AN ECOLOGICAL SISTEMS THEORY APPROACH...

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An Ecological Systems Theory Approach in Looking at Mental Health Care Barriers in the Latino Community

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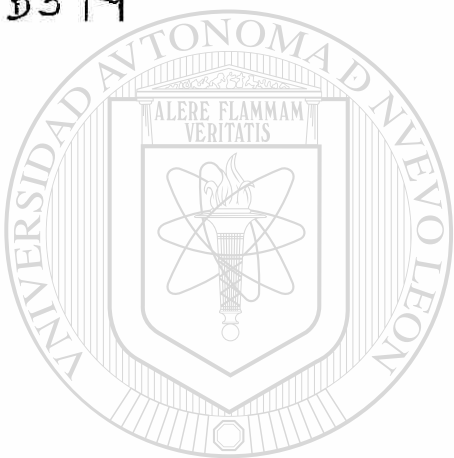

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CHAPTER 1

INTRODUCTION

A Micro Systems Examination of Barriers to Mental Health Care for Latinos

Mental illness in the Latino community can be viewed as a phenomenon that one has no control of. In fact, for many Latinos mental illness can be looked upon as an event caused by an individual to another whose goal is to cause ill will. Garcia and Zea (1997) summarize mental illness in the Latino community by stating the following, "For many Latinos, emotional or mental problems are a sign of weakness, lack of strength or character, bad luck, the result of a spell or a similar supernatural event, or simply God's will" (p.99).

These types of perceptions have an effect on the quality of lives of Latinos in the United States, as a result, this document discusses mental health care for Latinos in the United States. The rapidly growing number of Latinos coupled with low utilization of mental health care presents a challenge for all mental health professionals including the field of social work. The National Association of Social Workers (NASW) (1996) Code of Ethics states:

> The primary mission of the social work profession is to enhance human wellbeing and to help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. (p. 1)

Therefore, it is imperative that the field of social work assist in enhancing mental health care for Latinos and examine barriers that Latinos encounter in accessing mental health care. As a result, this paper investigates possible barriers using an Ecological Systems Theory approach to better understand the phenomena.

The World Health Organization (WHO) defines mental health as "a state of wellbeing in which the individual realizes his or her own abilities, can cope with the normal stresses of life,

can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO, 2001, p. 2). The United States Department of Health and Human Services (USDHHS) and its component, Substance Abuse and Mental Health Services Association (SAMHSA) (2002), have defined mental health as follows:

> How a person thinks, feels, and acts when faced with life's situations. *Mental Health* is how people look at themselves, their lives, and the other people in their lives; evaluate their challenges and problems; and explore their choices. This includes handling stress, relation to other people, and making decisions. (p. 27)

The WHO and SAMHSA's definitions of mental health focus on individual abilities to recognize their own abilities regarding mental health.

> The Surgeon General defined mental health as
>
> the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity; from early childhood until late life, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience, and self-esteem. (USDHHS, 1999, p. 29)

These definitions define mental health, and, no matter how it is defined, mental health is a crucial aspect in every person's life and is critical to the well being of every individual. Nevertheless, mental illness is a huge burden for the United States at all levels of government (local, state, federal) and will be discussed in the next section of this document.

Impact of Mental Illness

According to the Surgeon General's report (1999), the burden of mental illness on U.S. health and production has been miscalculated. The Surgeon General indicates that data collected

by a study called the *Global Burden of Disease* found that mental illness is ranked second, following cardiovascular illnesses, in estimates of the level of burden of diseases in established market economies. The study states that "mental illness emerged . . .as a surprisingly significant contributor to the burden of disease" (p. 6).

Mental illness is especially burdensome for U.S. citizens, particularly for Latinos who were estimated to be at 44.3 million as of July 1, 2006—14.8% of the total U.S. population. This reflects a 3.4% increase between July 1, 2005, and July 1, 2006, making Latinos not only the largest, but also the fastest-growing minority group in the U.S. (U.S. Census Bureau, 2007, p. 1). Given the importance of mental health and the growing population of Latinos, it is essential to examine the relationship between the two. This matter has been researched rather modestly; as a result, it is the purpose of this manuscript to assist in understanding the barriers of mental health care by Latinos.[1]

Statement of the Problem

The U.S. Latino population increased by approximately 22 million, from 22.3 million in 1990, to 44.3 million in 2006 (U.S. Census Bureau, 2001, U.S. Census Bureau, 2007). Estimates project that by July 1, 2050; Latinos will make up almost one-fourth of the U.S. population (U.S. Census Bureau, 2000). These numbers, coupled with the lower utilization of mental health care by Latinos, present a national concern. According to the *New Freedom Commission on Mental Health* (2003), approximately $79 billion are spent annually due to the indirect costs of mental

[1] Throughout this paper there will be different names used to refer to Latino sub-groups (e.g., Hispanic, Chicano, Puerto Rican, and Mexican-American). When these sub-groups are being referred to, it is implying only that subgroup, and not all Latinos; however, these subgroups make up Latinos.

illnesses in the U.S. The majority of the money ($63 billion) was due to "loss of productivity as a result of illnesses" (p. 4).

Key studies conducted during different decades have found that Latinos have a very low rate of utilizing mental health care. In 1959 a study in Texas (Jaco, 1959) concluded that Mexican Americans utilize mental health services much less than do Whites and African Americans (Jaco). Another study conducted by Karno and Edgerton (1969) supported Jaco's findings. According to the 1969 study by Karno and Edgerton, Mexican Americans accounted for "2.2% of State Hospital admissions, 3.4% of State Mental Hygiene Clinic admissions, 0.9% of Neuropsychiatric Institute outpatient admissions and 2.3% of inpatient admissions" (p. 233). The researchers suggested that the expected numbers should have been closer to 9% and 10%.

The most recent data supporting underutilization of mental health care by Latinos is the Los Angeles Epidemiological Catchment Area Study (LA-ECA Study) (Karno et al., 1987) and the Mexican-American Prevalence and Services Study (MAPPS) (Vega, W. A., Kolody, B., Aguilar-Gaxiola, S., Alderate, E., Catalano, R., & Carveo-Anduaga, J., 1998). In the LA-ECA study, Mexicans who spoke mostly Spanish were seven times less likely to use outpatient mental health services compared to non-Hispanic Whites. Also, "Mexican Americans with a diagnosed mental disorder were half as likely as non-Hispanic Whites to make a mental health visit" (Guarnaccia, Martinez, & Acosta, 2005 p. 34,). The MAPPS study has similar findings as the LA-ECA study, in which the researchers concluded that only 25% of Mexican Americans who were identified as having a DSM disorder sought care for their mental health (Guarnaccia et al., 2005).

However, it is possible that one reason for the underutilization of mental health care by Latinos is due to using the extended family as a support system. According to Vega and Alegria

(2001), "Larger social networks composed of family and friends in Puerto Rico may keep individuals out of formal mental health treatment, in sharp contrast to the 'classic' finding among Whites, where social networks facilitate entry into psychotherapy" (p.196). This explanation could possibly help understand the low rates of utilizing mental health care amongst Latinos.

The underutilization of mental health care by Latinos is troublesome because Latinos have been identified as being high-risk for developing mental illness, specifically, depression, anxiety, and substance abuse (National Alliance on Mental Illness, 2003, p. 1). Furthermore, 48% of U.S. born Mexican Americans shows signs of mental illness or substance abuse (Sherer, 2002).

It is obvious that with Latinos being high risk for developing mental illnesses, underutilizing mental health services, and being the largest minority group in the United States, that it does not add up to be a good combination. In fact this presents a major challenge to U.S. policy makers, practitioners, and others who try to meet the growing demand of mental health care for Latinos. Therefore, a great need to address the underutilization of mental health care by Latinos is present. Lopez (2002) reflects this concern:

> The need for researchers to address the mental health needs of Latino persons who live in the United States and its territories is urgent. The Latino population is not only growing but is also spreading to new parts of the United States. (p. 1572)

The explanations for the underutilization of mental health care by Latinos have not been substantial; few theories have been hypothesized to explain or shed light on the underutilization of mental health care. Nevertheless, a need for further examination of other possible explanations or causes of the low rate of utilization of mental health care by Latinos exists. As a result, the

purpose of this study is to examine theories and current practices that affect service utilization of mental health care by Latinos.

Latino's Utilization of Mental Health Services

Using Empirical Methods

Empirical studies such as the MAPPS (Vega et al., 1998) and the LA-ECA Study (Karno et al., 1987) used large-scale surveys and interviews administered within public health. The MAPPS study (Vega et al.) conducted face-to-face interviews (used a translated and culturally adapted version of the Composite International Diagnostic Interview [CIDI]) with 3,012 adult Mexican Americans (18-59 years of age) who were residents of Fresno County, California.

The LA-ECA Study (Karno et al., 1987) also sampled Mexican American adults In Los Angeles, California. This study compared Mexican Americans' mental health with the White sample in Los Angeles and in four other national study sites. The researchers used the Diagnostic Interview Schedule (DIS) for interviewing and translated it into Spanish. Another study interviewed 783 Mexican Americans residing in the El Paso Standard Metropolitan Statistical Area. Face-to-face interviews were conducted in English and Spanish, depending on the preference of the subject being interviewed (Briones et al. 1990). A large number of studies that have found support for the underutilization of mental health care by Latinos have used secondary data analysis from the MAPPS study and the LA-ECA study (Vega, Kolody, & Aguilar-Gaxiola, 2001; Peifer, Hu, & Vega, 2000; Vega, Kolody, Aguilar-Gaxiola, & Catalano, 1999). Results have shown that additional funding to continue studying mental health care by Latinos is vital.

CHAPTER 2

LITERATURE REVIEW

Using Ecological Systems Theory

The problem of mental health care underutilization in Latinos is best understood by using the theoretical framework of Ecological Systems Theory (Bronfenbrenner, 1979). This theory contains four components—microsystem, mezzosystem, exosystem, and macrosystem. The microsystem component includes individuals and their families, the mezzosystem component includes neighborhoods, the exosystem component includes organizations (e.g., state government), and the macrosystem includes overall culture (i.e., all with increasing levels of intimate interaction with the individual) (Martin, 2007).

Therefore, according to the literature review the theoretical barriers that affect service utilization in Latinos have been broken down into four components. The microsystem component will cover the following barriers: (1) language, (2) self-reliant attitude, (3) religious beliefs, (4) alternative treatments, (5) attitudes toward mental health services, (6) citizenship status, (7) unfamiliarity with mental health services (8) stigma of mental illness, (9) inability to recognize mental illness, (10) acculturation, and (11) cost/lack of insurance. The mezzosystem component will cover the following barriers: (1) lack of bilingual/bicultural professionals, and (2) location and accessibility of mental health services. The exosystem component will cover the following barriers: (1) system bias, (2) lack of information, and (3) current practices. The macrosystem component will cover the following barrier: (1) cultural barriers.

Barriers at the Microsystem Level

Language. According to Vega and Alegria (2001) language barrier plays a significant role in the underutilization of mental health care by Latinos. This barrier appears to have no

solution in sight as the number of Spanish speaking people continues to increase, and the number of bilingual mental health professionals is low. A census brief in 2003 "indicated that Spanish speakers grew by about 60% and Spanish continued to be the non-English language most frequently spoken at home in the United States from 1990 to 2000" (Shin & Brunno, 2003, p. 3). Unfortunately, as the numbers of Spanish speakers increases so do the numbers of those who have poor English speaking ability; in fact, approximately 8 million Spanish-speaking people have poor English speaking skills (Shin & Brunno). Having poor English speaking abilities presents challenges to those Latinos who want to seek mental health services. They are unable to communicate their needs and as a result, the threat of their dropping out of treatment is a probability. A study by Laval, Gomez, and Ruiz (1990) supported the view that Spanish-speaking monolingual clients who have communication difficulties with English monolingual mental health professionals tend to drop out early from treatment.

