Published in final edited form as:

J Transcult Nurs. 2012 October ; 23(4): 359–368. doi:10.1177/1043659612451259.

Mental Health Needs and Service Utilization by Hispanic Immigrants Residing in Mid-Southern United States

Ana J. Bridges, PhD¹, Arthur R. Andrews III, MA¹, and Tisha L. Deen, PhD¹

¹University of Arkansas, Fayetteville, AR, USA

Abstract

Purpose—This study assessed mental health needs and service utilization patterns in a convenience sample of Hispanic immigrants.

Design and Method—A total of 84 adult Hispanic participants completed a structured diagnostic interview and a semistructured service utilization interview with trained bilingual research assistants.

Results—In the sample, 36% met diagnostic criteria for at least one mental disorder. Although 42% of the sample saw a physician in the prior year, mental health services were being rendered primarily by religious leaders. The most common barriers to service utilization were cost (59%), lack of health insurance (35%), and language (31%). Although more women than men met criteria for a disorder, service utilization rates were comparable. Participants with a mental disorder were significantly more likely to have sought medical, but not psychiatric, services in the prior year and faced significantly more cost barriers than participants without a mental disorder.

Conclusions—Findings suggest that Hispanic immigrants, particularly those with a mental illness, need to access services but face numerous systemic barriers. The authors recommend specific ways to make services more affordable and linguistically accessible.

Keywords

Hispanic; Latino; mental health; service utilization; immigrant; psychiatric/mental health; survey design

The demographic make-up of the United States is rapidly changing such that Hispanics are expected to comprise nearly 25% of the U.S. population by the year 2050 (U.S. Census Bureau, 2003; U.S. Department of Health and Human Services, 2001). New Hispanic immigrants enter the country on a daily basis, primarily from Mexico (Pumariega, Rothe, & Pumariega, 2005). Many immigrants come to work in fields and farms, living in rural areas (U.S. Department of Health and Human Services, 2001), whereas others migrate to large,

© The Author(s) 2012

Corresponding Author: Ana J. Bridges, Department of Psychology, University of Arkansas, 216 Memorial Hall, Fayetteville, AR 72701, USA abridges@uark.edu.

Tisha Deen is now at the Department of Health Services Research, University of Arkansas for Medical Sciences, Little Rock, Arkansas.

Declaration of Conflicting Interests The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

inner-city neighborhoods (Pumariiega et al., 2005). Some immigrants seek refuge from political hardship in their country of origin (Farias, 1994); others hope to find expanded economic opportunities (Pumariiega et al., 2005).

Immigrants face numerous stressors and barriers to establishing a life in a new country. They often experience a diminishing of social supports, leaving behind family and friends in their native countries (Flaskerud & Winslow, 1998). Finding employment can be difficult and exacerbated by citizenship status (U.S. Department of Health and Human Services, 2001).

Frequently, immigrants live below the poverty level (Frias & Angel, 2005) and, for those in urban settings, in high-crime areas (Pumariiega et al., 2005). Difficulties speaking the English language can contribute to barriers in becoming acculturated and limit an immigrant's mobility within the United States.

These sorts of stressors (few social supports, unemployment, poverty, and exposure to community violence) adversely affect mental health (Atdjian & Vega, 2005). However, research studies consistently point to lower physical and mental health service utilization rates by Hispanics, in general (Lewis, West, Bautista, Greenberg, & Done-Perez, 2005), and immigrants, in particular (Bridges, de Arellano, Rheingold, Danielson, & Silcott, 2010; Vega, Kolody, Aguilar-Gaxiola, & Catalano, 1999). In comparison with European Americans, Hispanics have been found to use mental health services less often (Hough et al., 1987), remain in treatment for less time (Sue, Fujino, Hu, Takeuchi, & Zane, 1991), and receive appropriate treatment less often (Acosta, 1979; Young, Klap, Sherbourne, & Wells, 2001).

There are many reasons why Hispanics may underutilize health and mental health services relative to European Americans. For example, Hispanics may conceptualize mental health symptoms as physical problems (e.g., Acosta, 1979; Peifer, Hu, & Vega, 2000). Therefore, rather than seeking help from a psychologist or mental health care provider, Hispanics may see a physician for aches and pains. Recent Hispanic immigrants are more likely to consult with primary care physicians and general health clinics prior to being referred for psychiatric services (Vega et al., 1999).

In some cases, a lack of knowledge of available services accounts for lower utilization rates for mental health services (Biegel, Farkas, & Song, 1997). However, as acculturation to the United States and knowledge about mental health services increase, so too do utilization rates. Studies find that when Hispanic women knew someone who had used mental health services in the past, they were more likely to use such services themselves (Alvidrez, 1999). Hispanics from Puerto Rico, a group considered to be highly familiar with mainland U.S. culture, use mental health services at a higher rate than other Hispanic immigrants living in the United States (Alegría et al., 2007).

A third reason for lower utilization rates may be a lower need (U.S. Department of Health and Human Services, 2001). Studies suggest that U.S.-born Hispanics and those who immigrate as children have rates of mental disorders that approximate those found in the general U.S. population, whereas more recent adult immigrants have significantly lower

rates of depression and anxiety (Breslau et al., 2007; Burnam et al., 1987; Escobar, Nervi, & Gara, 2000; Heilemann, Kury, & Lee 2005; Holman, Silver, & Waitzkin, 2000; Vega, Sribney, Aguilar-Gaxiola, & Kolody, 2004). Data from the National Comorbidity Study–Replicated found that lifetime prevalence rates for Hispanic immigrants was 23% for anxiety disorders and 13% for mood disorders compared with 29% for anxiety and 21% for mood disorders in U.S.-born Hispanics (Breslau et al., 2007). However, some researchers have found equal rates (Adams & Boscarino, 2005; Bridges et al., 2010; Robins & Regier, 1991) or even higher rates (Cervantes, Salgado de Snyder, & Padilla, 1989) of psychiatric distress when comparing immigrant with U.S.-born Hispanics.

