Latino Mental Health in the United States:

A Community-Based Approach

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NATIONAL COUNCIL OF LA RAZA

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Founded in 1968, NCLR is a private, nonprofit, nonpartisan, tax-exempt organization headquartered in Washington, DC. NCLR serves all Hispanic subgroups in all regions of the country and has regional offices in Chicago, Los Angeles, New York, Phoenix, and San Antonio.

NCLR's Institute for Hispanic Health is dedicated to reducing the incidence, burden, and impact of health problems in Hispanic Americans. The Institute works in close partnership with NCLR Affiliates, government partners, private funders, and other Hispanic-serving organizations to deliver quality health interventions. These interventions focus on the improvement of access to and utilization of health promotion and disease prevention programs. We are committed to providing technical assistance and science-based approaches that are culturally competent and linguistically appropriate.

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Latino Mental Health in the United States: *A Community-Based Approach*

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I. BACKGROUND

Since 2004, NCLR's Institute for Hispanic Health has engaged in multiple efforts pertaining to mental-health-related issues among Hispanics.* Through those efforts, it has demonstrated that community-based education programs have great potential to increase awareness and promote positive behavioral changes among Latinos. NCLR's work in this arena has primarily focused on training Latino community members as *promotores de salud* (lay health educators).† Furthermore, NCLR has actively engaged in discussions with academics, researchers, policymakers, and community leaders to better understand and address the barriers Latinos face in accessing mental health services and care. Below is a timeline of the activities that have occurred:

2004: Latino Mental Health Summit

NCLR hosted a research conference on the current mental health needs of Latinos in the United States. NCLR, in collaboration with the California State University, Long Beach, convened the Latino Mental Health Summit, which featured presentations by leading mental health researchers along with work group meetings to elaborate on the most pressing mental health issues among Latinos.

2005: Report

The outcomes of the Latino Mental Health Summit led to the publication of *Critical Disparities in Latino Mental Health: Transforming Research into Action*.[1] Its purpose was to better inform the health care community about the mental health issues that Latinos in the United States face.

2006–08: *Promotores de Salud* Project

NCLR developed the award-winning project, *De Blanco y Negro a Colores: Entendiendo la Depresión* (From Black and White to Color: Understanding Depression),‡ after conducting formative research on the awareness of, knowledge of, and actions related to depression among Latinos in the United States. The project included culturally appropriate and relevant mental health education materials. Subsequently, these materials were used to initiate a *promotores de salud* approach to raising awareness of and knowledge related to depression among Latinos. Between April 2006 and December 2008, *promotores de salud* in El Paso, TX; Union City and Hayward, CA; Miami and Orlando, FL; and Lancaster, PA conducted outreach to Latino adults. Additionally, culturally sensitive and linguistically appropriate mental health information was shared with the Orlando and Lancaster communities through Latino-focused radio programs and public service announcements. These shows were based on materials and messages from national organizations whose primary focus is mental health, as well as information provided by Latinos interviewed on the subject.

2008: A Meeting on Latinos and Mental Health

"Latinos and Mental Health: A Community-Based Approach Meeting" was held during the 2008 NCLR Annual Conference. Mental health experts, government agency representatives, and leaders from community-based organizations were invited to discuss community-based approaches to providing mental health services to the Latino community as well as concerns or suggestions they had on best practices in community-level mental health services. Their recommendations have been directly incorporated into this report.

NCLR has been involved in several other mental health-related efforts from 2003 to 2008, including the American Psychiatric Association (APA) Women's Mental Health Roundtable and Leadership Summit in December 2007 and as a participant on the Multicultural Steering Committee for the Substance Abuse and Mental Health Services Administration's Campaign for Mental Health Recovery. Additionally, NCLR has presented its Latino mental health research findings at multiple forums, including the National Hispanic Medical Association's (NHMA) 12th Annual Conference, the 2007 and 2008 APHA Annual Meetings and Expositions, and the 2007 and 2008 NCLR Annual Conferences.

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* The terms "Hispanic" and "Latino" are used interchangeably by the U.S. Census Bureau and throughout this document to refer to persons of Mexican, Puerto Rican, Cuban, Central and South American, Dominican, Spanish, and other Hispanic descent; they may be of any race.

† *Promotores de salud* serve their own communities as liaisons between health care service providers and community members by sharing information and resources to improve the health of people. A more detailed description of the *promotores'* role is presented in a subsequent section of this report.

‡ Winner in the 18th Annual American Public Health Association (APHA) Public Health Materials Contest, Public Health Education and Health Promotion Section

This report builds on NCLR's experience and prior efforts in Latino mental health. Its purpose is to contribute to an increased understanding of the challenges that Latinos in the United States face in accessing mental health services and taking care of their mental health.

II. LATINO MENTAL HEALTH IN THE UNITED STATES

In order to best approach Latinos' mental health needs and concerns, it is indispensable that research and practitioners become familiar with the distinct demographic composition, socioeconomic makeup, and cultural and linguistic background of Latino communities in the United States.

Latino/Hispanic Demographics

Hispanics are the largest ethnic minority in the United States. As of July 1, 2008, the U.S. Census Bureau estimates that there are nearly 47 million Hispanics in the U.S., constituting 15.4% of the total U.S. population. This total does not include the approximately four million residents of Puerto Rico,[2] the vast majority of whom are Hispanic.

These estimates reflect a 3.2% increase from 2006 to 2007, making Latinos the fastest-growing minority group in the U.S.[3] It is estimated that nearly two-thirds (62.7%) of the total Hispanic population in the U.S. are native-born.[4] As of 2008, 91% of Hispanic children in this country (ages 0–17 years) were born in the U.S.[5]

When referring to Hispanics in the U.S., it is important to consider their racial and ethnic diversity. Over 60% of all Hispanics in this country are of Mexican origin (64%), followed by Puerto Rican (9%), Cuban (3.5%), Salvadoran (3.1%) and Dominican (2.7%) origins. The remaining 17% are from Central America, South America, or other Hispanic or Latino origins.[6]

The U.S. Census Bureau estimates that 12% of the total U.S. population age five and older speak Spanish at home, constituting 34 million U.S. residents. Seventy-eight percent of all Hispanics age five and older speak Spanish at home.[7]

Hispanic Mental Health Studies

Many studies have been conducted to assess the prevalence of mental illnesses in the U.S., several of which have focused on the Hispanic population. Their findings support the need for different prevention approaches and mental health care efforts for Hispanic and non-Hispanic populations.

Between 1980 and 1984, the National Institute of Mental Health (NIMH) chose Los Angeles, California as one of the sites to conduct its landmark **Epidemiologic Catchment Area (ECA) Program**. The ECA surveyed 1,243 community and institutionalized adults in Los Angeles and its other four study sites,[8] using Spanish and English versions of the Diagnostic Interview Schedule (DIS) to appraise the prevalence of disorders classified under the Diagnostic and Statistical Manual of Mental Health Disorders, Third Edition (DSM-III). Los Angeles was selected as one of the ECA sites in order to increase the total percentage of Hispanic respondents to the overall study.

The **Hispanic Health and Nutrition Examination Survey (Hispanic HANES)** was conducted by the National Center for Health Statistics (NCHS) between July 1982 and December 1984. Its purpose was to acquire physical and mental health data on Hispanic, Spanish-speaking Americans by surveying large samples of Mexican Americans, Puerto Ricans, and Cuban Americans.[9]

In 1987, Canino and colleagues conducted one of the largest and most important studies on Puerto Ricans' mental health. The **Puerto Rico Island Study**[10] surveyed a stratified sample that was representative of Puerto Rico's population (n=1,513) using a Spanish-translated version of the DIS. This was the first time such a comprehensive mental health study was done in Puerto Rico.

During the 1990s, the **Mexican American Prevalence and Services Study (MAPPS Study)**[11] became the first to present the lifetime prevalence of 12 DSM-III-R psychiatric disorders, utilizing a translated and

culturally adapted version of the Composite-International Diagnostic Interview (CIDI) survey. It assessed the rates of mental illnesses by place of residence (rural vs. urban) and immigration status, and it documented the need for mental health services among Mexicans and Mexican Americans in the Fresno, California region.