Even more disturbing is the high probability of misdiagnosing Latinos as a result of English speaking deficiencies. Ruiz (2002) points out that some studies reveal the effects of language barriers in assessment and diagnosis of Latino clients. These effects include Latino clients being diagnosed with schizophrenia and other types of psychoses that are misdiagnosised. In turn, the misdiagnosis of Latinos can have ripple effects in their families and their communities, eventually leading to confirmation that the clients were indeed suffering from *locura.*

Misdiagnoses can also lead to Latinos inappropriately medicating that can result in serious side effects. If a misdiagnosis of schizophrenia is given to a Latino client and prescribed *Thorazine* to aid in reducing the symptoms of schizophrenia, then he/she is at risk for developing

tardive dyskinesia, which is "a condition marked by involuntary muscle spasms and twitches in the face and body" (Physician's Desk Reference, 2002, p. 201).

Self- reliant attitude. In a recent study by Ortega and Alegria (2002) evidence was gathered supporting that a self-reliant attitude could lead to the underutilization of mental health care. The study conducted in Puerto Rico found that Puerto Ricans who were less likely to seek mental health care felt that they could take care of their own mental health problems. The self-reliant attitude can be attributed to other cultural constructs in the Latino male population, such as *machismo*. Machismo demonstrates that one should be strong enough to cope with life's problems and not need assistance from mental health professionals. Latino males are significantly more likely to refuse substance abuse services because they feel that they can quit abusing drugs on their own. (Lonshore, Hsieh, Anglin, & Annon, 1992).

Religious beliefs. Religious beliefs may represent a barrier to seeking mental health care for Latinos who believe that their disability, whether it is physical or mental, is entirely in God's hands, *esta en las manos de dios* (Smart & Smart, 1991). The underlying message is that only GOD has the power to cure them from their disability; this thinking obstructs help seeking behavior.

In 2004 about 23% of Latinos (9.5 million) identified themselves as Protestants or other Christians (including Jehovah's Witnesses and Mormons). Thirty-seven percent (14.2 million) of all Latino Protestants and Catholics state they have been born again or are evangelical (Espinosa, Elizondo, & Miranda, 2005). In the 1970s about 95% of Mexican Americans considered themselves to be Catholic (Acosta & Evans, 1982). It is important to note that the intention of this author is to create awareness of the possibility that religion may act as a barrier to seeking mental health care, and not that all religions are against healthcare/mental health care.

Alternative treatment. Latinos may seek other forms of treatment for their symptoms of mental illness. One noted form of treatment is paying a visit to a *curandero* or *esperitista* who perform folk healing using various methods of treatments that include "herbs, massage, diets, advice, prayer, suggestion, and persuasion" (Acosta & Evans, 1982, p. 65). Curanderos have a long history of working with Latinos, in particular Mexican Americans. Over generations curanderos have established trusting relationships with the Latino community, and as a result, curanderos are better able to understand cultural phenomena such as *nervios, susto*, and *mal de ojo.*

As a result, visits to see a curandero increase because of the trusting (see *confianza* p. 29, for further explanation) relationship that has been established between Latino clients and curanderos. Cuellar et al. (1995) reports that making use of folk healers can lead to underutilization of mental health care.

A study conducted in 2000 by Macias and Morales in South Los Angeles County, concluded that 7.2% of the respondents reported using a folk healer for mental health care. More recently, the U.S. DHHS (2001) stated that some studies have shown as many as 44% of the respondents use "*curanderos* or other traditional healers for their general and mental health care" (p. 22). Although the percentages vary across studies regarding usage of folk healers, it is important that this barrier continues to be explored as a possibility for obstructing mental health care in Latinos.

Attitudes toward mental health services. Latinos are known to have a long mistrust of U.S. establishments. Researchers in the early 1970s (Torrey, 1972) postulated that Chicanos viewed mental health institutions as alien, hostile and the White staff as cold. This impression is also reflected in a study by Kline (1969) who states, "The Spanish-American's perception of the

'Anglo' as cold, exploitive, and insincere leads both to underutilization of available psychiatric services among this group and to special problems in the treatment of those who do seek help" (p. 88). Although these studies are outdated this author believes the strong possibility that the findings continue to be a significant factor in Latinos underutilizing mental health care.

Citizenship status. It is not uncommon for undocumented immigrants to fear *"la migra"* (immigration). Some undocumented immigrants fear seeking assistance in a government entity because they fear that the agency and immigration are somehow connected, which would result in revealing their citizenship status and the probability of being deported. Especially if children are involved—not knowing if they would be deported and their children left behind or vice-versa would ultimately be an overwhelming experience, and therefore help is not sought. As a result, citizenship status is a major barrier to Latinos in accessing mental health care (Vega & Alegria, 2001)

Unfamiliarity with mental health services. It is highly probable that Latinos really do not understand the role of a psychotherapist or any other mental health professional, and as a result, seeks help in a medical setting. Karno, Ross, and Caper (1969) suggest that Latinos traditionally have a tendency to seek help from family physicians for mental health issues. In addition, it can be somewhat confusing to comprehend that mental health professionals can hold different academic degrees but still are able to perform psychotherapy. For example, a psychologist and a licensed clinical social worker are able to conduct psychotherapy, but being called a psychologist compared to a licensed clinical social worker makes them sound like two different distinct areas of practice. This leads to confusion and ultimately to a lack of understanding of the roles of mental health professionals. In 1971 Knoll shared similar concerns stating that in her experiences working with a grass roots organization in Detroit, Michigan, the majority of

Chicanos did not seek counseling from family service agencies because they were unfamiliar with the services the agencies provided.

Furthermore, Latinos fear that if they are seen for services, their information might be made public to their friends, family, and to the community. Latinos might be briefed on the issue of confidentiality during the treatment process. However, when a child abuse report or some other mandated reporting is involved, confidentiality no longer applies. As a result, a report is made bringing about an investigation in which the community becomes aware of the situation, and as a consequence the community no longer trusts the agency and fears being serviced by the agency.

Stigma of mental illness. The stigma of mental illness is an influential one. In many Latino communities mental illness is associated with people suffering from being *"loco"* or experiencing *locura* (see appendix A for further explanation). Being *loco* has strong negative implications. It implies that the person is often dangerous to the community and experiencing an incurable disease (Guarnaccia et al., 2005), which can lead to feelings of helplessness, so no help is sought. The stigma of mental illness in the Latino community is very strong. Jenkins (1988) found that many Mexican-American families label their relatives as suffering from *nervios* (see appendix A for further explanation) and not schizophrenia, because this downplays the severity of the illness and encourages family support.

Inability to recognize mental illness. In many Latino communities, mental or emotional problems can be attributed to experiences out of their control (e.g., *fatalismo*, [discussed later], supernatural phenomenon), and viewed as a weakness. Such phenomenona are *susto, mal de ojo*, and *nervios* (see appendix A for further explanation). These phenomena have very similar symptoms of diagnosable mental disorders.

Many times Latinos state that they are experiencing *susto* or *nervios* and grumble about somatic complaints. In a study by Barrio, Yamada, Hough, Hawthorne, and Jeste (2003) Latinos reported a higher rate of somatic symptoms compared to Euro American and African American patients diagnosed with schizophrenia. Another study by Guarnaccia et al. (1993) suggested that Puerto Rican women often associated feelings of powerless and interrupted societal relations as *ataques de nervios* (nerve attacks). These studies demonstrate the possibility that Latinos do not recognize symptoms of mental illness parallel to those of the mental health scheme in the United States. As a result, Latinos' perception of mental illness is not congruent with mainstream mental health, contributing to the underutilization of mental health care.

Acculturation. Acculturation also seems to have an impact on whether or not Latinos seek mental health services. According to Wells, Golding, and Hough (1989) the more acculturated the person is, the more willing he or she is to seek mental health services. This may be due to the possibility that Latinos who are more acculturated are able to speak better English, know where services are located, may have better employment that offers mental health insurance, and may better understand the mental health treatment process which contributes to higher frequencies of mental health visits.

Cost/lack of insurance. According to Woodward, Dwinell, and Arons (1992), cost has been found to be one of the major barriers in accessing mental health care. This is troublesome due to Latinos being more likely to be uninsured compared to any other ethnic or racial group. In 2004, 1 in every 3 Latinos did not have insurance coverage (Moniz & Gorin, 2007). According to Vega and Alegria (2001) lack of insurance is one of the major barriers in accessing mental health care by Latinos. This could be attributed to the fact that Latinos are less likely to have insurance provided by their employers. In 2003 approximately 40% of Latinos received

insurance through their employers, compared to 70% of Whites (Moniz & Gorin, 2007). As a result, Latinos would have to assume the medical debt, and this could become a huge financial burden for them and their families. This is especially a concern since nearly 22% of Latino families live under the poverty level line compared to 10% for the total population in the United States (Ruiz, 2002; Lopez, 2002).

Barriers at the Mezzosystem Level

Lack of bilingual/bicultural professionals. A shortage of bilingual/bicultural mental health professionals in the U.S exists. Latinos make up approximately 14.8% of the total population in the U.S., yet account for only a fraction of health/mental health care professionals. Latinos make up only 2% of the medical field with 5.4% physicians, 4.6% psychiatrists, 3% nurses, 2.2% dentists, and 2.2% pharmacists (Ruiz, 2002).

This is troubling because "Spanish-monolingual Latinos are better serviced by health professionals who know their culture and language" (Preciado & Henry, 1997, p. 239). This notion is also shared by a study conducted by Sue et al. (1991) in which they found that Mexican American patients who had Latino mental health professionals stayed in treatment longer and their levels of functioning increased compared to those Mexican American patients who did not have Latino mental health professionals. It is important that the number of bilingual/bicultural professionals increase to assist with issues surrounding language, culture, and other barriers that prevent Latinos in accessing mental health care.

Location and accessibility of mental health services. Mental health agencies are many times not in Latino communities. This presents a major hurdle for Latinos who live in rural areas and work in the agriculture industry. They would have to take time off from work to get to the agency on time for their appointment (because agencies do not offer services convenient for

these workers). This would create a monetary cut in their check, and would ultimately affect the income of the household. If a Latino client working in the fields goes to therapy once a week for an hour, which would approximate 8-10 hours of missed work a month (e.g., including travel, arranging family to take care of younger children) this would calculate to a reduction of approximately 10% of the monthly salary (40hr/work week). Consequently, a Latino client will stop coming. Moreover, the possibility that the Latino client will lose his/her job as a result of missing hours at work.

Barriers at the Exosystem Level

System bias. Guarnaccia, Martinez, and Acosta (2005) state more evidence exists in the medical setting regarding discrimination against Latinos trying to access mental health care; however, a high probability exists that it is also occurring in the entire mental health setting as well. An example of system bias deals with Mexican Americans in California being the targets of English-only laws (Guarnaccia et al.). This in turn makes it more difficult for limited English-speaking Latinos to access mental health care.

Lack of information. Most of the time mental health settings are not in the same location as the medical setting. This can be somewhat confusing to Latinos, especially if the information is written in English. Not having the correct information of where to seek mental health services can be discouraging and eventually lead to not receiving mental health care (Guarnaccia et al., 2005).

Current practices. Psychotherapy can be viewed as *talk therapy* and relies on clients' ability to articulate their feelings (Preciado & Henry, 1997). Because of this it is crucial that mental health professionals understand and take hold of cultural concepts (e.g., personalismo,

fatalismo) to be able to allow a strong therapeutic relationship to take place, and as a consequence have Latino clients feel comfortable and continue treatment.

The American Psychiatric Association (APA) (2000) states that "it is important that the clinician take into account the individual's ethnic and cultural context in the evaluation of each of the DSM-IV axes" (p. 897). Even so, it is highly likely that many mental health professionals diagnose a client without ever taking into consideration the client's culture. This can lead to serious consequences and can actually exacerbate the symptoms a client is experiencing. For example, it would not be surprising to hear Latino clients state that they have had some close encounter with "*La Virgen*" (Virgin Mary) or some other saint or prophet that belongs to their respective religion. If a mental health professional does not take into consideration that *La Virgen* is seen as a powerful and influential religious icon, this may lead to a serious misdiagnosis and possible enhancing or creating false symptoms of mental illness that were not present before. Burruel and Chavez (1974) give the following illustration:

> Obviously, language is a basic tool in treatment, but how effective can treatment be when words or terms can have different connotations? For example, a Mexican American patient was referred by another agency with a diagnosis of paranoid schizophrenia. This was based on her statements that her ex-husband's ex-wife was 'trying to get her' and had put a hex on her. Discussion with the patient in her own language clearly indicated that much of what she was saying was based on a very common folk belief related to *brujeria* (witchcraft). Is it paranoia, or do we need to know more about the culture to separate that which is common to a group from that which is more clearly individual? (p. 124)

These practices provide a serious mismatch between Latino clients and mental health professionals. In fact, these practices have been carried out for many years and have been a significant factor in the low rates of mental health services used by Latinos. Torrey (1972) highlights this issue:

> One explanation for the underutilization of Anglo psychotherapists by Mexican Americans is that Anglo psychotherapists utilize psychotherapy . . . geared for Anglo culture and do not adapt them for the Mexican American patients. This is, I believe, the most important explanation of why Mexican Americans underutilize mental health services. (p. 117)

Overall, it is vital that mental health professionals take into account culture when working with Latinos. If not, these practices will continue to act as barriers for Latinos seeking mental health services.