Yet another possible explanation for lower utilization rates is that Hispanics may be more likely to use folk healers, *curanderos*, or other alternative service providers (Higginbotham, Treviño, & Ray, 1990) or prefer to seek help from a religious leader (Delgado, 1998). However, one study found that less than 3% of Mexican American adults with a mental disorder seek the help of clergy and other informal providers (Vega, Kolody, & Aguilar-Gaxiola, 2001).

An obvious barrier to service utilization is language. While 40% of Hispanics living in the United States are not proficient in the English language (U.S. Department of Health and Human Services, 2001), only 1% of licensed psychologists speak Spanish (Williams & Kohout, 1999).

Finally, there are real economic barriers and perceived social consequences that could impede service seeking. Hispanics often lack health insurance or are underinsured (U.S. Department of Health and Human Services, 2001). Those who do not have reliable transportation have difficulties making and keeping appointments (Bridges & Lindly, 2008). Fears of deportation and distrust of service providers impede help seeking (Lewis et al., 2005).

Purpose of Study

The scientific literature is consistent in documenting under-utilization of physical and mental health services for recent Hispanic immigrants, but less consistent about the possible reasons for this underutilization. Furthermore, we lack knowledge about reasons for service utilization, satisfaction with services, and perceived barriers to help seeking, especially for recent immigrants residing in more rural areas of the country. Therefore, the present study assessed the mental health needs, service utilization rates, satisfaction with services, and perceived barriers to help seeking in immigrant Hispanic adults residing in Arkansas, the state with the largest increase in immigrant Hispanics of any state in the past 15 years (U.S. Census Bureau, 2003).

Method

Hispanic immigrant adults from two counties in northwest Arkansas were recruited for participation in this study. A multimethod (self-report, semistructured interview, open-ended questions) assessment was conducted, focusing on prevalence rates of mental illness, service

utilization patterns, and acculturation. Prior to beginning data collection, approval for the study was obtained from the university's institutional review board.

Participants

A convenience sample of 84 participants completed the study. Inclusion criteria were the following: age 18 years or older, immigrant from Central or South America, and resident of northwest Arkansas. The first two participants' data were not used due to changes in data collection procedures. An additional participant had an unusually large number of missing data points. Therefore, the final sample consisted of 81 adult Hispanics immigrants. Demographic data for these participants are provided in Table 1. A total of 54 women and 27 men were interviewed. Mean age was 34.6 years ($SD = 10.6$). Most were married (62%) and the majority had children (86%). Most participants (84%) emigrated from Mexico. The majority (72%) had their spouse and children living in the United States. Educational achievement was relatively low in this sample. Forty-three percent had not graduated from high school; 26% had only attended elementary school. Approximately two thirds of the sample reported being currently employed (67%).

The majority of interviews (40%) took place in private rooms at a local community recreation center. Other interview locations included churches (20%), public libraries (21%), the university (2%), participants' homes (5%), and a local organization providing support and educational services to the Hispanic community (4%). Location information was missing for 9% of participants. Most interviews were conducted in Spanish (83%) or a mixture of Spanish and English (5%). Only 10% of participants elected to be interviewed in English.

Measures

The Mini-International Neuropsychiatric Interview (MINI; Sheehan et al., 1998), a structured interview that uses decision-tree logic to arrive at diagnoses consistent with the Diagnostic and Statistical Manual of Mental Disorders (*DSM*; American Psychiatric Association, 1994), was used to assess mental illness. Only modules for anxiety disorders, including posttraumatic stress disorder, and mood disorders, including major depression, were employed in the current study. The MINI has been translated into Spanish and validated with 126 primary health care patients in Spain (Bobes, 1998).

The Acculturation Rating Scale for Mexican Americans–II (ARSMA-II; Cuéllar, Arnold, & Maldonado, 1995), a 30-item self-report scale, was used to assess acculturation to native (Hispanic) and host (U.S.) cultures. Items on the ARSMA-II can be averaged to yield an Anglo Orientation Subscale score (AOS) and a Mexican Orientation Subscale score (MOS). The scale has good internal reliability and construct validity, as reported by the authors. In this study, the scale was modified so that items referred to Hispanics rather than Mexicans. The two subscales assessing acculturation had excellent internal consistency ($\alpha = .97$ for AOS and $.99$ for MOS).

The Service Utilization Interview (Bridges, 2007) is a semistructured interview developed by the principal investigator that assesses past year use of health and mental health services,

satisfaction with services, and perceived barriers to service utilization. An initial dichotomous question inquires whether or not the participant sought services of a specific kind in the previous year (including from a physician or medical doctor, counselor/therapist, religious leader, or alternative healer such as a *curandero*, naturalist, or herbalist). If the participant indicates that they have sought such help in the past year, follow-up questions ask the reasons for service seeking (open-ended), satisfaction with services (on a 1–4 Likert-type scale, 1 = *not at all*, 2 = *only slightly*, 3 = *mostly*, 4 = *completely satisfied*) and, if the participant indicates low satisfaction (a score of 1 or 2), an additional open-ended question inquires about the reasons why satisfaction was low. At the end of the interview, one final open-ended question asks participants to report reasons why they do not use or barriers participants encountered when trying to seek health and mental health services. A forward–backward translation procedure was employed to translate the Service Utilization Interview into Spanish. Additional measures were included in the protocol to assess cultural values and stressful life events, but these data are not presented here.

