacceptable, would be best classified as a deficiency in the reliability of the outcome data and affect the category of .3 in quantitative randomized controlled trials. The criteria for Quantitative randomized controlled trials are provided below.

2.1. Is randomization appropriately performed?

2.2. Are the groups comparable at baseline?

2.3. Are there complete outcome data?

2.4. Are outcome assessors blinded to the intervention provided?

2.5 Did the participants adhere to the assigned intervention.

The criteria for Quantitative descriptive studies are provided below.

4.1. Is the sampling strategy relevant to address the research question?

4.2. Is the sample representative of the target population?

4.3. Are the measurements appropriate?

4.4. Is the risk of nonresponse bias low?

4.5. Is the statistical analysis appropriate to answer the research question?

The criteria for Mixed methods studies are provided below.

5.1. Is there an adequate rationale for using a mixed-methods design to address the research question?

5.2. Are the different components of the study effectively integrated to answer the research question?

5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?

5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?

5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?

Having examined study shortcomings, we are better positioned to evaluate any impact on the validity and appraisal of study outcomes, conclusions reaches, and possible future directions or suggestions considered.

Study Outcomes

The nature of this mixed methods review precludes the use of a strictly quantitative summary measure and, therefore, outcomes and conclusions will be determined and stated employing a qualitative approach while referring to quantitative data as necessary. The review produced agglomeration of results in three broad areas, with some studies overlapping groupings. The three zones which were encompassed in the review included studies concerning methods by which accessibility might be increased for Latinos; a second area included modalities employed with comparison of treatment results in some studies, and, constructs of import for maximal

promotion of treatment outcome was the third broad area which emerged from the review. The grouping discussing accessibility has three studies under this heading and study outcome discussion will begin in this area.

Promotion of treatment accessibility for Latinos

Studies show depression interventions are efficacious when applied to Latinos (Miranda et al., 2003; Sanchez-Lacay et al., 2001; Wells et al., 2004; as cited in Caplan and Whittemore, 2013) but to state there is an underutilization of mental health services by Latinos is almost a tautology. Among the reasons for this apparent disconnect, an unexplored factor might be habitation of Latinos in underserved or rural areas (Chong & Moreno, 2012) An RCT study by Chong and Moreno (2012), which involved 167 low-income, adult Latino patients experiencing MDD, were randomly assigned to receive treatment as usual (TAU) or webcam psychiatric services (WEB). All patients were selected from a community health center (CHC), with WEB treatment consisting of six monthly telepsychiatry sessions conducted at the CHC; TAU involved CHC care from their providers.

Data produced by Chong and Moreno's study (2012) yielded the results below. Acceptability, measured by client perceived working alliance, antidepressant use, satisfaction with visit, and comparative appointment keeping between TAU and WEB, did not differ regarding appointment keeping, but WEB patients rated visit satisfaction and WA significantly higher than the TAU group. WA and visit satisfaction improved in both patient groups, with TAU displaying a steeper degree of improvement (assignment versus time interaction) but WEB also approaching the zenith of visit satisfaction by study's end. Antidepressant use was significantly higher in the WEB group and depression decreased more rapidly in the WEB group as well but no overall depression score differential was apparent between groups. However,

results on depression symptoms showed a significant decrease in depression symptomology in both conditions. Appointment setting produced similar results in differing areas of care, with TAU patients setting a greater number of primary care appointments and WEB patients making a greater number of mental health appointments.

This approach would appear to aid increasing service accessibility in indirect and more obvious manners. Indirectly, the WEB condition produced higher visit satisfaction and should lead to increased attendance, as observed in the concluding sentence above, patients exposed to WEB therapy are more inclined to access mental health treatment via greater appointment setting. Additionally, WEB patients are willing to pay more for a mental health appointment (50% of WEB patients) than TAU patients (12%) as opposed to a primary care visit – even though told they would have to see a mental health practitioner more frequently (Chong & Moreno, 2012). This would appear to suggest a greater proclivity towards initiating mental health treatment despite economic considerations if a telepsychiatry modality is employed. In fact, WEB patients had a greater appreciation for their modality than TAU patients. More directly, telepsychiatry, though not studied excessively in Latino populations, appears to be a method by which access to culturally congruent mental health practitioners might be affected, with distance of travel simultaneously eliminated as a barrier for underserved Latino populations (Vega et al., as cited in Chong & Moreno, 2012).

Another approach which might increase accessibility of mental health services in the Latino population could be through increasing the willingness of the patient to carry out recommendations provided by their primary care provider (PCP). These health specialists may be of central import in referring patients for depression treatment. As studies indicate Latinos do not typically follow through on PCP's suggestions (De Figueiredo, Boerstler, & Doros, 2009; Miranda

