Lessons from the Use of Vignettes in the Study of Mental Health Service Disparities

Sheri Lapatin, Marta Gonçalves, Anna Nillni, Ligia Chavez, Roxana Llerena Quinn, Alexander Green, and Margarita Alegría

Objective. To examine the development, feasibility, and use of a vignette approach as an important tool in health services disparities research.

Data Source. Interviews with vignette developers and qualitative data from a novel mental health services disparities study that used vignettes in two samples: (1) predominantly low-income parents of children attending mental health specialty care who were Latino or non-Latino White and (2) Latino and non-Latino mental health clinicians who treat children in their practice.

Study Design. We conduct a content analysis of qualitative data from patients and providers in the Ethnic Differences Study to explore the feasibility of vignette methodology in health services disparities research, and we identify lessons learned that may guide future vignette development.

Principal Findings. Vignettes provide a valuable approach that is acceptable to participants, elicits important insight on participant experience and services, and sheds light on factors that can help optimize study design for exploring health disparities questions.

Conclusions. Researchers, clinicians, and others should consider a set of factors that help determine when a vignette approach is warranted in research, training, or for other uses, including how best to address identified weaknesses.

Key Words. Vignettes, disparities, mental health services

BACKGROUND

A major undertaking in the field of disparities research is identification of appropriate methodologies and analysis techniques that enable researchers to examine health service disparities. Vignettes have emerged as a viable method (Shulman et al. 1999; Martinez and Guarnaccia 2007), given that they can systematically adjust for individual factors—such as race, ethnicity, and

gender—while holding all other factors constant. A "vignette" is a story that provides concrete examples of people and their behaviors in certain situations, upon which research participants can formulate opinions and comment on what they or a third person would do or how they would react in a certain situation (Hazel 1995; Hughes 1998; Barter and Renold 1999, 2000; Schoenberg and Ravdal 2000). Vignette patients are fictional individuals, exempt from human subject requirements, who can be analyzed as a counterfactual population. Vignettes have been developed across many mediums, including written stories that are administered in person or delivered by mail, videos, music, and photography (Finch 1987; Cohen and Strayer 1996; Valenti and Costall 1997; Hughes 1998). They have been used to analyze perceptions, beliefs, and attitudes of respondents toward health care concerns such as depression and violence (Barter and Renold 2000; Cabassa 2007) or clinician decision making with patients of different ethnicities (Shulman et al. 1999; Schoenberg and Ravdal 2000; Green et al. 2007).

In health services research, vignettes have been used to look at various health topics among multicultural consumers (Cabassa et al. 2007; Martinez and Guarnaccia 2007) and to examine decision making or reactions to a hypothetical patient among clinicians (Shulman et al. 1999; Green et al. 2007). As vignettes are fictional, they are often considered a non-threatening, impersonal approach to uncover overt or explicit opinions (Hazel 1995; Hughes 1998; Barter and Renold 1999, 2000; Schoenberg and Ravdal 2000). Cabassa (2007) created vignettes depicting an individual meeting DSM-IV criteria for major depression to elicit Latino immigrants' perceptions of depression and attitudes toward treatment. Similarly, Martinez and Guarnaccia (2007) designed vignettes to explore Latinos' recognition of depression and treatment suggestions. Using videotaped vignettes of eight standardized patients who varied by age, race, and gender, Shulman et al. (1999) examined differences in physicians' clinical decision making, finding that patient race and gen-

———————

Address correspondence to Sheri Lapatin, Center for Multicultural Mental Health Research, 120 Beacon Street, 4th floor, Somerville, MA 02143, e-mail: slapatin@charesearch.com. Marta Gonçalves, Ph.D., is with the Center for Multicultural Mental Health Research, Cambridge Health Alliance-Harvard Medical School, Lisbon University Institute ISCTE-IUL, Lisboa, Portugal. Anna Nillni, B.A., is with the NYU Steinhardt School, Media, Culture and Communication, New York, NY. Ligia Chavez, Ph.D., is with the Medical Sciences Campus, University of Puerto Rico, San Juan, Puerto Rico. Roxana Llerena Quinn, Ph.D., is with the Department of Psychiatry, Children's Hospital Boston, Fegan, Boston, MA. Alexander Green, M.D., M.P.H., is with The Disparities Solutions Center, Massachusetts General Hospital, Boston, MA. Margarita Alegría, Ph.D., is with the Center for Multicultural Mental Health Research, Cambridge Health Alliance-Harvard Medical School, Somerville, MA.

