Expanding Possibilities: Flexibility and Solidarity with Under-resourced Immigrant Families During the COVID-19 Pandemic

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The novel coronavirus has added new anxieties and forms of grieving to the myriad practical and emotional burdens already present in the lives of underserved and uninsured immigrant families and communities. In this article, we relate our experiences since the COVID-19 crisis to the lessons we have learned over time as mental health professionals working with families in no-cost, student-managed community comprehensive health clinics in academic-community partnerships. We compare and contrast the learnings of flexibility of time, space, procedures, or attendance we acquired in this clinical community setting during regular times, with the new challenges families and therapists face, and the adaptations needed to continue to work with our clients in culturally responsive and empowering ways during the COVID-19 pandemic. We describe families, students, professionals, promotoras *(community links), and IT support staff joining together in solidarity as the creative problem solvers of new possibilities when families do not have access to Wi-Fi, smartphones, or computers, or suffer overcrowding and lack of privacy. We describe many anxieties related to economic insecurity or fear of facing death alone, but also how to visualize expanding possibilities in styles of parenting or types of emotional support among family members as elements of hope that may endure beyond these unprecedented tragic times of loss and uncertainty.*

Keywords: Under-resourced; Immigrants; Community Clinic; Health Disparities; Latinx; Telehealth; COVID-19 Impact

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The new coronavirus (COVID-19) pandemic has become a worldwide source of stress affecting global health and mental health, whether through direct experience with the disease or due to the social and economic changes associated with it. A recent study of more than 10,000 adults shows a high level of fear of COVID-19 and its consequences, associated with high incidences of depressive and anxiety symptoms (Fitzpatrick, Harris, & Drawve, 2020).

Although initially the pervasive nature of the pandemic brought up the idea that anybody was at risk of contracting the illness and that COVID-19 would be "the great equalizer," this pandemic has evidenced that racial minorities, and under-resourced and immigrant families are the communities most likely to be negatively affected by healthcare disparities and to experience the heaviest burden of disease (Fortuna et al., 2020). COVID-19 has not been the exception. Information about race and ethnicity has been collected for less than half of US cases (45%). However, data for the first 5 months of 2020 show that racial and ethnic minorities are disproportionately affected by COVID-19. Of those infected, 33% were Hispanic and 22% were Black (Stokes et al., 2020), even though these groups account for 18.3% and 13.4% of the population, respectively (U.S. Census Bureau, 2020).

In relation to mental health, Fitzpatrick et al. (2020) found that COVID-19-related fear and associated anxiety and depressive symptoms were higher for women, Hispanic, Asian, and immigrant individuals and also for families with small children. Exposure to multiple chronic stressors (racism, financial instability, crime, etc.), traumatic experiences, social inequalities, immigrant stressors, and barriers to access to services have a negative effect on both the health and mental health of these under-resourced communities (Fortuna et al., 2020).

Several characteristics of COVID-19 have made it especially painful and anxiety-provoking. For many families, this disease has meant the loss of a generation of elders which has led to grief and sadness (Fortuna et al., 2020). These losses are especially poignant in three-generational families under the same roof where elders have a central role in family functioning. Relational tensions brought about by school closures, distancing from peer groups, and homeschooling of children and adolescents bring an unparalleled disruption to daily life (Lee, 2020). Also, acquiring new family routines in relation to hygiene, social interaction, and other areas of daily functioning has led to exhaustion and constant vigilance (Rivera & Carballea, 2020). Possible long-lasting effects are mediated by the compounding stressors affecting parents' and grandparents' capacities to provide a comforting environment for their children and adolescents, which is a well-known protective factor for anxiety, depressive, and trauma-related disorders (Fortuna et al., 2020). For these reasons, addressing the mental health effects of this pandemic would require interventions that address the whole person in their family and community contexts, and integrate the provision of physical health, mental health, and social services (Fortuna et al., 2020).

Community-oriented approaches to comprehensive collaborative and patient-centered health care hold promise for the reduction of health and mental health inequalities in low-income underserved populations (Aponte & Nickitas, 2007). They represent local solutions in settings that help address multiple barriers to care such as lack of insurance, limited economic resources, and lack of transportation. They can also become the sites for true collaboration between community members who understand their community needs and possible solutions, and professionals who are willing to listen and to learn.

In this article, we present the lessons we have learned for over a decade as mental health professionals working with underserved and uninsured clients in no-cost, student-managed community integrative health clinics based on academic-community partnerships. We compare and contrast those learnings with the new challenges we face, and the

adaptations made as we work with our clients from a culturally responsive framework during the COVID-19 pandemic.

The Student-Run Free Clinic Project

The Student-Run Free Clinic (SRFC), a project that created no-cost community medical clinics, is part of the Department of Family Medicine and Public Health of the University of California in San Diego (UCSD). In 1997, Ellen Beck, M.D, with enormous vision and social and economic justice commitment, in partnership with passionate medical students and dedicated community partners initiated this project by partnering the University with the community to organize free clinics with a dual purpose: (a) address integrated health-care needs of uninsured and underserved adult patients (those who had nowhere to turn and did not qualify for or could not afford health insurance); and (b) become a training ground for students interested in continuing their careers serving underserved and vulnerable populations utilizing a humanistic transdisciplinary empowerment model with the community as teacher in the fields of medicine, pharmacy, dentistry, nursing, acupuncture, law, and social work. In addition to general primary care, 20 specialty services of oncology, nephrology, neurology, gynecology, and mental health are provided by volunteer professionals supervising teams of students. There is also a legal clinic serviced by law students and volunteer attorneys that provide consultation, advice, and referrals. The medical students acquire training in family medicine with the underserved through comprehensive patient care under the supervision of attending physicians, take didactic interactive courses related to underserved health care, learn community advocacy, and have ongoing opportunities for self-reflection (Beck, 2005; Beck et al., 2008b; Wortis, Beck, & Donsky, 2006).[1]