Barriers at the Macrosystem Level

Cultural barrier. According to Vega and Alegria (2001), "the term 'cultural barriers' was coined to describe how part of Latinos' underutilization of health and mental health services could be attributed to stigma of mental illness or uncertainty about what the established medical system could offer" (p. 195). As a result, cultural constructs such as *familismo, fatalismo, machismo, personalismo,* and other cultural characteristics will be examined as barriers in Latinos seeking mental health care.

- *Familismo*

  Familismo is an important value that Latino families possess. Family cohesiveness, family loyalty, harmony, and attachment among members, are central elements in familismo (Cuellar, Arnold, & Gonzalez, 1995). These can very well act

as factors in seeking mental health care. In times of crisis or emergencies, family members act as an emotional support system for the one in need and therefore no outside help are sought. According to Keefe, Padilla, and Carlos (1978), the pattern of using the family as a social support network can have an impact in seeking mental health care. It is important to note that in many Latino communities, families are composed of immediate family members as well as non-immediate members. Examples include lifelong friends, relatives, and the acquiring of *comadres* (godmothers) and *compadres* (godfathers) through religious baptismal customs (Acosta & Evans, 1982).

When issues arise within *la familia*, especially mental health issues, these are dealt with privately, within the family, and remain private. This demonstrates the strong commitment and loyalty that members in the family have toward *la familia*. As a result, seeking outside help could be viewed, as disloyalty to the family and mental health care is not sought.

- *Fatalismo*

Cuellar et al. (1995, p. 341) define fatalismo as "the extent to which people feel their destinies are beyond their control." Little evidence suggest that fatalismo can have an effect on help-seeking behavior toward mental health care; however, this concept goes hand-in-hand with the inability to recognize symptoms of mental illness that can eventually lead to mental health care not being sought.

- *Machismo*

Machismo targets Latino males and refers to having *manly traits* (Martin, 1979). Even though some traits have been associated as negative, other more encouraging

traits include taking care of family, being respectful, honest, loyal, fair, trustworthy, and strong. Unfortunately, being strong means not showing or displaying any symptoms of weakness that can lead to feelings of emasculation, thus, asking for help can imply not being strong. As an end result, mental health care would not be wanted.

- *Personalismo*

  Choca (1979, p. 63) defines personalismo as, "a warm and personal way of relating to the client." Actions of personalismo may include appropriate touching of clients when greeting takes place, sharing stories, or exchanging gifts. Personalismo presents a contradictory scenario to the actions of many mental health agencies; in fact, many institutions have policies that prohibit such actions as warranted by personalismo. Many Latinos do not feel the "warmth and personal way" with mental health professionals. Consequently, no rapport is made between Latinos and mental health professionals resulting in discontinued mental health care (Choca, 1979).

Other cultural characteristics are *respeto* (respect), *dignidad* (dignity), and *confianza* (trustworthiness). Respect is an important aspect of the Latino culture. Respect involves associating elders with wisdom, from which *consejos* (advice) is usually sought after. These occurrences can be challenging for elders to seek mental health treatment, especially if mental health professionals are younger than elder Latino clients. It is not uncommon for Latino elders to express themselves as, "Cómo me van a decir a mí de la vida, si yo ya viví," translating into, "How are they going to tell me about life, if I already have lived life," indicating that young people are incapable of being "wise" enough to give *consejos*.

Many Latinos have a strong sense of d*ignidad* (pride). As a result, Latinos may find themselves being too proud to seek help, as it would jeopardize their dignity. In the meantime, they repress their symptoms of mental illness and do not seek mental health care.

Confianza also has the possibility of affecting Latinos in seeking mental health care. If Latinos are unable to establish a trusting relationship with mental health professionals, they are unlikely to return for treatment and will possibly forfeit any future attempts to seek help.

Summary and Conclusions from the Literature Review

Overall, a great need for future research in understanding cultural components in Latinos and its affects on the underutilization of mental health care exists. Few studies, if any, have addressed the fit between the mental health system and Latinos. This reality leaves a huge gap in comprehending how these cultural factors influence help-seeking behavior in Latino communities.

Conclusion

Latino mental health care is facing a crisis in the United States. Understanding family dynamics and culture in Latinos is complex but necessary for retention and treatment in mental health care. Therefore, an urgent need of mental health professionals in the Latino community who can assist in enhancing mental health services at all levels of social work practice, such as therapists, researchers, policy advocates, and other key players.

Lopez (2002) also echoes this concern and goes on to state, "The continued failure to address the significant unmet needs for mental health services among Latinos will result in an increasing burden to Latino families and communities and to the United States overall" (p.

Many Latinos have a strong sense of d*ignidad* (pride). As a result, Latinos may find themselves being too proud to seek help, as it would jeopardize their dignity. In the meantime, they repress their symptoms of mental illness and do not seek mental health care.

Confianza also has the possibility of affecting Latinos in seeking mental health care. If Latinos are unable to establish a trusting relationship with mental health professionals, they are unlikely to return for treatment and will possibly forfeit any future attempts to seek help.

Summary and Conclusions from the Literature Review

Overall, a great need for future research in understanding cultural components in Latinos and its affects on the underutilization of mental health care exists. Few studies, if any, have addressed the fit between the mental health system and Latinos. This reality leaves a huge gap in comprehending how these cultural factors influence help-seeking behavior in Latino communities.

Conclusion

Latino mental health care is facing a crisis in the United States. Understanding family dynamics and culture in Latinos is complex but necessary for retention and treatment in mental health care. Therefore, an urgent need of mental health professionals in the Latino community who can assist in enhancing mental health services at all levels of social work practice, such as therapists, researchers, policy advocates, and other key players.

Lopez (2002) also echoes this concern and goes on to state, "The continued failure to address the significant unmet needs for mental health services among Latinos will result in an increasing burden to Latino families and communities and to the United States overall" (p.

1572). This document should add to the literature and contain relevant information to help further understanding of the barriers that exist between mental health care and Latinos.

Research Question and Hypotheses

As a result of the literature review regarding barriers in accessing mental health care by Latinos, the following research question and hypotheses are as follows. Research Question: What are the perceived barriers in the Latino community in accessing mental health care? What effect do age, gender, education, and health demographics have to do with mental health care barriers in Latinos?

Reasoning for hypotheses. In the beginning of this document this author stated that issues pertaining to Latino mental health have been researched rather modestly, specifically mental health care barriers. This is evident by the review of the literature for this document which examines several barriers using the Ecological Systems Theory. However, only those barriers from the data set that match the literature review coupled with evidence of support will be examined in this study. Furthermore, only barrier variables at the microsystem level of the Ecological Systems Theory will be assessed in this study; due to the unavailability of barrier variables at the mezzosystem, exosystem, and macrosystem levels in the data set.

According to Vega et al.(2001), "The research literature on the phenomenology of mental illnesses and improving access and quality of care for Mexican Americans, and other Latinos, remains about where it stood 25 years ago" (p.133). This document attempts to provide important information to improve the research literature regarding mental health care for Latinos. Therefore, it is important that the social work profession contribute to enhancing mental health services for Latinos by conducting important research such as this document.

Hypotheses

Hypothesis 1 (Microsystem Level): According to Lonshore, Hsieh, Anglin, & Annon (1992), Latino males are significantly more likely to refuse substance abuse services because they feel that they can quit abusing drugs on their own, displaying a "self-reliant attitude". As a result, Hypothesis 1 proposes that men are more apt than women to have a "self-reliant attitude" toward mental health services as a barrier in seeking mental health care. Specifically, an association between gender and "self-reliant" attitude exists as a barrier in seeking mental health care (see Figure 2.1).

Hypothesis 2 (Microsystem Level): According to Torrey (1972) and Kline (1969), Latinos viewed mental health institutions as alien, hostile and the White staff as cold. Because of the dates of these studies, and lack of recent research to conclude the same findings, Hypothesis 2 proposes that older Latinos are more apt than younger Latinos to have an "attitude" toward mental health services as a barrier in seeking mental health care. Specifically, an association between age and "attitude" exists as a barrier in seeking mental health care (see Figure 2.1).

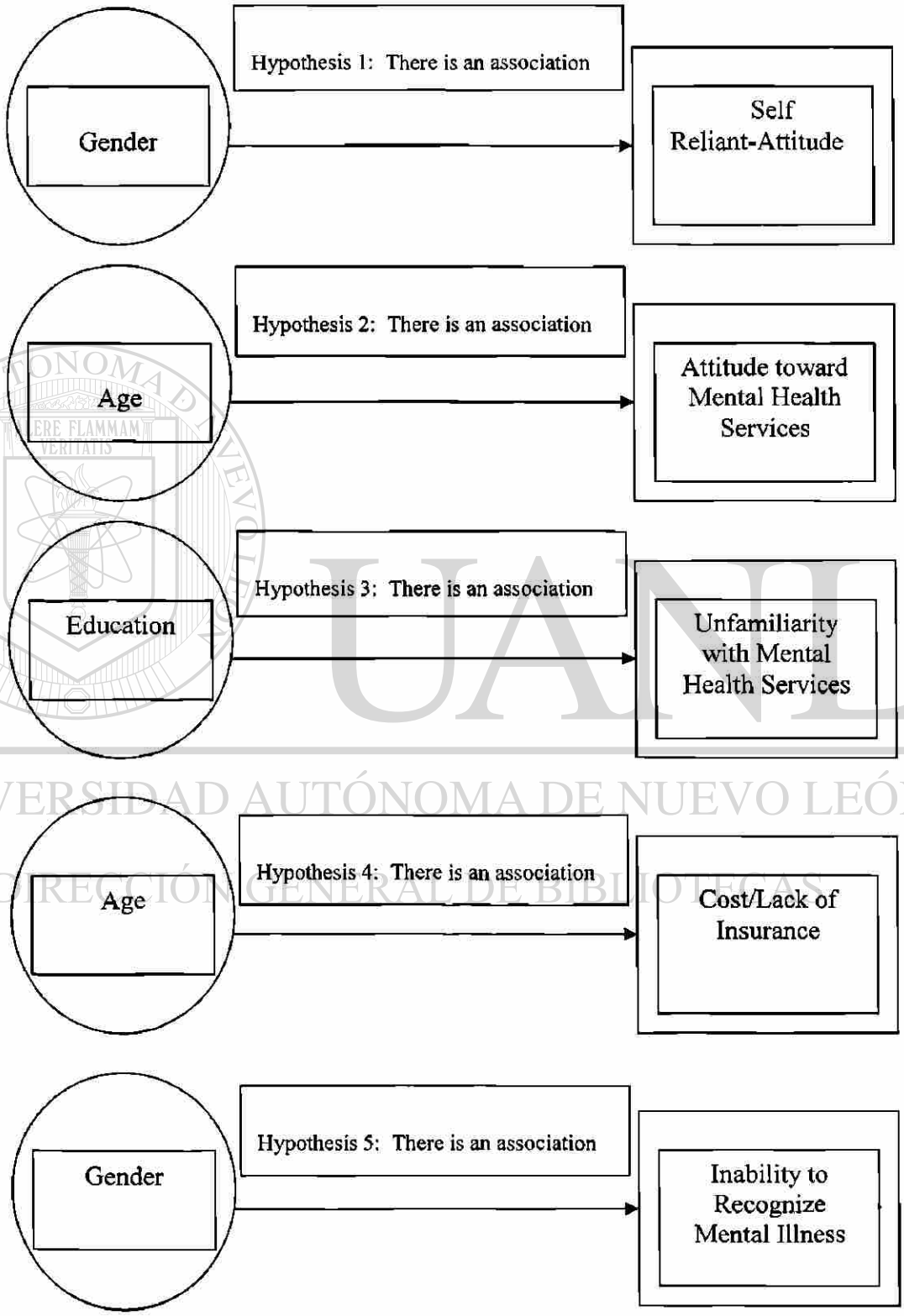
Hypothesis 3 (Microsystem Level): Karno, Ross, and Caper (1969) suggest that Latinos traditionally have a tendency to seek help from family physicians for mental health issues. This could be as a result of not being familiar with mental health services. As a result, Hypothesis 3 proposes that Latinos who have less than a college education are more apt to have "unfamiliarity with mental health services" as a barrier in seeking mental health care. Specifically, an association between education and "unfamiliarity with mental health care" exists as a barrier in seeking mental health care (see Figure 2.1).