der may influence clinician recommendation, despite identical patient clinical characteristics. Green et al. (2007) reported on the use of vignettes administered through an Internet-based tool and using implicit association tests (IATs) (Project Implicit, Harvard; http://www.implicit.harvard.edu), finding that while most physicians did not admit to explicit racial preference, many showed implicit preference for White patients that predicted differences in their treatment recommendations. Wakefield et al. (2006) looked at vignettes administered to social work graduate students, laypeople, and clinicians to assess judgments of a White or Mexican youth with antisocial behaviors. By adjusting text to explain behavior as either an environmental reaction or an internal dysfunction, the team found ethnicity/race differences in the impact of context on judgments of whether or not the youth had the disorder (Wakefield et al. 2006). Given the opportunities vignettes create for exploration of complex health issues, studies have summarized both methods for their construction among particular groups (Schoenberg and Ravdal 2000) and suggested factors for consideration in drafting them, including keeping them "realistic," ensuring they parallel the study's research hypothesis, and including a sufficient number of stories to fully examine the issue at hand (Barter and Renold 1999; Wason, Polonsky, and Hyman 2002; Seguin and Ambrosio 2002).

Our study moves this literature forward by outlining a step-by-step approach to creating vignettes in a health disparities study that explores both clinical and consumer assessment of child need for mental health care. We assess feasibility and acceptability of vignette use by studying reactions of vignette respondents themselves, who share their thoughts and feelings about the study. Ultimately, we hope to facilitate construction and use of vignettes to explore complex disparities questions, aimed at improving the quality of health services and care for ethnic minority populations.

STUDY DESIGN

The current study uses three different data sources to accomplish its main objectives. First, we draw on interviews and conversations with study staff from the *Ethnic Differences in Perceived Impairment and Need for Care* study (Chavez et al. 2010) to describe the process of vignette development. Second, we utilize qualitative data gathered from parents interviewed as part of the Ethnic Differences Study to explore the feasibility and acceptability of the vignette approach. Parent participants were asked, "What were you thinking after read-

ing and rating this vignette" after each story. Third, we analyze qualitative data gathered from providers as part of the Ethnic Differences Study. Both parents and providers were asked for observations or comments on the study itself at its conclusion.

For the study staff data, the first author developed an interview guide, which included questions on the vignette development process, vignette construction to enable a disparities focus, vignette use in qualitative research, and vignette challenges and benefits in the study of service disparities. The first author conducted in-depth qualitative interviews with two clinical psychologists, one of whom drafted the study vignettes and one of whom participated in reliability and calibration with clinicians. She additionally incorporated conversations with the study PI and another senior investigator, both co-authors on this manuscript, as well as descriptions from study coordinators, interviewers, researchers, and investigators, and synthesized this data into a set of steps for vignette creation.

For Ethnic Differences study data, we selected a subset of 101 parent and 45 clinician respondents, described more fully in Tables 1 and 2, who provided qualitative responses as part of the full Ethnic Differences sample. The original study consisted of 185 parents and 189 providers (see Chavez et al. 2010 for more details on the full sample). The qualitative subsample of Latino and non-Latino parents and providers is similar to the full subsamples in the original study. Consistent with the distribution of characteristics in the full sample, the U.S. Latino qualitative parent sample was less educated, younger, and with lower economic resources than the non-Latino Whites. Similar to the full study sample, there were also a greater number of non-Latino psychiatrists and social workers participating in the qualitative study.

Parents, either Latino or non-Latino White who had a child aged 9–17 currently in treatment (e.g., inclusion criteria), were recruited from outpatient child and adolescent mental health clinics where they had brought their own child for treatment. They were interviewed one on one by trained research staff in a tape-recorded structured interview. Research staff in Boston included bilingual research assistants and coordinators, half of whom were Latino and half non-Latino, who were trained and supervised by the project PI to ensure standardized interviewing techniques. They also took part in training on qualitative interview techniques, including asking open-ended questions and probing for detail, with an expert in medical ethnography as part of another Advanced Disparities Center subproject, the Patient Provider Encounter Study (Alegría et al. 2008). Inclusion criteria for providers were being a Latino or non-Latino mental health clinician and cur-

Table 1: Demographic Characteristics of Parent Participants U.S. Qualitative Sample