In 1992, the **National Comorbidity Survey (NCS)**—the first nationally representative mental health survey in the U.S. that used a fully structured research diagnostic interview to assess psychiatric disorders—provided a wider view on Latinos' mental health. While the ECA and MAPPS Study's Hispanic subsample was solely of Mexican American origin, the NCS included a more current and diverse Hispanic subsample consisting of adults from different Latin American countries. However, its interviews were conducted solely in English, limiting NCS's assessment to English-speaking Latinos.[12] The **NCS Replication (NCS-R)**, conducted in 2001–2003 and based on APA's newly released DSM-IV guidelines, was also conducted in English.[13]

Between May 2002 and December 2003, the **National Latino and Asian American Study (NLAAS)** was conducted.[14, 15] This nationally representative community household survey estimated the lifetime and 12-month prevalence of mental health disorders and mental health services utilization among U.S. Latinos and Asian populations, as well as cultural, social, and contextual factors that may correlate with the expression of mental illness. Over 2,500 noninstitutionalized Latinos of Mexican, Puerto Rican, Cuban, and other Latin American origin were surveyed. The NLAAS instruments were available in Spanish.

Other smaller studies carried out between the early 1980s and today have used mental health data collection instruments such as the DIS and the Centers for Epidemiologic Studies Depression Scale (CES-D). These and other mental health scales and instruments will be described in a subsequent section of this report.

Psychiatric Disorders among Hispanics

Findings from the NCS-R show that Hispanics have a lower lifetime prevalence of psychiatric illnesses than non-Hispanic Whites.[16] However, the NCS-R also found that the course of mental illness tends to be much stronger and persistent among Hispanics and Blacks compared to non-Hispanic Whites.[17, 18]

The NCS-R illustrated a lower risk for depression, dysthymia, generalized anxiety disorder (GAD), social phobia, and panic disorder for Latinos and Blacks when compared to non-Hispanic Whites.[19] However, other studies suggest that Latinos have higher rates of mental disorders than other minority racial/ethnic groups in the U.S. For example, a primary care study carried out at a university-affiliated clinic in New York found that the rate of depression among Latinos (22%) is clearly higher than that of Blacks (10%).[20]

The overall lower lifetime prevalence of psychiatric illnesses among Latinos in the U.S. is unexpected, given the multitude of social adversity factors that Hispanic Americans and Hispanic immigrants face. Analyses of NCS-R data contradict the so-called "double jeopardy" theory that would have expected a higher prevalence of mental disorders among racial/ethnic minorities with low socioeconomic status.[21] Rather, they show that the long-standing rates of religious participation, religious affiliation, and other social resources available amid Hispanic communities can have a strong, positive, and even protective impact on Latinos' health.

It is important to note that research findings from the NCS-R and other landmark studies are reflective of social realities in the U.S. during the 1980s, 1990s, and early 2000s. Given the multiple, complex, and ever-increasing changes in the U.S. cultural and social scenario, further current, in-depth examinations of the trends of mental illness among Latinos and other minority groups are needed.

Differences among Hispanic Subgroups

In a comprehensive literature review of Hispanic mental health issues, Guarnaccia and colleagues

(2002) stated that Mexican Americans had overall similar rates of psychiatric disorders compared to non-Hispanic Whites in Los Angeles and other ECA sites.[22] Nonetheless, it cannot be assumed that all Hispanic subgroups share these same rates. The U.S. Department of Health and Human Services recognizes that different Hispanic subgroups present different mental health characteristics.[23]

For example, the NLAAS found that Puerto Ricans living in the U.S. mainland show the worst mental health status when compared to Cubans, Dominicans, and Mexicans.[24, 25] This is deemed by researchers as paradoxical, since Puerto Ricans are American citizens and do not have to encounter many of the immigration issues that other Hispanic groups face when living in this country.[26] Still, no major differences were found between the rates of mental disorders in Puerto Rico compared to the five ECA study sites in the mainland.[27]

Additionally, there are some documented differences in the prevalence of mental disorders across U.S.-born and immigrant Hispanic subgroups. These differences are explained in a subsequent section of this report, focused on immigration-related factors that affect Latino mental health.

Suicide and Mental Disorders

Suicide rates differ among the various racial/ethnic groups in the U.S. For all of them, however, depression or other mood disorders account for 20–35% of all U.S. deaths from suicide.[28] Yet the rate of suicide among Hispanics in the U.S. is one-half that of non-Hispanics Whites. In terms of Puerto Ricans, even though their depression rates are the highest among Hispanics, they seem to be the Hispanic subgroup least inflicted by suicide.[29]

According to the ECA and Hispanic HANES, 17–20% of the Cuban Americans, Mexican Americans, and Los Angeles Hispanics surveyed who had a history of suicide attempts reported a lifetime history of major depressive episodes. In terms of the sampled Puerto Ricans, 37% of those who reported lifetime major depression had a history of suicide attempts.[30] The Hispanic HANES also found that Puerto Ricans with significant depressive symptoms are 4.5 times more likely to report a history of suicide attempts than those without depression.[31] This proportion is about the same as that for Mexican Americans and Cuban Americans combined.

III. FACTORS THAT AFFECT LATINO MENTAL HEALTH

Research shows that there are a wide variety of factors that may affect an individual's mental health. These factors can be sociodemographic, cultural, community-based, or environmental. Also, it is not unusual to see the co-occurrence of multiple mental disorders or the comorbidity of mental and physical illness. Apart from these risks factors, Latinos' mental health is also affected by immigration-related factors and limitations faced in their access to health care services.

Sociodemographic Factors

Sociodemographic factors that affect Latinos' mental health can relate to their gender, age, employment, education level, income, and marital status, as well as the social/familial support networks available for the individual.

Gender: There are documented gender differences in the prevalence of different mental health disorders. For example, women report higher rates of depressive symptoms than men. Hispanic women have been found to have a significantly higher prevalence of depression symptoms than White, Black, Chinese, and Japanese women through data collected from 42- to 52-year-old participants in the Study of Women's Health Across the Nation (SWAN) in 1995–1997.[32] This difference may be related to the low socioeconomic status of the Hispanic women participants, 45% of whom had less than a high school education and 28% of whom reported having fair or poor perceived health.

Age: Older Mexican Americans living in higher-density Mexican American neighborhoods report lower mean CES-D scores. This is part of what

researchers have called the "Hispanic paradox." Older Mexican Americans show similar or better indicators of health than more advantaged, older non-Hispanic Whites, even though they suffer greater disadvantages in health insurance, income, education, and housing.[33]

Among the elderly, the DSM-based 1996 Health and Retirement Survey (HRS)—a study of a national probability sample of noninstitutionalized members of the 1931–1941 U.S. birth cohort—showed that Hispanics (10.7%) tend to have a significantly higher prevalence of major depression than Blacks (8.85%) and Whites (7.75%).[34] Also, the probability of having elevated rates of major depression is nearly 1.4 times higher for elderly Hispanics than for elderly Whites.

In terms of recent immigrants, some age differences in the risk for mood and impulse control disorders have been identified. Adolescent (age 13–19) and adult (age 20+) immigrants have shown a lower risk for developing mood and impulse control disorders than children (ages 0–12).[35] Some recent studies contradict this finding, stating that there are no significant differences between U.S-born or child-arrival (age 0–6) Latinos and later-arrival (6+ years) Latino immigrants after adjusting for family stressors and contextual and social status factors.[36]

Still, it is important to consider the impact that immigration to the U.S. may have on Latino children. Recent studies have shown that the first onset of mental disorders usually occurs during the childhood or adolescent years, even though it is likely that the individual will not be diagnosed or treated for the condition until several years later.[37] Research also suggests that the racial/ethnic differences in the lifetime prevalence of mental illnesses emerge early in childhood and are likely to be related to environmental factors present during the early years. Therefore, it is important to emphasize social and family-related factors that begin early in life; doing so could protect against the onset of mental illnesses for Latinos.[38]

Social and Family Support: Strong social and family support may buffer the effect of other disadvantageous factors, as it is many times equated with high degrees of family cohesiveness. Although family cohesiveness may be emotionally rewarding for the immigrant, it can also contribute to increasing the acculturation stress experienced. The stronger the cohesiveness within the family, the more difficult and delayed the acculturation process will be for the immigrant.[39] Additionally, family conflicts and burdens have been consistently associated with increased risk for mood disorders.[40]

Marital Status: Marital status affects the odds of having depression. Among widowed, separated, or divorced immigrant Latinas, the odds of having depression is 1.79 times greater than for immigrant Latinas who are married or living with a partner, as found in a study on the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) carried out between March 1997 and May 2002.[41] Other studies confirm this finding, showing higher depressive symptom scores for separated or divorced and older Mexican American women.[42]

In addition, an analysis of ECA and Hispanic-HANES data found that 10.2 per 100 separated or divorced Puerto Rican men in the mainland U.S. report a one-year prevalence of major depression, compared to 13.1 per 100 Puerto Rican women.[43] The prevalence for separated or divorced Puerto Rican men is about 2.5 times that of their White counterparts and about four and nine times that of Cuban Americans and Mexican Americans, respectively. For separated or divorced Puerto Rican women, the prevalence of major depression was similar to that of their White counterparts (12.1 per 100) and nearly 2.5 times that of Cuban and Mexican Americans.

