Comprehensive In-Depth Literature Review and Analysis of Hispanic Mental Health Issues

With Specific Focus on Members of the Following Ethnic Groups: Cubans, Dominicans, Mexicans and Puerto Ricans

Completed by:
Peter J. Guarnaccia, Ph.D.
Professor and Medical Anthropologist
Institute for Health, Health Care Policy and Aging Research
Rutgers, The State University of New Jersey
and
Igda Martinez, B.A.
Research Assistant
Center for State Health Policy
Rutgers, The State University of New Jersey

Contributor:
Henry Acosta, MA, MSW, LSW
Project Director
Changing Minds, Advancing Mental Health for Hispanics

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Introduction

The New Jersey Mental Health Institute, Inc. (NJMHI), an outgrowth of the New Jersey Association of Mental Health Agencies, Inc., identified and accepted the challenge of increasing access to and enhancing the quality of mental health services for Hispanics after the release of several national reports. The reports clearly identified the significant rise in the number of Hispanics in the United States, their projected increase over the next few decades, their underutilization of mental health services, their over-representation in vulnerable high need groups such as the homeless and the incarcerated, and the existence of disparities in the quality of health care provided to them as an ethnic group. The reports also urged national, state, and local private and public institutions to take action to better understand and address the barriers facing the Hispanic population with regards to accessing mental health services. The NJMHI is taking action through its *Changing Minds, Advancing Mental Health for Hispanics* project and welcomes the opportunity to not only increase access to mental health services for Hispanics, but to also enhance the quality of mental health services received by Hispanics.

The primary goal of *Changing Minds, Advancing Mental Health for Hispanics* is: ***To understand the belief systems, attitudes and barriers facing the at-risk Hispanic population in need of mental health services and implement effective strategies to address identified barriers.*** The objectives focus on in-depth research, which entails a comprehensive literature review and analysis and conducting our own study; creation of a model that includes best practices for mental health agencies and clinicians; information dissemination in the form of a nationwide quarterly newsletter, trainings and conference presentations; and an evaluative component. The project also aims to heighten awareness, understanding and acceptance of those with mental illness among the Hispanic population and provide them with concrete ways to access treatment services.

The following report, which was summoned specifically for *Changing Minds, Advancing Mental Health for Hispanics*, provides a comprehensive review of professional literature on mental health issues as they relate to Hispanics' mental health service utilization, clinical best practices, and barriers to treatment. The report focuses on the following four ethnic groups: Cubans, Dominicans, Mexicans and Puerto Ricans. It also contains information on the social and cultural background of Latinos in the United States and provides an analysis of what is known to date, gaps in research and service delivery, and recommendations for future action.

We welcome you on the journey of increasing access to and enhancing the quality of mental health services for Hispanics. Together, we know we can make a difference. To do so, we must first understand the problems as they are experienced first hand, and then stop, listen to those impacted by the disparities, involve them in the solution process, and then remain focused and passionate about our efforts.

Key Issues: "Changing Minds, Advancing Mental Health"

1. Latino Mental Health

- Of the four major groups, Puerto Ricans on the mainland experience the worst mental health status based on the results of large epidemiological studies. This is a paradoxical finding given that Puerto Ricans are citizens. Puerto Ricans should be a special focus of preventive interventions and outreach efforts to provide care.
- Little is known about the mental health of Dominicans, particularly those who are undocumented. Issues of racism are particularly prominent for Dominicans. More research on the mental health of Dominicans is needed.
- As Latinos acculturate to mainstream U.S. society, their mental health appears to worsen. This finding is best documented for Mexican Americans. This is particularly true for substance use and abuse disorders. Special preventive interventions are needed for recent immigrants to prevent the development of mental health problems.

2. Latino Mental Health Utilization

- Latinos tend to underutilize mental health services, although this is most true for Mexican Americans and least true for Puerto Ricans and Cubans. Also, immigrants are much less likely to seek help for mental health problems than their U.S. born counterparts. Most of the utilization research has been carried out with Mexican Americans. There are no data on the mental health utilization needs and patterns of Dominicans.
- When Latinos seek care, they are most likely to seek care in the general medical sector rather than the specialty mental health sector of the health care system.
- More work needs to be done with general community health providers that serve Latinos to identify and address mental health problems among their patients. Mental health programs for Latinos would be more effectively located in community health programs than in specialty mental health centers.
- Latinos who have been in mental health treatment in their home countries are more likely to have received medication than therapy. It is important to assess if they continue to receive psychiatric medications from relatives in their home countries.

3. Latino Mental Health Barriers

- The two major barriers to receiving mental health care for Latinos are language barriers and lack of health insurance.
- Insurance issues are tied to the undocumented status of a signifi-

cant portion of the Latino community and to the sectors of the economy where many recently arrived Latinos work.

- Lack of knowledge about what mental health services are and where to get services are other major barriers for Latinos. Use of alternative health providers, including clergy, does not appear to prevent use of medical/mental health services, but seems to be complementary to that use.
- There is a critical need for more bilingual/bicultural mental health professionals.
- Training programs for interpreters, and for staff to work with interpreters, are critical for programs that serve the Latino community.
- The Latino community needs more information about their rights to mental health services regardless of their legal status.
- Innovative insurance programs for mental health services for Latinos are needed [along the lines of special health insurance programs for pregnant women and children].
- Informational programs to inform the Latino community about mental health services and their locations are indicated. These programs could incorporate alternative providers as educators for reaching the Latino community.