& Cooper, 2004, as cited in Ishikawa et al., 2014), Ishikawa et al. (2014) investigated these aspects of interaction in their study, which is instructive in determining the factors of import in patient follow through. The OLT study was open to Latinos, with this sample producing depression scores on the Patient Health Questionnaire (PHQ-9) in the moderate-severe range of depression and the sample preferring psychotherapy over medication 72% to 7%, respectively, to combat their mood disorder. Study results indicated working alliance affected aspects of patient follow through of PCP treatment recommendations, while the working alliance itself was affected by patient characteristics. For instance, immigrant status was indicative of significantly higher mean WA ratings and provider cultural competence. Greater acculturation resulted in decreased ratings of the WA. Results also indicated the intention to follow through on PCP referrals, when considering a PCP's cultural competence, was mediated by the PCP-patient WA and the patient's chronological age. So that the intention of following up on a referral recommendation requires a strong WA to then assess a provider's level of cultural competence as adequate; cultural competence and working alliance ratings were, in fact, strongly correlated ($r = .77$, $p < .01$) (Ishikawa et al., 2014). However, neither WA, intention to follow through, nor cultural competency, predicted actual treatment recommendation uptake. Findings, nonetheless, support studies which indicate the WA affects patients' treatment choices (Fuertes et al., 2007; Horvath & Symonds, 1991; Julius et al., 2009; Martin, Garske, & Davis, 2000; as cited in Ishikawa et al., 2014). The authors posit the patient-PCP WA may be the most efficacious manner by which to initiate patient consideration of treatment.

A qualitative study by Wells, et al., (2015) investigated factors which might be conducive towards the continued involvement of 446 cancer patients, with 48% exhibiting dysthymic symptomology and the majority being Latino, female, and foreign-born. This was a sub-study of

the Alleviating Depression among Patients with Cancer (Ell et al., 2007) and utilized Meichenbaum and Turk's five adherence dimensions to determine barriers to client retention. An analytic approach employing grounded theory was used which included "analytic methods of "'Coding, Consensus, Co-occurrence and Comparison'" (Willms et al., 1990 as cited in Wells et al., 2015). Five strategies were seen as increasing patient retention: informational approaches to clarify misunderstandings or confusion; for instance, explaining treatment benefits and making possible treatment options known to patients; instrumental approaches, i.e., material requisites or procedural safeguards, such as appointment notices or bus transportation; provider-patient strategies such as quickly initiating constant patient/provider interaction, especially with language congruency; approaches in the clinical setting, e.g., patient empowerment, logistical issues with clinic personnel or scheduling and, lastly, helping clients in navigating the health system and depression treatment strategies, such as tracking depression scores, to validate treatment approaches.

Study results point to the strategies' effectiveness stemming from communication skills and rapport-building as applied to health care systems and patient needs. The establishment of the WA is seen as a requisite for retention of patients, promoting medication observance and acceptance, and aiding in fulfillment and satisfaction of and with treatment interventions (Arnow et al. 2013; Imel et al. 2013; as cited in Wells et al. 2015). The skills emphasized in these five approaches strengthen abilities which encourage therapeutic alliance development and thereby promote, through the aforementioned methods, promotion of adherence to and continued increased access to helpful interventions. This study also supports the feasibility of telehealth communications using technology (as in Chong & Moreno above, and as in the parent study) in being useful by providing and maximizing clinician provided patient support (Wells et al. 2015).

Treatment Modalities and Outcome

It would seem, given characteristics of particular ethnic classes, minorities, or social-economic groups, the approach utilized in regard to modality might be more or less efficacious given the particular cultural values or mores of the group in question. Various modalities were employed in this review; some in isolation, while others were utilized in tandem for comparative purposes, e.g., Chong and Moreno (2012), in that case comparing clinic-based telepsychiatry (WEB) and treatment as usual (TAU). In toto, six of the 11 studies included in this review dealt with the efficacy of differing modalities. One of these studies utilized data from the parent study, Collado et al., 2019.

An exploratory study (n = 79) by Bernal et al. (1998) investigated factors associated with value of psychotherapy in a Puerto Rican population; among those factors, the impact of the therapeutic relationship was assayed and the effect on symptomology determined. Psychotherapeutic approaches included Psychoanalytic Therapy with a critical-social perspective, System therapy, Object Relations theory, Ego psychology, Lacan based psychoanalytic theory, Interpersonal therapy, and Constructionist based psychotherapy. Instruments measuring the factors of interest included the *Integrative Psychotherapy Alliance Scale* (*IPAS),* a psychotherapeutic alliance scale which assesses tasks, bond, and goals. Scales measuring symptom severity included the *Beck Depression Inventory (BDI*, a 21-item self-report measuring depression). Also employed was the Symptom Checklist-36. This instrument measures distress which is psychiatric or psychological in nature which has occurred in the past seven days.

Use of a Reliable Change Index (RCI), proposed to measure effectiveness and clinically significant differences (Jacobson & Truax, 1991, as cited in Bernal et al., 1998), determined

significant and positive correlations were obtained between symptom severity (r = .22), age (r = .24), number of sessions (r = .18), working alliance (r = .73) and the RCI effectiveness factor. The latter (WA and RCI) held across gender, with the former three correlations only applicable to females; the correlations suggest the existence of these factors in a therapeutic dyad resulted in better outcomes. Alliance and number of sessions was also correlated (r = .22), indicating a stronger alliance results in an increased number of sessions. A multiple regression equation resulted in the proportion of effectiveness variance explained by the alliance, as compared to other factors, as being highly significant and accounting for 45% of the variance in effectiveness. Therefore, the authors propose process factors, i.e., the alliance and therapy sessions, can foretell psychotherapy efficacy in client satisfaction, changes in presenting issues and overall gains experienced from therapy.