Currently, there are four SRFC clinics in different areas of the city of San Diego providing services to a primarily Latinx population of Mexican origin. Latinx families account for a disproportionate share of uninsured and underinsured Americans. Lacking affordable and quality health and mental health care, and services that are culturally and contextually attuned, many Latinx families are deprived of equal and just treatment (Falicov, 2014; National Council of La Raza, 2005; Ruiz, 2002). Three of the clinics offer mental health services. The clinics operate in spaces lent by religious or academic organizations and are open for around 5 hours per day, 1 day per week, and on different weekdays depending on the location. The clinics have, for the most part, been at the same locations for many years. This evidences a particular relation between the clinics and the communities they serve. SRFCs have built long-lasting partnerships of mutual respect and trust with local organizations to share physical and service resources. Also, the individuals and families who attend the clinics rely on their consistency.

The SRFCs and COVID-19: Innovative Solutions to New Challenges

Although the COVID-19 pandemic has affected virtually all areas of the world, manifestations are different depending on the location. In San Diego, infection and mortality rates have been low compared to other regions of the country. Despite recent acceleration, California still has a relatively low mortality rate (14 per 100,000 people, compared to 258 in New York City, and 37 nationwide; New York Times, June 22, 2020). Within California, however, San Diego County has one of the highest infection rates (number of positive cases per 100,000 people) and, as of June 22, there were 338 deaths reported (New York

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[1]For the mission, philosophy, and educational approach and curricula of the SRFCs, see: https://medschool.ucsd.edu/som/fmph/education/freeclinic/about/Pages/mission.aspx.

Times, June 22, 2020). Some factors that might have contributed to these rates in San Diego are early adoption of shelter-in-place measures and lower population density.

Despite these mitigating factors, disparities persist. The health and economic effects of the pandemic have impacted more severely the Hispanic, Black, and Pacific Islander communities in San Diego County. Hispanics account for 34% of the county population, but constitute 67% of COVID-19 cases. In addition, the infection rates for Blacks and Hispanics are respectively two and four times the rate for the White population in the area (City News Service, June 17, 2020). These discrepancies can be partially explained by the over-representation of Hispanics and Blacks among essential workers and in jobs that require direct contact (e.g., food service, retail, childcare, transportation, and postal services). A study by the San Diego Association of Governments (SANDAG, 2020) found Hispanic and Black families are three times more likely to live in the zip codes most affected by both COVID-19 and unemployment than their White counterparts. These areas are in the southern portion of San Diego County, closer to the United States–Mexico border, and are the places from which the SRFCs receive most of their patients. The impact of COVID-19 and its ramifications have also directly affected the provision of SRFC services.

During COVID-19, the SRFC physicians, pharmacy team, medical students, staff, volunteers, mental health team, social workers, and *promotoras* (experienced community members who are core staff and act as "trust bridges" to the community; Beck, 2005) have come together to continue to provide health, mental health care, and emotional support through telemedicine and delivery of medications and food to patients' homes. Attending physicians, students, support personnel, and the pharmacy team are onsite. However, all patient visits are done by telehealth (phone or video) which has been both challenging and rewarding.

Our patients are some of the most food insecure in the nation. Students have created, in partnership with Feeding America and the Supplemental Nutrition Assistance Program, a system where patients are screened for food insecurity and receive two bags of healthy food during medical visit (Smith et al., 2016). During COVID-19 initially, families came to the clinics' parking lot while students and physicians brought medicine and food to their cars. Now, for further protection, these are delivered to patients' homes by students.[2]

Being part of the SRFCs has always been inspirational and life-transformative (Smith et al., 2014). Coping with COVID-19, medical students, physicians, social workers, interpreters, psychiatrists, psychotherapists, and support staff in solidarity with each other and with patients have embraced new and innovative forms of patient care while developing clinical skills despite the challenges of social distancing.

Mental Health Services for Uninsured and Underserved Families at the SRFCs

Immigrant Latinx patients are more likely to seek or accept mental health services within a community medical setting than independently seeking these services when they suffer depression, anxiety, trauma, or relational conflicts (Falicov, 2014; Valdez et al., 2011; Vega et al., 2001). Mental health distress may also manifest in different "idioms of distress" and somatic complaints such as headaches, stomach aches, or fatigue that are brought up with health practitioners (Falicov, 2009a).

The SRFCs have had, almost from their inception in 1997, psychiatry clinics with volunteer psychiatrists in teaching roles guiding medical students in diagnostic evaluation and psychotropic prescribing skills. There were also limited psychotherapy services provided. In 2007, the first author, a bilingual–bicultural psychologist and family therapist, began her involvement with the clinic by volunteering to provide culturally and

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[2]See website description of current COVID-19 services at SRFCs: https://medschool.ucsd.edu/som/fmph/education/freeclinic/pages/default.aspx.

contextually attuned individual and family therapy to the medical patients in one of the clinic locations (Beck, Dominguez, & Falicov, 2008a). After a few years of increasing referrals, the need for expansion of psychotherapy services became evident. She gradually recruited volunteer psychiatrists, psychologists, and marriage and family therapists who provide psychotherapy in three of the four clinics today. This is how the second and third authors became involved in this project (Falicov, Dominguez, Gonzalez, D'Urso, Abrams, & McClish, 2019). When conducting psychotherapy sessions, it becomes clear that for many families, financial, housing, food, or transportation needs are overwhelming stressors that must be addressed urgently (Sousa & Rodriguez, 2012). In such cases, we coordinate care and advocacy with our social work team.