Income: ECA and Hispanic-HANES data also show that having low income, especially for Puerto Ricans, may influence rates of major depression and other mental disorders. Puerto Rican men with an income less than $5,000 or not working for pay reported prevalence of major depression at a rate of 12.3 and 6.5 per

100 Puerto Ricans, respectively. This is 9.5, four, and 1.5 times the prevalence reported among low-income Mexican Americans, Whites, and Cuban Americans, respectively. It is four, 2.5, and 2.8 times the prevalence for Mexican Americans, Whites, and Cubans not working for pay, respectively.[44]

In terms of women, the pattern persists. Puerto Rican women with an income less than $5,000 (15.6 per 100) or not working for pay (ten per 100) report the highest prevalence of major depression that, consistent with the literature, are higher than the prevalence reported for men. The prevalence of depression among low-income Puerto Rican women is about six, three, and 3.5 times higher than that of their Cuban American, White, and Mexican American counterparts, respectively. In terms of unemployed women, the prevalence of major depression among Puerto Rican women is about two times that of Mexican American, White, and Cuban women.[45]

Although there is extensive research supporting economic disadvantage as a risk for mental disorders, a recent analysis of NLAAS data found that Latinos with a family income less than $15,000 were at a lower risk for anxiety disorders when compared to those with higher incomes ($35,000–$74,999), when adjusting for social standing. The authors believe this could be due in part to the low expectation of social mobility for Latinos at the lowest economic levels. Although they remain at risk for depressive disorders, their low expectations buffer them from anxiety disorders.[46]

Employment and Education: Migrant farmworkers have been identified as a high-risk group for psychological distress,[47] and Mexican Americans compose the largest ethnic minority within this industry. For better-educated Puerto Ricans, their mental health profile resembles that of the general U.S. population, having done well in studies both on the island and the mainland.[48] Across all Hispanic subgroups, being out of the labor force and perceived low social standing serve as risk factors for anxiety, depressive, and substance use disorders.[49]

Hispanics' demographic characteristics and socioeconomic disadvantages affect the prevalence of mental illnesses. Still, it has been found that mental health disparities between Hispanics and non-Hispanic Whites persist even after differences in socioeconomic status, region of residence, and other sociodemographic factors have been controlled.[50]

Cultural Factors

Acculturation, common spiritual or religious beliefs and practices, and idioms of distress are some of the cultural factors that may affect Latinos' mental health. Hispanics' distinct views and practices pertaining to mental health services utilization can also affect their mental health.

Acculturation: Acculturation is the process of acquiring the norms, values, ideas, behaviors, and other cultural elements of the dominant society in which an individual is immersing him or herself.[51] This includes both internal and external processes of the individual in adapting and conforming to the dominant culture.

As Hispanics acculturate to mainstream American society, their mental health seems to worsen. Utilizing English language proficiency as a limited yet commonly used indicator/proxy for acculturation, it has been found that U.S.-born and English-language-proficient Latinos have higher rates of psychiatric disorders than Spanish-speaking Latinos.[52] Other external acculturation factors include changes in demographics, immigration experiences, and the host culture's social nature.[53]

Also pertaining to the complex process of acculturation are internal factors, which are not as likely to be explored in the scientific research literature. These include the immigrant's preference for Spanish—regardless of his or her English proficiency—and family cohesive forces. These factors contribute to the acculturative stress experienced by immigrants.[54]

Intergenerational and gender-related conflicts also contribute to triggering mental disorders, such as depressive symptoms, among Hispanics. The changing views of younger generations, in

terms of the way illnesses are interpreted and their views regarding sexuality, spirituality, or gender roles, may give way to experiencing depressive symptoms.[55]

In contrast to the traditional, one-dimensional acculturation model, which assumes that by acquiring the dominant culture the individual disengages from the native culture,[56] it is possible for an individual to experience multiple cultural attachments. This may impact illness interpretation and treatment negotiation[57] as people go through the process of becoming more fluent in one culture. Various studies have found—though not definitively—that experiencing the stress related to acculturation increases the risk of depression and suicidal ideation.[58, 59] Exposure to discrimination also increases the risk for 12-month depressive, anxiety, and substance use disorders.[60]

For Mexican Americans, acculturation increases the risk of developing substance abuse disorders, which are generally more prominent in the U.S. than in Mexico.[61] Puerto Rican mental health is prominently affected by the loss of cultural identity.[62]

Utilization of mental health services: The worsening of mental health could also be attributed to various cultural factors that affect Hispanics' utilization of mental health services. Hispanics seem restrained when talking about mental illness for fear of being stigmatized as "crazy." Because they have attached this stigma to psychological disorders, Latinos who have the means often seek help from their physicians rather than a psychologist to avoid embarrassment or *verguenza*.[63] As such, the physical manifestations of mental illness are treated and their treatment becomes more medically based (e.g., through pharmaceuticals or medical procedures) rather than working with a psychologist or psychiatrist.[64]

Fatalism is another cultural factor that may affect the utilization of mental health services. Fatalism is the belief that the environment controls the outcomes of one's life. Those who ascribe to this belief feel that events occur only as a result of good fortune, God's will, or an enemy's harmful wishes. Latinos who suffer from mental health problems and believe in fatalism could be less inclined to seek help for their psychological needs.[65, 66, 67] However, it should be noted that not all Latinos are fatalistic and, as such, each individual should receive treatment based on their unique needs.

There are other cultural factors that influence Latinos on whether they should or should not seek mental health services. The individual's attachment and loyalty to his or her family—*familismo*—is another.[68] This attachment is due to strong support given by the family in times of difficulty and sorrow. In addition, Latinos tend to value privacy,[69] and so they are apprehensive when it comes to sharing their mental health problems with those outside of their family circle, such as counselors, psychologists, or psychiatrists.

Due to *familismo*, relationships with extended family members are common. These extended family systems, as well as Catholic and Protestant churches and *curanderos* or *espiritistas* (folk healers or spirit mediums), frequently serve as alternate sources of mental health support.[70, 71]

Common spiritual or religious beliefs and practices: Spirituality in this context refers to a person's belief that their health problems come from supernatural forces. This makes an individual less likely to seek and use mental health services.[72] Thus, religious organizations play a big part in the mental health treatment of Latinos, as many may seek the assistance of spiritual leaders to help them resolve their problems.[73] *Curanderos* are often sought out because they are thought to be able to communicate with the spiritual world.[74] Their use is generally limited to Puerto Ricans, and additional studies regarding the use of *curanderos* for mental health problems in other Caribbean islands (e.g., Dominican Republic, Haiti, and Cuba) were not found. Therefore, there is a need to expand the base of knowledge of folk healing with regard to the mental health of these understudied groups.

Idioms of distress: Scientific literature also notes that Hispanics present several cultural idioms of distress, which can make it difficult for the physician to give a precise diagnosis. The *ataques de nervios* (nervous attack), for example, are acute fits of emotionality, which can be expressed by some depressed Hispanics in response to interpersonal stressors. Clinicians who are aware of this will be careful not to misdiagnose it as a panic episode.

The label *locura*, or madness, carries strong negative connotations among Latinos. A person said to be *loco* is thought to be severely ill, potentially violent, and incurable. Hispanics may prefer to refer to the person as suffering from *nervios* as a way of lessening the taboo associated with this experience among family members and the community.[75] However, Latinos are less likely to indicate stigmas as a barrier to mental health treatment.

For Puerto Ricans, the *ataques de nervios* are important signs of psychological distress, especially for the poor or working class. Mexican Americans, on the other hand, are more likely to show *susto* (fright). In either case, these cultural idioms of distress have complex relationships to the psychiatric diagnosis.[76]

Community/Environmental Factors

Neighborhood conditions are many times responsible for higher stress levels that may result in poor mental health. Researchers have identified owning a house or living in an apartment as a protective factor against depression.[77] Nevertheless, due to the socioeconomic status of many Hispanic immigrants, owning a house is usually not an option and has become even more difficult given the current economic climate. Furthermore, the environment's impact on low-income individuals is frequently identified as being worse than that of middle- and high-income households,[78] creating potentially stressful situations that may trigger mental distress. For example, perceived low neighborhood safety has been associated with increasing the risk for depressive, anxiety, and substance use disorders.[79]

The ethnic composition of one's neighborhood is also considered a protective factor against depression. Given that Hispanics "acculturate to a patchwork of local cultural contexts rather than to a homogenous Anglo society,"[80] neighborhoods with high ethnic density may buffer the damaging effect of poverty on Hispanics' health, especially among older Hispanics and Mexican Americans.[81]

Also, the lack of community-based health and prevention programs may contribute to presenting and inadequately managing mental disorders. These programs may originate from the public, private, or nonprofit sectors, including public health and health care, social, educational, and public safety services. Having these services available in low-income communities is especially important, since many will have limited access to them.