Though individual results for the varied forms of psychotherapy noted above were not provided to determine best fit for this population , results indicate effectiveness as measured by overall client-rated comparative harm and benefit, reflective contemplation of clients with regard to preliminary and final degree of discomfort with the presenting issue, and client's satisfaction with treatment in general were positive with a rounded 53% of the sample indicating moderate, little, or no discomfort after treatment, a definite positive change from the initial 90.6% which indicated a "'lot of discomfort'" with their presenting problem. 59.5% of the sample indicated above moderate or moderate benefit gained from the intervention and a satisfaction with therapy mean of 2.99 on a four-point scale. 61.7% of clients indicated being satisfied or very satisfied with the intervention, 26.1% were indifferent, and 12.2% reported no satisfaction. Overall, as seen from the client's perspective, the varying psychotherapeutic interventions were

comparatively efficacious, with working alliance, number of sessions, symptom severity, and age predictive of effectiveness. Only WA accounted for a significant amount of the effectiveness variance (45%).

A comparative approach to modalities was carried out by Chong and Moreno (2012) in their evaluation of the relative benefits of WEB and TAU. As it is observed that treatment in a typical primary care locale is generally deficient to clinic-based treatment, the authors hypothesized comparatively superior results for the WEB intervention. At the time of study proposal, the CHC did not have an enhanced primary care model in place (which was in place at the time of the study execution), which may have impacted the results obtained in unanticipated manners (Chong & Moreno, 2012).

As the results in "promotion of treatment accessibility" above indicate, telepsychiatry could be a viable approach for depressed, unacculturated, low-income Latino patients. It also compares favorably in the areas of satisfaction with sessions, antidepressant medication use, and higher alliance ratings produced. Completed number of appointments, number of mental health appointments made, and mean number of missed appointments were also at higher and favorable levels for WEB. Three areas where TAU slightly outperformed WEB was mean proportion of completed primary care visits, patients who made a primary care appointment, and mean number of missed appointments. Nonetheless, feasibility of WEB is indicated by significantly higher improvement in depression for patients than TAU. Days lost from work or school and unproductive days at work results were more positive for WEB but not significantly so as compared to TAU, though both groups made significant improvements in days lost from work or school. Overall though, it would seem telepsychiatry is acceptable, feasible, and, in general holds benefits not as strongly evident in TAU.

Another study which made comparative evaluations of two alternative forms of treatment concerns the RCT by Collado et al. (2016a), $n = 46$. This randomized controlled study measured outcomes concerning the utilization of Behavioral Activation Treatment for Depression (BATD) as compared to supportive counseling (SC). Outcomes consisted of treatment adherence and satisfaction, therapeutic alliance, depression, and BATD hypothesized mechanisms of change. When compared to SC, BATD resulted in more pronounced MDD remission at treatment's end, less depressive symptoms over time, and increases in environmental reward and activity. These gains were consistent after 1-month follow up. However, despite these beneficial results, treatment satisfaction and therapeutic alliance, as measured by the Therapeutic Alliance Questionnaire (TAC), did not vary in relation to condition. Completed sessions did not differ between conditions, nor attrition or homework completed in each condition. These latter similarities and similarity of satisfaction and WA notwithstanding, mental health benefits accrued via employment of the BATD modality support prior literature results and indicate its superior efficacity in reduction of depression, promotion of environmental reward and augmentation of activity levels as compared to supportive counseling. Additionally, 78% of BATD participants attended 80% of sessions or greater; this can be positively considered as evidence of BATD's promise as a modality with potential for promotion of adherence in a depression reduction program among Latino populations (Collado et al., 2016a).

The review produced one OLT focusing on preventative intervention of depression, which was executed as a pilot test for the Beardslee Preventative Intervention Program for Depression. Studies indicate children of depressed mothers are more prone to develop depression themselves (Weismann et al., 2005 as cited in D'Angelo et al., 2009). Therefore, this intervention was geared towards promoting resiliency and strength in youth reared by a

depressed parent; as such, it is not an intervention geared towards control of depression in adult patients, though Latina mothers were the focus in all six modules while children were only participants in two modules. Furthermore, given some of the measures employed with adults, e.g., the Integrative Psychotherapy Alliance Scales, Hamilton Depression Rating Scale (HDRS) and Global Assessment Scale (GAS)) and the results concerning the participant mothers, it seemed behooving and instructive to summarize outcomes of the study as related to the mother's mood disorder and related WA factors.

The program intervention applied an outlook which considers resiliency as applicable not only to the youth in question but also to parental figures involved. This also reflects a concern with the effectiveness of parenting accompanied with the understanding of what depression entails for the family. Results of the evidence-based depression prevention pilot study – the Beardslee Prevention Intervention Program for Depression (PIP) - indicate its suitability for use in a Latino urban population. The program involved maternal Latinas, which represented 100% of the adult participants in the studies and consisted of mothers from nine individual families experiencing depression. Estimation of therapeutic alliance strength was measured by use of The Integrative Psychotherapy Alliance Scales and assessed the mother's relationship with the therapist. Parental depression was measured by the Hamilton Depression Rating Scale; parental functioning was assessed by pre- and post-intervention use of the Global Assessment Scale (GAS). The GAS post intervention scores obtained by subjects demonstrated statistically significant improvement as compared to the preintervention score; additionally, working alliance ratings were 6.97 out of a range of 1-7, or essentially at the ceiling (D'Angelo et al., 2009), and indicates the cumulative level of satisfaction with the intervention. This intervention, implemented in Boston, appears to have been successfully utilized with an urban, Latino sample

and is likely appropriate as a method for preventative control of depression in families experiencing maternal depression and may additionally aid in improving overall maternal functioning and possibly aid in reduction of depressive symptomology.