The approach of the mental health team is based on a systems-ecological orientation that respects cultural diversity without relying on ethnic stereotypes, and promotes empowerment by supporting strength-based rather than deficit-oriented approaches (Falicov, 2014). Identifying strengths has empowering effects and more so in situations of despair or hopelessness in families and communities who are economically marginalized and culturally or racially discriminated against. We center clients' voices as the experts on their needs and their preferred ways to address them. We favor a ground-up approach to learning from clients about their cultural preferences and their contextual stressors, endeavoring to move from professional-led to client-led solutions. In this respect, the mental health services share the SRFC philosophy inspired by Tervalon and Murray-Garcia (1998)'s concept of *cultural humility* as a commitment to self-awareness by the providers in order to redress power imbalances and develop nonpaternalistic partnerships. Students and practitioners adhere to the premise that the patient or the client is the teacher/expert on their own lives. Recent studies support the effectiveness of ground-up and shared decision-making approaches in the treatment of ethnic minorities (Falicov, Nakash, & Alegría, in press; Fraenkel, 2006; Parra-Cardona et al., 2009). Modifying existing mainstream psychological practices or finding innovations that consider culture and context can result in increased access, appeal, and retention in mental health services (Falicov, 2009b; Kanel, 2002).

The psychotherapy team shares strength-based, constructionist approaches to cultural diversity and social justice as a philosophical base for community services. Within this umbrella, the conceptual frameworks of the therapists include family and community system-oriented, structural, collaborative, narrative, solution-focused, emotion-focused therapy, cognitive-behavioral, relational psychoanalysis, or experiential approaches. Some therapists use these approaches flexibly, depending on the needs of the case. They adhere to the notion that it is possible to address social justice through a variety of approaches (McDowell, Knudson-Martin & Bermudez, 2019). Our priorities in selecting mental health volunteers are based on what we believe are healing common factors: professional excellence, passionate community concern and dedication, skills to listen collaboratively and respect local knowledge, and appreciation for the ecology of families and, whenever possible, bilingual/bicultural skills.

Recently, medical students have been involved in psychotherapy sessions and report a better understanding of the process. They reported appreciating the collaborative nature of the sessions which has helped them modify their views of therapy as being practitioner-led and prescriptive. These exposures may increase students' cultural and contextual understandings of our population and model reflective skills to use in their own practice as physicians.

The Impact of COVID-19 in Mental Health Services to Latinx Families

The current pandemic starkly confirmed the far-ranging inequalities that impinge on the survival of people of color. Inequalities in access to the medical system cause a host of

untreated or undertreated health conditions (diabetes, hypertension, heart disease, obesity) that decrease immune responses to infection. Exposures and vulnerability to infection are intensified by dangerous work conditions and essential jobs, overcrowded housing, and neighborhoods that lack protective supplies and preventive information. These inequalities are further intensified for under-resourced immigrants who lack health insurance, experience job instability, unstable housing, underemployment and underpayment, language and culture differences, and diverse beliefs about health and cure. The case examples illustrate how some of these intensified anxieties were addressed in therapy.

> Lucía, 50, was followed up medically via telehealth. She told her physician that she had become depressed because her son, the main economic supporter of the family, had lost his job at a restaurant that closed due to social distancing policies. Because of this, the son had to move in with his mother and sister. In the initial video session, the therapist perceived that Lucia's depression was related to quarreling between her children. The therapist suggested inviting her children to the next video session to discuss their worries and find ways to support each other. Lucía saw this as a way to help her grown children relieve their current distress. During the family session, it became clear that Lucia conceived of her role in hierarchical terms as a parent bent on solving her offspring's problems with suggestions and advice. Rather than appearing receptive, these attempts seemed to irritate her children. Understanding the family interactions from a culturally sensitive, structural family therapy viewpoint, the therapist praised the mother for her maternal good intentions but created an age-appropriate boundary. The main therapy message reversed the idea that the mother needed to resolve their conflicts like she did when her children were younger. Rather, the new losses of security and uncertainty brought about by the pandemic called for increased family cohesion and solidarity initiated by the young adults.

COVID-19 in immigrant family and community contexts may evoke new anxieties in the face of uncertainty, such as prospects of going to a hospital without health insurance, leaving a job because of illness, or asking for help from an already stressed social or family network.

> Eugenia, a 58-year-old client who was attending the clinic for several health issues, and who had received psychotherapy for anxiety symptoms in the past, saw an exacerbation of her anxiety due to COVID-19. Phone sessions were scheduled for psychotherapy. Phone was preferred over video because it allowed Eugenia the freedom to walk to an area in her home where she had privacy to discuss her concerns. Video sessions were discarded because they would require using the only computer in the home, located in her daughters' room. Eugenia knew that her physical conditions made her more vulnerable to complications related to the novel coronavirus. She was also aware that COVID-19 treatment included isolation to avoid contagion. As a monolingual Spanish-speaking immigrant relying on a reduced circle of love and help, the idea of being away from her family and possibly dying alone in a hospital in a strange land was devastating for Eugenia and led to intense fear and anxiety symptoms. Her therapist (second author) engaged the collaboration of Eugenia's physician via phone. With the information given by her physician, Eugenia understood better the symptoms of COVID-19 and the ways this disease propagates. This knowledge was empowering as Eugenia felt better prepared to protect herself and her daughters, although this protectiveness, perhaps a cultural preference, made her still reluctant to share her fears with them in a family session. Emotionally focused interventions such as empathic reflections and emotional heightening gave Eugenia the space to fully express her fears. From the perspective of this therapeutic model, our sense of felt security comes from our closest bonds. To increase Eugenia's sense of felt security, these bonds were explored. Eugenia expressed that her strength comes from the love and connection between her and her two adult daughters, who have always supported each other through thick and thin. Eugenia also said that her faith in God was a source of comfort and hope, and that praying and "putting things in His hands" were something that filled her with peace when she felt afraid. Interestingly, this was a new therapist for Eugenia whom she only met on the phone. Eugenia expressed how comforted she felt by the conversations with the therapist and how much she wished she could get to know her in person soon.