	US			
	Latino		*Non-Latino*	
	N = 57		*N = 44*	
Parent Characteristics	*N*	*%*	*N*	*%*
Gender				
Male	4	7	7	16
Female	53	93	37	84
Education				
$\leq$ High school	14	25	1	2
More than high school	43	75	43	98
Economic status				
Live very well/comfortably	14	25	29	67
Live from check to check	26	46	12	28
Almost poor/poor	16	29	2	5
Age				
26–35 years old	14	25	3	7
36–45 years old	32	56	17	39
46–55 years old	8	14	20	45
56+ years old	3	5	4	9

Note: Percentages are out of those who responded.

rently seeing children at least weekly in their practice. Providers were recruited via surveys mailed to professional mental health or service organizations, recruitment at national professional meetings, and referrals by other colleagues who participated in the study. In each case, providers responded individually with their written answers in the survey.

To best explore service disparities that might affect help-seeking, the research team chose to focus on the subset of parents obtained in Boston, MA, and provider interviews obtained in the mainland United States, as this subgroup included Latino participants of minority status. The Ethnic Differences study was approved by the IRB at the Cambridge Health Alliance and University of Puerto Rico study sites, as well as individual clinics at other institutions that participated.

Vignette Development: Interviews with Ethnic Differences Study Staff

Interviews and conversations with the Ethnic Difference Study staff highlight that vignette creation is a multistep process that benefits from a multidisciplin-

Table 2:   Demographic Characteristics of Provider Participants in a U.S. Qualitative Sample

	US = 45			
	Latino		Non-Latino	
	N = 13		N = 32	
	N	%	N	%
Gender				
Male	4	31	8	26
Female	9	69	23	74
Occupation				
Child/adolescent psychologist	5	38	8	25
Child/adolescent psychiatrist	1	8	8	25
Social worker	3	23	14	44
Other	4	31	2	6
Number of children provider serves (per week)				
<10 children/adolescents	4	33	17	53
Between 10 and 50 children/adolescents	7	58	13	41
Between 51 and 100	1	8	2	6
More than 100 children/adolescents	0	0	0	0
Average years providing mental health services for children and adolescents	20		17	
Service Latinos in practice	12	100	26	81
Received cultural competency training	11	85	25	83
Age				
26–35 years old	3	25	6	20
36–45 years old	3	25	6	20
46–55 years old	4	33	9	30
56+ years old	2	17	9	30

Note: Percentages are out of those who responded.

ary team's input to refine content and format. The study team included Latino and non-Latino child psychologists, psychiatrists, statisticians, psychometricians, anthropologists, and research project managers, who worked through a series of steps to ensure that key themes, content, and format were vetted and appropriate for participants.

Step 1: Identification and Prioritization of Content and Format by Expert Panel of Child Providers. The Ethnic Differences research team identified use of clinical vignettes as a helpful and practical method to address its research ques-

tions. The team reviewed the literature seeking information for why Latino children living in the United States have the highest rates of unmet need for mental health services compared with White children (Chavez et al. 2010). A hypothesis was that there could be less problem recognition of mental health problems in providers and parents of Latino children. Study developers hoped to explore parental and provider attitudes that might differentially impact help-seeking in Latino children compared with White children (Chavez et al. 2010). Vignettes would enable manipulation of the perceived ethnicity of counterfactual children—Latino or non-Latino White—who presented with mental health disorders in identical ways to see if providers and parents would differentially identify the disorders, recognize a problem, and seek care.

The process of developing vignette stories for the study began in October 2005, and lasted through January 2006. As background material, the group carefully explored existing vignettes developed by Pescosolido and Jensen (Pescosolido et al. 2008) and qualitative content categories from two previous studies, the San Diego Patterns of Care (POC) and the Service Use Need and Outcomes in Puerto Rican Children. The purpose of this review was to see if (1) preexisting or only slightly modified vignettes could be used in the study; (2) to identify typical mental health problems in this population; and (3) to review the types of questions following each vignette to which parents would respond. The research team decided to use a written vignette approach —created and calibrated by the group—as it provided the ability to incorporate clues about severity, while ensuring participants' ability to envision the vignette characters for themselves.