It is noted mothers reported no ill effects from intervention participation, with the PIPS program being considered neither unhelpful nor hurtful (D'Angelo et al., 2009). Additionally, though no changes in HDRS scores were reported, WA and GAS results were positive, and the authors note several attendant benefits which would not be necessarily wise to dismiss out of hand as possibly conducive to reducing or aiding in the reduction of depressive symptomology. It was hypothesized simply speaking of these issues promotes a sense of *desahogo,* or getting things off one's chest, which might be conducive and in the end preventative. The mothers reported, furthermore, by being exposed to bilingual/bicultural personnel, they may have acquired *confianza* in their preventionists and perhaps the sense of having acquired an ally in their struggles. Parents affirmed an increase in parental skills and strategies from guidance provided through module interactions involving the children – this could have promoted self-efficacy and increased feelings of self-worth. The families acknowledged a sense of resiliency and being able to manage depressive symptomology while also being able to continue parenting successfully. Lastly, parents described being able to better address their depressive condition as a result of the openness promoted by confronting its existence. In summary, it seems though depression reduction in adults was not the express goal of the intervention, there are many accompanying benefits which appear to aid in the reduction and control of depressive symptomology, while also, at minimum, augmenting the adult's level of functioning as reflected in GAS scores.

Interian et al., (2010) present the use of another intervention approach in their study with their employment of Motivational Interviewing (MI). As this was a study which employed grounded theory, save for quantitative demographic data and numerical number of patients in respective conditions, the information presented will be of a qualitative nature. Adaptations of this modality involved four main outcomes consisting of re-conceptualizing medication as a means by which the patient could *luchar* (fight back) against concerns, re-formulating the WA so that the caretaker could develop *confianza* with the patient via *personalismo* (personalism). This utilized motivational methods without involving medication by which depression might be alleviated, also visual illustrations regarding doses, and enhancements on methods by which information dealing with antidepressants could be disseminated. The study was useful in determining various factors in the promotion of medication adherence among Latino groups while simultaneously applying MI methods modified for this group of Latinos. The efficacy of this approach was not determined with respect to relief of depression symptomology but did, nonetheless, determine methods by which MI, and perhaps other interventions, could be best adjusted to suit interventions for this demographic.

Constructs of Import in Treatment of Latino Populations

Certainly, there are a vast number of constructs of relevance when it comes to treating Latinos in a psychotherapeutic manner; likely, there are also differences between Latinos of Caribbean, Central or South American, and North American origin. However, this review will limit itself to the constructs of relevance found within the studies of this review and, additionally, constructs dealt with will have appeared in multiple articles (two or more). Review will be initiated from overarching topics of concern for all mental health patients, such as psychotherapy

and its ancillary concerns with discussion directed to how the topic impacts the Latino population, proceed with constructs of concern for minorities generally, and, lastly, deal with topics of specific concern to Latino groups.

Psychotherapeutic approaches in general would appear to be the most wide-ranging topic which could be dealt with, and we might begin by observing, though *peor es nada,* (i.e.," nothing would be worse") primary care would seem to not be the ideal approach in regard to mental health care for Latinos. A study by Fortuna et al. (2010) found, in fact, that while 73% of the sample in their study (Non-Latino White, Latino, Asian, African-American) answered the query, "Were you satisfied with the treatment provided to you by the provider: Yes or No?" affirmatively, retention of the patient in the mental health care intervention was best predicted by whether the patient received treatment from a mental health specialist or a general health provider. This is not to say PCPs cannot impact the intentions of clients, with the converse being demonstrated by Ishikawa et al. (2014) when it was shown working alliance predicted intention of treatment recommendation uptake. However, almost half of the patients in this study had not initiated treatment uptake at conclusion of the study and the authors mention these results to be reflective of prior studies regarding the care for Latinos and point to the need to improve this percentage of success in initiating treatment.

Since primary care is the nexus through which patients often enter the health care system (Villalobos et al., 2016), modifications which improve on recommendation uptake, retention, or increase of positive outcome in mental health interventions within the primary care system are desirable. One of these factors which could impact the preceding might be the choice between the use of interpreters or mental health providers which speak the same language as the patient. As pertains to the WA, results of the study indicate the alliance benefits through use of bilingual

providers from an increased sense of privacy, trust, and a willingness of self-disclosure – as compared to interpreter use. Nonetheless, interpreter use was seen as having the superlative benefit of providing increased access to services for patients (Villalobos et al., 2016). Although primary care is seemingly not the ideal tool for psychotherapeutic interventions, it serves a role in providing an intermediate function of service and could perhaps increase uptake of PCP recommendations through appropriate modifications in approach.

Psychotherapy which is carried out in less traditional settings was also explored via studies encountered in this review. Of the different approaches employed, treatment as usual, as exemplified in Chong and Moreno (2012), appeared generally inferior to the telepsychiatry afforded (see above) – despite the fact TAU was provided in a setting which delivered an enhanced model of primary care with mental health services being made available for patients. Chong and Moreno see telepsychiatry as a viable intervention for patients requiring mental health services, and this view is further supported by Villalobos et al. (2016) and Wells et al. (2015) as it pertains to tele-services for clients.