Immigration-Related Factors

Data from the NCS, NCS-R, and NLAAS demonstrate that U.S.-born Hispanics have a significantly higher risk of having psychological disorders than foreign-born Hispanics.[82, 83] This risk persists even after controlling for age, income, and education level,[84] and it is as present for the U.S-born descendants of immigrants and subsequent generations.[85]

Although NCS-R analyses found that this tendency—also known as the "immigrant paradox"—did not vary by race/ethnicity,[86] a combined and more detailed examination of the NCS-R and the NLAAS found that the immigrant paradox applied for all mental health disorders among Mexican immigrants, but only for substance use disorders among Cuban and other Latin American immigrants. Puerto Ricans in the U.S. had no differences in the prevalence of these mental disorders associated with their place of birth.

The MAPPS study showed that recent Mexican immigrants living in the U.S. for less than 14 years report a rate of mental illnesses that is one-half that of their U.S.-born counterparts.[87] They primarily suffered from alcohol and substance use disorders and other mental illnesses such

as major depression and anxiety. Additionally, second- and later-generation Mexican Americans are found to be at a higher risk of mental disorders than newly arrived immigrants. Possible causes for this are ethnic discrimination, lack of job mobility, economic decline, and frustrated social and material aspirations.[88]

The ECA's social selection hypothesis explains this by stating that recent immigrants are often the hardiest members of the community, experiencing significant improvement in living conditions upon their arrival to the U.S. As time passes, however, longer-term residents and U.S.-born Mexican Americans tend to respond with a sense of deprivation, especially when comparing their current status to the overall standards of living in the United States.[89] Additionally, given that we see these differences emerge gradually, sometimes over generations, it is believed that any protective factors that immigrants had at the time of arrival to the U.S. are only partially transmitted to their U.S.-born descendants.[90]

Immigration policy debate: The tone observed during the current immigration debate could prompt an increase in stress levels for Latinos in the U.S. and, ultimately, levels of depression, as a relationship exists between stressful situations and clinical depression. A nationwide survey by the Pew Hispanic Center found that over half of Hispanics in the U.S. worry about deportation among their family and friends. Between one in eight and one in four Latinos say that increasing attention on immigration issues has had a specifically negative effect on them, and more so among Hispanics who are not citizens. Effects include difficulty in locating and accessing government services, work, and housing and an increased likelihood of being asked to prove their immigration status by providing documentation.[91]

Given the emphasis on family among Latinos, separation from family and friends due to immigration-related issues damages and even breaks the centrality of Latino families to social life (*familismo*). Already, separation from children has been found to significantly increase the risk of depression among immigrant Latinas. The odds of depression among immigrant Latinas separated from their children were 1.52 times greater than the odds of depression for immigrant Latinas living with their children. The latter had similar odds for depression as immigrant Latinas with no children.[92]

Comorbidities

The term "comorbidities" implies that the individual simultaneously shows symptoms for and is diagnosed with two distinct illnesses. These can both be mental illnesses (for example, depression and substance abuse), but it can also be the co-occurrence of a physical and mental illness.

Hispanics who present depressive or anxiety disorders may also report other physical illnesses, many of which are chronic diseases. An analysis of the NLAAS on Latinos' prevalence of mental and physical illnesses found that Puerto Ricans most frequently met the criteria for comorbid mental illnesses. Across all Latino subgroups, diabetes and cardiovascular disease were most commonly associated with anxiety disorders. Having a history of asthma made it more likely for the person to show depression and the co-occurrence of anxiety and depression.[93]

The risk and impact of the co-occurrence of mental and physical illnesses also affect elderly populations. An analysis of data from the Hispanic Established Population for the Epidemiologic Study of the Elderly (H-EPESE) for noninstitutionalized Mexican Americans age 65 years or older found that reporting at least one chronic medical condition or at least one activity of daily living limitation was associated with higher mean CES-D scores.[94] The SWAN study found that several health factors can increase the odds of higher CES-D scores by twofold or threefold. These health factors include vasomotor symptoms, physical symptoms, fair/poor perceived health, osteoarthritis, and irregular menstrual cycles, each independently.[95]

Apart from being related to the co-occurrence of anxiety disorders, diabetes has also been

found to be associated with the presence of depressive symptoms among Hispanics, who are twice as likely as non-Hispanic Whites of similar age to have diabetes. A study on diabetes and Puerto Ricans carried out in 2004 by the Department of Nutritional Sciences and Cooperative Extension System of the University of Connecticut, in association with the Hispanic Health Council, found that 45% of the participants had symptoms suggestive of depression. It stated that a lack of appetite was consistently mentioned as a reason for not having breakfast, lunch, or dinner, possibly reflecting a large prevalence of depressive symptoms. It also noted that high depression levels may be related to food insecurity and other socioeconomic factors,[96] which greatly impact the mainland's Hispanic population.

Depression among Hispanics has also been associated with the presence of somatic symptoms, which mimic physical illness, at times of psychological stress. Among the most common somatic symptoms are chest pain, muscle tension, diarrhea, fatigue, and headache. The somatic symptoms can involve numerous body systems: cardiovascular, respiratory, gastrointestinal, and central or peripheral nervous systems. Mexican American women are more likely to report somatic symptoms than White women, but Puerto Rican men and women have higher rates of somatization than Mexican Americans and Whites.[97, 98]

Depression is a strong risk factor for the development of activities of daily living (ADL) disabilities. In the HRS study, the rate of incidence of ADL disabilities almost doubled for depressed Hispanics when compared to their nondepressed peers (7.8% vs. 4.2%).[99]

Depression and stress: The relationship between depression and stress has been thoroughly investigated, and there is evidence in support of the role of stress in causing clinical depression.[100, 101, 102] Some people develop depression after a stressful life event, such as the death of a loved one, the end of a relationship, or the loss of a job. When under stress, the body releases the hormone cortisol. Its function is to prepare the body to deal with a stress factor by mobilizing energy reserves.[103] Life events and difficulties can result in hypercortisolism, an excessive release of cortisol in the body,[104] which may cause the decreasing of serotonin (a chemical messenger that transmits nerve signals between nerve cells and causes blood vessels to narrow).[105] This chain event could lead to the development of a major depressive disorder.

It must be noted, though, that these events do not underlie all major depression.[106, 107] There are some individuals with a major depressive disorder who do not have hypercortisolism, and there are depressed individuals with hypercortisolism and increased levels of serotonin,[108] as opposed to decreased. Individuals' different results in levels of serotonin and cortisol do not imply that these factors are unimportant. They should not be disregarded in further studies of the connection between depression and stress.

Access to Health Care

In the United States, Hispanics have the lowest rate of public or private health insurance. In 2008, they were also nearly three times as likely to be uninsured year-round (28.5%) compared to non-Hispanic Whites (10.3%).[109] Only 43.8% of Latinos in the U.S. had private health insurance, compared to 75% of non-Hispanic Whites.[110] More Latinos (30.4%) than non-Hispanic Whites (27.5%) had public health insurance.[111]

Hispanics are less likely to have consistent and continuous access to health services than non-Hispanics.[112] Furthermore, they also present disparities in health care access by subgroups. Many Latino immigrants work in industries or jobs that do not provide health benefits. This plus the high cost of health services, low wages, work stress, and immigration issues all pose barriers for Hispanics to access and use health services.[113] Furthermore, the proposal and approval of laws that do not expand health services or Spanish-language informative materials limit Hispanics' access to health and social services, especially in the border states.

As American citizens, Puerto Ricans have access to public health services and do not need to fear having to deal with immigration issues. Financial issues are also a lesser problem for them, since they have access to public health services and are eligible for federal health programs and benefits both in Puerto Rico and the U.S mainland.[114]

In addition, Cuban Americans experience less discrimination when accessing health services in the south Florida area than anywhere else, due to the high concentration of Cubans and Cuban Americans in that city,[115] including Cuban American physicians and other health professionals.

Latino Mental Health Care and Services Utilization

Latinos have been found to underutilize mental health services, and this is most true for Mexican Americans.[116] Individuals in Puerto Rico are more likely to access outpatient mental health services than other low-income Latino subgroups in the U.S.,[117] following their trend for general health services utilization.[118] Cuban Americans, especially in the South Florida area, are considered to be the Latino subgroup most likely to use mental health services.[119]

Both the MAPPS and ECA found that when Hispanics do seek assistance and treatment for their mental health disorders and concerns, they mostly do so by seeking their general practitioner's help rather than that of a mental health specialist. This is consistent for both immigrants and U.S.-born Hispanics.[120] Mexican Americans with diagnosed mental disorders from the ECA sample were half as likely as non-Hispanic Whites to visit a doctor for mental health assistance.