Changes and Adjustments

The principal investigator completed the first two interviews to ensure comprehension of items (particularly those that were forward–backward translated) and ease of administration and scoring. Based on participant feedback, the research protocol was shortened (specifically, we reduced the number of modules from the MINI we administered by eliminating rare disorders such as obsessive–compulsive disorder and reduced the ARSMA-II to 16 items assessing language use, television and reading habits, food preferences, and friendships). The principal investigator completed an additional six interviews throughout the data collection period. Changes appeared to have improved ease of data collection and reduced participant burden while retaining relevant information to meet the specific aims of the study.

Procedures

Numerous Hispanic community leaders and clergy assisted in recruitment of participants. Additional participants were recruited by the principal investigator when she conducted free workshops on motivation enhancement, self-esteem, and anger management for local Hispanic residents. Interested individuals were invited to call the principal investigator's office.

An initial telephone screening was done with each person to ensure eligibility and to explain the purpose of the study and the nature of participation, including the limits of confidentiality. Interested and eligible parties were scheduled for a 1.5 hour appointment at a community location of their choosing. One of six trained bilingual undergraduate research assistants met with each participant individually. All appointments were digitally audio-recorded to ensure protocol fidelity. The principal investigator listened to each audio recording to check accuracy of data entry.

Participants were first provided with written and verbal information about the study and asked to sign an informed consent form. All questions were answered prior to participation. Once consent was granted and questions answered, the participants completed a

semistructured interview and self-report measures. Participants had the option of having the research assistant read the self-report measures out loud. More than half of the participants chose this option (55%). On completion of the study, participants received a \$25 gift card.

Results

Prevalence of Mental Illness

Table 2 provides current mental illness prevalence rates for participants. One third of participants (33.3%) met current criteria for a psychiatric disorder. Specifically, 18.5% of participants met criteria for major depressive disorder (MDD), 9.9% met criteria for posttraumatic stress disorder (PTSD), and 23.5% met criteria for generalized anxiety disorder (GAD). Comorbidity among these disorders was common, with 14.8% of participants endorsing sufficient symptoms to be diagnosed with more than one disorder. Although more women (24.1%) than men (7.4%) met criteria for MDD, a gender comparison using Fisher's exact test was not significant ($p = .078$). Similarly, although 29.6% of women and 11.1% of men met criteria for GAD, the difference was not statistically significant ($p = .095$). Men (3.7%) and women (13.0%) had statistically comparable rates of PTSD ($p = .258$). Fisher's exact test comparing men and women on any mental illness diagnosis (MDD, PTSD, or GAD) approached statistical significance ($p = .051$). Specifically, 40.7% of female participants met criteria for a current mental illness, compared with 18.5% of male participants.

Service Utilization

Figure 1 displays service utilization rates for participants. The most commonly used health service in the past year was a visit to a physician or primary care doctor (42.0% of participants). Most reported consulting with a physician for chronic illness such as diabetes or allergies, migraines/headaches, and pain. However, 4 of the 34 participants who reported consulting with physicians did so for depression and anxiety. Participants indicated that they were "mostly satisfied" with services they received from physicians ($M = 3.03$, $SD = 1.08$). Satisfaction ratings for men ($M = 3.08$, $SD = 1.08$) and women ($M = 3.00$, $SD = 1.10$) were not significantly different, $t(31) = .21$, $p = .834$.

Alternative healers were also used for health-related concerns (12.3%). Of the 10 people who consulted with an alternative healer in the past year, most did so for somatic reasons such as gastrointestinal or body aches and pains. Less often cited reasons included depression, intimate partner problems, and to cure a hex. In general, participants were dissatisfied with services they received through alternative healers ($M = 2.25$, $SD = 1.28$). No significant differences in satisfaction ratings between men ($M = 1.50$, $SD = .71$) and women ($M = 2.50$, $SD = 1.38$) were observed, $t(6) = -.95$, $p = .379$.

Mental health care provided by counselors and therapists was used by 23.5% of the sample. The most frequently cited reasons for using mental health services were for depression, family problems, and domestic violence. Participants expressed high satisfaction with services they received from counselors and therapists ($M = 3.56$, $SD = .81$). Men ($M = 4.00$,

$SD = 0.00$) expressed significantly higher satisfaction than did women ($M = 3.46$, $SD = 0.88$), $t(12) = 2.21$, $p = .047$.

Religious leaders were also frequently consulted (35.8%), nearly always for help with psychological problems, including intimate relationships, parenting, sadness, and worry. Participants indicated that they were quite satisfied with services they received from religious leaders ($M = 3.43$, $SD = 0.84$). Satisfaction ratings for men ($M = 3.71$, $SD = 0.49$) and women ($M = 3.33$, $SD = 0.91$) were not significantly different, $t(26) = 1.05$, $p = .305$.

Fisher's exact tests were conducted to explore gender differences in past year service utilization rates. No significant differences emerged between men and women for past year consultation with physicians (men, 44.4%; women, 40.7%; $p = .814$), counselors or therapists (men, 11.1%; women, 29.6%; $p = .095$), alternative healers (men, 7.4%; women, 14.8%; $p = .483$), or religious leaders (men, 25.9%; women, 40.7%; $p = .226$).