4. Latino Mental Health Clinical Best Practices

- There is extremely limited research information on what mental health treatments work best for Latinos. Latinos have been severely under represented in research studies on mental health treatments, both medications and therapies.
- Earlier studies of diagnosis among bilingual Latinos indicated that Latinos appeared healthier when they were interviewed in Spanish than when they were interviewed in English. Better protocols for assessing language abilities in clinical assessment are needed. More attention needs to be paid to linguistic and cultural issues in the diagnostic process.
- Clinicians need to know more about cultural issues in the diagnosis of Latino clients. Symptoms such as “hearing your name called when no one is there” and “seeing or feeling presences” are common among some Latinos and not necessarily indicative of psychosis. Cultural syndromes such as *ataques de nervios* among Puerto Ricans and *susto* among Mexican Americans have complex relationships to psychiatric diagnoses.
- The adaptation of Cognitive Behavioral Therapy (CBT) for depression among Latino clients has received the most work. Research shows that CBT interventions work well for Latinos.
- There has also been considerable work on family interventions to alleviate the stresses of differential acculturation across generations and to aid families in helping the recovery of relatives

with serious mental illness. These models need to be tested and disseminated more widely.

- There is some evidence that when Latinos do get into care, they receive lower quality care than European American clients. This includes receiving older forms of medication for their conditions and receiving less psycho-therapeutic interventions. Clearly, quality improvement programs are needed to insure that those Latinos who get into mental health care receive the optimal treatment.
- Latinos appear to have significant concerns about psychotropic medications. These include both the strength and the addictive potential of those medications. Latinos need more education about psychotropic medications, their effectiveness, and their potential for addiction.
- There is very limited information that some Latinos may respond differently to psychotropic medications, particularly anti-psychotics, than European Americans. Latinos may be more sensitive to the side effects of medications than European Americans. Clinicians should consider starting Latinos on lower doses of medication and raising those doses more slowly than with European American patients.
- There is some data that when Latino clients see Latino (or bilingual/bicultural) therapists, they are more likely to remain in care and to have better outcomes. This is particularly true for recently arrived and Spanish speaking clients.

Social and Cultural Backgrounds of Latinos in the United States

Latinos are a diverse cultural group; the use of a general label is both conceptually and practically inappropriate. Latino groups differ in national origin and history; in the particular social formations within each country that shape age, gender and class relationships; in the pressures within each country that have led to migration and the differing waves of migration; and the differing relationships with the United States through time that have affected how those migrants were received (Bean & Tienda, 1987; Melville, 1994; Molina & Aguirre-Molina, 1994; Molina, Aguirre-Molina & Zambrana, 2001; Portes & Bach, 1985; Grenier & Stepick, 1992). These features have not only created marked differences among the Latino groups, but considerable intra-cultural variation within groups as well. At the same time, changes within United States society and cultures have affected where migrants have gone, how they have been received, the opportunities they have had to develop themselves as individuals and groups, and the cultures of the United States with which the migrants have interacted (Pedraza-Bailey, 1985; Portes & Bach, 1985; Portes & Rumbaut, 1990; Portes & Stepick, 1993; Rogler, 1994).

Cuban Americans

Cuban Americans, who are concentrated in Miami, Florida with secondary centers in other parts of Florida and the New York metropolitan area, make up 3.5% of the mainland Latino population, reflecting a relative decline in the Cuban population relative to the growth of other Latino groups in the U.S. (Census 2000). In New Jersey, Cubans comprise 7% of the Latino population or 77,337 individuals.

While some Cubans migrated to the U.S. prior to the Cuban Revolution in 1960, the establishment of a large Cuban community post-dates the Revolution. Much of the intra-group diversity among Cubans mirrors the different waves of emigration from Cuba. The first migrants, who were more educated and professional, received considerable aid from the U.S. government to secure loans to start businesses and to transfer their professional credentials as doctors, lawyers, etc. (Pedraza-Bailey, 1985; Portes & Bach, 1985; Grenier & Stepick, 1992). As a group, Cubans have the highest levels of socioeconomic status of all Latino groups. They also have the highest rate of retention of Spanish as their primary language. Cubans have developed a vibrant ethnic enclave in Miami, where Cubans have become a dominant force in the political and cultural life of the city (Portes & Stepick, 1993).

The U.S. government has treated Cubans as the classic political refugee group (Pedraza-Bailey, 1985; Portes & Bach, 1985), in spite of the fact that economic issues have always been prominent, and in recent waves of Cuban immigrants the most prominent reason for leaving. Both fears of political reprisals and chronic economic distress have provided a powerful push for Cubans to leave. The pulls have been freedom from fear of political persecution, greater range of economic opportunities, and the desire to reunify with family members who had left in earlier waves of immigration. Both the loss of material wealth in Cuba as a result of leaving and the separation of families are potent sources of distress from the leaving process.

Strong family ties which serve as the basis for bringing new family members to the U.S. and a strong ethnic enclave in Miami have made the migration for many Cubans less stressful than for some other Latino groups. U.S. government aid for the resettlement of Cubans has also been decisive in their successful adaptation (Grenier & Stepick, 1992). The relatively lower rates of distress and disorder in studies of Cuban mental health result in part from this aid, as well as fromthe higher pre-migration social status of Cuban immigrants. The somewhat higher rates of disorder within the Mariel Cuban group are due to the migration of a small sub-population with pre-existing psychiatric disorder as well as the different social characteristics of this group. Those poorer and less connected among the Marielitos experienced more distress and more discrimination than earlier waves of Cubans. While one would expect that the longer stays in detention of this group would adversely affect the mental health of the Marielitos, a study by Eaton and Garrison (1992) did

not support this expectation. One of the most potent sources of emotional distress for Cuban immigrants is the separation of families between Miami and Cuba and the great difficulties of returning to Cuba for important family transitions. However, the epidemiological data does not provide evidence of the impact of this source of psychological distress in symptoms or disorder.

For Cubans, the development of a public and private medical and mental health care system staffed by and, in the case of the private sector, owned and operated by Cubans greatly facilitated access to services. At the time of the arrival of the Marielitos, a Cuban psychiatrist directed the public mental health center in Little Havana, and it had a number of Cuban mental health staff (Portes et al., 1992). At least in Miami, language barriers have been alleviated significantly. In the early phases of migration, financial access was guaranteed by the U.S. government's support package for Cuban refugees. The general high socioeconomic status of settled Cubans makes financial access unproblematic as well. Both *santeria* and *espiritismo* are active in the Latino communities of Miami, though their on-going role in mental health care is less well documented than for Puerto Ricans.