Hispanic immigrants are less likely to seek mental health services than those Hispanics born in the United States. Specifically, the MAPPS study found that Mexican American immigrants use 40% of the mental health services that U.S.-born Mexican Americans use. Additionally, the rate of U.S.-born Mexican Americans who access psychiatric treatments and services is seven times greater (8.8%) than that of foreign-born Mexicans (1.2%).[121] Previously discussed cultural factors such as *familismo*, spirituality, and fatalism are influential in the poor seeking of these mental health services.

Access to mental health services: Cuban Americans, having the highest socioeconomic status among Hispanic subgroups and a strong social support system, especially in the South Florida area, are the Hispanic subgroup most likely to access mental health services.[122] An analysis of MAPPS data on actions related to seeking mental health assistance found that having private health insurance increases the likelihood of Mexican Americans accessing mental health services by nearly four times (OR=3.78). On the other hand, having public health insurance increases their likelihood of accessing the general medical sector (e.g., family practitioners) for psychiatric disorders by more than twofold (OR=2.57). While having public health insurance did not effectively relate to accessing mental health services, the researchers still consider it indispensable for low-income Latinos in the U.S. to be able to receive assistance and treatment for their psychiatric conditions.[123]

Access to culturally and linguistically relevant mental health services: Knowing where to find a mental health service provider increases the likelihood of accessing such services by 4.68 times.[124] Still, this does not specify whether providers are culturally and linguistically competent enough to provide services to specific community members.

Having access to culturally and linguistically appropriate mental health services is indispensable to reducing the low levels of mental health services utilization among Latinos. When issues pertaining to access, cultural, and linguistic issues are significantly reduced, the rate of Latinos seeking mental health services (8.3%) is similar to that for the total U.S. population (8.1%).[125]

Religion and spirituality are closely linked to Latinos' cultural heritage and traditions.

Furthermore, many Latinos choose to reach out to their church ministers or pastors for counseling and other mental health assistance. A study found that immigrant Latinas are nearly ten times (OR=9.76, $p < 0.001$) more likely to endorse faith as a mental health care method than White women.[126] In this same study of 736 immigrant and 33 U.S.-born Hispanic women, 90.7% of immigrant Latinas endorsed faith as a type of mental health care, followed by individual (83.3%) and group (64.7%) counseling. Among U.S.-born Latinas, individual counseling (81.3%) was the most frequently endorsed type of mental health care, followed by faith (65.6%) and family support (59.4%). Therefore, it is important for health service providers to understand and consider faith as a part of the treatment for their Latino patients.

IV. CHALLENGES TO LATINO MENTAL HEALTH

The burden of mental illness on Latinos in the U.S. is great; failing to meet their needs for mental health care services will result in an ever-increasing burden for Latino families, communities, and the U.S. overall.[127] Some of the challenges currently encountered by Latinos in treating and maintaining their mental health are explained below.

Economic Barriers

Based on 2008 one-year estimates of American Community Survey data, the U.S.'s median family income is $63,366. This is $7,469 less than the median family income for non-Hispanic Whites ($70,835), but about $19,929 higher than the median income for Hispanics ($43,437).[128]

Cuban Americans had a higher median family income ($51,290) than Puerto Ricans ($43,944) and Mexican Americans ($41,538). Cuban Americans had the lowest percentage of people living below the federal poverty level (14.2%) and, according to the 2008 Labor Force Statistics from the Bureau of Labor Statistics' Current Population Survey, lower unemployment rates for people 16 years and older (6.3%), compared to Mexican Americans (7.7%) and Puerto Ricans (10.3%).[129] The latter had the highest percentage of families in poverty (21.1%).

Poverty is a barrier to health care. Low-income U.S. Hispanics find it difficult to make visits to the clinic. Problems arising from poverty, such as family burdens, multiple job responsibilities, and transportation issues, all make it difficult for them to access health and mental health care services.[130]

Analysis of 1990–1992 data from the National Comorbidity Survey found that poor Hispanics—defined as those with a family income that is less than $15,000 per year—are less likely to have access to specialty mental health care than poor non-Hispanics.[131] More recently, Hispanics were half as likely as their non-Hispanic White counterparts to afford mental health care in the past year. They were also 58% less likely to afford medications in the past year.[132]

Even though Puerto Ricans access health and mental health care services more frequently than the other Hispanic subgroups in the U.S., they also have the lowest socioeconomic status among the major Latino groups. Therefore, their frequent access to health care is not necessarily related to their economic status but to being American citizens and their access to federal and public health care services. As evidenced by findings from the Puerto Rico Island Study and Hispanic HANES, poor Puerto Rican populations in both Puerto Rico and New York had similar rates for depression symptoms and diagnoses. This further strengthens the argument that poverty is directly related to increasing psychological distress.[133]

Access

Access barriers are closely related to economic barriers. Mental health services can be costly, and many low-income Latinos lack health insurance. Even though there are some free or low-cost services available,[134, 135, 136] many Hispanics are unaware of or unable to access them.

Still, these are not the only barriers that Latinos encounter when trying to access physical and

mental health care services in the U.S. Other obstacles include inadequate transportation access or means[137] and familial responsibilities, such as watching over children. As a result, community mental health programs should be encouraged to be located near Hispanic communities (where public transportation is accessible), arrange transportation for their clients, and provide child care services.[138]

Language Barriers

Language differences make it difficult for non-English-speaking U.S. Hispanics to receive any type of health care services, including mental health care. Although the majority of Hispanics in the U.S. speak Spanish and are also proficient in English,[139] not having access to health care services in Spanish makes it difficult for Hispanic patients to easily communicate with their doctors. This also makes it more difficult for physicians and health care personnel to clearly explain the diagnosis and treatment to the patient. A national study of racial and ethnic disparities in health care access found that Spanish-speaking Hispanics are significantly less likely to make a physician or mental health visit than Whites.[140] This communication barrier makes it hard for clinicians to assess the true health status of their patients, complicating the detection of major depression and other mental illnesses.[141]

A west coast survey of 7,093 English-speaking Latinos, non-Hispanic Whites, and Spanish-speaking Latinos found that the latter group reported significantly greater dissatisfaction with the communication skills of their medical providers when compared to their English-speaking and non-Hispanic White counterparts.[142]

Many patients have relied on interpreters, often English-speaking family members, to accompany them on health care visits. A study of Spanish-speaking patients at a large HMO in the northeast region found that those who received professional interpreter services while receiving health care services made more office visits, filled more prescriptions, and participated in a larger amount of preventive services.[143]

Nevertheless, relying on family members for interpretation and translation may lead to confidentiality problems when dealing with sexual abuse, substance abuse, suicide, and other mental health issues.[144] Therefore, health service facilities should provide training opportunities for interpreters and staff, as establishing the patient's language preference should be the first step in serving Latinos in health care.

Health Literacy Barriers

The language barrier encountered by many Hispanics seeking health care is greatly related to their low levels of health literacy. A study of two large urban public hospitals found that 62% of Spanish-speaking Hispanics lacked the health literacy skills to function in health care settings and fulfill the expectations of evidence-based clinicians, compared to 35% of the English-speaking Hispanics surveyed.[145]

U.S. Medical System Barriers

The different expectations of the medical system and Hispanic folk culture in the U.S. are also at times responsible for the misdiagnosis and inadequate treatment of mental health disorders. For example, many clinicians who are unfamiliar with the Hispanic culture could misdiagnose psychosis when a Hispanic patient reports "hearing your name called when no one is there" or "seeing or feeling presences," traits commonly reported by nonpsychotic Hispanics. Health service providers may have inappropriate expectations leading to erroneous decisions.[146]

Additionally, limited understanding or knowledge of how to navigate the health care system in this country may restrict access to mental health services. Immigrant Latinos are especially affected by this, which may cause them to be unable to access the services they need or become intimidated by a health care system that is much more complex and layered than the one they might have had in their home country.[147]

Lastly, many Hispanics do not seek health care services because of their immigration

status, wrongfully assuming that they are ineligible for any health care or mental health assistance. Regardless of immigration status, it is important that the Hispanic community receives more information about their access to mental health services.