Fisher's exact tests were also conducted to explore differences in past year service utilization rates for participants with and without a current diagnosis of MDD, PTSD, or GAD. A significant difference was found for consultation with physicians: 59.3% of participants with a current psychiatric diagnosis consulted with a physician in the past year compared with 33.3% of participants without a current mental illness diagnosis, $p = .033$. No significant differences emerged between diagnostic groups for past year consultation with counselors or therapists (current diagnosis, 25.9%; no diagnosis, 22.2%; $p = .783$), alternative healers (current diagnosis, 18.5%; no diagnosis, 9.3%; $p = .288$), or religious leaders (current diagnosis, 48.1%; no diagnosis, 29.6%; $p = .140$).

Satisfaction With Services

Satisfaction ratings are presented in Figure 2. Of participants who sought specific services, satisfaction rates were highest for services rendered by counselors or therapists ($M = 3.56$, $SD = 0.81$). Participants were similarly satisfied with help they received from religious leaders ($M = 3.43$, $SD = 0.84$). Services rendered by physicians were mostly satisfactory ($M = 3.03$, $SD = 1.08$). In contrast, participants expressed higher dissatisfaction with help they received from alternative healers ($M = 2.25$, $SD = 1.28$). Follow-up questions asking why participants were not mostly or completely satisfied with these services revealed that dissatisfied participants continued to experience symptoms after consulting with an alternative healer.

T tests were conducted to explore differences in satisfaction ratings for services utilized in the past year for participants with and without a current psychiatric diagnosis. Participants with a current psychiatric diagnosis ($M = 2.87$, $SD = 1.19$) and without ($M = 3.17$, $SD = 0.99$) were similarly satisfied with services rendered by physicians, $t(31) = 0.79$, $p = .433$. Similarly, participants with a current psychiatric diagnosis ($M = 3.60$, $SD = 0.89$) and without ($M = 3.55$, $SD = 0.82$) were similarly satisfied with services rendered by counselors and therapists, $t(14) = -0.12$, $p = .906$. No significant differences in satisfaction ratings for religious leaders was observed between participants with a psychiatric diagnosis ($M = 3.17$, $SD = 0.94$) and those without ($M = 3.63$, $SD = 0.72$), $t(26) = 1.47$, $p = .155$. There was a marginally significant difference in satisfaction ratings for alternative healers in the two

groups: participants with a psychiatric diagnosis indicated satisfaction ratings in the *not at all satisfied* and *mostly unsatisfied* range ($M = 1.50$, $SD = 1.00$) compared with a *mostly satisfied* average rating for participants without a psychiatric diagnosis ($M = 3.00$, $SD = 1.16$), $t(6) = 1.96$, $p = .097$.

Barriers to Service Utilization

Figure 3 presents information about barriers to health and mental health service utilization reported by the sample. The most commonly identified barriers participants reported facing when seeking health and mental health services were economic. Specifically, responses to the open-ended question revealed that 58.8% of participants reported that services were too costly and 35.0% were impeded from service seeking because of lack of health insurance. Also, presenting as a significant barrier to service utilization was the lack of Spanish speaking providers: 31.3% of participants reported this as a reason they did not seek some services. Other reasons, including a belief that the services would be unhelpful (6.3%), lack of knowledge about helping services (3.8%), fears of being deported (6.2%), and lack of transportation (5.0%), were rarely cited.

Fisher's exact tests were conducted to explore gender differences for barriers to service utilization (Figure 3). No significant differences emerged between men and women for health insurance status (men, 30.8%; women, 37.0%; $p = .626$). However, there was a marginally significant difference for cost as a barrier to help seeking (men, 42.3%; women, 66.7%; $p = .053$). There was a significant gender difference in perceptions of the utility of physicians and helping professionals. Specifically, 15.4% of men believed that services would not help with their problems, whereas nearly all women believed services would be helpful (98.1%; $p = .036$). No significant gender differences were observed for transportation barriers (men, 3.8%; women, 5.6%; $p = 1.00$), knowledge about services (men, 3.8%; women, 3.7%; $p = 1.00$), language barriers (men, 30.8%; women, 31.5%; $p = 1.00$), and fear of deportation (men, 3.7%; women, 7.4%; $p = .660$).

A final set of Fisher's exact tests were conducted to explore differences between participants with a psychiatric diagnosis and those without on perceived barriers to help seeking. No significant differences emerged between participants with and without a psychiatric diagnosis for health insurance status (current diagnosis, 37.0%; no diagnosis, 34.0%; $p = .808$). However, there was a significant difference for cost as a barrier to help seeking (current diagnosis, 77.8%; no diagnosis, 49.1%; $p = .017$). No significant differences emerged in perceptions of the ability of physicians and helping professionals to be useful (with diagnosis, 0%; no diagnosis, 9.4%; $p = .161$), although it is notable that *none* of the participants currently meeting diagnostic criteria for MDD, PTSD, or GAD reported that they believed services would not be helpful to them. On the other hand, there was a significant difference between the two groups in knowledge about helping services. Specifically, although 11.1% of participants with a current diagnosis did not know about some helping services, none of the participants in the no diagnosis group reported this as a barrier to service utilization ($p = .036$). No significant differences between diagnostic groups were observed for language barriers (current diagnosis, 33.3%; no diagnosis, 30.2%; $p = .$

803), transportation (current diagnosis, 11.1%; no diagnosis, 1.9%; $p = .109$), and fear of deportation (current diagnosis, 11.1%; no diagnosis, 3.7%; $p = .327$).