 Immigrants suffer a series of traumas during the migration process: losses of family, language, and culture; unwelcoming reception by the host culture; and persistent economic vulnerability (Falicov, 2014). While immigration is a stressful process per se, the anomic conditions of isolation caused by fear of discrimination and detention, even for those immigrants with legal or quasi-legal status, are an insidious psychological stressor in today's intense official persecutory anti-immigrant climate. Most immigrants have lost many valuable relationships and cultural anchors. Rebuilding social and family closeness, community supports, religious participation, and other cultural rituals are protective elements against isolation, separation, and suffering after immigration (Falicov, 2014; Sluzki, 2008). During COVID-19, the need to maintain social distance precisely when physical and social presence are needed the most, blocks the protective in-person family and community elements for immigrant families, such as church going, or family or neighbor visiting. These experiences that lend connection, belonging, and affirmation of identity become background rather than foreground because of the need to maintain social distance.

Physical connection may also be constructed culturally in nonverbal habitual ways. In most Latinx groups, kissing, hugging, or shaking hands are thought to be signs of affection and sociability often extended to people with whom one has a prolonged relationship, including psychotherapists, a cultural characteristic that has been dubbed "personalismo" (Falicov, 2014) For this reason, we inquire about the effects of social distancing when talking with our clients electronically. Also, replacing physical expressions of affection with caring words from a therapist during COVID-19 may be comforting. These include "I hope you and yours stay healthy and safe," or "I hope you all don't worry too much," or even "I send hugs to all of you." A statement from a therapist to clients such as "Know that you can always call on me" has more poignant implications at this time.

We also regularly inquire about the place of religion, spirituality, and faith in our Latinx clients' lives, as we have learned from them about the powerful contribution of religious beliefs and practices to their well-being, particularly in hard times (Falicov, 2009a; Falicov, 2014). Church going and its social resources are drastically curtailed during COVID-19. However, silent and shared prayer or lighting candles as expressions of trust in God's will continue to be a central resource for our clients at this time.

COVID-19 stressors are not always the focus of the psychotherapy sessions. For some clients, the sessions continue to be largely focused on previous concerns and even some new expanded possibilities opened by the sheltering-at-home situation. In fact, as practitioners inquire about possible concerns related to the pandemic, clients and *promotoras* have reported that some clients have found ways of adapting to the uncertainty of the situation without their lives getting dramatically worse. Crowding and confinement, which may be stressful experiences for resourceful families during the pandemic, may be less onerous to our clients. Enduring poverty, immigration, or language and transportation limitations, these families have adapted over time to a much more limited lifestyle situated almost exclusively in the smaller ecology of their neighborhood. Also, it is possible that given their experience of frequently coping with multiple sources of adversity, clients have developed skills and family resiliencies (Walsh, 2007) that are being put in practice as they face the effects of the pandemic.

Facilitators of Engagement in Mental Health Services: Before and After COVID-19

Physicians' support

The care provided by the physicians and the students at the SRFC clinic is a stellar example of knowing and caring for the whole person of each patient, their families, and

communities. The positive attitudes toward our services have ensured that we have frequent referrals for psychotherapy. Studies have shown that the success of mental health services in primary care settings is dependent on physicians' attitudes (Beacham et al., 2012). Attending physicians working with medical students at the clinic identify when a patient needs mental health services either because of coping with a difficult medical illness, because the patient's health complaints are insufficient to explain their degree of emotional distress, or by conducting regular screenings for depression and anxiety (Soltani et al., 2014). In solidarity, during COVID-19, physicians and students have continued to identify and promptly refer to us those patients in need of mental health attention.

Locating mental health services in the community

The health clinic where the first author originally provided psychotherapy services operated for many years in two empty classrooms and mobile trailers on the grounds of an inner-city public school and sometimes at a nearby community center. Three of four clinics function in neighborhood churches. The physical location of the clinics in a church space with waiting rooms that have chairs close to each other invites social viewing and conversation among the patients. In one of the locations, the room has a table where patients, while waiting, can make crafts under the guidance of a talented community facilitator. Next to it, shelves that offer water bottles, chips, cookies, coffee, and sandwiches at minimal cost are handled by volunteer patients. Medical students get energetically engaged with the patients in these spaces. The ambiance lends a collective sense of belonging, privacy, and even ownership. Many patients tell us that they have found in this environment an extension of "family," perhaps that is the reason why patients bring traditional homemade foods for the students, staff, and other patients when possible. Many describe these actions as their way to "give back," and it is nurturance appreciated by all.

Since COVID-19, this place of encounter has been temporarily lost. The new ways in which the community may be connecting and caring for each other are not evident to us, as we used to witness in the waiting rooms. Knowing that the network experiences that happen face to face contribute to the clients' sense of community, we continue to brainstorm creative ways to provide spaces for collective connection. Aspects of our professional community of care are recreated when our team of students, providers, and staff make the effort to continuously check in with our patients and families using electronic means.