Stigmas and Awareness of Available Services

Latinos are greatly concerned about the stigmas associated with mental health and mental illnesses. There are stigmas related to receiving treatment for mental illness, carrying a social consequence of being diagnosed with a mental condition. For example, a study on Latino depression patients and stigmas found that Latinos view the use of depression medication as associated with having a more severe illness, being weaker, or not being able to cope with problems. Such beliefs negatively affect Latinos' adherence their treatment.[148]

Many of the stigmas and taboos associated with mental health and illness are due to myths and inaccurate information about the origins of mental illness and its consequences. A qualitative study on knowledge, perceptions, and beliefs regarding mental health and depression among Latinos in three communities and *promotores de salud* in California, Florida, and Texas found that many Latinos believe that being depressed is not a medical condition but just being in a very sad mood.[149] Others think that suffering from depression or other mental illnesses is a consequence of their ancestors' bad works, a reflection of that person's own weakness or lack of character, a punishment from God, or the result of witchcraft. Furthermore, *promotores* believe that Latinos usually do not speak to others about depression and mental illnesses because of a lack of health insurance or information about available resources.

Latinos' misinformation on mental illnesses and conditions is likely related to the lack of access to mental health information or services in many communities. Therefore, increasing awareness of mental health providers among Latino communities should be encouraged. Latinos who recognize their need for and are willing to receive mental health services are often unaware of the existence of the services or consider them too difficult to find. Consequently, they do not seek them out.[150] Increasing awareness of available services is critical.

Premature Discontinuation of Treatment

The differences between clinicians' expectations and those of Hispanic folk culture, plus the economic, language, and health literacy barriers encountered by many Latinos, could account for why Latinos don't access mental health care services and report premature treatment discontinuation.

Given the great importance that stable care has for the treatment of severe and persistent mental illness, continuity has become an indicator of the quality of care among those dealing with the deinstitutionalization and fragmentation of services for the mentally ill.[151] Although relatively little attention has been given to the issue of continuity of care among Hispanics, Latinos diagnosed with depression have higher rates of early treatment nonadherence than non-Hispanic Whites.[152] The lack of adherence to treatment further contributes to increasing the disparities in their health care.

An analysis of a 1,347-person sample of 2000 MEPS-Household Component participants found that Hispanics with self-reported depression were significantly less likely to fill antidepressant prescriptions than Whites (OR=0.47). They were also less likely to use some form of depression treatment (OR=0.46)[153] and less likely to receive guideline-adherent treatment when suffering from anxiety disorders and depression compared to Whites.[154]

Additionally, a study of English- and Spanish-speaking primary care patients found that non-Hispanic Whites and Latinos presented no statistically significant differences in their choice of medications versus counseling as treatments for depression. Nevertheless, they do prefer counseling to the use of antidepressant medication.[155]

V. EXPERIENCE- AND RESEARCH-BASED BEST PRACTICES

Collectively, the insight gained from research on mental health and minority populations in the U.S.—especially Latinos—can provide great insight into what the next steps should be to help improve the mental health of Hispanic Americans. The experience of community-based organizations and other nonprofits, *promotores de salud*, communication agents, researchers, and other outreach workers contribute to enriching our knowledge of what works and what does not.

This section presents an overview of recurring themes and best practices identified throughout the scientific and gray literature, and the experiences of researchers and others working in the mental health arena. Its purpose is to highlight a sample of best practices currently being implemented to help address mental health issues among Latinos.

Mental Health Measurement Tools Validated for Use among Hispanic and/or Spanish-Speaking Populations

In order to diagnose and assess Latinos' mental health status, it is necessary to have reliable, valid, and culturally and linguistically competent psychometric instruments and measures available for use among Latino populations in the U.S. Furthermore, it is indispensable that these are also available and validated in Spanish. Some of the most frequently used and recognized mental health measurement tools—validated among Latinos and/or available in Spanish—are presented in this section.

Diagnostic Interview Schedule (DIS): The DIS was originally developed by the NIMH in English as a diagnostic instrument that could be administered by both by interviewers and clinicians as part of a large-scale epidemiological study. It was translated and validated in Spanish prior to its use in the Puerto Rico Island Study[156] and other studies.

Center for Epidemiologic Studies Depression Scale (CES-D): The CES-D was developed by Lenore S. Radloff for the Center for Epidemiologic Studies. It is a short, 20-item, self-reporting scale intended for the general population to measure if a person experienced certain depressive feelings or symptoms in the past week. A Spanish version of the CES-D is also available.

Patient Health Questionnaire (PHQ-9): The PHQ-9 is a nine-item, self-administered version of the Primary Care Evaluation of Mental Disorders (PRIME-MD) instrument specifically tuned to diagnosing depression. It is based directly on the major depression criteria from the DSM-IV. The PHQ-9 has been validated in English, is available in Spanish, and is considered an effective, short assessment tool to identify the presence and severity of depression symptoms.[157]

National Latino and Asian American Study instrument: The NLAAS has been frequently cited as one of the most recent sources of mental health information on Latin Americans in the United States. Multiple versions of this instrument were available, and it was developed taking into consideration the cultural and linguistic needs of the cross-cultural population it served.[158]

Spanish Behavior and Symptom Identification Scale (BASIS-24): Early in 2009, the validation results of the revised Spanish-version of the BASIS-24 were published. This 24-item scale allows for the calculation of an overall mental health score for the patient, as well as an assessment of six domains of mental health and psychiatric symptoms, including substance abuse, depression/functioning, interpersonal relationships, emotional liability, self-harm, and psychotic symptoms. This self-assessment mental health instrument was tested on a sample of nearly 600 mental health patients in Massachusetts, Puerto Rico, and California.[159]

CONNECT-S: As a measure of continuity of care in mental health services, the CONNECT-S instrument was designed to be used with

severely mentally ill persons. Its Spanish-language test and validation results were released in 2007 after being tested with 150 Puerto Rican mental health outpatients in Puerto Rico and San Antonio, Texas. CONNECT-S consists of 12 scales to assess the quality of the interactions between patients and mental health service providers in terms of 1) practitioner knowledge of patients, 2) flexibility, 3) practitioner availability, 4) practitioner coordination, and 5) smoothing transitions.[160]

Other tools: Additional psychometric tools have been developed and validated in Spanish. Some of these are especially useful when addressing specific mental health conditions (e.g., Alcohol Use Disorder and Associated Disabilities Interview Schedule (AUDADIS)) or age groups (e.g., Child Health and Illness Profile-Adolescent Edition (CHIP-AE)).[161] Other assessment tools include the Burden Assessment Scale (BAS), which assesses the mentally ill patient's family burden; the Family Burden Scale, which assesses how the caregiver's life is impacted by mental illness; and the World Health Organization's Disability Assessment Scale (WHO-DAS II), which measures the functioning and disability in both physically and mentally ill patients.[162]

Development of Culturally and Linguistically Competent Mental Health Measurement Tools for Hispanics

Two basic stages should be undertaken in the development of culturally and linguistically competent mental health measurement tools for Latinos: cultural adaptation and translation.

Ensuring linguistic competence of measurement tools implies much more than the translation of the instrument from its original language—usually English—into Spanish. It seeks to ensure that the translated instrument remains the semantic, conceptual, and technical equivalent of the original version.[163]

As seen in the federal mandate for the provision of culturally and linguistically appropriate health information (title VI of the Civil Rights Act of 1964), the term "linguistically appropriate" has frequently been interpreted as meaning "language translation." This interpretation fails to address the importance of linguistic distinctions such as word choice, sentence structure, and colloquial variation among languages. Instead, most health communication strategies only target the translation of information into another language.[164]

Populations with low socioeconomic status generally require health information at a fifth grade reading level. Materials translated into Spanish should take literacy levels into consideration in addition to cultural aspects that can improve the material by making it more targeted and relatable.

The cross-cultural adaptation of any measurement tool goes beyond the literal or linguistically equivalent translation of the original instrument. The goal is the cross-cultural and conceptual equivalent of both instruments.[165] Some of the ways in which this process can be conducted include focus group discussions, cognitive interviews, and the review of materials by a bicultural committee of experts.

The linguistic and cultural adaptation of a measurement tool is a sequential, phase-based process. Ideally, it should include 1) translation from English to Spanish by a professional translator; 2) review of the translated instrument by a bilingual expert committee, preferably a multinational group; 3) focus group discussions with the new Spanish-language instrument; 4) discussion of focus group results with the bilingual committee and any necessary edits to the instrument; 5) back-translating the document to its original language (from the new Spanish version back to English); and 6) review of the back-translated instrument by a bilingual committee.[166] Once this process is complete, the new Spanish-language instrument is ready to be tested with Spanish-speaking participants.