Dominicans

Migrants from the Dominican Republic comprise another important Latino group from the Caribbean (Garrison & Weiss, 1987; Grasmuck & Pessar, 1991). The 2000 Census counted approximately 750,000 Dominicans, accounting for 2% of the Latino population in the U.S. Dominicans have concentrated heavily in the New York metropolitan area, particularly in the neighborhood of Washington Heights. However, in the past decade they have moved out to surrounding areas and now make up 9% of the Latino population in New Jersey (102,630 persons). Dominicans come primarily from urban centers of the Dominican Republic, though there is also a significant rural population, many of whom step-migrated through the capital city of Santo Domingo.

The Dominican migration began after the assassination of the dictator Trujillo in 1961 and the U.S. occupation in 1965. The U.S. government facilitated the emigration of political dissidents as a political safety valve to reduce the level of protest against the U.S. occupation and the imposition of a pro-U.S. government (Grasmuck and Pessar, 1991). Dominican emigrants were often middle class individuals who have been frustrated by the lack of jobs and economic under-development in the Dominican Republic; more recent waves have come from the poorer sectors of Dominican society. The earlier waves of migrants created a base of legal residents who could bring relatives in a chain migration from the island. While earlier waves of Dominican migrants often experienced downward mobility in terms of job status, the wage differentials between New York and the Dominican Republic were so great that even less prestigious jobs provided the income for acquiring a middle class lifestyle

that would be unattainable at home.

The Dominican experience is mixed in terms of the reasons for migrating. Extreme poverty in the Dominican Republic, pushes many Dominicans to migrate. Like Cubans, some Dominicans fled political persecution, although from a right-wing rather than left-wing government. However, unlike Cubans, Dominican political refugees were not officially recognized and did not receive the same aid. Some Dominicans left the Dominican Republic because of high unemployment on their island. Many Dominicans come as a result of family reunification efforts as well. Those Dominicans who are undocumented suffer stress due to their precarious status in the U.S. The Dominican enclave in Washington Heights is quite large, but cannot match Miami in its social and economic development.

Sources of psychological distress prominently appear in both Dominicans' home communities and in the neighborhoods of New York City where they have settled. However, there is a need for systematic community studies of the mental health of the Dominican community in the U.S.

Mexican Americans

People of Mexican origin make up the largest portion of Latinos in the U.S. Current population estimates are that there are 35.3 million Latinos in the United States and that 58.5% of them are of Mexican origin. People of Mexican origin now number 102,929 in New Jersey [a 263% growth since the 1990 Census] and comprise 9% of the New Jersey Latino population (U.S. Census Bureau 2000). Mexican diversity results from differences in the generation that migrated, length of residence, legal status, social status, ethnic background, and reasons for migration. A significant portion of the Mexican origin population cannot be considered immigrants. This group, who often refer to themselves as *Hispanos*, established themselves in the southwestern states during the period of Spanish colonialism and were incorporated into the U.S. through colonial expansion of the U.S. At the same time, Mexicans overwhelmingly make up the largest group of new immigrants to the United States.

Wide variations exist in educational level, occupational status and income within the Mexican American community. Mexican Americans differ in their knowledge of and preference for use of Spanish and English. While some Mexican Americans actively work in agricultural occupations and make up the largest ethnic group among migrant farm laborers (Chavez, 1992), the overwhelming majority of Mexican Americans now work in the services and industrial sectors of large Southwest cities such as San Antonio and Los Angeles [the second largest Latino city in the Americas]. At the same time, Mexican Americans, because of their proximity to Mexico, their large communities throughout the Southwest, and their continued high rates of immigration, have a strong cultural base from which to reinforce their cultural identity.

Mexican migrants largely leave economically depressed rural areas, although a significant portion of migrants first go to cities within Mexico. Government policies since World War II that have favored the urban working class over rural populations, economic restructuring programs imposed on Mexico by international lending agencies, and development of an industrial zone in northern Mexico further facilitated by the North American Free Trade Agreement (NAFTA) all have created an economic situation which disadvantages the rural sector. The severe poverty in rural areas has led to the exodus of those most able to organize and finance a trip to the U.S. and the first waves of migration include a preponderance of young men. The migration process has transformed local social structures at the same time as it has injected more cash and brought more consumer goods into the local economy in Mexico. The magnitude of the Mexican migration means that many migrants can get information and contacts for making the trip, and even with increased border patrols, the number of possible crossings make the trip relatively certain (Massey, 1987). The major stressors of the trip are its cost, dealing with unscrupulous *coyotes* and sometimes exploitative Mexican border police (Conover, 1987), and the fears and reality of apprehension by the U.S. border patrol (Cervantes, et al., 1989).

Mexican immigrants have found large communities in the U.S. where they have large numbers of co-ethnics, frequent kin and people from their home communities to whom they can turn for aid, and, until relatively recently, a vibrant southwest economy with many jobs in the service sector, manufacturing, and in agriculture. Given the poor state of the Mexican economy, Mexican immigrants find a considerable earnings differential, making frequent trips or prolonged stays very attractive. At the same time, the long hours of work, difficult working conditions, and isolation due to work schedules take their toll on immigrants' mental health. In particular, Mexican American farm workers are at particular risk of psychological problems from the combination of stressful work and living conditions, toxic exposures to pesticides with neurological effects, and substance abuse. Another high risk group are older Mexican women from lower social class backgrounds, particularly those who have experienced marital disruption and lost the economic and social support marriage continues to afford.

Second and later generation Mexican Americans are at higher risk for developing psychological disorder than new immigrants. By the second generation, issues such as ethnic discrimination, lack of job mobility, economic decline in the southwest, and frustrated social and material aspirations lead to a rise in psychological distress and disorder. Also, acculturation to the larger society increases the risk of developing substance abuse disorders, as both drugs and drug abuse are more prominent in the U.S. These social stressors create higher rates of disorder in second generation Mexican Americans (Vega et al., 1998).