Patients may have more than one appointment per day with physicians and mental health or social work service. This somewhat evokes what a visit to the clinic pre-COVID-19 was like. Virtual coordination has been indispensable to smoothly deliver these combined services. This coordination often requires several staff involved: an IT person, a student who enters the appointments in the electronic clinic records, a *promotora* who follows up via phone with the patient, and several practitioners. These efforts rely on systems that have become more complex but had already been established before COVID-19. Patients have reported that these efforts make them feel that they still have a community that cares and provides safety and security.

Flexibility of physical space for psychotherapy sessions

Within the church-clinic settings, psychotherapy sessions are conducted in a variety of places according to availability. It could be sitting at a small table in the same room with other tables occupied by physicians, students, and interpreters engaged in medical appointments, or in private all-purpose rooms that house file cabinets and supplies that need to be fetched by someone, briefly interrupting the session. The sanctuary of the church can be used too, where at one extreme there may be an acupuncture session in progress with patients in massage tables, and at the other extreme, near the altar, the psychotherapy session is taking place. The limitations in physical resources require providers

to be flexible and adaptable. We find ourselves performing the balancing act of procuring the safety, confidentiality, and privacy necessary for conducting psychotherapy sessions while sharing the physical space with other clinicians. Seating arrangements, screens, and other physical barriers, along with softer voices, aid in creating an atmosphere of privacy and confidentiality conducive to psychotherapy for our clients in the midst of space limitations.

Physical location was radically disrupted by COVID-19. The space that offered both the possibility of social interaction and the privacy to discuss one's concerns is no longer available. Appointments need to be conducted now via telehealth with many barriers to be bridged. The flexibility gained by therapists functioning in a weekly changing space has become an invaluable asset in these changed circumstances. Other forms of flexibility discussed below have always been needed and have become even more salient during this pandemic.

Flexibility of time in convening and holding psychotherapy sessions

Mainstream clinical procedures have an implicit or explicit cultural expectation that the client will show up for scheduled appointments regularly, will be on time, will not overpass the allotted talk time when the end of the therapy hour approaches, or will bring other family members as planned for family sessions. Contrary to those mainstream cultural expectations of punctuality, regularity, and prompt response to calls, many underresourced families are not always able to maintain a regular attendance, and sometimes, they only come sporadically. Other times, they just do not show up, without giving notice because they could not afford to renew their cell phone card, or their car broke down or they did not have money for public transportation. Sometimes, they do not bring another family member to the session as planned because they could not find their spouse or their adult son because he had just gotten an hourly job after months of searching. Sometimes, clients come two hours early because that is when they could get a ride. Other times, they come two hours late because a neighbor or relative could only bring them at that time. Therapists at SRFCs often try their best to see these clients, even if it means juggling schedules and delaying other clients, with their permission, rather than sending clients home, recognizing that they have tried hard to keep the session and it may take a long time before they can come again or bring family members to the session. Among the pathways to reduce inequality, flexibility, and procedural accommodation between provider and client are the foundation for a trusting relationship and a working alliance.

We believe it is possible to conduct effective, helpful, and even fairly orderly treatment in the face of these procedural differences. To accept these differences, the therapist needs to trust the client's motivation and question their own ingrained and often misguided beliefs that events, such as late arrivals, are psychologically motivated or signal resistance to treatment or a lack of commitment to change. The practitioner's trust on the clients' interest in psychotherapy is essential when issues of engagement, convening, and retention are further encumbered by new barriers of time, location, and electronic resources. We consider this recognition of reality-based contextual constraints as a form of solidarity.

During COVID-19, these learnings about flexibility and accommodation of space and time have continued to expand our understanding of the possible. The fact that therapy is now provided via telehealth and that arrangements for transportation are not an issue has expanded possibilities for scheduling at different times of the day and days of the week. Clinicians have opened their schedules to fit the availability of families and their limited access to technological means, continuing the practice of flexibility and consideration for clients' constraints.

Reaching underserved families via telehealth

For most well-resourced populations during COVID-19, healthcare appointments, educational events, and social interactions take place virtually via ICT or IT (information communication technologies) such as Zoom, which allow the benefits of connection during this time of social isolation. For under-resourced families, new and complex challenges emerge. Many economically limited Latinx do not have computers and tend not to use the Internet. They suffer what has been called "cyber lag." While the majority have cell phones and most have smartphones (Brown, Lopez, & Lopez, 2016), they tend to use them only for calling and texting, the latter depending on the age-group. Studies show that among contemporary immigrants, family and community attachments continue intensely at long distance via phone, text, and video (Falicov, 2007), and recently with the application WhatsApp. Unfortunately, these media are not HIPAA-compliant and cannot be used for clinical purposes, whereas those that are HIPAA-compliant, like Zoom, are not easily available without an email address or Internet connection.

The use of virtual technology is not entirely new to working with immigrant families at the free clinic. For therapeutic purposes, we have connected family members geographically dispersed using videoconferencing platforms nationally and binationally. Virtual connections for family therapy have accelerated and expanded locally during COVID-19, making more visible technologies that were tangential to our work, but not totally invisible.

Electronic technology limitations intensify the perils of inequality and require focused attention to reduce it. The presence of an IT person at SRFC, fully dedicated to exploring the feasibility of setting up video calls with clients, while training students, practitioners, interpreters, and clients in IT use, is indispensable to providing services during this pandemic. Interpreters are valuable aids to explore and walk-through the feasibility of remote sessions. Unencumbered by language barriers, they help clients figure out the best means of communication, time, and place in the household. Other barriers to virtual or even phone use arise: lack of time for essential workers or mothers schooling children, work situations with no privacy, and any area with poor reception. Living in very small quarters greatly encumbers the privacy needed to have a therapy hour for individuals, couples, and even families. Interruptions of children or other home occupants occur. The presence of others may limit sharing private thoughts or information that may need to remain confidential. For that reason, therapists check at the beginning of the phone or video session whether the individual, couple, or family members have the privacy and comfort to start the session. Other times, sessions need to be momentarily put on hold while the client answers the relentless questions of a nearby child. Sometimes, more than one person needs access to the same phone in the household. A visually impaired patient who is very lonely sheltering at home asked us to call him for counseling appointments in the mornings because it is the time that he is alone, and has access to the only phone family members share. In the afternoon, others usually need to use the phone, but also, he is less lonely then as his spirit is lifted by the company of their voices.