Discussion

The results of this study should be evaluated with its limitations in mind. Our study employed convenience sampling and thus the findings may not generalize to other immigrant Hispanics. However, random sampling of a transient population presents unique challenges. Many traditional methods of random sampling rely on established addresses or land line telephones, which do not capture adequately many immigrant Hispanics (U.S. Census Bureau, 2003, 2007). We did not assess for the length of time participants had resided in the United States and so could not distinguish how this may have affected mental health and service utilization. The relatively small sample size suggests that the prevalence rates we obtained may be biased, although we compare these with the national samples to help contextualize our results.

The goals of this study were to determine needs for, perceptions of, and barriers to mental health service utilization in a sample of Hispanic immigrants residing in Arkansas, the state that has seen the largest growth in its Hispanic population of any state over the past 15 years (U.S. Census Bureau, 2003). Our results suggest that there is a high need for mental health services in immigrant Hispanics. In this sample, 18.5% of participants met criteria for MDD, 9.9% met criteria for PTSD, and 23.5% met criteria for GAD. A total of 33.3% of the sample met criteria for one of these three disorders, comparable with the National Latino and Asian American Study (NLAAS; Alegria et al., 2008), which found 29.7% of Latinos met criteria for a psychiatric disorder. Although women were more likely to meet criteria for a psychiatric disorder in this sample, gender differences did not reach statistical significance.

Rates for GAD were remarkably higher in our study participants than those in the NLAAS. Although the NLAAS obtained rates of MDD of 15.2%, comparable with this study's 18.5%, GAD rates in the national sample were only 4.1%, compared with 23.5% in this study (Alegria et al., 2008). This may be a result of the numerous real-world stressors faced by these participants and the assessment tool employed in the current study. Specifically, the MINI asks participants whether or not they have been excessively or uncontrollably worried about "many things." Certainly, many of our participants face myriad challenges and difficulties with employment, finances, family strains, acculturation, and discrimination. In short, the high GAD rates obtained in this study may be more reflective of the true stressors faced by these participants than a disorder characterized by worry that is in excess of what the situation merits.

Participants in this study were significantly more likely to have consulted with a physician in the previous year (42.0%), followed by religious leaders (35.8%), mental health professionals (23.5%), and alternative healers (12.3%). Consultation with religious leaders occurred most often for mental health concerns, including depression, anxiety, and family discord. Therefore, consistent with what other researchers have suggested (Delgado, 1998), we found evidence that immigrant Hispanics use religious leaders for specialty mental health care. Notably, satisfaction ratings were highest for mental health professionals and

religious leaders compared with physicians and alternative healers, suggesting that services sought to alleviate psychiatric problems were making a significant positive impact in these participants' lives. Given the lack of Spanish speaking mental health professionals (Williams & Kohout, 1999), it is heartening to know that religious leaders are meeting mental health needs in a satisfactory capacity.

Although large studies ($N = 3,623$) using telephone-administered surveys to national samples find low rates of alternative healers (e.g., 4%; Higginbotham et al., 1990), smaller studies find rates that are more similar to those in the current study (Padilla, Gomez, Biggerstaff, & Mehler, 2001; Risser & Mazur, 1995). Risser and Mazur (1995) found that 20% of the 51 Hispanic mothers they interviewed had taken their children to a folk healer. Padilla et al. (2001) found that 29% of the 405 Hispanic adults in their study had consulted with a folk healer at some point in their lives. Our finding that 12.3% of participants had consulted with an alternative healer in the past year is therefore not surprising. Queries about reasons for alternative healer utilization revealed that most participants sought help for physical problems, such as back aches and gastrointestinal pain. We explored what percentage of people who had seen an alternative healer also consulted with a physician in the past year. Of those who had sought services from an alternative healer, 50% had not seen a physician in the past year, suggesting that alternative healers are serving as medical professionals and helping fill a gap in utilization of physicians. However, our results also suggest that participants are dissatisfied with alternative healers and do not find that their symptoms are usually resolved, suggesting that medical needs are being inadequately addressed.

Although female participants in our study used most health and mental health services at higher rates than men, gender differences did not reach statistical significance. Other studies have also found that Hispanic women use health services more than Hispanic men. Marks, Garcia, and Solis (1990) report that although Hispanic men engage in more health risk behaviors, such as smoking, compared with Hispanic women, women are significantly more likely to seek medical services. Similarly, Vega et al. (1999) found that Hispanic women with a mental disorder were 2.2 times more likely to see a medical professional and 3 times more likely to see a mental health professional than Hispanic men with a disorder.