There has been considerable debate about the under-utilization of

mental health services by Mexican Americans. While the growth of large Mexican communities in major cities throughout the southwest has led to the development of bilingual/bicultural mental health services, access issues are still significant. Lack of health benefits in the jobs and industries where Mexican immigrants are concentrated, the high cost of services and relatively low wages, pressures of work, and legal status issues all act as barriers to service utilization. Within the community, the stigma of mental illness also acts as a barrier to help-seeking in the mental health sector. The extended family system, Catholic and Protestant churches active in the community, and folk sector resources such as *curanderos* and *espiritualistas* all provide alternative sources of support for those in distress (Casas & Keefe, 1978; Chavez & Torres, 1994). However, most recent research indicates that use of alternative resources does not deter formal mental health services use, but rather that structural barriers in gaining access to services and in the service system are more prominent (Treviño & Rendón, 1994). Ethnographic work suggests that those who use multiple sectors may be the most active help-seekers (Chavez & Torres, 1994).

Puerto Ricans

Puerto Ricans account for 10% of the mainland Latino population and number 3.4 million individuals. In New Jersey, Puerto Ricans are the largest Latino group, numbering more than 350,000 or about 33% of the New Jersey Latino population (2000 Census). New York City (PMSA) is the largest mainland Puerto Rican city with over 800,000 Puerto Ricans (2000 census). However, this metropolitan area now accounts for less than a third of the mainland Puerto Rican population. While New York City was at one time the largest Puerto Rican city, the rates of return migration and growth of the metropolitan area now make the San Juan - Bayamon PMSA larger at 1.8 million people. Additionally, Chicago, Philadelphia, Newark (NJ), Hartford (CT) and a number of smaller industrial cities throughout New Jersey, Connecticut, Massachusetts and Eastern Pennsylvania all have sizable Puerto Rican communities.

Puerto Ricans experience the lowest socio-economic status of the major Latino groups. Puerto Ricans are United States citizens, ensuring free movement from the Island of Puerto Rico to the mainland. The United States government plays an active role in controlling the economy and the social life of the Island, including a major effort to industrialize the Island starting in 1947 and several attempts to make English the language of instruction in schools and of daily life. In cities like New York, at least a generation of Puerto Ricans have lived all of their lives on the mainland, many of whom use English as their primary language. While Puerto Ricans have easier access to social ties on the Island, their ties to an autonomous culture are more tenuous than other Latino groups, because Puerto Rican culture has been more dramatically transformed by

almost a century of American dominance.

The major push to emigrate is the lack of employment on the Island due to long term economic policies that destroyed small-scale agriculture and encouraged high-technology industrial development that created few entry-level jobs for lower skill workers. For many years, the majority of those who left were poorer Puerto Ricans, many of whom migrated through the San Juan metropolitan area. The exodus of professionals seeking better job opportunities and salary structures in the U.S. increased in the 1970's and 80's, particularly to the urban northeast, but also to Florida and Texas.

Puerto Ricans have concentrated in the urban northeast in New York City and surrounding smaller urban centers. A declining employment base with the broad de-industrialization of the northeast and a rise in poorly paid and limited benefit jobs in the service sector are the major stressors Puerto Ricans face on the mainland. While there are significant Puerto Rican communities in several northeast cities, Puerto Ricans still experience high levels of discrimination. Urban renewal processes have continued to disrupt Puerto Rican communities so that social networks and community organizations have had to be rebuilt. These social transformations have pushed Puerto Ricans to the least desirable neighborhoods of New York City and to other urban centers in decline such as Bridgeport, CT and Reading, PA. At the same time, a recent study by Rivera-Batiz and Santiago (1994) indicates that Puerto Ricans born on the mainland are improving their economic status, although a significant proportion (30%) of mainland Puerto Ricans remain in poverty. It is not surprising that the group with the highest rate of psychological distress and disorder is the poorest segment of the population regardless of where they reside (Vera et al., 1991), as Puerto Ricans are exposed to the same politico-economic system on the mainland and on the Island. Better educated Puerto Ricans have done well on both the Island and mainland and their mental health profile resembles that of the general U.S. population (Canino et al., 1987).

Loss of cultural identity is a prominent issue related to Puerto Rican mental health (Flores, 1993). Decades of efforts to Americanize Puerto Rico have taken their toll on the sense of cultural autonomy Puerto Ricans experience relative to other Latino groups, who draw renewal from relatively intact home cultures. The development of a Nuyorican culture, while a vibrant force on the mainland, has led to discrimination when migrants return to Puerto Rico to live (Flores, 1993). The high rates of circular migration have created a sub-population who are "neither here nor there." While the implications of these issues are difficult to document in terms of specific mental health outcomes, they provide an important context for understanding the Puerto Rican migrant experience in comparison to that of other Latino immigrants.

Puerto Ricans are relatively high utilizers of health services, particularly the general medical sector. Access to a widespread public health

system (until very recently) in Puerto Rico and eligibility for health benefits and federal health programs on the mainland make financial access issues less of a barrier than for other Latinos. Given the high use of the medical sector both in Puerto Rico and the mainland (Treviño & Rendón, 1994, Vera et al., 1991), recognition of mental health problems by primary care providers is a significant issue. Recognition of the idioms of *nervios* and *ataque de nervios* as important signs of psychological distress among many Puerto Ricans, especially those from working class and poor backgrounds, can contribute to recognition of psychosocial problems in primary care. At the same time, there are not simple translations of these idioms of distress into psychiatric diagnoses; rather they cut across a range of distress and disorder requiring careful assessment of both the symptoms and contexts of experience (American Psychiatric Association, 1994; Guarnaccia, et al., 1993). Both *espiritismo* and *santeria* continue to flourish in Latino neighborhoods of New York City; their presence is more variable in smaller cities in the northeast where Puerto Ricans have spread. In epidemiological studies, the use of the folk sector appears limited for mental health problems; however, the long history of rich ethnographic reports of the use of these resources argue for the continued importance of this sector in mental health help-seeking (Garrison, 1977; Harwood, 1977; Koss-Chioino, 1992). Less studied, but potentially as important, is the role of both the Catholic and newer Protestant churches, their clergy, and lay organizations in support of people in psychological distress.