Despite these barriers, the clinic's team and our client families continue to be the creative problem solvers that embody the free clinic philosophy by stretching the limits of the possible. For instance, a client may realize that a grandson who is a high school student or the adult daughter of a neighbor could lend a computer and help to set a video session for telehealth. Sometimes, there are unexpected treatment insights of using video by seeing the home situation, perhaps the crowding, the warmth of grandmother and grandchild, or the level of noise. Indeed, the video session can become a virtual home visit. Similarly, phone sessions also offer opportunities to get a glimpse of family relationships. During a phone session, when a client was tearfully sharing the pain of a recent loss, the client's

daughter brought her tissues, offered a hug, and whispered in her ear "You are not alone." Although the client quickly apologized for the "interruption," this event opened new avenues in the session. Client and therapist explored the ways the former experienced the love and support of her daughters during this painful time.

Relying on promotoras as community links

It is often the case that clinic patients do not have experience with mental health professionals or are not clear of why they were referred. As therapists, we are aware that as we are strangers, why should people open their hearts and minds to us? A *promotora* is a long-time resident of the community who deeply understands its challenges. She has the role of being a lay health facilitator and advisor. She is the confidant to whom families tell what ails them, what is happening in their lives, how going to church helps them, how worried they are about the son's vulnerability to gangs, or about a girlfriend they do not approve of, or about a husband who drinks too much. In the SRFCs, the *promotoras* often began as patients, became volunteers, and have become the clinic's most treasured employees. Because of their wisdom and community know-how, they are also invited to the University as valued teachers of the students and the faculty.

A *promotora* is the meaningful link between the mental health team and the community. She often functions for us as a "patient consultant." Not only is she supportive of our services and knows us well, she is the intermediary that introduces us to a patient by saying in her own words: "This is Celia, or Alba, or Sol. She is one of our "consejeras" ("counselors"). You can talk with her, you are in good hands with her." This powerful introduction destigmatizes psychotherapy services, and it paves the way for the client to feel more open and trusting of us. The door has been opened to allow us to be embraced as part of the circle of safety and the community of concern at the clinic.

Promotoras are effective in Latinx communities because they are acquainted with their community social networks, cultural values, and health and mental health needs. They are also able to communicate in a language and idioms that are appropriate and accessible to the needs of the community (Rhodes et al., 2007). They are often seen as role models of resilience in the face of adversity and as displaying behaviors to be emulated (Edelblute et al., 2014; Waitzkin et al., 2011).

During COVID-19, with the best of intentions, the therapists of our clinics offered to expedite the process by booking their own appointments to relieve the *promotora* of this task. They soon discovered that clients sometimes did not answer the phone or returned calls, and sometimes did not comply with the scheduled appointment. Why? The therapist often blocked their phone number or simply their phone numbers were not recognized, and the client, protective of their families, did not answer. The trusted person whose name and number were recognized and answered immediately was the community *promotora*. Therefore, during COVID-19, in the absence of face-to-face contacts, the services of the *promotora* to set up and remind clients of their telehealth appointments have become even more essential.

Bilingual–bicultural services

Offering psychotherapy in Spanish is another door that eases the relationship with Latinx clients. Language concordance is ideal when clients are primarily monolingual immigrants. Spanish as the language of birth creates a powerful connection that overrides nationality among Latinos. Our bilingual therapists are immigrants from Argentina, Mexico, Colombia, and Costa Rica, yet their different nationalities are overridden by the emotional impact of a shared language. It is interesting that studies of cultural adaptations of mainstream interventions indicate that language is the most important factor linked to effectiveness of the intervention, over and above ethnic matching (Griner & Smith, 2006).

During the pandemic, having bilingual/bicultural therapists facilitates the therapeutic connection in circumstances when the lack of face-to-face contact can initially make the sessions feel distant or impersonal.

Using interpreters

We make use of excellent interpreters when the mental health professional does not speak Spanish. A sensitive and warm interpreter, who uses accessible language and perhaps even decreases the distance and possible stigma of mental health treatment by engaging the client more fully in conversation, is a great asset. Fortunately, training programs for providing accurate and clinically relevant translation and interpretation have been developing nationwide (DeAngelis, 2010). During COVID-19, we have continued to use interpreters to translate psychiatric evaluation interviews with medical students and non-Spanish-speaking psychiatrists. Interpreters may be needed too in psychotherapy appointments conducted by a mental health practitioner and a student over several sessions. Consequently, there may be several professionals involved in a phone or a video appointment with clients. Interpretation during video or phone psychotherapy sessions is more taxing for all parties, but specially for interpreters because the length of sessions and the scarcity of nonverbal cues are more difficult than during medical appointments.

A support and empowering group

An asset to the mental health services in SRFCs is a community patient group called *El Grupo de Empoderamiento y Ayuda Humanitaria* (The Group of Empowerment and Humanitarian Help). A *promotora* began to facilitate these weekly meetings with a student many years ago. The group met continuously on a weekly basis until it was interrupted by social distancing restrictions during the COVID-19 pandemic. This group provides an important resource of emotional healing for our clients. In fact, participants have described the group as "life-saving," as "part of extended family" they could rely on at times of need, and as a space that offers acceptance and healing (Beck et al., 2008a). This is a drop-in collaborative group for clinic patients of any gender that is also open to health and mental health providers, social workers, students, and clinic staff. Hierarchies are minimized as we all share current personal issues and learn from each other.