We also explored how psychiatric symptoms related to service utilization. Prior studies have found that mental health service utilization is higher in people with a mental illness than those without (Cabassa, Zayas, & Hansen, 2006); however, rates of service utilization for mental health services did not differ significantly between participants with and without a disorder. In contrast, we did find that participants with a psychiatric disorder were significantly more likely to have consulted with a physician in the prior year than participants without a disorder. Our results thus support the assertion that Hispanics with psychiatric problems may somaticize their symptoms and consequently seek help from physicians (Peifer et al., 2000). Although participants with a psychiatric disorder were significantly more likely to have consulted with a physician in the previous year than participants without a psychiatric disorder, when asked the reason for their consultation, most stated aches and pains, consistent with somatization symptoms. Interestingly, of the four participants who reported seeing a physician for mental health reasons, only two of

them had a current psychiatric diagnosis. Although these findings are consistent with somatization theories, it is also possible that participants with greater physical problems developed mental health problems as a result of these health concerns. This would be consistent with other research demonstrating that physical problems can often lead to mental health problems (Kisely & Simon, 2005). Therefore, the temporal ordering of physical and mental health complaints preclude our drawing firm conclusions about the higher rate of physician visits in participants with mental health problems. Future studies may wish to include medical record reviews or conduct more in-depth examination of medical history and timeline in order to disentangle these two possibilities.

Consistent with many other research studies on health disparities (for a review, see U.S. Department of Health and Human Services, 2001), we found that the biggest barriers to service utilization in our participants were economic and linguistic. Responses to an open-ended question revealed that nearly 60% of participants reported a cost barrier and 35% reported lack of insurance as a primary reason for not seeking help when needed. Economic barriers were more salient for women than men and for participants with a psychiatric disorder than those without. Similarly, one third of participants reported that the combination of their lack of ability to speak English and service providers' lack of ability to translate into Spanish significantly impeded help seeking. A gender difference emerged in lack of knowledge about helping services: significantly more men than women reported this as a reason for not seeking help. Similarly, participants with a current psychiatric diagnosis were more likely to state lack of knowledge about services as a reason for underutilization. It appears that increasing knowledge about helping services would be particularly beneficial for men and those with a mental disorder. On the other hand, responses to the same open-ended question generally did not support lack of transportation, lack of faith in the efficacy of services, and social costs (e.g., fears of deportation; stigma) as common reasons for low health and mental health utilization. Less than 7% of participants reported these as barriers.

The barriers identified in the current study should be considered with the study's methodology in mind. The open-ended nature of the question assessing barriers to service utilization may underestimate some of these barriers. It may be that many more participants would have endorsed these items had they been asked simply to state whether they agreed or disagreed that each presented a barrier to them, personally. However, the open-ended nature of the question also represents a strength of the study: rather than just obtaining rates of agreement, it allows us to see what reasons participants generate for their own lack of service utilization.

Conclusions and Recommendations

The results just described support some explanations for lower mental health service utilization in Hispanic immigrants compared with nonimmigrants and non-Hispanics, but not others. We found some support that higher somatization of psychiatric problems accounts for utilization of physicians rather than mental health professionals. We also found that religious leaders and folk healers serve as proxy health professionals, although low satisfaction with folk healers suggests some medical needs remain. Given the high prevalence rates for MDD, GAD, and PTSD, our results suggest that immigrants do have a

high need for mental health services. When we asked participants directly what barriers they faced when accessing health and mental health services, the most commonly identified ones were economic and language. Importantly, participants in this study were largely aware of services and believed services would be helpful. Thus, the biggest impediments to service utilization were environmental and systemic.

Our results suggest that to improve access and utilization of services, efforts need to be made to make services more affordable and linguistically accessible. Greater efforts should be made to recruit bilingual students into medical and mental health professions and, once recruited, efforts to retain and support these students will be critical. Since the gap between need and number of physicians and mental health providers who speak fluent Spanish will likely remain for some time, hiring medical assistants and paraprofessionals who are bilingual would improve access and utilization. Working closely with community leaders, particularly religious leaders, to ensure adequate training in assessment of mental health problems and to form a personal system of referrals would likely be beneficial. Providing services on a sliding fee scale and allowing people to make small and regular payments will help make services more affordable. In addition, advocating policy changes to increase depth and breadth of health insurance coverage would go a long way toward ameliorating help seeking barriers.

Our findings suggest that Hispanic immigrants need to access and largely are aware of mental health services. Findings also suggest that services rendered by health and mental health professionals are largely successful at alleviating problems. Religious leaders act as important members of the helping community for Hispanic immigrants and could be more deliberately incorporated into the help-seeking pipeline. However, barriers are both frequently encountered and disproportionately so for people with a mental illness. As health and mental health professionals, it is our job to work toward increasing health care access and reducing health disparities for Hispanic immigrants.

Acknowledgments

Funding The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This research was supported in part by a grant from the Bernice Jones Endowed Chair in Community, Department of Sociology and Criminal Justice, J. William Fulbright College of Arts and Sciences, University of Arkansas.

References

- Acosta FX. Barriers between mental health services and Mexican Americans: An examination of a paradox. *American Journal of Community Psychology*. 1979; 7:503–520. [PubMed: 525631]
- Adams RE, Boscarino JA. Differences in mental health outcomes among Whites, African Americans, and Hispanics following a community disaster. *Psychiatry*. 2005; 68:250–265. [PubMed: 16253112]
- Alegría M, Canino G, Shrout PE, Woo M, Duan N, Vila D, Meng X. Prevalence of mental illness in immigrant and non-immigrant U.S. Latino groups. *American Journal of Psychiatry*. 2008; 165:359–369. [PubMed: 18245178]
- Alegría M, Mulvaney-Day N, Torres M, Polo A, Cao Z, Canino G. Prevalence of psychiatric disorders across Latino subgroups in the United States. *American Journal of Public Health*. 2007; 97:68–75. [PubMed: 17138910]