Hypothesis 4 (Microsystem Level): According to Vega and Alegria (2001), lack of insurance is one of the major barriers in accessing mental health care by Latinos. As a result,

Hypothesis 4 proposes that younger Latinos (25 years old and younger) are more apt than older Latinos (26 years old and older) to have "cost/lack of insurance" as a barrier in seeking mental health care. Specifically, an association between age and "cost/lack of insurance" exists as a barrier in seeking mental health care (see Figure 2.1).

Hypothesis 5 (Microsystem Level): Guarnaccia et al. (1993) suggested that Puerto Rican women often associated feelings of powerless and interrupted societal relations as *ataques de nervios* (nerve attacks), demonstrating the possibility that Latinas do not recognize symptoms of mental illness. As a result, Hypothesis 5 proposes that Latinas are more apt than men to have "inability to recognize mental illness" as a barrier in seeking mental health care. Specifically, an association between gender and the "inability to recognize mental illness" exists as a barrier in seeking mental health care (see Figure 2.1).

Fig. 2.1. Drawing of Hypotheses using the Microsystem Level Barriers of Ecological Systems Theory.



CHAPTER 3

METHODOLOGY

Overview of the National Survey on Drug Use and Health (NSDUH)

Introduction. This dissertation utilized secondary data from the National Survey on Drug Use and Health, 2005 (NSDUH) provided by the United States Department of Health and Human Services (USDHHS) and the Substance Abuse and Mental Health Services Administration (SAMHSA). The NSDUH is supported by the Office of Applied Studies (OAS) within the SAMHSA and is carried out by RTI International, Research Triangle Park, North Carolina. The 2005 NSDUH primary principle is to measure the occurrences of drug use in the United States, however, the survey also covered questions concerning issues surrounding mental health. This is the first in a coordinated 5-year sample design providing estimates for all 50 States plus the District of Columbia for the years 2005 through 2009 (Office of Applied Studies, 2005).

Sample. The target population for the 2005 NSDUH survey was the civilian, noninstitutionalized (e.g., persons living in shelters, rooming/boarding houses, college dormitories, migratory workers' camps, halfway houses) population of the 50 States plus the District of Columbia who were 12 years of age or older at the time of the survey, including civilians living on military bases. Person that were not included in this survey were active-duty military personnel, persons with no permanent address (e.g., homeless person), and people who were either in jails or hospitals (OAS, 2005). It is important to note that respondents that were 12 years or younger were not eligible to be asked questions regarding mental health service utilization.

Sample Design. The 2005 NSDUH utilized a multistage area probability sampling procedure for each of the 50 states and the District of Columbia. The first step for the 50 State design designated eight states (California, Florida, Illinois, Michigan, New York, Ohio, Pennsylvania, and Texas) as large sample States. The sample sizes in these States varied from 3,562 to 3,699 and were large enough to support direct State estimates. The other 42 States and the District of Columbia were used to support State estimates using small area estimation (SAE), these States produced sample sizes ranging from 840 to 978 (OAS, 2005).

The second step stratified the States into 900 State sampling (SS) regions, which appointed large states with 48 regions each and 12 regions for each small sample State. Using the 2000 census geography, these regions were adjacent areas designed to produce an equal number of interviews. Next, was to select census tracts which according to Office of Applied Studies (2005), "census tracts are relatively permanent statistical subdivisions of counties and provide a stable set of geographical units across decennial census periods" (p.6). Each SS region was assigned 48 census tracts that were selected with probability proportional to size. Within the 48 census tracts, neighboring census blocks were joined to form area sectors. Within each sampled census tract one sector was chosen (OAS, 2005).

The sampled sectors were divided into four separate samples, assigning one sampled sector a three-month period for the purpose of having the survey uninterrupted in the field. In each sector a list of addresses was formed, as a result, 175, 958 addresses were selected, however, only 146, 912 were determined to be eligible sample units. In the eligible sampling units, the interviewer randomly selected eligible persons using an automated screening procedure via a handheld computer. As a result, 68,308 persons were sampled which was representative of the U.S. general population aged 12 or older, however only 55,905 appear on public record due to

steps used to protect the identity of respondents. This survey oversampled youths and young adults, therefore each State's sample was roughly equally distributed among the following age groups: 12 to 17 years, 18 to 25 years, and 26 years and older. Furthermore, State samples were representative of their respective State populations. It is also important to note that respondents who completed a full interview were given an incentive payment of $30 dollars for their participation (OAS, 2005).

Data Questionnaire. The National Survey on Drug Use and Health (NSDUH) questionnaire (formerly titled National Household Survey on Drug Abuse) primarily measures the prevalence and correlates of drug use in the United States. The 2005 NSDUH questionnaire is put together by the Office of Applied Studies and is not standardized. The questionnaire involved face-to-face interviews as well as self reporting responses by subjects.

Data Collection. Letters of introduction were sent out to sampled addresses and a field interviewer followed for a visit. During the visit the field interviewer proceeded with a screening procedure using a handheld computer that involved listing all of the members living in the household as well as collecting their basic demographic data. The demographic data is used by a preprogrammed selection algorithm to have the computer select zero to two sample persons, taking into consideration the makeup of the household. This assisted in selecting the required sample sizes for the individual population age sets (OAS, 2005).

If the computer selected people to be interviewed, the field interviewer immediately made an effort to facilitate the NSDUH interview with those people in the home selected by the computer. The field interviewer requested the people selected to a private area (away from other household people) within the home to facilitate the interview. After being in the private area the

interview proceeded with the respondents answering questions stemming from a computer-assisted personal interviewing (CAPI), which the field interviewer read the questions and a self-administered interview (ACASI). The average length of an individual interview was one hour (OAS, 2005).

The questions that were administered by the field interviewer consisted of basic demographic data as well as questions pertaining to immigration, current school enrollment, employment and workplace issues, health insurance coverage, and income. The questions that were self-administered consisted of use of tobacco, alcohol, marijuana, cocaine, crack cocaine, heroin, hallucinogens, inhalants, pain relievers, tranquilizers, stimulants, sedatives, and information regarding injection drug use, perceived risks of substance use, substance dependence or abuse, arrests, treatment for substance use problems, pregnancy and health care issues, and mental health issues (OAS, 2005).

In summary, the interview began with the field interviewer asking questions from the computer and entering the responses into the computer. Next, the respondent answered questions from the computer by themselves in which they had the option of reading the questions to themselves or listening through headphones and entering their responses directly into the computer. Then, the field interviewer concluded the interview by completing the interview questionnaire. Finally, the respondent were given $30 dollars cash payment for their participation (OAS, 2005). At the end of the work day, if the field interviewer had conducted any interviews, the field interviewer transmitted the data via home telephone lines to RTI in Research Triangle Park, North Carolina (OAS, 2005).

The 2005 NSDUH used in-person interviews with the people selected to assist in increasing reporting, compliance, and truthfulness regarding drug use behavior and mental health

issues. In fact, the Office of Applied Studies (2005) reported an interview response rate of 76 percent. Senior RTI staff members supervised and directed approximately 700 field interviewers for the 2005 NSDUH (OAS, 2005).

Strict measures were used in ensuring respondents confidentiality, this included separating respondents identifying information from survey responses. Respondents were also briefed that their responses and identities would be held in accordance with Federal law rules and regulations (OAS, 2005). As a result, participants were made fully aware of issues pertaining to confidentiality and how their identities would be protected.

Sample for this Dissertation. This dissertation is concerned with barriers that Latinos encounter in accessing mental health care services. As a result, the sample for this dissertation consists only of the Latino respondents ages 18 years and older (n=5,468) from the 2005 NSDUH. This is a secondary data analysis of an existing posted dataset and is available for public use.

Variables for this Dissertation. This study uses a category of questions from the adult mental health utilization section for its variables that pertained to not receiving mental health treatment or counseling Latinos needed, which will be considered "barriers" (n=284). The actual question is as follows, *"Which of these statements explains why you did not get the mental health treatment or counseling you needed?"*(Survey label ADMT27)

Barrier Variables. The following are possible answers ranging from 1-14 (categorical level variable) the respondent could have entered into the computer. If a respondent entered one of the fourteen possible choices for "not seeking mental health treatment or counseling," then that variable was recoded as having "yes" for having that particular barrier. If a respondent did not enter any of the fourteen possible choices for "not seeking mental health treatment or

counseling," then that variable was recoded as having "no" for not having that particular barrier in accessing mental health care (see figure 2). In summary, because it was a multiple response question each possible response was treated as a different item in the analysis; either respondent's chose a particular response and that response was coded as "yes," if respondent's did not chose a particular response then the non-response was coded as "no."

Figure 2. Survey Questions and Barrier Variables from Dataset

Survey Question 1-14	***Survey Label***
You couldn't afford the cost	AUUNCOST
You were concerned that getting mental health treatment or counseling might cuase your neighbors or community to have a negative opinion of you	AUUNBR
You were concerned that getting mental health treatment or counseling might have a negative effect on your job	AUUNJOB
Your health insurance does not cover any mental health treatment or counseling	AUUNNCOV
Your health insurance does not pay enough for mental health treatment or counseling	AUUNENUF
You did not know where to go to get services	AUUNWHER
You were concerned that the information you gave the counselor might not be confidential	AUUNCFID
You were concerned that you might be committed to a psychiatric hospital or might have to take medicine	AUUNCMIT
You didn't think you needed treatment at the time	AUUNNOND
You thought you could handle the problem without treatment	AUUNHNDL
You didn't think treatment would help	AUUNNHLP
You didn't have time (because of job, childcare, or other commitments	AUUNBUSY
You didn't want others to find out that you needed treatment	AUUNFOUT

You had no transportation, or treatment was too far away, or the hours were not convenient	AUUNNTSP

Socio-Demographic Variables. Age: Age was categorized into the following grouping: 18-25 years old, and 26 years old or older (survey label CATAG 2). *Gender*: All respondents were either classified male or female based on the self-identified responses (survey label IRSEX). Other responses were not allowed (i.e. transgender). *Marital Status*: Survey respondents were classified into one of the following categories based on their current marital status: Married, Widowed, Divorced or Separated, Never Been Married (survey label IRMARIT). *Education*: This variable describes the highest level of education attained by the respondent, which is divided into three parts: Less than high school, High school graduate, Some college/ College graduate (survey label EDUCATHP). *Health*: This variable describes their current overall health and categorized into four parts: Excellent, Very good, Good, Fair/ Poor (Survey label HEALTH2). *Military*: This variable describes if the respondent has ever been in the armed forces and given two options to answer: Yes, No (survey label SERVICE). *Pregnancy*: This variable describes whether the respondent was pregnant during the interview and what age group the respondent was in: 15-17 years old, 18-25 years old, 26-44 years old, and otherwise, which were for respondents 14 years and younger or respondents older than 44 (survey label PREGAGE2).

Matching Literature Review Barriers with Data Variable Barriers. In an effort to make the reading easier for understanding the barriers Latinos encounter in accessing mental health services, this author identified the barriers in the literature and matched them with the barriers in the data set (see figure 3). Again, please note that only those barriers at the microsystem level and have evidence of support were evaluated in the hypotheses, as a result, this author has

provided rationale for matching the barrier variables from the data set (respondent's responses) with the literature review barriers (research variable).

Self-Reliant Attitude. According to Ortega and Alegria (2002) evidence was gathered supporting that a self-reliant attitude could lead to the underutilization of mental health care. The study conducted in Puerto Rico found that Puerto Ricans who were less likely to seek mental health care felt that they could take care of their own mental health problems, thus displaying that they could take care of their own issues and exhibiting a "self-reliant attitude" which is a barrier in seeking mental health treatment. The respondent's response (data variable barrier) from the questionnaire reads, "You thought you could handle the problem without treatment," which reflects a "self-reliant attitude" and a barrier in seeking mental health treatment.