Step 2: Draft of Vignettes by a Clinical Psychologist Team.   A team of four child clinicians took part in the process of authoring the vignettes. A clinical psychologist drafted the first round of vignettes, describing this work as "more an art than a science." A few criteria were critical: because clinicians as well as parents would rate the vignettes, the developers noted that it was important to balance clinical considerations with believability for a parent. The stories needed to fulfill Diagnostic Statistical Manual (DSM) criteria for the disorders, while also matching the lived experience of visualizing what children "really look like" and not being so transparent that they would be obvious about the diagnosis. Developers describe the deliberate use of vignettes to create a distance —a standpoint from which the respondent can both think *about* the vignette, as well as place him/her self *within it,* facilitating not only an intellectual but

also an affective experience for the reader. An important element was inclusion of not only pathological but also positive attributes about the vignette child, in an order that was kept constant and standardized across the stories to avoid potential order effects and confounding variables.

With these areas in mind, a core set of eight vignettes were written, to represent one of two externalizing disorders (attention deficit hyperactivity disorder or oppositional defiant disorder) and two internalizing disorders (depression and social phobia). For each disorder, vignettes were made to vary across severity levels, gender, and ethnic background (achieved by varying the vignette child's name to Ann/Anna, Mary/Maria, Michael/Miguel, and John/Juan). In addition, two calibration vignettes were created, displaying a child who exhibited no psychological problems (Angela), and another with an extreme level of internalizing and externalizing disorder severity (David).

Step 3: Reliability Test and Calibration Process by Eight Providers in Boston, Eight Providers in Puerto Rico. To ensure reliability across participants, vignettes were tested with a panel of 16 expert clinicians who rated impairment of the vignettes using the Children's Global Assessment Scale (C-GAS). Eight providers met in Boston and eight in Puerto Rico to rate and jointly discuss each vignette. Scores were tallied, and an average C-GAS score was calculated. If the score did not fall within the range it was developed to represent, the vignette was modified and recalibrated until there was general agreement on the severity of the child that the vignette represented. This back-and-forth process was used to standardize the vignettes, despite initial variation in calibration among clinicians themselves.

Step 4: Adaptation and Translation by a Bilingual Team of Professionals. A bilingual team translated and adapted the stories into Spanish using translation protocols similar to the ones used for diagnostic instrument translation (Camino and Bravo 1994; Matias-Carrelo et al. 2003). Vignettes were back translated to assure original meaning and were reviewed by a group of mental health researchers to ensure conceptual equivalency.

Step 5: Question and Randomization Scheme Development by a Psychometrician. To assess parental and clinician assessment, the research team drafted a series of questions with Likert scale response categories, such as asking how

serious was the child's problem, how likely was the problem to improve, and whether the child needs mental health services and/or medication. Additional questions were included for parents, such as how annoyed they think their child's teacher would be with this behavior. The team consulted with a psychometrician to help develop the complex randomization scheme needed to assemble and administer parent and provider vignettes, with randomized number tables used to guide the assembly of interview packets. Each participant rated the two calibrating vignettes and four experimental vignettes, assembled through an incomplete block design that balanced vignette content with the manipulated factors. The vignettes were then administered in a randomized order for each participant. A formal qualitative component was added after the quantitative session was piloted, given that many participants provided input and shared personal stories after reading and rating the vignettes.

Feasibility and Acceptability for Patients and Providers—Qualitative Data

Analytic Strategy.   For the current study, we conducted a content analysis (Ryan and Bernard 2003) of patient and provider responses to the qualitative questions following each vignette survey and at the conclusion of the interview. The goal was to identify themes related to participant reaction to the stories to facilitate an understanding of how effective the stories were in meeting the developers' goals. For patients and providers, we look at *feasibility*—whether participants were able to complete the survey, and *acceptability*—overall satisfaction and whether the stories appeared useful and relevant to their needs and concerns.

The first phase involved analyzing the audiotapes and interviewer handwritten notes regarding parent and provider reaction to the vignettes. As a second step, two authors transcribed this material and a native-Spanish-speaking research assistant verified accuracy in Spanish. The two authors individually reviewed the transcribed qualitative data and coded into buckets of occurring themes. From this analysis, the authors developed a set of 10–12 themes that emerged across cases and identified areas of difference between Latino and non-Latino participants. The two authors came together with a third author to discuss the themes developed and to reach consensus in areas where interpretation of parent or provider comments may have differed. To address differences, the first and second author listened together to the audio recordings of the qualitative material and discussed and came to a conclusion about meaning. Authors discussed together these key themes and decided

upon major categories of information among parents and providers. The study PI and a senior investigator provided guidance and insight throughout this process.