Collado et al. (2016a) presented another psychotherapy modality through employment of BATD and demonstrated its greater comparative efficacy in reduction of depressive symptomology as compared to supportive counseling – though not also demonstrating greater WA strength. This approach was utilized in a population of Spanish-speaking preference to reduce depressive symptomology and, along with telepsychiatry, and Bernal et al.'s (1998) varied psychotherapies provides alternative approaches to assisting mentally disordered Latino individuals. Results from Bernal's study, as noted above, demonstrate the efficacy of the psychotherapies involved, particularly as related to the WA, though the individual efficacy of the psychotherapies concerned was not provided. D'Angelo et al.'s (2009) adaptation of the

preventative depression program modified for Latinos demonstrated the utility of this particular intervention and its beneficial characteristics, among them a WA alliance of exceptional strength. Additionally, the intervention alluded to acculturative stress experienced by the participants and the difficulties experienced by Latino individuals as a consequence of their immigrant status, which is dealt with further below.

Among other issues concerning psychotherapeutic interventions, medication looms large; Interian et al. (2010) concludes, that, while medication adherence is an issue of concern for Latinos particularly, developing modifications to the MI modality apropos for a Latino population, e.g., utilizing medications as a means by which the patient can *luchar* against their affliction, the MI modality can be adapted to suit mood disorders afflicting Latino populations, promote medication adherence and concurrently maintain the core of MI methodology. Additionally, Wells et al. (2015) determined informational tactics regarding the characteristics of medication adherence could aid in dispelling misconceptions and myths regarding treatment by psychotropic methods. Furthermore, this clarification and promotion would appear to be of benefit for Latino populations as Fortuna et al.'s (2010) survey found the prescription of medication (and presumably adherence) is associated with a greater number of mental health visits or continued attendance. Aspects of interventions which promote medication adherence would appear to be suitable for this population.

However, an issue which might accompany medication prescription, along with psychotherapy, is the self-perceived stigma of partaking in psychotherapeutic interventions. Collado et al. (2019), Interian et al. (2010), and Wells et al. (2015) determined Latino patients are afflicted with inordinate levels of mental health stigma (MHS) or stigmatizing beliefs. Data from Collado et al.'s (2019) study demonstrated stigmatizing beliefs about treatment and

determined, in this case, supportive counseling resulted in lower levels of MHS among patients subjected to this modality, as compared to BATD. Moreover, MHS was correlated over time with the WA and depressive symptoms, but not related to discontinuation of treatment. Interian et al's (2010) study supports the finding of stigma as a relevant concern for Latinos; their results indicate stigma associated with antidepressants was ranked second among concerns for this group of Latinos. This study produced alternatives to resolve stigmatic issues including informing no one of their medication use, informing only trusted individuals, inviting relevant others to attend a session, and informing others of facts on depression.

Another factor of relevance for Latinos is language concordance and this is supported by studies from Interian et al. (2010), Villalobos et al., (2016), and Wells et al. (2015). Interian and colleagues state as "language is a carrier of culture," the authors attempted to move beyond simple use of the Spanish language and attempted deeper integration of language concordance by including phrases of relevance to the study's Latino population; Interian et al. (2010) posit doing so permits a greater level of empathy, as called for by the MI protocol they employed. Villalobos et al. (2016) also note several benefits of language concordance. In their study, they determined the effects of interpreter use on the therapeutic alliance via qualitative and quantitative data obtainment. A cohort of Spanish-speaking clients (n = 458), 33.8% with depressive symptoms, seen at an integrated behavioral health care setting responded to therapeutic alliance scale questionnaires. Their responses produced results from patients serviced by interpreters which were equivalent to scores from patients provided access to a bilingual behavioral health consultant; that is, WA ratings were similar even with multiple regression analysis controlling for likely significant demographic covariates. Other results indicated a patient preference for bilingual providers but with patient understanding of interpreter roles in increasing service access

and communication with providers for limited English proficient patients. Working alliance was high in both cohorts, and Villalobos et al. (2016) note benefits such as an increased rapport and communication when bilingual providers are employed and a satisfaction of patient's preference for direct communication with the mental health professional. Wells et al. (2015) also note rapport between patient and provider is maximized as a result of language congruency and the increased skill in communication such language concordant interactions promote.

A further gain of language concordance might well be the patient's sense of increased cultural competence perceived in their provider. This can be seen to be beneficial in studies by D'Angelo et al. (2009) and Ishikawa et al. (2014). D'Angelo et al. observed the seeming similarities with the bilingual/bicultural preventionists might have promoted an increased sense of being respected, understood, and listened to, which may have added to *confianza* increasing when relating to preventionist on the part of the patient. Ishikawa et al. observe ratings of WA and cultural competence to be interrelated ($r = .77$, $p < .01$), with cultural competence an indicator of a patient's intent of uptake of treatment recommendation when mediated by the dyads WA. Though dependent on the WA to some degree, cultural competence nonetheless is seemed relevant for recommendation uptake in their study.