Attitudes toward mental health services. Torrey (1972) postulated that Chicanos viewed mental health institutions as alien, hostile and the White staff as cold, thus displaying that mental health services would not help and exhibiting an "attitude toward mental health services" which is barrier in seeking mental health treatment. The respondent's response (data variable barrier) from the questionnaire reads, "You didn't think treatment would help," which reflects an "attitude toward mental health services" and a barrier in seeking mental health treatment.

Unfamiliarity with mental health services. Knoll (1971) found that the majority of Chicanos did not seek counseling from family service agencies because they were unfamiliar with the services the agencies provided in Detroit, Michigan. Thus, displaying the possibility that Chicanos are also unfamiliar with mental health services and exhibiting "unfamiliarity with mental health services" which is a barrier in seeking mental health treatment. The respondent's response (data variable barriers) from the questionnaire reads, "You were concerned that the information you gave the counselor might not be confidential," and "You were concerned that

you might be committed to a psychiatric hospital or might have to take medicine," which reflects "unfamiliarity with mental health services" and a barrier in seeking mental health treatment. Due to the fact that mental health professionals address issues surrounding confidentiality and having to take medication is voluntary. Also, being committed to a psychiatric hospital only applies in severe circumstances and does not apply to issues surrounding non-severe mental illness.

Cost/lack of insurance. According to Woodward, Dwinell, and Arons (1992), cost has been found to be one of the major barriers in accessing mental health care. Also, Vega and Alegria (2001) found that lack of insurance is one of the major barriers in accessing mental health care by Latinos, thus displaying that cost and lack of insurance is a barrier in seeking mental health treatment. The respondent's response (data variable barriers) from the questionnaire reads, "You couldn't afford the cost," "Your health insurance does not cover any mental health treatment or counseling," and "Your health insurance does not pay enough for mental health treatment or counseling." These responses reflect "cost/lack of insurance" as a barrier in seeking mental health care.

Inability to recognize mental illness. Guarnaccia et al. (1993) suggested that Puerto Rican women often associated feelings of powerless and interrupted societal relations as *ataques de nervios* (nerve attacks). These studies demonstrate the possibility that Latinos do not recognize symptoms of mental illness parallel to those of the mental health scheme in the United States, as a result, Latinos' perception of mental illness is not congruent with mainstream mental health, thus, displaying the possibility that Latinos may think they do not need mental health treatment and exhibiting "inability to recognize mental illness" which is a barrier in seeking mental health treatment. The respondent's response (data variable barriers) from the

questionnaire reads, "You didn't think you needed treatment at the time" which reflects the "inability to recognize mental illness" and a barrier in seeking mental health treatment.

Figure 3. Matching Literature Barriers with Data Variable Barriers.

Literature Review Barriers	*Variable Barrier Labels*
Language	NONE
Self-reliant attitude	AUUNHNDL,
Alternative Treatments	NONE
Attitudes toward mental health services	AUUNNHLP
Citizenship status	NONE
Unfamiliar with mental health services	AUUNCFID,AUUNCMIT,
Stigma	AUUNNBR,AUUNJOB,AUUNFOUT,
Lack of bilingual/bicultural staff	NONE
Location & accessibility	AUUNBUSY,AUUNNTSP
Cost/lack of insurance	AUUNCOST,AUUNNCOV,AUUNENUF,
System bias	NONE
Lack of information	AUUNWHER,
Inability to recognize mental illness	AUUNNOND,
Acculturation	NONE
Current practices	NONE
Cultural Barriers	NONE

Statistical Analysis. Chi-square was used to determine association for age, gender, education, and health by barrier. Univariate and descriptive statistics was also applied to the variables being

researched. These statistical procedures were used in an effort to better understand mental health care barriers in the Latino community.

Support For Using Chi-Square. According to Weinbach and Grinnell (2007), "Research articles using chi-square analyses appear frequently in the professional literature . . . it is especially well suited for social work research situations" (p.190). However, the most important reasons that chi-square was used is it assists in answering the research question and hypotheses.

CHAPTER 4

DATA ANALYSIS

This dissertation consists only of the Latino respondents 18 years or older (n=5,468) from the 2005 NSDUH and only looked at barriers that Latinos encounter in accessing mental health care services at the microsystem level. The 2005 NSDUH asked respondents questions pertaining to mental health only if they were 18 years or older, therefore, in this study, data from the original survey related to mental health care barriers and key demographics were considered to determine their association for Latinos 18 years old and older.

Demographics Analysis

Age. In 2005, 5,468 Latinos 18 and older participated in the NSDUH study. The majority of them were ages 18-25 years old (56.4%) and the remainder of the group was 26 years or older (43.6%). *Gender.* The majority of respondents were female (52.6%) and males made up the rest of the sample (47.4%). *Marital Status.* The majority of respondents reported never married (50.3%) followed by those who reported being married (25.2%). Those reported being divorced or separated accounted for 6.3% of the sample followed by those who reported being widowed at 1.6%. *Education.* The majority of respondents reported having less than a high school education

(38.3%). Those that reported having a high school diploma accounted for 31.3% of the sample, followed by those who reported having some college or being a college graduate (30.4%).

Health. The majority of respondents reported being in very good health (32.4%), followed by those who reported being in good health (31.9%). Those who reported being in excellent health made up 22.5% of the sample, followed by those reported in being in fair or poor health (13.3%).

Service. The majority of the respondents have never been in the United States armed forces (67.6%), while those who have served in the armed forces accounted for 4.4%. *Pregnancy.* The majority of the female respondents age 18-44 reported being pregnant at the time of the survey (88.0%) (See Table 4.1).

Summary of Demographic Analysis. The majority of respondents for this study were pregnant female's ages 18-25 years old. According to the Centers for Disease Control pregnancy rates for Latinas ages 18-24 years old in 1999 averaged 154 per 1,000 (CDC, 1999). In addition the majority have never been married with less than a high school education. The majority also reported being in very good health with no service in the United States armed forces (see Figure 4.1).

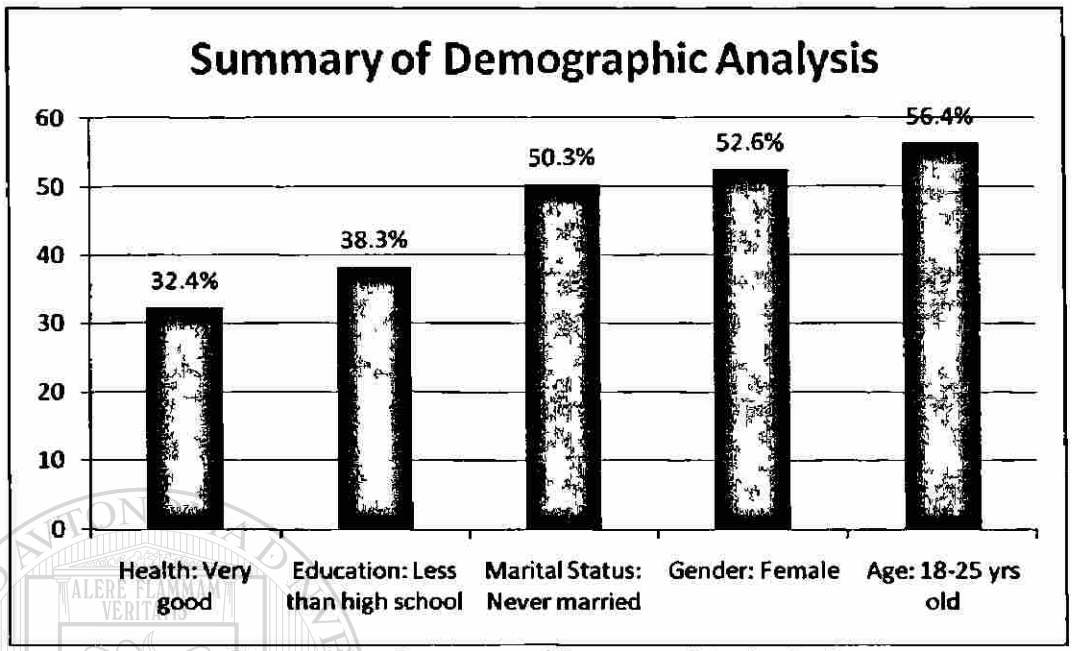


Figure 4.1 – Summary of Demographic Analysis

Table. 4.1 - Demographic Analysis

AGE

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	18-25 Years Old	3083	56.4	56.4	56.4
	26 or Older	2385	43.6	43.6	100.0
	Total	5468	100.0	100.0	

GENDER

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	2591	47.4	47.4	47.4
	Female	2877	52.6	52.6	100.0
	Total	5468	100.0	100.0	

MARITAL STATUS

	Frequency	Percent	Valid Percent	Cumulative Percent

Valid	Married	1377	25.2	30.2	30.2
	Widowed	85	1.6	1.9	32.1
	Divorced or Separated	346	6.3	7.6	39.7
	Never Been Married	2749	50.3	60.3	100.0
	Total	4557	83.3	100.0	
Missing	LEGITIMATE SKIP Respondent is <= 14 years old	911	16.7		
Total		5468	100.0		

EDUCATION

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Less than high school (EDUCCAT2=1)	2095	38.3	38.3	38.3
	High school graduate (EDUCCAT2=2)	1709	31.3	31.3	69.6
	Some College/College Graduate (EDUCCAT2=3,4)	1664	30.4	30.4	100.0
	Total	5468	100.0	100.0	

HEALTH

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Excellent (HEALTH=1)	1228	22.5	22.5	22.5
	Very Good (HEALTH=2)	1770	32.4	32.4	54.8
	Good (HEALTH=3)	1742	31.9	31.9	86.7
	Fair/Poor (HEALTH=4,5)	728	13.3	13.3	100.0
	Total	5468	100.0	100.0	

SERVICE

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	243	4.4	6.2	6.2
	No	3698	67.6	93.8	100.0
	Total	3941	72.1	100.0	
Missing	LEGITIMATE SKIP	1527	27.9		
Total		5468	100.0		

PREGNANCY

		Frequency	Percent	Valid Percent	Cumulative Percent

Valid	18-25 Years Old	3083	56.4	56.4	56.4
	26-44 Years Old	1727	31.6	31.6	88.0
	Otherwise (12-14, 45 or Older)	658	12.0	12.0	100.0
	Total	5468	100.0	100.0	

Hypotheses Analysis

Hypothesis 1

Gender and Self-Reliant Attitude. No statistically significant difference exists between gender and self-reliant attitude (chi square = .027; p=.498), therefore no association between gender and self-reliant attitude exists. Men (24.7%) and women (25.6%) reported approximately the same in terms of "not receiving mental health treatment due to thinking they could handle their problems without mental health treatment." Large percentages of responses were not entered by respondents for this barrier variable question by men (75.3%) and women (74.4%), indicating that "not seeking treatment due to thinking that they could handle their problems on their own" was not an issue for them. According to the literature review, men should have shown a higher percentage as to having self-reliant attitude as a barrier in seeking mental health care.

Hypothesis 2

Age by Attitude toward Mental Health Services. No statistically significant difference between age and attitude toward mental health services exists (chi square = 1.239; p=.186), therefore no association between age and attitude toward mental health services exists. Respondents ages 18-25 accounted for 11.2% of reporting that mental health treatment would not help (attitude toward mental health services), compared with respondents 26 years old and older accounted 6.9% of reporting that mental health treatment would not help. Large percentages of responses were not entered by respondents 18-25 years old (88.8%) and respondents 26 years old and older

(93.1%), indicating that "not seeking mental health treatment due to thinking that mental health treatment would not help" was not an issue for them. According to the literature review older Latinos viewed an "attitude" toward mental health services as a barrier in seeking mental health care.

Hypothesis 3 (First variable)

Education by Unfamiliarity with Mental Health Services. Two variables were used to make up the barrier variable, unfamiliarity with mental health services. The first variable is "not receiving mental health treatment due to being obligated to take medications or being committed" (survey label AUUNCMIT). The second variable is "not receiving mental health treatment due to issues surrounding confidentiality" (AUUNCFID).