RESULTS

Parents

Response to Vignette Format: Feasibility and Acceptability. Qualitative findings for parents show feasibility of the vignette process. Almost all participants who consented to take part in the study were able to successfully complete the study and its questions, with the exception of one case in which a participant ran out of time and had to leave before administration was complete. Different strategies supported participant completion, such as having vignette stories and questions read aloud to participants rather than responding to the experimental stories silently on paper. Some parents were also pleased that the questionnaire was administered in a clinic waiting room while their child was in care.

Findings from the parent sample displayed acceptability of the vignettes by both Latino and non-Latino White parents, albeit with distinct areas of concern. The majority of Latino and non-Latino parents displayed a positive response to the stories and subject matter, noting that the study was as follows: *"Very interesting; I like how it can help children"* (C12),[1] or commenting, *"I loved the study, because it's basically stuff that my children have gone through so I know"* (C11). A key response was that parents could identify on an emotional level with the children described in the stories. Parents expressed "hope" or "worry" about the child described: "*I felt bad for David and his family and his friend*" (A97). Parents could "recognize" the child described, reporting that he or she reminded them of their own child or of others they knew—a neighbor's child, or perhaps a student. One parent expressed that "*It was very interesting...different scenarios...just the fact that I could bring them back to my own personal situation*" (A77). The process of identifying with the stories was conscious for some parents, who commented, *"My own experiences, experiences with my child, probably make me see all these issues through a certain prism"* (A63).

Parent Confidence in Their Response. While parents had generally positive feedback, they differed in terms of level of understanding of the vignettes and

certainty related to the research questions being posed. Some parents expressed confidence in responding to the questionnaire, indicating "*I think they're [the stories] all pretty clear cut what's wrong with them [the children]*" (B69). Other parents expressed less confidence in the methodology noting: "*I am not sure how [the study and answering these questions] helps you…I'm not sure if this is for improving care*" (A49). Some respondents identified challenges to confidently answer the study questions, partly related to lack of full information. One noted, "*The stories—if they were a little bit more defined and detailed I think it would help*" (B93). Related to this challenge was that parents questioned whether they had responded "correctly" to the questions. One asked, "*I'm not a mental health professional so why do you want my opinion on these stories*?" (A75).

Reflection on Related Themes. Vignette stories also elicited reflection and commentary from parents on subject matter and themes of importance to them. Open-ended questions at the conclusion of the study seemed to effectively elicit parental feelings and responses about child mental health status and need for help-seeking. One noted, "*I think it's very important, mental health—and especially today, and for Hispanics who are dealing with difficult situations*" (C42). One parent indicated the need to address mental health issues openly. "*I still think there's a tremendous stigma on mental health, it's huge, um and that's the sad part…I still think there is a tremendous amount of denial*" (A25). Other parents provided opinions on the decision-making process of what constitutes need that requires bringing a child to care, and multiple parents reflected on whether they agreed or not with the use of medication.

Cultural Considerations. Parents also identified cultural considerations related to the Latino child in the stories such as recent migration, and whether this destabilization should be considered in assigning psychopathology. In response to the vignette about the normal child, one Latino Spanish-speaking parent noted: "*the majority of people who…come from one country to another, leaving behind a life, have many changes, many psychological problems, mental problems…*" (C13). When reading one of the experimental vignettes, a parent inquired, "*I'm assuming that Maria—she doesn't speak English very well?*" (A101). Later, this parent commented, "*one of the doubts that I had was whether this child had just come from her country and she was new to the system and if she didn't have the language skills at school maybe that's why she was the way she was*" (A101). Another Latino parent

mentioned, *"I think it would be really interesting to look at immigrants versus first generation and their attitudes towards stuff like this"* (C27).

Providers

Response to Vignette Format: Feasibility and Acceptability. Providers successfully filled out the survey; however, the mail-based format represented a challenge. Mail recruitment, originally designed to take place in Boston or Puerto Rico, was expanded nationwide to ensure that sufficient numbers of surveys were received. Providers completed the survey, albeit noting places where responding was a challenge, and only 37 percent filled out the handwritten qualitative portion at the end of the survey. One provider requested that the survey might be shortened, and another hoped that it might be administered in person.