The study by Caplan and Whittemore helps illustrate the specificity of some issues Latino individuals must deal with. In this case, gender-based violence and childhood adversity as it pertains to a sample of Latinas ($n = 12$) was evaluated to determine barriers which prevent their engagement in treatment with a focus on how gender-based violence (GBV) and childhood struggles impact the propensity for pursuit of treatment. The impact of cultural values was also assessed in this investigation. The study was qualitative in nature and descriptive of impediments this population might encounter. Treatment engagement (TE) was conceptualized in this study as

identification of a mental health issue, seeking mental health care, and participating and continuing in the indicated course of care (Dixon et al., 2011 as cited in Caplan & Whittemore, 2013). TE is thought to be enhanced by bicultural, bilingual therapists and the inclusion of cultural values, e.g., *marianismo,* which describes female roles in Latin society or *familismo,* the propensity for close family ties; however, these same values may also impede TE and even the working alliance. This study hypothesized these cultural values might prevent disclosure of GBV in a therapeutic session and the authors intent was to examine such barriers to TE with respect to GBV and childhood adversity (Caplan and Whittemore, 2013). Results indicated TE and perceived lack of support was reflective of negative childhood experiences and GBV and a dread of sharing information and disgrace. The authors also suggest those experiences color the meaning of personal and cultural values, treatment efficacy, and religiosity. Latinas would not expect family support to result with the revelation of GBV or childhood adversity. Only situational depression, e.g., losing a job, and similar events would result in family support. Study results indicated unease with disclosure of GBV also affected a helping relationship with health professionals and thus could impact the therapeutic relationship in diverse ways (Caplan and Whittemore, 2013).

The value of *marianismo*, women being morally and spiritually better, able to endure suffering and be self-sacrificing, submissive, and maintaining positive relationships, is thought to impact TE since, according to this value, the well-being of one's family and children is of higher importance than caring for one's self (Caplan and Whittemore, 2013). Other cultural values include religious factors which influence potential patients to place a higher premium on the efficacy of prayer, and faith in healing, with causal beliefs grounded in supernatural influences. Beliefs of one's own self-efficacy and strength in overcoming depression also impacted TE. Difficulties with

treatment further negatively affected TE and included a dislike of medication, e.g., addictiveness, bad therapy experiences, for instance, therapist turnover, and discounting their disorder.

The impact of cultural values on TE is evident particularly when GBV within the family is involved, as Latinas feel they would be held culpable and studies support most women will not broach the subject of GBV with family (Bauer, Rodriguez, Quiroga, & Flores-Ortiz, 2000, as cited in Caplan and Whittemore, 2013). The ambivalence created by within family GBV is compounded by the possible sense of loss of the protection of a cultural value (*familismo*) and the simultaneous dictum which requires it be upheld. – therefore, adding to the ambiguity of choosing TE. *Marianismo* also appears to be reflected in an unwillingness to participate in depression treatment related to GBV, a willingness to suffer, and rejection of illness severity. In fact, it's been found half of Latina women endure domestic violence (Ingram, 2007, as cited in Caplan and Whittemore, 2013) and furthermore, the women in the study did not discuss various aspects of GBV with health-care providers and even with their therapists. Given the rates of childhood sexual abuse (15.3%) and childhood maltreatment (33%) in the Latino population (Warner et al., 2013, as cited in Caplan and Whittemore, 2013), awareness of barriers to the discussion of GBV would be a welcome adjunct to the literature.

Some of the various issues which Latinos deal with have been enumerated and their impact in various areas noted; in the final chapter, summaries and conclusions will seek to present an overarching theme by which these individual strands may be tied together with the common threads of the working alliance, its relevance to mood disorders, and the means by which these may be united for the benefit of the Latino demographic.

CHAPTER IV

SUMMARY AND CONCLUSIONS

Latinos underutilize mental health services (Jimenez et al., 2015; Villatoro, et al., 2014) and are disadvantaged with respect to mental health care quality and health insurance coverage (Medicine, 2002; Zuvekas and Fleishman, 2008; as cited in Berdahl & Stone, 2009). Less than 1 in 20 Latinos avail themselves of specialist mental health services and less than 1 in 10 Latinos utilize general healthcare provider services (US Department of Health and Human Services 1999; as cited in Berdahl and Stone, 2009). With such statistics the necessity of any resource which can mitigate underutilization and promote the converse is certainly beneficial towards maximizing the mental health of this group. The working alliance is often considered to be one of the most important, if not the most important factor in beneficial and positive results of psychotherapeutic interventions. Mood disorders have been cited above as a psychological disorder which has special relevance among the Latino population. This review was, therefore, initiated to determine how the working alliance impacts mood disorders and what can be done to utilize such a process variable for the maximum benefit of Latino's psychological well-being. With that approach in mind, the review produced studies which dealt with a gamut of factors which, with appropriate analysis, may be conducive in extracting items related in such a way that their combination to an overall structure connecting their related interplay may be constructed. Individuals involved in the study or treatment of mood disordered Latinos may gain a greater understanding of these interactions to promote the overall mental health of Latinos.