Latino Mental Health Status

Several major studies have examined the mental health of Latinos in the U.S. These include: the Hispanic Health and Nutrition Examination Survey [HHANES] (National Center for Health Statistics, 1985; Moscicki, Rae, Regier & Locke, 1987); the Los Angeles site of the NIMH Epidemiologic Catchment Area Program [ECA] (Regier, Meyer, Kramer, Robins, Blazer, Hough, Eaton & Locke, 1984; Karno, Hough, Burnham, Escobar, Timbers, Santana & Boyd , 1987); studies in Puerto Rico of mental health and mental health service utilization (Canino, Bird, Shrout, Rubio-Stipec, Bravo, Martinez, Sesman & Guevara , 1987, 1990; Vera, Alegria, Freeman, Robles, Rios, & Rios, 1991); and the Mexican American Prevalence and Services Study [MAPPS Study] (Vega, Kolody, Aguilar-Gaxiola, Alderete, Catalano & Caraveo-Anduaga, 1998). The major instruments in these studies were the NIMH Center of Epidemiological Studies Depression Scale (CES-D), the NIMH Diagnostic Interview Schedule (DIS), and the Composite International Diagnostic Interview (CIDI). All of these studies included large samples of Mexican Americans. The HHANES included samples of Mexican Americans, Puerto Ricans and Cuban Americans. No major mental health studies have included Dominicans or some of the other rapidly growing Latino

groups such as Colombians and Ecuadorians. The National Latino and Asian American Study [NLAAS] of the mental health of these rapidly growing ethnic groups will provide national data on the mental health of the Latino population. While again the focus will be on the three largest Latino groups, there will be a sample of "Other Latinos" that should include a sizeable sample of Dominicans.

Hispanic Health and Nutrition Examination Survey

The Hispanic Health and Nutrition Examination Survey (HHANES), a major national study developed to assess health conditions and health needs of the Latino population in the U.S., incorporated the CES-D and the depression section of the DIS. The Hispanic HANES, which was conducted between 1982 and 1984, consisted of a medical history, a physical examination, and two measures of depression designed to identify significant pathology in Latino groups. Using self-identified ethnicity, the researchers sampled 7,462 Mexican Americans in the five Southwestern states; 2,834 Puerto Ricans in the New York metropolitan area; and 1,357 Cubans in Miami, Florida. The age range of those included in the study was six months to 74 years of age. These data are, to date, the best available on the physical and mental health of large representative samples of Latinos in the U.S., though the NLAAS will finally provide an updated picture of the mental health of Latinos.

Compared to Cuban and Mexican-Americans, Puerto Ricans had much higher rates of both symptoms of depression and depression "cases" using the CES-D and a greater prevalence of Major Depressive Episode using the DIS. The weighted prevalence estimates for each group (Moscicki et al., 1987) are presented in Table 1.

Table 1
Rates of Depressive Caseness and Major Depression in the Latino Health and Nutrition Examination Survey

Diagnosis	Mexicans	Cubans	Puerto Ricans
CES-D Caseness	13.2	9.5	27.9
Major Depressive Episode (Lifetime)	4.2	3.9	8.9

[Source: Moscicki et al., 1987]

The higher rates of CES-D scores need to be interpreted with some caution. Analyses by Angel and Guarnaccia of the Hispanic HANES indicate consistent differences in the way Latinos conceptualized depres-

sion, as reflected in the conflation of poor physical health with psychological distress (Angel & Guarnaccia, 1989) and differing factor structures of the CES-D from those found in other studies using these measures (Guarnaccia, Angel & Worobey, 1989).

The Los Angeles ECA Study

The Los Angeles site of the NIMH Epidemiologic Catchment Area Program [LA-ECA Study] over-sampled Mexican-Americans to allow for a comparison of their mental health with the Anglo-American sample there and in the other four sites of the national study. The researchers carefully translated the DIS into Spanish for this study (Karno et al., 1987). They collected information on migration history to compare the mental health of recent arrivals from Mexico to longer term residents and those born and raised in the U.S. The overall rates of psychiatric disorder for Mexican-Americans were strikingly similar to those of non-Latino Whites in Los Angeles and to respondents in the other ECA sites. For example, only 3% of Mexican Americans met criteria for Major Depression. This is slightly lower than Mexican Americans in the Hispanic HANES and much lower than the rates for Puerto Ricans. The researchers have argued that these results contradict earlier studies showing higher rates of distress for Mexican-Americans using symptom scales rather than diagnostic interviews. At the same time, a finding of the LA-ECA suggests that cultural factors and migration issues played important roles in response to the DIS.

In comparing native born Mexican-Americans to immigrants from Mexico, native born populations had higher rates of disorder (Burnham, Hough, Karno, Escobar & Telles, 1987). The immigrants might have been expected to experience greater stress due to migration and lower economic and educational levels. The authors argued that these results support a social selection hypothesis for levels of pathology among Mexican immigrants. They argued that recent immigrants are often the hardiest members of their communities and experience a significant improvement in living conditions compared with their home communities in Mexico. Over time, longer term residents and U.S.-born Mexican-Americans respond with a sense of deprivation after they compare their status to the standards of living in the U.S., fitting with a social stress approach. In comparing rates of disorder with non-Latino Whites, both a social selection hypothesis for recent immigrants and a social stress hypothesis related to frustrated aspirations for natives received some support. Furthermore, they found that acculturation to U. S. society increased the risks of developing both alcohol and drug abuse/dependence disorders; problems which were more prevalent in the non-Latino white population. These findings raise important questions about past studies comparing Latinos in their home countries and in the U.S. without carefully analyzing migration status and acculturation interactions. The study

shows the varied impacts of immigration and acculturation processes across different psychiatric disorders, arguing for more complex and heterogeneous models of ethnicity and of the relation of migration to mental health. These findings were more strongly supported by the research of Vega and colleagues (1998) in the MAPPS Study discussed below.