Several clinicians noted that they were pleased with the study and approach. The study team received several requests that findings be shared with them at the completion of the study (BP11, BP13, BP25), and one provider wanted to learn more about the study design to do similar work on the subject (BP84).

Cultural Considerations. Latino clinicians in particular were pleased that the study addressed cultural issues, noting that it is very important "*to discuss cultural issues, which are hardly ever spoken about in families. Children suffer due to the fact that their parents have expectations/social values based on their personal experiences back home and their children's are different based on U.S. culture*" (BP17). Another Latino clinician indicated, "*I find your endeavor to be brilliant because many psychiatrists have preconceived notions on what is expected from various ethnic groups*" (BP101).

Concern with Limited Information. Providers, more so than parents, expressed concern with the limited information available in the vignettes, in that they were lacking the full clinical picture to confidently respond. Several noted that "*it was difficult to answer how much the child's problem will improve, without knowing more information*" (BP86; also BP29, BP31, BP35, BP40), for example, about family supports, community resources, and whether the child's basic needs are met. Others were unsure how to respond to a question about whether the child's problem will improve: *"Sometimes I imagined the question to be with treatment and other times without treatment"* (BP109; also BP24, BP25, BP23). *One*

provider emphasized that it was "unethical" to respond to a question about medication, without more in-depth information about the case. Another suggested, "I think most people can benefit from mental health services at various life stages, so I don't think you have to be deeply troubled to benefit" (BP78). One provider criticized the study as being too transparent, so as to bias the responses.

DISCUSSION

Data collected with study staff displayed several lessons learned for the construction of vignettes that can be used for disparities analysis. Interviews with the Ethnic Differences research team indicate the importance of ensuring that the research question at hand can be best addressed by a vignette approach. Vignettes themselves should be crafted to facilitate participant identification with the story, and reflection on it, and clinical criteria should be balanced by development of "realistic" characters. Vignette stories would benefit from the ability to vary elements of race, ethnicity, and gender in a standardized way. Existing studies using vignettes in a certain content area could be studied to determine whether they could be easily adapted and used in other studies. Nonetheless, it is important to ensure that research procedures are standardized and quality control is a priority. Story calibration is essential to ensure that vignettes are read as intended, and thus vignette drafting is an iterative process. Randomization processes are often complex and must be adequately constructed to ensure effective analysis. The short and succinct nature of the written vignette suggests that authors pay close attention to wording and a pilot test or focus group with potential respondents be used to assess correct wording.

Findings from this study also confirm previous work, which suggests that vignettes are a feasible and appropriate methodology for disparities research. The positive reaction by both Latino and non-Latino parents to stories suggests that vignettes are both acceptable and believable for exploring attitudes on health care services and need. Given that parents and providers brought up the issue of incomplete information, it might be useful in future vignette studies to include a brief introduction that explains that respondents shouldn't feel uncomfortable answering even with incomplete information. For providers in particular, it would be helpful to consider how little of the full clinical picture clinicians *ever* have when initially evaluating and diagnosing a patient. A companion study to this project, the Patient Provider Encounter Study (Alegría et al. 2008), looked at initial evaluations between mental health providers and adult patients, and found that clinicians often make diagnostic judgments despite sig-

nificant missing information about whether their patient fulfills clinical criteria for certain psychiatric disorders. Although this paper does not closely address the quantitative results described in Chavez et al. (2010), we note that the quantitative study successfully displayed significant differences between parent and provider participants, both Latino and non-Latino, that were found as a result of the manipulation of information displayed in the vignettes.

Finally, the nature of respondent commentary and reflection suggest other areas of vignette use beyond research studies, which might target training parents, teachers, or others to identify certain elements of a child's mental health condition or impairment through vignette studies. The request by many parents for support in distinguishing between mental health impairments and the normal changes of adolescence suggests that vignettes might themselves be used to help parents identify these distinctions. One parent noted, *"They should have more stories like this for kids, growing up with certain problems"* (A46). This is congruent with existing work using narratives in health promotion research to improve knowledge, change attitudes, and motivate health behavior change. Kreuter et al. (2007) highlight the four distinctive capabilities of narratives in overcoming resistance, facilitating information processing, providing surrogate social connections, and addressing emotional and existential issues. As Larkey and Hecht (2010) describe, narratives have the ability to promote health behavior change by effectively reaching the "minds and hearts." "Education entertainment" tools used among Latinos can help engage and create a personal connection to characters that helps them overcome individual-level challenges linked to disparities in access to and quality of care (Cabassa et al. 2010). In Wilkin et al.'s (2007) study with a breast cancer telenovela story line, respondents who reported identifying with the characters were more likely to have called a clinic, hotline, or health care setting after hearing about the program and were more likely to indicate that they told others about the topic they read.