Any approach towards maximizing the mental well-being of this group would be wise to consider the whole range of interactions which can aid in promoting this goal. The review identified 11 studies dealing with disparate subjects such as prevention, retention, and treatment. Noting which approaches, or combination of approaches, could aid in maximizing client engagement would be instrumental in achieving such a goal – perhaps even the linking of various procedures being advisable. Most studies dealt with aspects of mood disorders in isolation, but the studies could be agglomerated under three areas of relevance for future actions directed to promote the mental health of Latinos. Various of the included studies dealt with issues which could aid in promoting access and attendance of psychotherapeutic facilities by Latino members. Also, modalities of treatment were determined which seemed most amenable and efficacious for this population, and, lastly, in relation to treatment, various studies determined similar approaches which might best promote positive interactions with Latino individuals. Since increasing accessing and accessibility are the initial means towards acquiring a greater number of this population for treatment, issues dealing with this topic are dealt with initially.

An approach increasing Latino participation in psychotherapeutic services might be promoted by developing programs or media which aim at curbing the sense of stigma attached to the simple act of accessing and participating in therapeutic services. As noted in Collado et al. (2019), Interian et al. (2010), and Wells et al., (2015) mental health stigma (MHS) likely plays a role in behaviors oriented towards initiation of actions regarding psychotherapy and medications. For instance, Interian et al. (2010) found stigma second-ranked by 73% of their study participants regarding complications considered by Latinos pertaining to medications. Wells et al. (2015) also found their sample manifested stigmatizing beliefs regarding medication for

depression, e.g., medication being addictive and for crazy people. Clement et al. (2015) note MHS being well documented among minority populations, (as cited in Collado et al., 2019), but MHS appears to be controllable by intercession. Attacking stigmatizing beliefs via tele-media campaigns or visual ads in suitable publications may be a possible means of intervention and a method by which, through reduction of stigmatization, Latinos may voluntarily seek out treatment for suspected psychological syndromes and thereby increase access for this underserved group.

As PCP recommendations have been shown to demonstrate efficacy in regard to intention of uptake by patients in a strong WA, this group of professionals could also be an initial, and in the minds of patients innocuous, way by which stigmatization may be unknowingly reduced; perhaps posters or pamphlets may be made available at these locales, with PCPs providing further elaboration and support in addressing ambivalence regarding mental health issues. Furthermore, Perales, Reininger, Lee, and Linder (2018) found community health workers (CHW), trained solely in motivational interviewing techniques, aided in promoting behavior change in participants by seemingly instinctive use of therapeutic approaches more commonly found in counseling and psychotherapeutic settings. Possibly, shifting counseling interventions, particularly regarding more severely mood-disordered individuals, towards CHWs and training them in stigma-reductive approaches may further behoove Latino patients by increasing their willingness to seek out appropriate treatment by more qualified mental health professionals.

As noted by other studies, numerous factors come into play when barriers to treatment are considered: cost, transportation issues, employment conflicts, cultural congruency, and immigration documentation concerns, for instance (Chong & Moreno, 2012; Wells, Lagomasino, Palinkas, Green, & Gonzalez, 2013). PCPs and CHWs, along with standard mental health care

facilities, can serve additional roles in facilitating treatment access for Latinos by being distributors of information by which this group may inform themselves of options available to them regarding material requisites for simply attending, or promoting and augmenting the desire to attend through the provision of culturally and linguistically concordant treatment providers. Among forms of intervention which may aid in diminishing multiple reasons for concern in this population, e.g., employment and transportation issues, telepsychiatry and telehealth approaches may be some of the more promising options through which accessibility may be augmented. Chong and Moreno's (2012) study supports the use of telepsychiatry as a viable option in providing acceptable treatment options for underserved populations via more accessible locales. Additionally, this approach may aid in the reduction of the stigma as noted above by perhaps eliminating the need to attend what would otherwise be a visibly mental health location. Wells et al. (2013) and Wells et al. (2015) also promote telehealth approaches, e.g., websites, videos, and CD-ROMs which could be utilized as auxiliary, supportive methods along with telepsychiatry or more traditional intervention counseling methods.

Telepsychiatry, then, could be the means by which necessary counseling and interventions are provided for underserved Latino populations, but another consideration would be the best modality by which to provide a required intervention. While medications certainly cannot be excluded as a form of treatment, it has been observed Latinos tend to prefer counseling approaches as opposed to medication interventions. Of the counseling options which were considered in this review BATDdes and MI appeared to promote beneficial outcome. Regarding stigma, SC seemed to have more of a beneficial outcome as compared to BATD (Collado et al., 2019) though with respect to depressive symptomology BATD resulted in more pronounced MDD remission at treatment's end and larger decrease of symptomology over time (Collado et

al., 2019). The authors suggest the incorporation of SC components to BATD, i.e., venting or *desahogo*) might accrue similar benefits of increasing stigma minimization in patients assigned to such a modified BATD approach, so that, overall, BATD might still be of maximal benefit as compared to SC, though future studies might aid in verification.

In passing, though the case study which incorporated Cognitive Behavioral Therapy (CBT) was excluded upon committee review, brief mention is made of this modality here as it indicated a potential beneficial therapeutic approach (Elligan, 1997). Organista (2006) likewise notes the reasonably successful outcome in Organista (1995) of a well-documented case study involving a woman of Central American ancestry experiencing MDD and panic disorder, and in a study by Organista, Munoz, and Gonzalez (1994), which included almost 50% Spanish-speaking Latinos, study members' depressive symptoms were reduced from severe to moderate in their CBT study. Organista (2006) also observes characteristics of the CBT modality which could be beneficial in its application. Stigma might be also reduced with this modality as patients consider the practice of using chalkboard interventions during sessions, homework, videos, and therapy manuals, more related to classroom practices, with some Latino patients referring to CBT experiences as "*la clase de depresión."* (the depression class) – which might aid in reduction of stigma as it relates to *familismo*. CBT can also be conveniently directed to more immediate concerns typically experienced by this group due to its problem solving and present-oriented approach. That Latinos tend to regard health professionals as authority figures also befits the application of CBT and its approach towards directive suggestions.