No statistically significant difference between education and the first variable ("not receiving mental health treatment due to being obligated to take medications or being committed attitude toward mental health services") exists (chi square = 2.124; p=.346), therefore no association between education and the first variable exists. Respondents with less than a high school education (16.9%) reported "not seeking mental health treatment as a result of being obligated to take medications or being committed." Respondents with a high school diploma (9.3%) reported "not seeking mental health treatment as a result of being obligated to take medications or being committed." Respondents with some college or being a college graduate (12.4%) reported "not seeking mental health treatment as a result of being obligated to take medications or being committed." Large percentages of responses were not entered by respondents who had less than a high school education (83.1%), who had a high school diploma (90.7%), and those who had some college or being college graduates (87.6%), indicating that

"not seeking mental health treatment due to thinking that mental health treatment might have them committed or obligated to take medication" was not an issue for them.

Hypothesis 3 (Second variable)

No statistically significant difference between education and the second variable ("not receiving mental health treatment due to issues surrounding confidentiality") exists (chi square = 7.68; p=.681), therefore no association between education and the second variable exists. Respondents with less than a high school education (11.7%) reported "not seeking mental health treatment as a result of being concerned regarding confidentiality." Respondents with a high school diploma (9.1%) reported "not seeking mental health treatment as a result of being concerned regarding confidentiality." Respondents with some college or being a college graduate (11.6%) reported "not seeking mental health treatment as a result of being concerned regarding confidentiality." Large percentages of responses were not entered by respondents who had less than a high school education (88.3%), who had a high school diploma (91.9%) and those who had some college or being college graduates (88.4%), indicating that not seeking mental health treatment due to thinking that mental health treatment would jeopardize their confidentiality was not an issue for them. According to the literature review Latinos traditionally have a tendency to seek help from family physicians for mental health issues. This could be as a result of not being familiar with mental health services as a result of education levels, however, the data analysis does not support this hypothesis, therefore, no an association between education and "unfamiliarity with mental health care" as a barrier in seeking mental health care.

Hypothesis 4 (First variable)

Age by Cost/Lack of Insurance. Three variables were used to make up the barrier variable, cost/lack of insurance. The first variable is "not receiving mental health treatment due to not being able to afford the cost of mental health treatment" (survey label AUUNCOST). The second variable is "not receiving mental health treatment due to health insurances not paying enough for mental health treatment" (survey label AUUNENUF). The third variable is "not receiving mental health treatment due to their health insurance not covering mental health treatment" (survey label AUUNNCOV).

No statistically significant difference between age and the first variable ("not receiving mental health treatment due to cost of mental health treatment") exists (chi square = .528; p=.275), therefore no association between age and the first variable exists. Respondent's ages 18-25 years old (39.1%) reported that they did "not seek mental health treatment as a result of not being able to afford the cost for mental health treatment," compared to respondents ages 26 years and older (43.7%) who reported "not seeking mental health treatment due to not being able to afford the cost of mental health treatment." Large percentages of responses not being entered were also recorded as respondents ages 18-25 years old made up 60.9% of responses not being entered compared to respondents ages 26 years and older making up 56.3%, indicating that "not seeking mental health treatment due to not being able to afford mental health treatment" was not an issue for them.

Hypothesis 4 (Second variable)

No statistically significant difference between age and the second variable ("not receiving mental health treatment due to their health insurance not paying enough for mental health treatment") exists (chi square = 1.453; p=.203), therefore no association between age and the

second variable exists. However, this is tentative due to 1 cell having less than the expected count of 5 in the chi-square tests.

Respondents ages 18-25 years old who reported "not seeking mental health treatment due not having enough health insurance coverage" was 2%, compared with respondents 26 years old and older which as 4.6%. Large percentages of responses not being entered were also recorded as respondents ages 18-25 years old made up 98.0% of responses not being entered compared to respondents ages 26 years and older making up 95.4%, indicating that "not seeking mental health treatment due to not having enough health insurance coverage" was not an issue for them.

Hypothesis 4 (Third variable)

No statistically significant difference between age and the third variable ("not receiving mental health treatment due to their health insurance not covering mental health treatment") exists (chi square = .253; p=.424), therefore no association between age and the third variable exists. However, this is tentative due to 1 cell having less than the expected count of 5 in the chi-square tests.

Respondents ages 18-25 years old who reported "not seeking mental health treatment due their health insurance not covering mental health treatment" was 6.1%, compared with respondents 26 years old and older which is 4.6%. Large percentages of responses not being entered were also recorded as respondents ages 18-25 years old made up 93.9% of responses not being entered compared to respondents ages 26 years and older making up 95.4%, indicating that "not seeking mental health treatment due to their insurance not covering mental health treatment" was not an issue for them. According to the literature review lack of insurance is one of the major barriers in accessing mental health care by Latinos. However, data from this study does not support the literature review, and as a result does not view "cost/lack of insurance" as a

barrier in seeking mental health care. On the other hand, two of the three variables used to make up this barrier variable show problems with the chi-square tests not meeting chi-square expected count requirements.

Hypothesis 5

Gender by Inability to Recognize Mental Illness. No statistically significant difference between gender and inability to recognize mental illness exists (chi square = .176; p=.438), therefore no association between gender and inability to recognize mental illness exists. Men (7.1%) and women (8.5%) reported approximately the same in terms of "not receiving mental health treatment due to thinking they didn't think they needed mental health treatment at the time." Large percentages of responses were not entered by respondents for this barrier variable question by men (92.9%) and women (91.9%), indicating that "not seeking mental health treatment due to thinking that they did not need mental health treatment at the time" was not an issue for them. According to the literature review, it was possible that Latinas do not recognize symptoms of mental illness. However, data from this study does not support the literature review, and as a result does not view "inability to recognize mental illness" as a barrier for women in seeking mental health care.

CHAPTER 5

DISCUSSION AND IMPLICATIONS

The purpose of this study was to examine the associations between key demographic variables and mental health care barriers in Latinos 18 years and older residing in the United States. Specifically, the following variables were examined; gender and self-reliant attitude, age and attitudes toward mental health services, education and unfamiliarity with mental health services, age and cost/lack of insurance, finally gender and the inability to recognize mental

illness. This study was based on existing datum from the National Survey on Drug Use and Health, 2005 (NSDUH) provided by the United States Department of Health and Human Services (USDHHS) and the Substance Abuse and Mental Health Services Administration (SAMHSA). The NSDUH is supported by the Office of Applied Studies (OAS) within the SAMHSA and is carried out by RTI International, Research Triangle Park, North Carolina. Additionally, only data from Latino respondents ages 18 years and older was included in the study.

Demographics

Demographics. The findings of demographics for this study are interesting. The majority of respondents for this study were pregnant female's ages 18-25 years old, never been married with less than a high school education. The majority also reported being in very good health with no services in the United States armed forces. It is highly probable that this study was conducted during times which were not practical, as a result, working adults were at their employment and not being able to participate in the study. It is also highly probable that Latinos hid during the visit from the field interviewer due to fear of representing an agency with "*la migra*" (Immigration).

Hypothesis 1: Gender and Self-Reliant Attitude

Gender and Self-Reliant Attitude. The first hypothesis of this study stated that men are more apt than women to have a "self-reliant attitude" toward mental health services as a barrier in seeking mental health care. However, the findings of this study do not support the first hypothesis, in fact, the findings suggest the opposite, that no association between gender and "self-reliant attitude" exists (see Figure 5.1).

According to Lonshore, Hsieh, Anglin, & Annon (1992), Latino males are significantly more likely to refuse substance abuse services because they feel that they can quit abusing drugs on their own, displaying a "self-reliant attitude". Unfortunately, the findings show that men (24.7%) and women (25.6%) reported having a self-reliant attitude toward mental health care just about the same. Therefore, these findings challenge the findings of previous studies.

Hypothesis 2: Age by Attitude toward Mental Health Services

Age by Attitude toward Mental Health Services. The second hypothesis of this study stated that older Latinos are more apt than younger Latinos to have an "attitude" toward mental health services as a barrier in seeking mental health care. However, the findings of this study do not support the second hypothesis, in fact, the findings suggest the opposite, that no association between age and attitude toward mental health services exists (see Figure 5.1).

Studies conducted by Torrey (1972) and Kline (1969), suggested that Latinos viewed mental health institutions as alien, hostile and the White staff as cold. Unfortunately, the findings for this study show that Latinos ages 18-25 (11.2%) and Latinos ages 26 years and older (6.9%) reported having an attitude toward mental health care just about the same. A thirty year gap between the previous studies and this one exists, which could very well be that age is not a factor in seeking mental health care, however, further study is needed.

Hypothesis 3: Education by Unfamiliarity with Mental Health Services

Education by Unfamiliarity with Mental Health Services. The third hypothesis of this study stated that Latinos who have less than a college education are more apt to have "unfamiliarity with mental health services" as a barrier in seeking mental health care. However, the findings of this study do not support the third hypothesis, in fact, the findings suggest the opposite, that no

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Hypothesis 3: Education by Unfamiliarity with Mental Health Services

Education by Unfamiliarity with Mental Health Services. The third hypothesis of this study stated that Latinos who have less than a college education are more apt to have "unfamiliarity with mental health services" as a barrier in seeking mental health care. However, the findings of this study do not support the third hypothesis, in fact, the findings suggest the opposite, that no

association between education and unfamiliarity with mental health services exists (see Figure 5.1).

Studies conducted by Karno, Ross, and Caper (1969) suggested that Latinos traditionally have a tendency to seek help from family physicians for mental health issues. It was expected that Latinos who have at least a college education would be familiar with mental health services and would seek more mental health care than those Latinos who have less than a college education. The findings for this study suggest that no association between education and unfamiliarity with mental health services as a barrier in seeking mental health care exists.

Latinos who have less than a high school education (16.9%), high school diploma (9.3%), or some college (12.4%) all reported just about the same as reporting that they did "not seek mental health treatment due to the fear of being committed or forced to take medications." Latinos also showed little concern regarding confidentiality as an issue. Latinos who have less than a high school education (11.7%), high school diploma (8.1%), or some college (11.6%) all reported just about the same as reporting that they did "not seek mental health treatment due to issues surrounding confidentiality."

Hypothesis 4: Age by Cost/Lack of Insurance

Age by Cost/Lack of Insurance. The fourth hypothesis of this study stated that younger Latinos (25 years old and younger) are more apt than older Latinos (26 years old and older) to have "cost/lack of insurance" as a barrier in seeking mental health care. However, the findings of this study do not support the fourth hypothesis, in fact, the findings suggest the opposite, that no association between age and cost/lack of insurance exists (see Figure 5.1).

Even though no association between age and cost/lack of insurance exists as a barrier in seeking mental health care, present are some differences in responses from Latinos regarding

cost/lack of insurance. Latinos ages 18-25 years old (39.1%) and 26 years and older (43.7%) reported a high percentage of stating that they could not afford mental health care. This supports the findings of Vega and Alegria (2001) in which they found that lack of insurance is one of the major barriers in accessing mental health care by Latinos. Furthermore, Latinos ages 18-25 (2.0%) and 26 years old and older (4.6%) had a lower percentage of responding that they did "not seek mental health care due to not having enough health insurance coverage." Finally, Latinos ages 18-25 (6.1%) and 26 years and older (4.6%) also had low percentages of responding that they did "not seek mental health care due to their health insurance not covering mental health treatment."

Results show a significant difference from Latinos responding that they did "not seek mental health care due to not being able for afford mental health treatment, not having enough health insurance, or their insurance not covering mental health treatment." However, cost/lack of insurance clearly has an impact on seeking mental health care and these findings also support the findings of Woodward, Dwinell, and Arons (1992), which state that cost has been found to be one of the major barriers in accessing mental health care for Latinos. Urgent relief is due in this matter as Latinos are more likely to be uninsured compared to any other ethnic or racial group. In 2004, 1 in every 3 Latinos did not have insurance coverage (Moniz & Gorin, 2007).