One limitation of the present study is that our sample of parent data is drawn from those whose children are already in mental health care, and providers who are familiar with this group. Vignette literature also points to the fact that there may be a significant gap between what people say they are going to do in response to a story and how they react in reality (Hughes 1998; Barter and Renold 1999, 2000). However, vignette methodology does enable valuable insight into perceived experience and choices in otherwise difficult-to-explore counterfactual situations, and literature suggests that assessments made on the basis of vignette case descriptions correlate highly with those made after examination of patients with equivalent symptoms seen in person (Kirwan et al. 1983a,b).

The finding, in this study and others, that stories result in parents' sharing of information about their own experiences, suggests that vignettes could also be used to help generate conversation on sensitive topics between a parent or adult patient and his or her provider, or to provide important information to help distinguish mental health disorders. This could occur not only in mental health waiting rooms but also in primary care practices, and perhaps schools or educational settings where parents are receiving services for their children. Parents' comments related to including the triangulation of parents, children, and teachers suggest an area for future intervention research. Vignette-based studies thus provide an opportunity to use research methodology to explore the opinions, needs, and hopes of the individuals who experience disparities in health care services and to conduct analyses that can produce valuable data for understanding health disparities realities. Health services researchers creating vignette-based studies are encouraged to adopt a vignette development process that is methodologically rigorous, attuned to the participant group, and structured to best addresses the research questions, to effectively inform and improve care in the diverse contexts in which health services disparities exist.

ACKNOWLEDGMENTS

NOTE

1. ID numbers are not patient record numbers; they are solely for research classification. Some interview quotes here have been translated into English from Spanish.

REFERENCES

Alegría, M., O. Nakash, S. Lapatin, V. Oddo, S. Gao, J. Lin, and S. L. Normand. 2008. "How Missing Information in Diagnosis Can Lead to Disparities in the Clinical Encounter." *Journal of Public Health Management and Practice* 14 (suppl): S26–35. November

Barter, C., and E. Renold. 1999. "The Use of Vignettes in Qualitative Research." *Social Research Update* 25 (9): 1–6.

———. 2000. "'I Wanna Tell You a Story': Exploring the Application of Vignettes in Qualitative Research with Children and Young People." *International Journal of Social Research Methodology* 3 (4): 307–23.

Cabassa, L. J. 2007. "Latino Immigrant Men's Perceptions of Depression and Attitudes Toward Help Seeking." *Hispanic Journal of Behavioral Sciences* 29: 492.

Cabassa, L. J., G. B. Molina, and M. Baron. 2010. "Depression *Fotonovela*: Development of a Depression Literacy Tool for Latinos with Limited English Proficiency." *Health Promotion Practice* 10.1177/1524839910367578.

Canino, G., and M. Bravo. 1994. "The Adaptation and Testing of Diagnostic and Outcome Measures for Cross-Cultural Research." *International Review of Psychiatry* 6: 281–6.

Chavez, L., P. Shrout, A. Alegria, S. Lapatin, and G. Canino. 2010. "Ethnic Differences in Perceived Impairment and Need for Care." *Journal of Abnormal Child Psychiatry* 8 (8): 1165.

Cohen, D., and J. Strayer. 1996. "Empathy in Conduct-Disordered and Comparison Couth." *Developmental Psychology* 32: 988–98.

Finch, J. 1987. "The Vignette Technique in Survey Research." *Sociology* 21: 105–14.

Green, A. R., D. R. Carney, D. J. Pallin, L. H. Ngo, K. L. Raymond, L. I. Iezzoni, and M. R. Banaji. 2007. "Implicit Bias among Physicians and Its Prediction of Thrombolysis Decisions for Black and White Patients." *Journal of General Internal Medicine* 22 (9): 1231–8.

Hazel, N. (1995). "*Elicitation Techniques with Young People.*" Social Research Update, Issue 12, Department of Sociology, University of Surrey, Guilford, England.

Hughes, R. 1998. "Considering the Vignette Technique and Its Application to a Study of Drug Injecting and HIV Risk and Safer Behaviour." *Sociology of Health & Illness* 20 (3): 381–400.