As noted above, though no innate predilection for psychopharmacological approaches is found to be the case for Latino populations, medication cannot be discounted as an approach and/or adjunct in treatment. An MI approach might be a suitable means by which medication

adherence and ambivalence towards medication use might be concurrently reduced. Interian et al. (2010) support this observation and note MI is an approach which, besides aiding in developing impetus for purposeful action, can also be a means through which Latino values may be appropriately integrated into an intervention – as MI behavior modifications are adjusted with respect for an individual's personal values and wishes as part of its protocol. More relevantly, a meta-analysis by Hettema et al. (2005) supports the observation for advantageous use of MI with ethnic and racial minorities (as cited in Interian et al., 2010).

Of course, the common thread of these modalities is the interaction of the WA and its impact on the patient. Other common threads which emerged was the wisdom of relating to and implementing interventions which consider Latino cultural values and promoting a sense of cultural congruency. It would also seem the levels of acculturation and enculturation could produce different types of help-seeking action as this would likely affect the intensity of adherence to relevant cultural values which in turn would impact attitudes towards the WA depending on the nature of the inclinations. A future area of study is suggested by this possibility. Other areas of future consideration might include the following:

1. A deeper understanding of how telepsychiatry impacts the WA and how levels of acculturation may moderate the effect of telepsychiatry on the WA
2. The differential impact and items of relevance as it pertains to the WA regarding Latinos and gender.
3. Promotion and investigation of referral uptake by D'Angelo et al's (2009) preventionists and measuring the level of impact as compared to PCPs.

4. Lastly, a comparative analysis of the strength of the WA in differing Latino groups might be instructive in determining whether varying approaches might be beneficial with the various groupings.

Implications for Clinicians

Results of this review could aid clinicians in various ways; clinicians can opt to develop skills in multicultural competency to not only aid the progress of their patients, but, more relevantly, to retain them and relate at more significant levels. Certainly, with the consequence of *not* understanding cultural mores and values appropriately outlined, it would be hard to understand why a clinician would not want to improve their TMC skills. Perhaps mental health center administrative staff could offer incentives or programs which promote this type of development. Mental health centers may also want to develop ways by which language concordance at their locations may be maximized, perhaps by using similar incentives. While interpreters facilitate the process of therapy, bilingual, and ideally bicultural, therapists appear to increase freedom of expression for patients. If a clinician is not bicultural, TMC is in order. Acquisition of another language by a clinician appears demanding but with the incentive of employers, or self-drive, perhaps achievable. Clinicians may want to consider some of the modality options presented in this review, be it MI and antidepressant adherence or BATD for reduction of depressive symptomology.

Mental health centers and clinicians may wish to consider the Preventive Intervention Program for Depression as it also appears to benefit adults and may prevent the next generation from suffering similar disorders. Furthermore, the program appears to offer additional benefits in day to day living and family cohesion beyond the ostensive preventative outcomes. Clinicians may wish to develop WA skills, so their patient may be more inclined to participate in planned

interventions or recommendations, and, if not provided by the clinician's center, perhaps the clinician may inform themselves on tangible means by which the client may be assisted in adhering to appointments and relevant regimens. Lastly, and simply, clinicians of all levels may inform themselves of stigma reducing approaches as it may apply to their client, to thereby increase continued attendance of sessions.

Limitations

It is hoped the information in this review aids in outlining approaches by which Latino populations can benefit. With the use of appropriate tools, PRISMA guidelines and the MMAT, the likelihood of valid conclusions being derived was increased. Finding the effect of the WA on mood disorders in Latino populations and characteristics of constructs which impact the WA was the goal of this review, but limitations are apparent in this endeavor. While the diversity of the studies was a boon, the limited number of studies dealing with particular issues resulted in only limited support per topic of relevance extracted from the review. This may not necessarily bring into question conclusions derived, but, nonetheless, more support for each topic would have been desirable. Another limitation is some of the studies may have required inference to determine the impact of constructs in question on the WA. As an assiduous effort was made to obtain the greatest number of studies possible, the paucity of studies obtained may be indicative of a shortage of material related to the WA, Latinos, and mood disorders in tandem.

Conclusion

Latinos are a group of individuals inclusive of various nationalities with likely differing qualitative characteristics and perhaps even varying significance in cultural values intrinsic to the groups which make up "Latinos". One thing the various subdivisions of this class likely holds in common, however, is the impact which the working alliance has on mood disordered individuals

of this demographic. It would seem more than a possibility that Latinos hold this in common with other ethnicities of the United States and ethnicities of the world as well. It is hoped this review provided insight into the relevance of the WA as it applies to mood disordered Latinos and aid in development of appropriate interventions regarding these constructs for the population.

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BIOGRAPHICAL SKETCH

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