Other Studies of Mexican Americans

Several other studies of the mental health of Mexican origin populations in the U.S. have compared Mexican-Americans across immigration and acculturation statuses and with other U.S. ethnic populations. Many of these studies have used the CES-D as the primary mental health measure (Burnham, Timbers & Hough, 1984; Frerichs, Aneshensel & Clark, 1981; Roberts, 1980, 1981; Roberts & Vernon, 1983; Vega, Warheit, Buhl-Auth & Meinhardt, 1984; Vega, Kolody, Valle & Hough, 1986; Vega, Kolody & Valle, 1987; Vernon & Roberts, 1982; see also Angel & Thoits, 1987 for a review). These studies find that older women who are less acculturated and more recently arrived and those who are separated or divorced have higher depression symptoms scores. Some of these studies have also identified migrant farm worker populations, among whom Mexicans are by far the largest ethnic group, as a high risk group for psychological distress (Vega, Scutchfield, Karno & Meinhardt, 1985; Vega, Warheit & Palacio, 1985). However, when socio-demographic factors are controlled for in these studies, the differences among sub-groups are often attenuated or disappear, arguing that the disadvantaged social status of Mexican-Americans compared to other ethnic populations underlie the higher rates of depressive symptoms.

Studies in Puerto Rico

Canino and colleagues (1987) designed and implemented the Puerto Rico Island Study at the same time as the ECA studies and used a parallel methodology. This study developed a stratified random sample for all of Puerto Rico. The researchers developed a translation of the DIS specifically for Puerto Rico (Bravo, Canino & Bird, 1987). The Puerto Rico Island Study, similar to the LA-ECA study, found that there were no major differences between the rates of mental disorder on the Island compared to the five Epidemiologic Catchment Area studies carried out on the mainland U.S. (Regier et al., 1984). Puerto Ricans in Puerto Rico were found to suffer from no greater mental disorder than people from a variety of ethnic and social class backgrounds on the mainland U.S. Similar to the LA-ECA study, 3% of Puerto Ricans in Puerto Rico met criteria for Major Depression.

The differences, reported earlier between Puerto Ricans and other Latinos in the HHANES using the DIS depression schedule and the CES-D, indicate more frequent disorder for Puerto Ricans living in the New York metropolitan area than those living in Puerto Rico. These findings

suggest a combined social causation and social selection explanation. The significant social disadvantage experienced by Puerto Ricans in New York (compared to other ethnic groups in New York, to Puerto Ricans on the Island and to other Latino groups) indicate that social factors play a prominent role in the production of psychological distress. At the same time, many of those who migrate from Puerto Rico to Manhattan lack the human and social capital to succeed on the Island. Because of their lack of human and social capital, they encounter problems in New York as well. Social selection arguments focus on their lack of capital as a key factor in their psychological problems. A more macro-social analysis argues that Puerto Ricans suffer both on the mainland and the Island from the same economic forces which marginalize low skill workers and which leave migration as one of the few economic options available. At this level, the same social stressors are causative of psychological distress in this group regardless of where they reside.

Research by Alegria and colleagues (Alegria et al., 1991) on the use of mental health services by poor Puerto Ricans on the Island provides an additional comparison. These researchers used the CES-D and DIS depression schedule in their study allowing for comparisons with the Hispanic HANES. By standardizing the comparison to poor populations both in Puerto Rico and New York, they found similar rates of depressive symptoms and diagnoses (Vera, et al., 1998). These findings further strengthen the argument that poverty has a direct impact on psychological distress.

Study of Cuban Refugees

An epidemiological study comparing Mariel Cuban and Haitian refugees from the early 1980's provides further insights into the effects of different characteristics of immigrants, their migration experience, and the nature of the sending and receiving contexts on their mental health and service utilization (Eaton & Garrison, 1992; Portes, Kyle & Eaton, 1992). These researchers argue that the comparison between these two groups of refugees who arrived in large numbers to Miami during the same period provide a valuable contrast in the contexts of the sending and receiving societies as well as characteristics of the refugees themselves. The researchers used a design similar to the Epidemiologic Catchment Area Studies to study the mental health consequences of migration and they used a modified version of the DIS to measure Major Depressive Disorder, Anxiety Disorders, Alcohol Disorder, and a psychosis screen. Their sample included 452 Mariel Cubans and 500 Haitians who entered the U.S. during the same period. The Mariel Cubans experienced more disorder than the Haitians or than other Latino groups. Approximately 4% of Cubans met criteria for Major Depressive Disorder in the Hispanic HANES. Mariel Cubans had the highest rates of disorder of any of the comparison groups; with 8.3% meeting criteria for Major Depressive Disorder; this is parallel to the rates of Major Depression among Puerto Ricans in New York and poor Puerto Ricans on the Island.

Mexican American Prevalence and Services Study (MAPPS)

The MAPPS study was a large (3,000 adults) study of a Mexican origin sample in Fresno, California (Vega et al., 1998). It used a similar methodology to the National Co-Morbidity Study. The study utilized a translated and culturally adapted version of the Composite International Diagnostic Interview (CIDI). The study particularly examined rates of mental illness by immigration status and rural/urban residence in Fresno country. The most important finding of this study was that as Mexican immigrants acculturated to U.S. society, their mental health worsened. Recent Mexican immigrants (those in the U.S. for 13 years or less) had almost half the rate of mental illnesses of Mexican Americans born in the U.S. That is, those people who recently came from Mexico had the lowest rates of mental illness, similar to those of Mexican nationals, while those who had been born in the U.S. had the highest rates of mental illness, similar to rates in the National Co-Morbidity Study. These findings were particularly true for alcohol and substance use disorders, though they cut across all the major depressive, anxiety and substance abuse disorders. Thus, rather than suggesting that those who are healthiest migrate, this study suggests that longer residence in the U.S. is deleterious to the mental health of persons of Mexican origin.