The topics of discussion are usually abstract, such as compassion, forgiveness, or self-care, or a Mother's Day celebration or a newspaper article with a human story, all of which do not demand self-disclosure, but nonetheless the conversation becomes therapeutic or psychoeducational. The topics stimulate reference to personal narratives of traumatic events, difficulties with parenting, or couple's issues. Health stressors of chronic illness and recurrent pain, or concerns about gangs or neighborhood safety are also brought up. At other times, the group engages in expressive art and crafts projects that lend a sense of useful participation when the products are sold by the women as their fund-raising contribution to the clinic, or the participants are happy to bring home a collage, gift earrings, or crafts to their family members.

The group ends with all participants standing up in a circle, holding hands and praying, a ritual that attests to the emotional power of religious devotion.

For us, as family therapists, one of the important lessons about family system changes is hearing how many clients of the group report significant family transformations which they attribute to bringing home what they have learned from the group[3]. There is openness in the group to hear various members bring up ideas or projects. For example, just prior to COVID-19 the third author engaged the group in a narrative technique of drawing and discussing their Tree of Life (Denborough, 2008). When one of the group members

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[3]Some testimonials of group members can be seen in this video link: https://youtu.be/VNlIRDe3KIo

became silenced by her own memories of trauma, the other group members came to her aid by sharing the many positive ways that she had touched their lives.

Over the years, the participation of members of the mental health team in this group has contributed to self-referrals from the patients, who either approach us or the *promotora* for requests for advice or counseling for themselves or their families. Conversely, our therapists, appreciating the group's mental health benefits, have also referred their clients to the group. During COVID-19, this face-to-face group is not in session as few patients can partake in a video group experience. Because the deprivation of this source of support and empowerment is significant, we are attempting to find creative ways to re-establish it. One idea is to mail envelopes of art supplies with instructions for projects and include a paid envelope with the clinic's address for return by those who would like their craft shared or displayed. As COVID-19 prevention restrictions relax, we are considering meeting in a park, as it occurred sporadically before, respecting social distance. It is possible that the bonds of friendship and reliance on each other that this group has provided over time are a form of increased social capital that may continue during COVID-19 either by phone talks, or favors, or simply by knowing that those relationships exist and could be called on.

Evolving Psychotherapy Conversations

We surmise from the interactions with clients that we have had so far during COVID-19 that it is important for therapists to first show concern about the impact of the pandemic on the total family and on each member before developing a shared agenda for the session. Expressing empathy for the pile-up of overwhelming stressors in these trying times is an important ground for connection. Engaging in a sense of presence and understanding for the universal uncertainties we all share, while supporting those specific cultural values and rituals that are possible to maintain, are important parts of healing conversations. But we also are attentive to openings for conversations about the learnings that come from immigrants' long familiarity with living with the uncertainty of shifting realities. These conversations may awaken in clients a greater consciousness of their family resilience in the face of new life challenges. Clients are often grateful about our contacts with them and express caring about our own health and the safety of our families.

In the current changed life scenario, we witness the intensification of old and new anxieties and fears as we saw earlier in the cases of the families of Eugenia and Lucia, with current presentations that require new supports and strategies. Nevertheless, new healing family developments are also reported, such as grown sons or daughters, including some who have been estranged, who have become more involved and concerned for their parents' daily needs and endeavor to protect them from the dangers of contagion. In some cases, mothers who are domestics temporarily unable to be employed are spending more time with their children with the benefit of getting to know them more. We have been amazed at the creativity of Latinx communities that celebrate *quinceañeras* (15-year-old traditional lavish birthday celebrations) or engage in funeral processions with caravans of decorated cars parading with their headlights on. An example of new developments and reflections evolving from this changed situation can be learned from the following psychotherapy case.

A case example

The client is Rocío, a Latina woman in her early 30s with two children, aged 11 and 8. Rocío receives help and financial support from the father of her youngest son; however, she is the primary caretaker for her children. Rocío has been a patient of the clinic for several years for various medical issues and has received mental health treatment at

different times with more than one clinician. Her mother and other family members have been patients in the same clinic, a situation that happens with some frequency and facilitates engaging in family therapy.

Six months ago, Rocío started coming to therapy again due to new relationship challenges with close family members for which she was already finding her preferred ways of being when the pandemic started. Due to shelter-in-place orders, Rocío was unable to work in her job at a school cafeteria, had to stay at home with her children, became worried about her financial situation, and had to engage in long-distance education with her children. The children were also anxious with the change in their routine, not seeing their friends and the confinement of their small apartment and not being able to play in the park. The therapist started online therapy having some sessions with Rocío alone and other sessions with Rocío and her children.

At a time of social distancing when the only way to receive education, health, or mental health services is virtual, a person who does not have Wi-Fi connection, a computer, or computer literacy is at a disadvantage. As is the case for most low-income immigrant families, Rocío did not have Internet access and had to go through the process of getting it in her home and learning about technology she had never been exposed to. Her cousin, who already had Internet, helped her by calling the company and arranging the Internet installation. She had to wait several days to get the service set up and had to redistribute her financial means to pay for it monthly. To receive mental health and healthcare services from our clinic, Rocío worked with medical students to set up a Zoom account on her phone and learn how to use it.