- Alvidrez J. Ethnic variations in mental health attitudes and services use among low-income African American, Latina, and European American young women. *Community Mental Health Journal*. 1999; 35:515–530. [PubMed: 10863988]
- American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 4th ed. Author; Washington, DC: 1994.
- Atdjian S, Vega WA. Disparities in mental health treatment in U.S. racial and ethnic minority groups: Implications for psychiatrists. *Psychiatric Services*. 2005; 56:1600–1602. [PubMed: 16339626]
- Biegel D, Farkas K, Song L. Barriers to the use of mental health services by African-American and Hispanic elderly persons. *Journal of Gerontological Social Work*. 1997; 29:23–44.
- Bobes J. A Spanish validation study of the Mini International Neuropsychiatric Interview. *European Psychiatry*. 1998; 13:198–199. [PubMed: 19698625]
- Breslau J, Aguilar-Gaxiola S, Borges G, Kendler KS, Su M, Kessler RC. Risk for psychiatric disorder among immigrants and their US-born descendants: Evidence from the National Comorbidity Survey-Replication. *Journal of Nervous and Mental Disease*. 2007; 195:189–195. [PubMed: 17468677]
- Bridges, AJ. Service utilization interview. In: de Arellano, MA., editor. Trauma, psychological sequelae, and service utilization rates in Hispanic adults. Medical University of South Carolina's Health Disparities Research Pilot Program; Charleston: 2007.
- Bridges, AJ.; Lindly, E. Service utilization and case management. In: Workgroup on Adapting Latino Services. , editor. Adaptation guidelines for serving Latino children and families affected by trauma. 1st ed. Chadwick Center for Children and Families; San Diego, CA: 2008. p. 53-56.
- Bridges AJ, de Arellano MA, Rheingold AA, Danielson CK, Silcott L. Trauma exposure, mental health, and service utilization rates among immigrant and United States-born Hispanic youth: Results from the Hispanic Family Study. *Psychological Trauma: Theory, Research, Practice, and Policy*. 2010; 2:40–48.
- Burnam MA, Hough RL, Escobar JI, Karno M, Timbers DM, Telles CA, Locke BZ. Six-month prevalence of specific psychiatric disorders among Mexican Americans and non-Hispanic Whites in Los Angeles. *Archives of General Psychiatry*. 1987; 44:687–694. [PubMed: 3498452]
- Cabassa LJ, Zayas LH, Hansen MC. Latino adults' access to mental health care: A review of epidemiological studies. *Administration and Policy in Mental Health and Mental Health Services Research*. 2006; 33:316–330. [PubMed: 16598658]
- Cervantes RC, Salgado de Snyder VN, Padilla AM. Posttraumatic stress in immigrants from Central America and Mexico. *Hospital & Community Psychiatry*. 1989; 40:615–619. [PubMed: 2737629]
- Cuéllar I, Arnold B, Maldonado R. Acculturation Rating Scale for Mexican Americans-II: A revision of the original ARSMA scale. *Hispanic Journal of Behavioral Sciences*. 1995; 17:275–304.
- Delgado, M. Social services in Latino communities. Haworth Press; Binghamton, NY: 1998.
- Escobar JI, Nervi CH, Gara MA. Immigration and mental health: Mexican Americans in the United States. *Harvard Review of Psychiatry*. 2000; 8:64–82. [PubMed: 10902095]
- Farias, P. Central and South American refugees: Some mental health challenges. In: Marsella, AJ.; Bornemann, T.; Erklblad, S.; Orley, J., editors. Amidst peril and pain: The mental health and well-being of the world's refugees. American Psychological Association; Washington, DC: 1994. p. 101-113.
- Flaskerud JH, Winslow BJ. Conceptualizing vulnerable populations health-related research. *Nursing Research*. 1998; 47:69–78. [PubMed: 9536190]
- Frias SM, Angel RJ. The risk of partner violence among low-income Hispanic subgroups. *Journal of Marriage and Family*. 2005; 67:552–564.
- Heilemann MV, Kury FS, Lee KA. Trauma and posttraumatic stress disorder symptoms among low income women of Mexican descent in the United States. *Journal of Nervous and Mental Disease*. 2005; 193:665–672. [PubMed: 16208162]
- Higginbotham JC, Treviño FM, Ray LA. Utilization of curanderos by Mexican Americans: Prevalence and predictors. Findings from HHANES 1982–1984. *American Journal of Public Health*. 1990; 80:32–35. [PubMed: 9187579]
- Holman EA, Silver RC, Waitzkin H. Traumatic life events in primary care patients: A study in an ethnically diverse sample. *Archives of Family Medicine*. 2000; 9:802–810. [PubMed: 11031385]