Developing culturally and linguistically competent measurement instruments goes beyond mere translation and remains a critical challenge for the mental health field. The goal

is to obtain the most accurate, reliable, and valid instrument possible for a specific population. If it is reliable, it will consistently yield the same results each time it is used under the same condition and with the same target audience. If it is valid, it will accurately assess the truth or falsehood of what we want it to measure. If it is semantically equivalent, then each item in the instrument means the same thing in English and Spanish, even across different cultures.[167]

Community-Based Programs

Apart from formal research and screening for mental health disorders among individuals, some community-focused interventions should be employed to increase awareness of and educate groups about mental health care and conditions. Some of the most effective methods that have been employed in Latino communities involve the use of *promotores de salud* and social marketing campaign efforts.

Using* promotores de salud*: *Promotores de salud,* or lay health educators, programs are becoming the principal strategy for increasing access to primary and preventative health services among low-income, immigrant Latinos. A *promotor* is a trusted member of the community and understands the community's needs. *Promotores* guide community members in accessing health and social services and other culturally competent services by building the capacity of individuals and communities through increased knowledge and awareness of health and health care issues. They do this while making the programs self-sufficient through outreach and advocacy.[168] While many do not possess a professional degree in health, social services, or education, *promotores* are trained to deliver health education sessions (*charlas*) and/or disease management strategies.

Research supports the effectiveness of *promotores* in community-based health care, social support, and education efforts. This has been found to be especially true among Hispanic populations,[169, 170] possibly due to the strength of community networks in Latino communities, as well as cultural attributes such as *familismo* and *confianza* (a strong value in interpersonal trust through warm and friendly relations), which complement and reinforce the *promotores* model.[171, 172]

Successful *promotores de salud* programs are those in which the *promotores* effectively guide their peer community members on how to take better care of their health and that of their families. Improving their health care includes learning how to navigate the local health care system, becoming empowered with knowledge on how to live healthy lifestyles, and learning how to manage diseases.

Effective *promotores* are respected and looked up to by their community as leaders who understand their day-to-day struggles and have gained their peers' trust. *Promotores* are members of the community they work in; many often mirror the members they serve. For example, many *promotores* are immigrants themselves and fluent in Spanish.

Using social marketing to educate and reach a larger audience: Social marketing uses marketing strategies to design and implement programs that influence behaviors that will ultimately improve health outcomes among target populations.[173, 174] Social marketers use marketing principles and methods to develop an exchange between the benefits of and barriers to a positive behavior.

Behaviors may be influenced so that the target population voluntarily accepts a new behavior, rejects a potentially harmful behavior, modifies a current conduct, or abandons a previous conduct.[175] Messages are designed specifically for this purpose and are disseminated through a wide variety of available electronic, print, and audiovisual means. Because Hispanics have been found to watch more television than the general U.S. population[176] and are more likely to act on the information they learn from television,[177] social marketers have frequently used this media channel to educate audiences on various health issues impacting Latinos.

The effectiveness of social marketing and health promotion efforts is assessed by determining

whether the specified goal in behavior, knowledge, or attitude change is obtained: How great was the impact? How long did it last? Were there any unintended outcomes?

For example, a study on a *telenovela* (Spanish-language soap opera) that used a breast cancer storyline found that audiences were influenced by the information discussed within the soap opera. Hispanic men and women alike showed increased knowledge about breast cancer screening and treatment, as well as increased behavioral intent to screen for breast cancer and obtain treatment after watching the shows.[178] By incorporating these health messages into a popular Spanish television show, audiences were able to connect with the characters and messages being portrayed. This strategy addressed the limited English proficiency, immigrant status, education levels, and, to an extent, socioeconomic barriers of the target population.

Other social marketing efforts have focused on the development of television, radio, and print public service announcements to empower communities with information and motivate them to take specific actions. Nonetheless, the most effective social marketing interventions are those that provoke a sustainable impact and operate in concert with other policy, education, and community-based efforts.

Mental Health Service Providers

Latino communities are frequently disconnected from mental health service providers either because they are limited or nonexistent in the community, inaccessible, or inappropriate for the community's needs. It is critical to recognize the Latino population's mental health needs and explore steps that can be taken to reduce the gap between them and mental health service providers.

Primary health care providers: The first way to connect the Latino community to mental health services is through their primary physicians. Therefore, it is recommended that basic mental health training is provided for physicians to increase their referrals to mental health services. As noted above, many Latinos may seek mental health treatment from physicians rather than mental health professionals. Moreover, Spanish-language courses should be offered to teach useful vocabulary that is commonly used in clinical settings, interpreters should be available and provided with the client's consent, and treatment adherence should be improved by informing the client of what to expect from therapy[179] with regard to its duration and why this length of time is necessary.[180]

Addressing stereotypes or stigmas: Another aspect that requires attention is the preexisting stereotypes that non-Latino therapists may have about Latinos.[181] When treating a client, whether Hispanic, Black, or non-Hispanic White, therapists should not allow cultural beliefs about their clients influence their work. They should also be aware of cultural differences that may change the therapist-client dynamic. In some cases, Latino clients may avoid eye contact with the therapist out of respect for the position of the therapist. This should not be taken as a sign of resistance or disrespect, nor should it influence further treatment of the client.[182]

Training providers in cultural competency: Research is limited with regard to therapists' knowledge of the various cultures and ethnic backgrounds of their clients; consequently, we do not know if educating therapists on these topics would increase or decrease the stereotyping of clients.[183] However, there appears to be a need to train therapists in treating Latino clients.[184] To improve treatment, Kouyoumdjian, Zamboanga, and Hansen suggest that "therapists can ask clients questions about their culture to determine the influence that cultural beliefs and values may be having on the client's problem."[185] Furthermore, providers and systems must respect the histories, traditions, and values of minority communities in the U.S. and understand their influence in their behavioral health.[186]

Increasing the number of Latino mental health providers: According to the Office of the Surgeon General, in 1990 there were only 29 Hispanic mental health professionals for every 100,000 Hispanics in the U.S. This markedly contrasts the reported 173 non-Hispanic White mental health professionals per 100,000 Whites.[187]

Considering that Hispanics are the fastest-growing and largest minority group in the U.S., the racial/ethnic composition of the total number of psychology degrees granted in this country during the past two decades further emphasizes the disparately low availability of Latino mental health professionals. Although the number of Hispanic American psychology doctoral graduates increased by nearly 25% between 2000 and 2006, the most recent statistics show that they compose less than 10% of the total degrees granted (see Table 1).[188, 189]

Other Efforts Targeting Mental Health and Latinos

The Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration supported the creation of the Eliminating Mental Health Disparities initiative to address the gaps in access to mental health services and support among culturally, racially, and ethnically distinct populations.[190] As part of their efforts, and in collaboration with the National Latino Behavioral Health Association, they have engaged in the creation of a database on consultants that may offer expertise and technical assistance on Latino mental health issues. Additionally, they contribute to the development, adaptation, and promotion of materials and pathways to reduce stigmas across cultural and linguistic settings.[191]

In the nonprofit sector, the National Alliance on Mental Illness (NAMI) Multicultural Action Center is dedicated to addressing mental health care disparities across diverse groups in the United States. Specifically, it focuses on ensuring access to culturally competent services and treatments and supporting people of diverse backgrounds who are affected by mental illnesses. Aside from their direct community education and advocacy efforts, NAMI engages in the development of various types of resources for physicians, community-based organizations, and faith organizations to better understand the culturally distinct needs of diverse groups in accessing and pursuing mental health services and treatments.[192]

Table 1. Doctoral Degrees in Psychology Granted by U.S. Institutions by Race/Ethnicity of U.S. Citizens, 2000 and 2006

Race/Ethnicity	2000	2006	Percent Change, 2000–2006
American Indian	0.7%	0.6%	-14.28%
Asian	4.0%	5.6%	40.00%
Black, non-Hispanic	6.1%	6.3%	3.28%
Hispanic	6.1%	7.6%	24.59%
White, non-Hispanic	83.1%	77.5%	-6.74%
Other	N/A	2.6%	N/A

Sources: Thomas B. Hoffer et al., *2000 Survey of Earned Doctorates* (Chicago: University of Chicago, 2001), Table 9; and Thomas B. Hoffer et al., *2006 Survey of Earned Doctorates* (Chicago: University of Chicago, 2007), Table 9.

VI. GUIDING PRINCIPLES FOR AN EFFECTIVE, CULTURALLY AND LINGUISTICALLY COMPETENT MENTAL HEALTH CARE SYSTEM

The mental health of populations is affected by a multiplicity of interrelated and independent factors at the individual, familial, societal, and environmental levels. In terms of minority populations and Latinos in particular, it is important for messages, approaches, and interventions to be culturally and linguistically competent. Based on the research reviewed above, successful programs, and prior initiatives conducted by NCLR's Institute for Hispanic Health, the following principles are recommended as guidelines for establishing an effective, culturally and linguistically competent mental health care system in the United States.