Hypothesis 5: Gender by Inability to Recognize Mental Illness

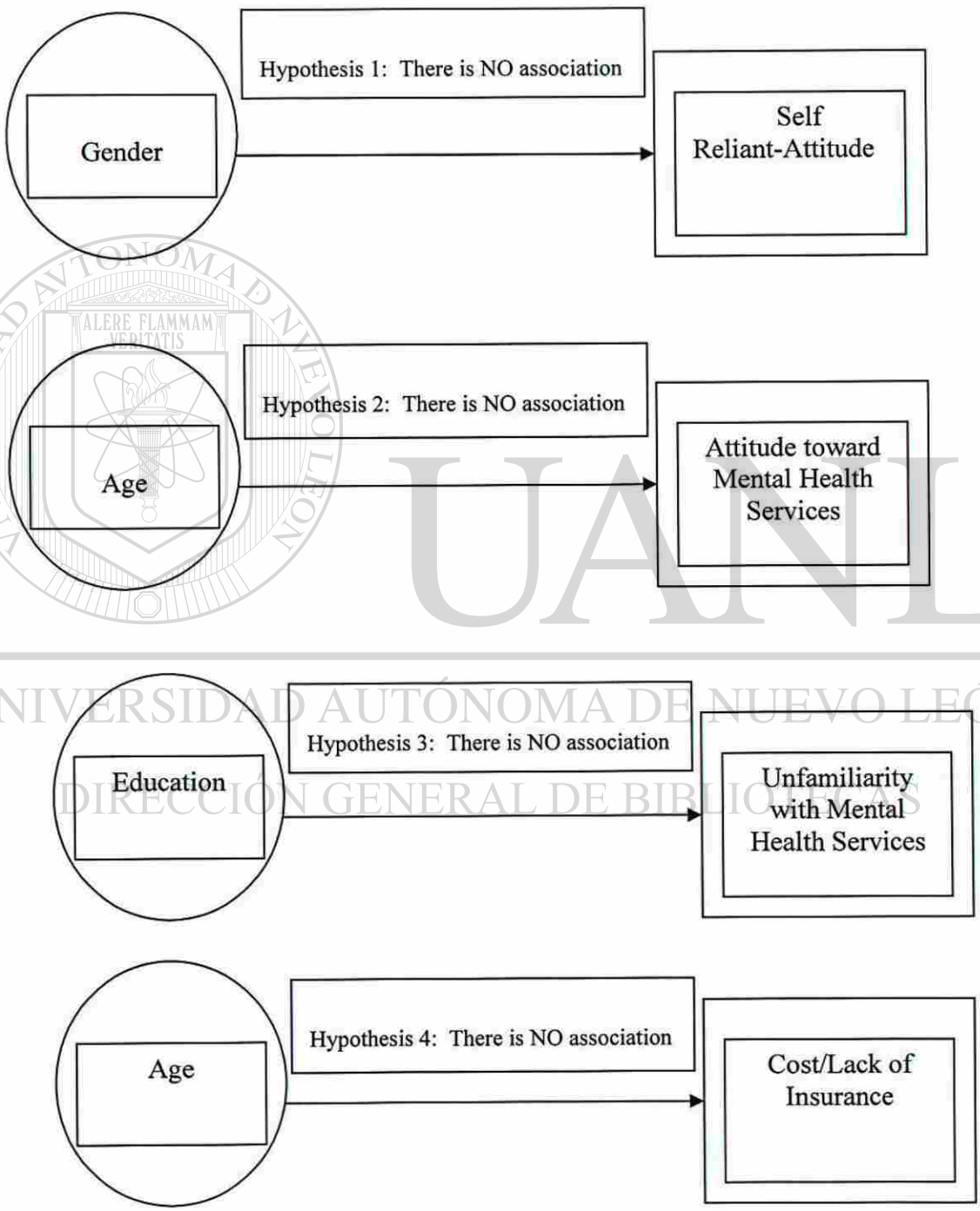
Gender by Inability to Recognize Mental Illness. The fifth hypothesis for this study stated that Latinas are more apt than men to have "inability to recognize mental illness" as a barrier in seeking mental health care. However, the findings of this study do not support the fifth hypothesis, in fact, the findings suggest the opposite, that no association between gender and inability to recognize mental illness exists (see Figure 5.1).

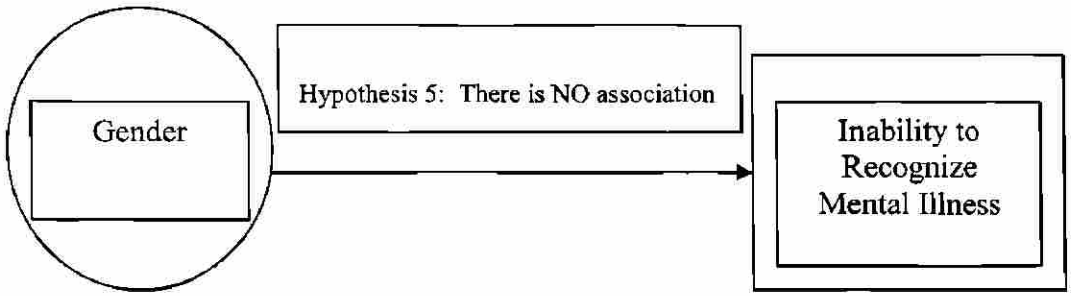
The findings from this study do not support the hypothesis that an association between gender and the inability to recognize mental illness exists. Men (7.1%) and Women (8.5%) reported just about the same in terms of "not seeking mental health treatment due to thinking they did not need treatment at the time." According to Guarnaccia et al. (1993) Puerto Rican women often associated feelings of powerless and interrupted societal relations as *ataques de nervios* (nerve attacks), demonstrating the possibility that Latinas do not recognize symptoms of mental illness. Though there is not a significant difference between men and women, women still had a 1.4% percent more in stating that they felt that they did not need treatment.

Summary

A high percentage of respondents did not enter reasons for not seeking mental health care. This is staggering, since 48% of U.S. born Mexican Americans shows signs of mental illness or substance abuse (Sherer, 2002). Even though, the sample for this study is not primarily Mexican American, the high percentage of Latinos not seeking mental health treatment is significant. It is likely that Latino respondents did not understand the question, "*Which of these statements explains why you did not get the mental health treatment or counseling you needed?*" The words mental health and counseling are not often heard of in Latino population, especially in less educated communities. Therefore, Latinos would have to understand exactly what mental health treatment and counseling mean in order to be able to accurately respond to the question yet, before this is accomplished Latinos would have to understand issues surrounding mental illness.

Fig. 5.1. Drawing result of Hypotheses using the Microsystem Level Barriers of Ecological Systems Theory





Implications

In this study Latinos ages 18 years and older in the U.S., found no associations between age and self-reliant attitude, age and attitude toward mental health services, education and unfamiliarity with mental health services, age and cost/lack of insurance, as well as gender and inability to recognize mental illness. As a result, this study has serious propositions for the field of social work in terms of research, policy, and practice.

Latino Mental Health and Research. It is quite clear with the results of this study that further in-depth mental health research is needed for Latinos in the U.S, specifically the impact of cultural characteristics on help-seeking behavior. More funding is needed to develop culturally sensitive instruments, questionnaires, and research methods. Mental health professionals see mental illness one way and Latino clients see mental illness in another way. Developing instruments, questionnaires, and measures in a language that Latinos can understand would make them culturally appropriate and increase response rates in studies (see Appendix B). Qualitative studies would be culturally appropriate to begin the journey of understanding mental health in Latinos (see Appendix B). Researchers should be trained and educated regarding the cultural characteristics of Latinos including exploring values to aid in improving utilization rates for mental health services. Treatments that address families and not just the individual are needed, since this is an extremely important cultural value in the Latino community (*familismo*).

To gain a better understanding of subsets of Latinos, conducting studies that pertain to Mexicans, Cubans, and Puerto Ricans, would be valuable to find similarities or differences. Finally, research of the best practices for mental health utilization and treatment for Latinos (Guarnaccia et al., 1993) calls for more mental health professionals who speak Spanish and are sensitive to the Latino culture.

Latino Mental Health and Policy. The current shortage of bilingual/bicultural mental health professionals makes it difficult to develop mental health practices for Latinos. Thus, recruiting bilingual and bicultural mental health professionals is imperative in decreasing mental health service barriers that Latinos encounter at all levels of practice (micro, mezzo, exo, and macro). To counter the shortage of bilingual/bicultural mental health professionals, schools of social work should strongly recruit students who are bilingual/bicultural and offer financial incentives (e.g., a forgivable loan). It is this author's hypothesis that financial incentives would attract Latino social work students, given that 21.7% of Latino families live under the poverty level compared to 10.2 % of the total U.S. population. Because of this, only 10% of Latinos actually accomplish four years of education compared to nearly 24% of the total U.S. population (Ruiz, 2002).

Furthermore, schools of social work should offer social work students more education and training in working with the Latino community. Latino clients would greatly benefit from social workers being able to identify cultural construct issues such as *familismo, fatalismo, machismo, personalismo,* and other cultural characteristics that are likely to act as barriers in accessing mental health care. This would also increase social work students' cultural competence a major component in social work.

The field of social work's purpose is to enhance and advocate for oppressed and vulnerable people, therefore it is crucial that social work take a primary role in advocating at the federal, state, and local levels of government. Social workers should advocate for culturally competent training facilities (see Appendix C) and develop, organize, and implement campaigns that provide outreach and education (this could be done by writing educational articles on mental health in Spanish newspapers and advocating for Spanish radio stations to air commercials addressing issues of mental health) for Latinos that address symptoms of mental illness and the importance of receiving mental health treatment. Providing the Latino community with information regarding mental health issues is very important. Latinos need to be exposed to information on mental health, mental illnesses and what treatments are available.

Social workers at all levels of practice could conduct outreach and distribute information on the difference between mental health professionals and medical doctors to assist in helping to understand professional roles. Also, Latinos that seek mental health care in medical settings should be screened for issues surrounding mental illness and if needed be referred out for appropriate mental health care by physicians. This would assist in distigmatizing mental illness, as more people get screened the less people will think that mental health treatment is only for "crazy" people and become routine. In addition, social workers could advocate with the Council on Social Work Education (CSWE) to increase Spanish course hours as a language supplement for social work degrees to assist with language barriers encountered by Spanish-speaking Latinos.

Social workers should strongly challenge policies that act as barriers for mental health care in Latinos. For example, agencies that provide mental health care should make it easier for Latinos to access mental health care by simplifying the intake process and assisting in gathering

the needed requirements for billing purposes. Latinos who feel overwhelmed by all of the paperwork at the initial intake or thereafter might give up and never return for treatment, especially if the documents are not in Spanish and help is not available. As a result, it is important for social workers to educate agencies concerning "too much paperwork" acting as a barrier for mental health care.

Latino Mental Health and Practice. In social work, interventions are usually taught to begin where the clients are, however, interventions are usually in words that are too academic and/or too insensitive, thus, making it difficult for Latino clients to establish a therapeutic relationship and understand the therapeutic process. It would be beneficial for Latino clients to have mental health professionals educate them about the therapeutic process and what it entails in "client words." Also, using self-disclosure on behalf of mental health professionals would alleviate any anxiety Latino clients may have about counseling and demonstrate *personalismo* on behalf of the mental health professionals.

Since Latino clients may have difficulty following the process of therapy and the suggestions/interventions that mental health professionals are utilizing; using drawings or visualization techniques in sessions would make a difference in Latinos understanding the therapeutic process. "Drawing it out" for Latino clients could very well act as a catalyst in assisting therapist and client meet therapeutic treatment goals, consequently, Latino clients could see positive change and begin to see mental health treatment as a "friend" and not a "foe".

Mental health professionals should provide case management services to Latino clients who may have difficulty accessing resources due to language, transportation, or other reasons. This would decrease other stressors and help Latinos clients stay in treatment. In addition, providing Latino clients with the most basic human needs would enhance the therapeutic

relationship by demonstrating that mental health professionals "care," thus, displaying *personalismo*. As a result, providing case managing services coupled with therapeutic interventions could be very productive for treatment goals. Also, since *familismo* is very important in the Latino culture, necessary steps should be taken to include family, priests, *curanderos*, and other important people in treatment sessions for Latino clients.

Strengths and Limitations of This Study

The strength of this study is the contribution it will make in assisting to understand the factors that contribute to the underutilization of mental health care by Latino in the United States. Furthermore, it will assist in contributing knowledge in an effort to eliminate disparities in mental health care for Latinos, which is a component of goal number 3 in the President's New Freedom Commission on Mental Health (DHHS, 2003). Overall, this study is a crucial step in understanding mental health and mental illness in Latinos.