Kirwan, J. R., D. M. Chaput de Saintonge, C. R. Joyce, and H. L. Currey. 1983a. "Clinical Judgment in Rheumatoid Arthritis. I. Rheumatologists' Opinions and the Development of 'Paper Patients'." *Annals of Rheumatic Diseases* 42 (6): 644–7.

———. 1983b. "Clinical Judgment in Rheumatoid Arthritis. II. Judging 'Current Disease Activity' in Clinical Practice." *Annals of Rheumatic Diseases* 42 (6): 648–51.

Kreuter, M. W., M. C. Green, J. N. Cappella, M. D. Slater, M. E. Wise, D. Storey, E. M. Clark, D. J. O'Keefe, D. O. Erwin, K. Holmes, L. J. Hinyard, T. Houston, and S. Woolley. 2010. "Narrative Communication in Cancer Prevention and Control:

A Framework to Guide Research and Application." *Journal of Health Communication* 15 (2): 114–35.

Larkey, L. K., and M. Hecht. 2010. "A Model of Effects of Narrative as Culture-Centric Health Promotion." *Journal of Health Communication* 15 (2): 114–35 DOI: 10.1080/10810730903528017.

Martinez, I., and P. Guarnaccia. 2007. "It's Like Going through an Earthquake: Anthropological Perspectives on Depression among Latino Immigrants." *Journal of Immigrant and Minority Health* 9: 17–28, doi: 10.1007/s10903-006-9011-0.

Matias-Carrelo, L. E., L. M. Chavez, G. Negron, G. Canino, S. Aguilar-Gaxiola, and S. Hoppe. 2003. "The Spanish Translation and Cultural Adaptation of Five Mental Health Outcome Measures." *Culture, Medicine, and Psychiatry* 27 (3): 291–313.

Pescosolido, B. A., P. Jensen, J. K. Martin, B. Perry, S. Olafsdottir, and D. Fettes. 2008. "Public Knowledge and Assessment of Child Mental Health Problems: Findings from the National Stigma Study-Children." *Journal of the American Academy of Child and Adolescent Psychiatry* 47 (3): 339–49.

Ryan, G., and H. Bernard. 2003. "Techniques to Identify Themes." *Field Methods* 15 (1): 85–109.

Seguin, C. A., and A. L. Ambrosio. 2002. "Multicultural Vignettes for Teacher Preparation." *Multicultural Perspectives* 4: 10–6.

Schoenberg, N., and H. Ravdal. 2000. "Using Vignettes in Awareness and Attitudinal Research." *International Journal of Social Research Methodology* 3 (1): 63–74.

Shulman, K., J. A. Berlin, W. Harless, J. F. Kerner, S. Sistrunk, B. J. Gersh, R. Dubé, C. K. Taleghani, J. E. Burke, S. Williams, J. Eisenberg, W. Ayers and J.J. Escarce. 1999. "The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization." *New England Journal of Medicine* 340 (8): 618–26. doi:10.1056/NEJM199902253400806.

Valenti, S. S., and A. Costall. 1997. "Visual Perception of Lifted Weight from Kinematic and Static (Photographic) Displays." *Journal of Experimental Psychology – Human Perception and Performance* 23: 181–98.

Wakefield, J. C., S. A. Kirk, K. J. Pottick, D. K. Hsieh, and X. Tian. 2006. "The Lay Concept of Conduct Disorder: Do Nonprofessionals Use Syndromal Symptoms or Internal Dysfunction to Distinguish Disorder from Delinquency?" *Canadian Journal of Psychiatry* 51 (4): 210–7.

Wason, K. D., M. J. Polonsky, and M. R. Hyman. 2002. "Designing Vignette Studies in Marketing." *Australasian Marketing Journal* 10: 41–58.

Wilkin, H. A., T. W. Valente, S. Murphy, M. J. Cody, G. Huang, and V. Beck. 2007. "Does Entertainment-Education Work with Latinos in the United States? Identification and the Effects of a Telenovela Breast Cancer Storyline." *Journal of Health Communication* 12 (5): 455–69.

SUPPORTING INFORMATION

Additional supporting information may be found in the online version of this article:

Appendix SA1: Author Matrix.

Please note: Wiley-Blackwell is not responsible for the content or functionality of any supporting materials supplied by the authors. Any queries (other than missing material) should be directed to the corresponding author for the article.