1. Research: Incorporating communities in the research and development processes

Participatory action research is a type of applied research process that seeks to address a specific concern or problem through the constant involvement of community members. It aims to empower the community with the knowledge obtained while raising awareness of an issue and potentially translating its findings into political action.[193] This type of research is also known as "community-based participatory research (CBPR)."

***Community-Based Participatory Research*:** CBPR is defined as "a collaborative approach to research that equitably involves all partners in the research process and recognizes the unique strengths that each brings."[194] In CBPR, communities stop being just the research participants and become equitable partners with the researchers. As partners, they are directly involved in the conceptualization, design, implementation, analysis, and dissemination of the project.

The Centers for Disease Control and Prevention (CDC) has established specific guidelines to determine whether a project follows the CBPR model or not, and the U.S. Department of Health and Human Services has funding opportunities available specifically for research following the CBPR model.[195] These guidelines and alternate funding opportunities are necessary considering the distinct characteristics of CBPR, which contrast the mainstream scientific research structure. For example, given the significant role communities play in the design and decision-making processes but their likely limited experience with scientific rigor and research methods, it is expected that the planning stages of a CBPR project could take as long as one year. However, the majority of grant opportunities currently available from the U.S. government—for example, the 2009 National Institutes of Health challenge grants—call for one- to two-year project periods, constraining the scope of the proposed research plans for CBPR projects. It is unfortunate that these limitations exist, since the projects have great potential to further benefit the community and expand after such intense planning and relationship-building efforts.

2. Support: Involving friends and family in mental health education programs and services

Knowing someone who suffers from a severe mental health condition, whether a friend or a family member, affects an individual both directly and indirectly. Therefore, immediate help is needed to get him or her appropriate diagnosis and treatment.[196] The most common and effective treatment offered to a friend or family member suffering, for example, from a depressive disorder is understanding, emotional support, and encouragement to find professional help with care and patience.[197] This principle applies to all types of mental health disorders. Some ways in which a family member could provide support in these situations include making an appointment on the other person's behalf, accompanying him or her to therapy sessions, and encouraging him or her to continue treatment.

The National Institute of Mental Health provides outreach guidelines for those who have a friend or relative who suffers from specific mental health conditions.[198] For example, the recommended NIMH guidelines for depression are as follows:

- Engage your friend or relative in conversation and listen carefully.
- Never disparage feelings your friend or relative expresses, but point out realities and offer hope.
- Never ignore comments about suicide and report them to your friend or relative's therapist or doctor.
- Invite your friend or relative out for walks, outings, and other activities. Keep trying if he or she declines, but don't push him or her to take on too much too soon. Although diversions and company are needed, too many demands may increase feelings of failure.
- Remind your friend or relative that with time and treatment, the depression will lift.

3. Media: Utilizing media resources

Creativity and innovation are needed in order to effectively design materials and strategies that address health communications to multicultural and diverse Latino communities. The health communication process includes multiple phases from planning and strategizing to materials development and testing.[199] The development process requires program designers to research the problem, including the targeted community's health and communication needs. Specific segments of the community can be targeted and the messages should be tailored to these populations.

Identification of appropriate communication channels is also vital to the effectiveness of health education programs.[200] In order to effectively reach Latino communities with positive mental health messages, it is important that programs and materials utilize these strategies during the development and implementation phases. Media resources—such as public service announcements, publicity coverage, advertisements, entertainment education, social marketing, and other mass media communication tools—may have a positive, effective impact on increasing awareness and providing mental health information resources to Latinos.

Build relationships with media in order to deliver effective mental health messages to Latino communities: The use of Spanish-language media outlets in radio, television, and print is highly recommended. It is important that producers, directors, and editors from Latino-reaching media—not only national networks and cable media, but also local outlets—join the conversation on how to effectively deliver mental health messages to the community.

Being in continuous contact with the community, local media outlets have a unique perspective on how to transmit information to their audiences in an understandable manner. It is important for the media to know who they can call when in need of culturally appropriate and relevant information related to mental disorders and health. It is also important for researchers to reach out to the media to disseminate this information in a comprehensible and accessible manner.

Develop and deliver mental health messages that are tailored to the community and coordinated with other messages that the community may be receiving: Working in close collaboration with community-based organizations and community leaders is necessary. They are the experts on their community's needs, likes, dislikes, desires, conflicts, barriers, and threats. Only community members can express those invisible barriers that outside researchers, program managers, and policymakers can inadvertently ignore and can be the determining factor in a mental health message's effectiveness or failure.

Also, it is possible that communities may be implementing other initiatives to address mental health. It is recommended that new

messages complement existing and proven efforts already established in the locality. Similar to the CDC's guidelines for CBPR, partnerships and collaborations between community-based organizations and the public and private sectors within a community are recommended to ensure consistent messaging.

4. Policy: Advocating or lobbying for policy changes and increased funding streams

Healthy People 2020: As part of the new objectives for Developing Healthy People 2020, the U.S. Department of Health and Human Services proposes to increase depression screenings by primary care providers (goal #MHMD HP2020–15). Unfortunately, the proposed text for this new objective limits itself to increasing the percentage of adult and youth (12–18 years old) screenings conducted during primary care physician office visits. Increased screenings should not be limited to office visits but also be emphasized at clinical locations. Furthermore, culturally and linguistically appropriate instruments should be available at all screening locations to best assess depression symptoms among the populations they serve.

Culturally and linguistically appropriate mental health services: In order to best address the mental health care needs of an individual, the mental health professional must be aware and knowledgeable of all environmental factors that affect that person's health. Thus, there must be clear, appropriate, and consistent communication between the mental health professional and the patient. As a first step, all mental health professionals must be trained in cultural sensitivity and aspects that may affect their patient's health and mental health diagnosis. Additionally, increased funding should be made available for scholarships, fellowships, and grants supporting the training of minority students as mental health professionals, psychiatrists, and researchers, as well as loan repayment programs for medical students and training for psychologists to focus on disadvantaged and minority populations.

Mental health promotion and access to services: One main ethical consideration when increasing people's awareness of mental health promotion and screenings for mental health disorders is the availability of resources and services. As people become aware of the need to take care of their mental health, are mental health professionals and services accessible within their community? Do they have the resources (e.g., health insurance) to benefit from these services? Many U.S. communities lack adequate access to mental health services and professionals, and this is more evident among the neediest. Policies should be established to ensure that all federal grants and programs targeting local mental health screening and awareness efforts include the means to expand the availability of services at those locations.

Health insurance for mental health services and treatment: Mental illnesses are health conditions that require both counseling and medication. In order to address primary and secondary prevention of mental illnesses, health insurance should cover mental health services and treatments. Furthermore, coverage should not be limited to medication or psychiatric services but also include medically prescribed psychological therapy, counseling, and related services. Funding should be made available to ensure access to mental health care and services for the millions of Hispanic Americans who lack health insurance.

Support for the role of **promotores de salud** ***in mental health promotion efforts:*** This support includes, but is not limited to, an increased availability of federal funds for mental health promotion and community health education efforts.

Adequate sampling of Hispanics for behavioral and pharmacological research focused on mental health: Too many studies stratify the racial/ethnic composition of their samples in the White, Black, and Other categories. The identification of Hispanic research participants should be mandated by all federally funded research projects. Furthermore, given the

limited availability of a recent, nationally representative study on mental health among U.S. Hispanics, NCLR has proposed such a mandate. The mandate should include specific information on country of origin to allow for comparisons across different Latino groups.

VII. FINAL REMARKS

Recognizing the challenges and barriers encountered by Hispanic Americans as they relate to mental health care services, NCLR is committed to expanding on its six-year history of research and mental health promotion experience to improve this aspect of Latinos' health.

NCLR's approach is to engage in linguistically and culturally appropriate Latino mental health research and education efforts. Through its *promotores de salud* projects, workshops, publications, presentations at professional conferences, and advocacy efforts, NCLR aims to be one of the leading voices on community-based approaches to improving Latino mental health. Its more than 40 years of multidisciplinary service to Latino communities in the U.S. has rightfully placed NCLR as a leading voice on the economic, social, educational, and health-related needs of Hispanic Americans. Following a socioecological approach, NCLR's Institute for Hispanic Health is aware of how multidimensional factors affect the overall well-being and health of communities and individuals.

NCLR will keep offering opportunities for members of its Affiliate Network to join the effort to provide tools and strategies to those working at the community level. Furthermore, NCLR will continue to provide Affiliates with technical assistance to increase their capacity to improve awareness of mental health conditions, services, and care within their communities.

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