Table 2
Rates of Psychiatric Disorders Across Major Studies of Latino Mental Health

Diagnosis	*LA-ECA* Mexican Americans (1243)	*Island Study* Puerto Ricans (1513)	*Mariel* Cubans (452)	*MAPPS* Mexican Americans (3012)
Major Depression	3.0 %	3.0 %	8.3 %	9.0 %
Panic Disorder	1.0	1.1	4.3	1.7
Phobia	7.3	6.3	15.6	7.4
Alcohol Disorders	5.3	2.7	6.0	3.3

[Sources: Canino et al., 1987; Karno et al., 1987; Portes et al., 1992; Vega et al., 1998]

National Latino and Asian American Study (NLAAS)

The NLAAS, which will be carried out in 2002, is the first nationally representative study of the mental health of Latinos and Asian Americans in the U.S. This study will include large samples of Puerto Rican, Mexican and Cuban subjects and a significant group of other Latinos. The NLAAS will also use the CIDI, culturally and linguistically adapted for different Latino groups. The NLAAS is designed to be parallel to two other national mental health studies: the follow-up to the National Co-Morbidity Study of the general U.S. population and a national study of the mental health of African Americans.

Latino Mental Health Utilization

Latinos, particularly Mexican Americans, have very low rates of use of mental health services (Briones, et al., 1990; Hough et al., 1987; Wells et al., 1987; Pescosolido et al., 1998; Vega et al., 1999; Peifer et al., 2000; Vega & Alegria, 2001; Vega et al., 2001; U.S. Department of Health and Human Services [USDHHS], 2001). Lack of health insurance and language barriers are the most commonly sited problems in Latino's utilization of mental health services. Immigrants are even less likely to use mental health services than U.S. born Latinos. When Latinos do seek help for mental health problems, they are more likely to do so in the general medical sector than in specialty mental health services.

The most robust findings of the underutilization of mental health services by Mexican-Americans come from the Los Angeles site of the Epidemiologic Catchment Area Study and from the MAPPS. In the LA-ECA Study, non-Hispanic whites were seven times more likely to use outpatient mental health services than Mexicans who spoke mostly Spanish. Mexicans who were less acculturated had very low use of any services that might address mental health problems, either in the specialty mental health sector or in general human services. Hospitalization rates were more similar across the groups, probably because hospitalizations involve more serious problems and because they are often initiated by third parties. Mexican Americans with a diagnosed mental disorder in the LA-ECA were half as likely as non-Hispanic whites to make a mental health visit.

The MAPPS study also found that Mexican Americans were low users of outpatient mental health services and identified even more striking differences between people of Mexico origin born in the U.S. and those born in Mexico. Overall, only a quarter of those with an identified DSM disorder sought mental health services. In looking within this group of those with a need for mental health care, immigrants used 40% of the services that Mexicans born in the U.S. did.

When Latinos seek help for mental health problems, they are more likely to seek help in general medical care settings than in specialty men-

tal health care. This finding came out particularly strongly in the MAPPS for Mexican Americans. The findings of the MAPPS corroborates earlier findings of the LA-ECA studies.

Studies among Puerto Ricans in Puerto Rico and Cubans in Miami provide a different picture for somewhat different reasons (Vega & Alegria, 2001; Burnette & Mui, 1999). Rates of utilization of outpatient mental health services in Puerto Rico are similar to findings among the general population in the U.S. Once barriers of language and culture are removed (and to some extent insurance status), Puerto Ricans in Puerto Rico seem to use similar amounts of mental health services as European Americans in the U.S. Cubans in Miami also have higher rates of utilization than Mexican Americans in California. The predictors of this utilization among Cuban Americans appear to include higher socio-economic status, special supports from government programs to provide health insurance, the presence of a large number of Cuban professionals, and the reproduction of the Cuban system of clinics in Miami. These studies indicate that for some Latinos, when cultural, linguistic and financial barriers are removed or lessened, rates of utilization of outpatient mental health services increase significantly.

Latino Mental Health Barriers

There are a wide range of barriers to seeking mental health care that have been identified in the Latino mental health literature (Hough et al., 1987; Pescosolido et al., 1998; Vega et al., 1999; Vega & Alegria, 2001; Vega et al., 2001; U.S. Department of Health and Human Services [USDHHS], 2001). These barriers can be organized into several dimensions: provider barriers, barriers in the service system, community-level barriers, barriers in the social networks of people in the community, and person-centered barriers. The most important system level barriers include lack of health insurance, language barriers, discrimination from the system and lack of information about services (especially in Spanish). Community centered barriers include the stigma of mental illness and the density of family and other support networks. Person-centered barriers include lack of recognition of mental health problems, stigma of mental illness, and a self-reliant attitude.

The major barriers to mental health service use among Latinos are lack of health insurance and citizenship and immigration status (USDHHS, 2001, Vega & Alegria, 2001). Thirty-seven percent of Latinos are uninsured; this is double the rate among European-Americans. A significant part of the reason for these high rates of lack of insurance is the low rates of provision of insurance by employers of Latinos. Forty-three percent of working Latinos received health insurance from their employers compared to 73% of European Americans.

Language barriers also figure prominently in writings on Latino's use of mental health services (Vega & Alegria, 2001; Prieto et al., 2001;

USDHHS, 2001). A large proportion of the Latino population in the U.S. speaks Spanish as their primary language, though this differs among the major Latino groups and across studies (in part, depending on how fully they include undocumented individuals). While some mental health programs, particularly in the Southwest and Northeast, have developed specific Latino-focused programs with large numbers of bilingual/bicultural mental health professional staff, the norm is that there are few, if any, bilingual/bicultural staff in mental health agencies and fewer masters and doctoral level professionals. The Miami area is somewhat of an exception given the large number of Cuban health and mental health professionals in the area. Thus, a major barrier for Spanish-speaking Latinos is the lack of providers who can offer mental health services in Spanish.