- Hough RL, Landsverk JA, Karno M, Burnam A, Timbers DA, Escobar JI, Regier DA. Utilization of health and mental health by Los Angeles Mexican Americans and non-Hispanic Whites. *Archives of General Psychiatry*. 1987; 44:702–709. [PubMed: 3632245]
- Kisely S, Simon G. An international study of the effect of physical ill health on psychiatric recovery in primary care. *Psychosomatic Medicine*. 2005; 67:116–122. [PubMed: 15673633]
- Lewis MJ, West B, Bautista L, Greenberg A, Done-Perez I. Perceptions of service providers and community members on intimate partner violence within a Latino community. *Health Education & Behavior*. 2005; 32:69–83. [PubMed: 15642755]
- Marks G, Garcia M, Solis JM. Health risk behaviors of Hispanics in the United States: Findings from HHANES, 1982–84. *American Journal of Public Health*. 1990; 80:20–26. [PubMed: 9187577]
- Padilla R, Gomez V, Biggerstaff SL, Mehler PS. Use of curanderismo in a public health care system. *Archives of Internal Medicine*. 2001; 161:1336–1340. [PubMed: 11371263]
- Peifer KL, Hu T, Vega W. Help seeking by persons of Mexican origin with functional impairments. *Psychiatric Services*. 2000; 51:1293–1298. [PubMed: 11013330]
- Pumariega AJ, Rothe E, Pumariega JB. Mental health of immigrants and refugees. *Community Mental Health Journal*. 2005; 41:581–597. [PubMed: 16142540]
- Risser AL, Mazur LJ. Use of folk remedies in a Hispanic population. *Archives of Pediatrics & Adolescent Medicine*. 1995; 149:978–981. [PubMed: 7655602]
- Robins, L.; Regier, DA. *Psychiatric disorders in America: The Epidemiologic Catchment Area Study*. Free Press; New York, NY: 1991.
- Sheehan DV, Lecrubier Y, Sheehan H, Amorim P, Javaris J, Weiller E, Dunbar GC. The Mini-International Neuropsychiatric Interview (M.I.N.I.): The development and validation of a structured diagnostic interview for DSM-IV and ICD-10. *Journal of Clinical Psychiatry*. 1998; 59:22–33. [PubMed: 9881538]
- Sue S, Fujino DC, Hu LT, Takeuchi DT, Zane NW. Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consulting and Clinical Psychology*. 1991; 59:533–540. [PubMed: 1918557]
- U.S. Department of Commerce, Economics and Statistics Administration. U.S. Census Bureau. The foreign-born population: Census brief. 2003. Retrieved from <http://www.census.gov/prod/2003pubs/c2kbr-34.pdf>
- U.S. Department of Commerce, Economics and Statistics Administration. U.S. Census Bureau. Extended measures of well-being: Living conditions in the United States. 2007. Retrieved from <http://www.census.gov/prod/2007pubs/p70-110.pdf>
- U.S. Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. Center for Mental Health Services. Mental health: Culture, race, and ethnicity—A supplement to mental health: A report of the Surgeon General. 2001. Retrieved from <http://www.surgeongeneral.gov/library/mentalhealth/cre/sma-01-3613.pdf>
- Vega WA, Kolody B, Aguilar-Gaxiola S. Help seeking for mental health problems among Mexican Americans. *Journal of Immigrant Health*. 2001; 3:133–140. [PubMed: 16228778]
- Vega WA, Kolody B, Aguilar-Gaxiola S, Catalano R. Gaps in service utilization by Mexican Americans with mental health problems. *American Journal of Psychiatry*. 1999; 156:928–934. [PubMed: 10360134]
- Vega WA, Sribney WM, Aguilar-Gaxiola S, Kolody B. 12-Month prevalence of DSM-III-R disorders among Mexican Americans: Nativity, social assimilation, and age determinants. *Journal of Nervous and Mental Disease*. 2004; 192:532–541. [PubMed: 15387155]
- Williams S, Kohout JL. Psychologists in medical schools. Research brief. *American Psychologist*. 1999; 54:272–276. [PubMed: 10217997]
- Young AS, Klap R, Sherbourne CD, Wells KB. The quality of care for depressive and anxiety disorders in the United States. *Archives of General Psychiatry*. 2001; 58:55–61. [PubMed: 11146758]

Figure 1.
Service utilization during the past year, by provider type ($N = 81$)

Figure 2.
Satisfaction with service utilized during the past year, by provider type ($N = 81$)

Figure 3.
Barriers to utilization of health and mental health services by Hispanic immigrants ($N = 81$)

Table 1Demographic Characteristics of Study Population (*N*=81)

	Mean (<i>SD</i>) or <i>N</i> (%)
Gender	
Men	27 (33%)
Women	54 (67%)
Age, in years	34.6 (10.6)
Marital status	
Single	18 (22%)
Married	50 (62%)
Divorced	11 (14%)
Have children	
Yes	70 (86%)
No	11 (14%)
Educational attainment	
Elementary (up to grade 6)	21 (26%)
Less than high school (grade 7+)	14 (17%)
High school degree or equivalent	9 (11%)
Some college	9 (11%)
College degree, advanced degree, or graduate degree	3 (4%)
Employment status	
Full time	47 (58%)
Part time	7 (9%)
Unemployed	27 (33%)
Immediate family (spouse, children) living in the United States	
Yes	58 (72%)
No	11 (14%)
Some yes, some no	11 (14%)
Acculturation	
AOS	2.65 (0.89)
MOS	4.55 (0.45)

Note: AOS = Anglo Acculturation Scale; MOS = Mexican Acculturation Scale. Percentages do not always sum to 100 due to missing data. Acculturation scores range from 1 to 5, with higher scores indicating higher acculturation.

Table 2Prevalence Rates of Current Mental Illness ($N = 81$)

	<i>N (%)</i>
Mental illness diagnosis	
MDD	15 (18.5%)
GAD	19 (23.5%)
PTSD	8 (9.9%)
Mental illness comorbidity	
MDD only	5 (6.2%)
GAD only	7 (8.6%)
PTSD only	3 (3.7%)
MDD and GAD	7 (8.6%)
MDD and PTSD	0 (0.0%)
GAD and PTSD	2 (2.5%)
MDD, GAD, and PTSD	3 (3.7%)

Note: MDD = major depressive disorder; GAD = generalized anxiety disorder; PTSD = posttraumatic stress disorder.