A cross-sectional survey research design was utilized for the 2005 NSDUH. According to Rubin and Babbie (2001), "research studies that examine some phenomenon by taking a cross section of it at one time and analyzing that cross section carefully are called cross-sectional studies," (p.126) this author believes this to be the strength of using a cross-sectional approach for the 2005 NSDUH. The weakness of using a cross-sectional time dimension design is that individuals were interviewed only once and were not interviewed further in subsequent years. Each survey provides information regarding drug use and mental health for the year of 2005 only and does not allow for observation of mental health change over time for specific individuals.

According to Rubin and Babbie (2001) the strength of using a survey research design is that survey findings, "may be more generalizable than the findings of experiments," (p. 380) however, the weakness is that survey research designs have limited internal validity. Rubin and

Babbie (2001) also state that, "survey research is generally weak on validity and strong on reliability" (p.381).

The instrument used to gather data in this study is not standardized, thus being a limitation to this study. Also, respondents were asked questions or asked to answer questions using a hand held computer regarding drug use and health. Two concerns arise from this, first, the respondent's level of English proficiency, second, the respondent's level of computer literacy. It is possible that some of the respondents did not have the level of language skills needed to answer questions accurately as asked by the field interviewer, and/or lacked computer skills needed to accurately answer questions posed by the computer, therefore, the possibility of the data reflecting a non truthful picture of Latinos in this study is highly probable.

This study utilizes secondary data analysis and as a result, it presents challenges as to the validity of what is being researched. This is reflected in the questions from the 2005 NSDUH survey not completely addressing all of the barriers from the literature review. The sample for study was rather homogeneous having a large percentage being pregnant female respondents, which is not an accurate representation of Latinos in the U.S. In addition, key variables that would identify Latinos from different geographical regions were not available in this data set. This would have been a great source of knowledge to verify if Latinos from one area have barriers that Latinos in another are do not, and vice-versa. Also, only Latinos 18 years and older were asked questions regarding mental health, this author believes it is vital to also include Latinos younger than 18 years old, especially since a large percentage of Latino families are migrating into the U.S. and experiencing issues surrounding acculturation.

The variables for this study are in categorical level of measurement, as a result, it limited the statistical analysis that prevented a more in-depth analysis of key variables. This is reflected

in key demographic categories such as age and health. Younger Latinos were identified from age groups 18 years old to 26 years old and older Latinos were identified from 26 years old and older. This presents a problem as a significant difference between a Latino respondent who is 27 years old and a Latino respondent who is 70 years old exists. The variable health describes Latinos' current overall health and categorized into four parts: Excellent, Very good, Good, Fair/ Poor, the issue with this variable is the obvious difference between someone responding as to having fair health and someone having poor health.

Ethical Concerns

Much of the necessary subject confidentiality was solved prior to the survey data's availability through SAMHSA. All names, addresses and other identifying information had been removed from the data with only subject numbers remaining. Downloaded files were stored on a computer with firewall and virus protection, even though the data set is for public use and on SAMHSA's website, files were not made available to other internet and other user access. IRB training was completed on April 17, 2007 as required by the University of Texas at Arlington (UTA) Office of Research Compliance (ORC) (2006a). According to the ORC on September 26, 2007, the database from SAMHSA used in this study, found "that it qualified as exempt from coverage under the federal guidelines for the protection of human subjects as referenced at Title 45—Part 46.101(b)(4)".

Appendix A

Glossary

Locura. A term used by Latinos in the United States and Latin American to refer to a severe form of chronic psychosis. The condition is attributed to an inherited vulnerability, to the effect of multiple life difficulties, or to a combination of both factors. Symptoms exhibited by persons with locura include incoherence, agitation, auditory and visual hallucinations, inability to follow rules of social interaction, unpredictability, and possible violence (American Psychiatric Association [APA]), 2000, p. 901).

Nervios. A common idiom of distress among Latinos in the United States and Latin America. A number of other ethnic groups have related, though often somewhat distinctive, ideas of "nerves" (such as nevra among Greeks in North America). Nervios refers both to a general state of vulnerability to stressful life experiences and to a syndrome brought on my difficult life circumstances. The term *nervios* includes a wide range of symptoms of emotional distress, somatic disturbance, and inability to function. Common symptoms include headaches and "brain aches", irritability, stomach disturbances, sleep difficulties, nervousness, easy tearfulness, and inability to concentrate, trembling, tingling sensations, and *mareos* (dizziness with occasional vertigo-like exacerbations). Nervios tends to be an ongoing problem, although variable in the degree of disability manifested. Nervios is a very broad syndrome that spans the range from cases free of a mental disorder to presentations resembling Adjustment, Anxiety, Depressive, Dissociative, Somatoform, or Psychotic Disorders. Differential diagnosis will depend on the constellation of symptoms experienced, the kind of social events that are associated with the onset and progress of nervios, and the level of disability experienced (APA, 2000, p. 901).

Susto ("fright," or "soul loss"). A folk illness prevalent among some Latinos in the United States and among people in Mexico, Central America, and South America. Susto is also referred to as *espanto, pasmo, tripa ida, perdida del alma*, or *chibih*. Susto is an illness to a frightening event that causes the soul to leave the body and results in unhappiness and sickness. Individuals with susto also experience significant strains in key social roles. Symptoms may appear any time from days to years after the freight is experienced. It is believed that in extreme cases, susto may result in death. Typical symptoms include appetite disturbances, inadequate or excessive sleep, troubled sleep or dreams, feelings of sadness, lack of motivation to do anything, and feelings of low self-worth or dirtiness. Somatic symptoms accompany susto include muscle aches and pains, headache, stomachache, and diarrhea. Ritual healings are focuses on calling the soul back to the body and cleansing the person to restore bodily and spiritual balance. Different experiences of susto may be related to Major Depressive Disorder, Posttraumatic Stress Disorder, and Somatoform Disorders. Similar etiological beliefs and symptom configurations are found in many parts of the world (APA, 2000, p. 903).

Mal de ojo. A concept widely found in Mediterranean cultures and elsewhere in the world. *Mal de ojo* is a Spanish phrase translated into English as "evil eye". Children are especially at risk. Symptoms include fitful sleep, crying without apparent cause, diarrhea, vomiting, and fever in a child or infant. Sometimes adults (especially females) have the condition (APA, 2000, p. 901).

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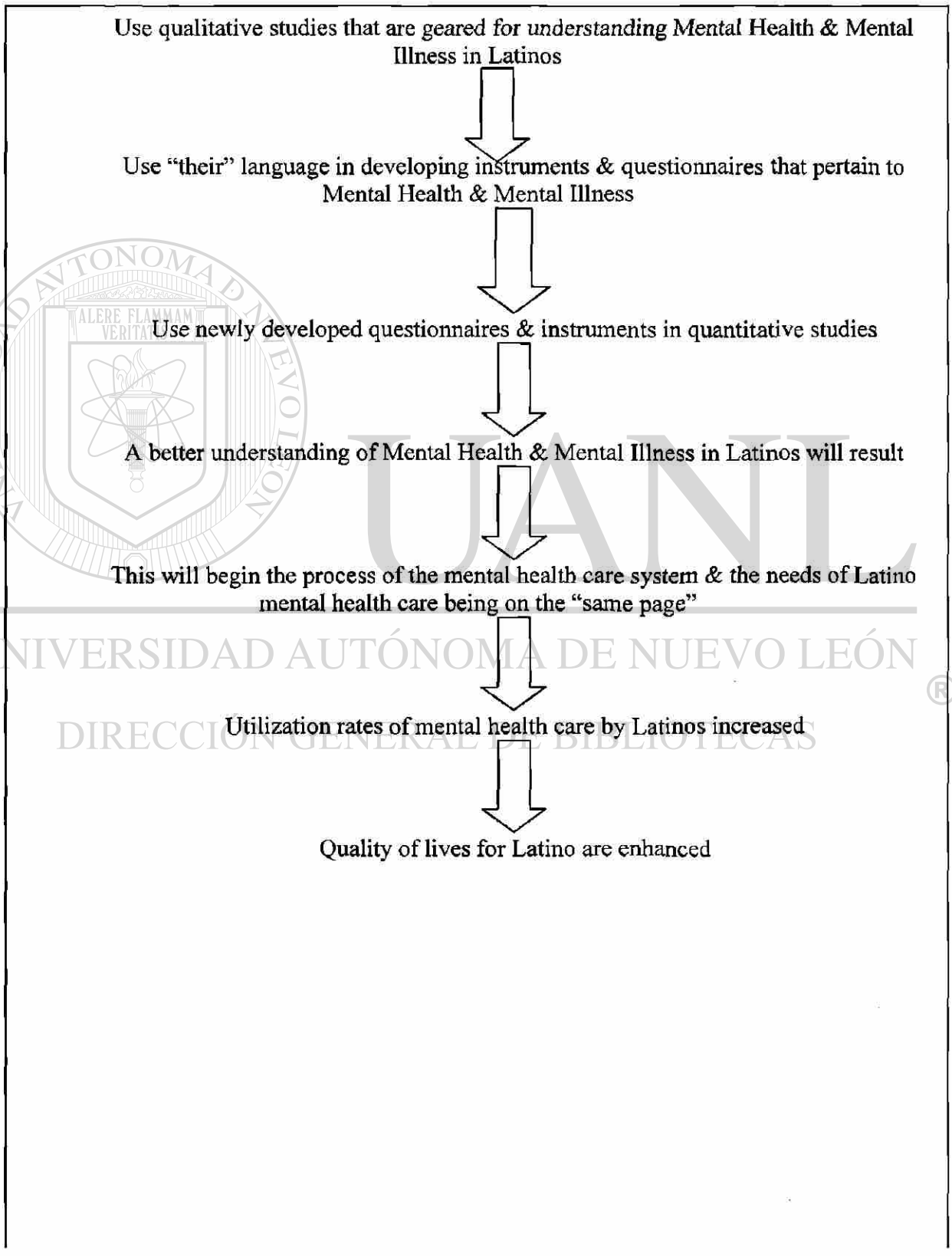
Appendix B

Using Qualitative Studies to Enhance Utilization Rates of Mental Health Care in Latinos.



Appendix C

Mental Health Policy Proposal for the President of the United States

Dear Mr. President.

The public mental health system needs to be transformed. Not only is the mental health system being ignored, but according to the Surgeon General's report (1999), the burden of mental illness on U.S. health and production has been miscalculated. The Surgeon General indicates that mental illness is the second costliest disease-related burden in established market economies, after cardio vascular illness. At least $79 billion is spent each year due to the indirect cost of mental illness in the U.S.

A factor contributing to the social and economic costs of mental health and mental illness in the U.S. is the lack of mental health professionals who provide adequate, culturally competent, mental health services to minorities. It is difficult to put a precise dollar amount on how much of the $79 billion spent each year is due to the lack of culturally competent mental health professionals in the mental health system, on the other hand, it is well documented that ethnic and racial minorities in the U.S. are less likely to seek mental health care compared to Whites. Therefore, underutilization of mental health care by minorities contributes to indirect costs of mental illness in the U.S.

Mental health is a crucial aspect in every person's life and is critical to the overall health of every individual. For that reason, to assist in enhancing mental health services to diverse populations in the United States, my proposal to you is to support my efforts in developing, organizing, and implementing state mental health training centers that conduct research on delivering culturally competent practices for minority populations, specifically to train mental health professionals appropriate cultural interventions to increase utilization rates in minorities.

This proposal requests the amount of $80 billion a year for 10 years. First, the states of California, Arizona, Florida, New York and Texas will share $8 billion to begin state mental health training centers. Then, each additional year $8 billion will be shared amongst five other state mental health training facilities to be identified at that time. This will continue until a state mental health training center is established in each state which will take a ten year span with a total budget of $80 billion. Although, some states are bigger than others and might need more money, necessary steps will be taken in order to make sure every state receives their fair share of money to put mental health training centers into operation. Finally, this proposal also requests continuing funding for an additional ten years.

This investment will have a significant impact on the yearly $79 billion cost that is associated with indirect mental illness in the U.S. Furthermore, it will have great impact on the quality of lives for minorities in the U.S. Additionally, the state mental health training centers will be able to provide mental health professionals the much needed training to work with diverse populations while promoting mental health and preventing mental illness in minority communities.

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