The third author worked with Rocío on understanding the effects of COVID-19 on her and her children's lives. The therapist learned different ways in which the uncertainty was creating a sense of fear and affecting Rocío's sleep. From a narrative perspective, the therapist engaged with the client in the practice of "double-listening" (White, 2006; Yuen, 2019), paying attention to the stories of struggle dealing with the practical and emotional impact of COVID-19, and simultaneously listening for her and her family's abilities to respond to these new challenges. In the conversation, alternative stories emerged, where Rocío spoke about how being at home was also having positive effects on her relationship with her kids, which surprised her.

This opened a conversation where Rocío shared that she noticed she was being more patient with her children, even during this session as they interrupted. As we explored this in detail, I asked Rocío how she would name this new way of being with her children and Rocío called it "amabilidad en el hogar" (kindness in the home). Through the conversation, we learned how kindness was showing up in big and small ways and its effects on each member in the family. This led to a conversation about the family legacy of *amabilidad en el hogar* as Rocío shared that this was a value she had learned from her mother who had passed away a few years ago and was Rocío's strong emotional support. Rocío shared stories about her own upbringing and how *amabilidad* or kindness was taught and modeled by the women in her family. At the end of the conversation, the therapist wrote Rocío a letter, which is a common narrative practice, to document her initiative to stay close to "amabilidad en el hogar durante los tiempos de Covid-19" (kindness in the home during the times of COVID-19).

Below is a fragment of the letter (Spanish original and English translation) where the therapist underlines the client's preferred ways of being with her children and her hopes to stay close to *amabilidad en el hogar* during hard times in her life. The therapist also conveys how she has been moved in her personal life to think and practice *amabilidad* and thanks the client for the invitation to do so, making transparent how much she learns from her client and is transformed by their conversations and relationship. In the next session, the therapist met with Rocío and her children where Rocío shared her new

discoveries with her children and they shared with her how they see her as happier and funnier and how they are enjoying their time with her more.

Fragment of the letter in Spanish:

. . ..cuando usted es mamá desde la amabilidad se acerca al tipo de persona que quiere ser y ha sido por mucho tiempo y también es otra forma de seguir honrando y recordando a su mamá. También lo bien que se siente al tratarse con amabilidad es algo que usted quiere recordar en estos tiempos difíciles, cuando la vida quizás nos invita a olvidar la amabilidad y a ocuparnos de otras cosas.

Fue un gusto como siempre hablar con usted Rocío y aprender de las formas que usted está pudiendo ser como mamá, me invitan a mí a querer quedarme cerca de este valor de la amabilidad también, como persona y como mamá. Muchas gracias por la invitación!

Con Cariño,

Sol

English translation of the fragment of the letter:

When you are a mom from a place of kindness, you get closer to the type of person you want to be and have been for a long time and it is another way to continue honoring and remembering your mom. Also, how good it feels when kindness is around is something you want to remember during these difficult times, when life invites us to forget about kindness and take care of other things.

It was a pleasure as always to talk to you Rocío and learn about the ways you are able to be as a mother, they invite me to want to stay close to kindness as well, as a person and as a mother. Thank you very much for the invitation!!

Fondly,

Sol

Conclusion

The continuation of no-cost mental health services to underserved and uninsured Latinx immigrant families as part of an academic student-managed community project during the COVID-19 pandemic illustrates attempts to overcome unprecedented new procedural and clinical practice challenges in the conceptions of structures, responses, time, and space for services.

Our team's overall goal is to reach this underserved population. Flexibilities of time and space, using procedures and protocols that alter the standard professional approaches used with over-resourced families, are necessary to overcome multiple contextual constraints. Rather than describing under-resourced families as "hard to reach," we believe that our adaptations are a form of justice and empowerment that have become even more compelling under COVID-19's new constraints. Relying on our learnings about providing services to under-resourced families and communities in regular times, during the COVID-19 pandemic, we expand the limits of what appears possible in a variety of new ways. Sessions are conducted via telehealth for clients that never had Wi-Fi or used computers before, accommodating to time slots of relative quiet or task-free time in the household, substituting the presence and support usually given by now socially distanced family and friends with empathy, caring words, and offers of phone support given by therapists. Reliance on community helpers or *promotoras* as intermediaries between professional staff and our client families to facilitate setting up and confirming appointments or legitimizing mental healthcare needs is even more necessary during COVID-19.

Deep commitment toward our clients as well as solidarity of purpose among the various members of the health and mental health team has become even more essential during these extraordinary circumstances. We consider concrete acts of care and solidarity, such

as home delivery of donated healthy food and medications by the medical students at the clinic an important aid toward the mental well-being of under-resourced families at this time of isolation and deprivation. No doubt, COVID-19 has created excruciating challenges for already overburdened immigrant families, but in their resilient ways, they also demonstrate new, often creative, and inspiring ways of responding, be it in terms of celebrations, funerals, or new ways of parenting their children, appreciating love bonds, or caring for their elders. Expanding the possibilities of our own flexibility and solidarity as a professional team embodies what we are learning from families whose resilience has helped them face with courage and dignity untold adversities and injustices over generations. Focusing on the strengths of families, we attempt to create space for both, honoring people's complex experiences and reactions in these anguished times and co-creating ways of responding together in this process, visualizing elements of hope and positive changes that may endure.

As we are finishing writing this paper, the country is shaken by the continuous police brutality against Black communities. The local and national protests have heightened our Latinx immigrant communities' fear of police violence, immigration agents, and government attacks toward their families. Our clinic students and the entire clinic's team have shown an outpouring of support and solidarity and have directed their attention to the effects of these stressors on the well-being of our clients. To respond to these current realities, a decision has been made in the SRFC project to strengthen the antiracism university curriculum in integrative health and mental health care for underserved families.

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