A related concern is discrimination against Latinos in mental health services. This discrimination results from both racial and cultural bias against Latinos. While there is more evidence of discrimination for medical conditions (Institute of Medicine, 2002), it is likely these factors operate in the mental health sector as well. Again, the issues differ for different Latino groups. Mexicans have been the focus of English only laws and propositions to limit their access to health and social services in California. Cubans in Miami experience less discrimination because of their dominance in the city, though the Mariel refugees appear to have been more stigmatized than earlier waves. Although Puerto Ricans have been citizens since the beginning of the last century, there is still considerable misunderstanding about their status. Some Latinos from the Caribbean are subjected to the double stigma of being Black and being Spanish speaking.

Lack of information about where to seek mental health services can also be a barrier, particularly lack of information in Spanish. Given that most mental health services are offered in separate settings from general medical services, it is not always clear even to the general population where to get these services.

The stigma of mental illness is particularly powerful as a barrier to seeking care. In particular, the label of *locura* or madness carries strong negative connotations. Someone who is *loco* is seen as severely mentally ill, potentially violent and incurable. Labeling a family member with mental illness as suffering from *nervios* serves to destigmatize that person's experience both in the family and the community (Jenkins, 1988a, b).

Latinos tend to have large family networks that are very important sources of social support and problem solving at times of crisis. The centrality of Latino families to social life is captured in the concept of *familismo*. However, it is important to recognize that many recently immigrated Latinos have fractured family systems as a result of the migration process. Those family members who are in the U.S. are often working long hours and have limited financial resources. Thus, the reality of family support may be considerably less than the ideal. A potent source of

potential stress is the gap between what Latinos expect in terms of family support and what is actually available to them. In the second generation, families are often fractured by the strains of acculturation and low socio-economic status. Some researchers have argued that extended family support systems among Latinos may serve as a barrier to seeking mental health care because the resources are available to deal with the problem in the community and because problems like mental illness are dealt with in the privacy of the family. Pescolido and colleagues in Puerto Rico (1998) did find that larger support networks led to longer and more complex pathways to care. Puerto Ricans in Puerto Rico consulted a number of informal advisors about what to do and received support from these family members that kept them out of the mental health system unless the problem was quite severe. Less work has been done in the U.S. on these factors. For those without supports, third parties, such as police or emergency workers, may intervene to bring Latinos to care.

Recent research in Puerto Rico has highlighted a self-reliant attitude as a barrier to seeking care (Ortega & Alegria, 2002). People who felt they should be able to cope with mental health problems themselves were less likely to seek care, even when they reported symptoms indicative of mental illness. This self-reliant attitude was recently expressed in a focus group of Latinos in Spanish as *ponerse de su parte* (contributing one's part). This attitude reflects the feeling that one should be strong enough to cope with life's problems on their own and with family and not need to depend on the mental health system.

Latino Mental Health Best Practices

There is a serious lack of research on best practices for mental health treatment of Latinos (Garcia & Zea, 1997; Rosenthal 2000; USDHHS, 2001). The literature contains many suggestions about Latino values (such as *respeto, personalismo, familismo*) that should be incorporated into mental health treatment. Articles also suggest that therapies that are more directive rather than insight oriented and more family rather than individual focused will be more effective with Latinos. However, the research base for these assertions is lacking.

> Given the significance of the Latino population in the United States, the reification of bits of stereotypic misinformation on practice with Latinos, and the paucity of rigorous practice outcome research, ascertaining which treatments are relevant and effective and what areas remain to be explored is an important endeavor. (Rosenthal 2000:219)

This section will follow the stages of providing care to summarize best practices for serving Latinos [for a Framework for Research on Hispanic Mental Health, see Rogler, Malgady and Rodgriguez, 1989]. These

stages include engaging the client in care, assessment and diagnosis, and providing treatment to both the ill individual and the family. Organista (2000) and Lopez and colleagues (2002) address the engagement phase of providing treatment. It is at this stage, that Latino values such as *respeto* and *personalismo* are particularly important. The balancing of respect for the client (as evidenced in forms of address that are age and gender appropriate) with warmth and personal interest (that are more engaging than the typical therapist stance with Anglo American clients) are important for establishing an effective therapist-client relationship. The importance of these values in bringing Latino patients into care are so often repeated that they have significant face validity. While there have not been specific empirical tests of the impact of *respeto* and *personalismo* on engagement, the ethnic matching literature [which will be discussed in more detail shortly] provides indirect evidence for this assertion. Latino clients who see Latino patients are more likely to return for follow-up visits, stay in care longer and are more satisfied with their care. Another critical factor in engagement is being able to communicate effectively with the client in her/his preferred language or combination of Spanish and English. Language use also affects diagnosis. Earlier research (Marcos, 1973a,b, 1976) indicated that bilingual Latinos tended to look more ill when interviewed in English than in Spanish.

In terms of assessment and diagnosis, there are issues at the level of recognition of symptoms and syndromes and issues related to the overall approach to clinical assessment. Issues of misdiagnosis of Latinos are an increasing area of concern. There are particular experiences of Latinos that frequently lead to misdiagnosis in the mental health system. Latinos tend to be very expressive of their physical and emotional pain, often through rich somatic idioms. This "somatization" of distress is misunderstood as either hypochondriasis or a lack of ability to express the psychological dimensions of emotional distress - neither of which is accurate (Angel and Guarnaccia, 1989; Escobar, et al., 1987, 1989). Rather Latinos express depression and anxiety through a mix of physical and emotional complaints. Spiritual and religious experiences of visions (Guarnaccia, et al., 1992), of hearing one's name called (often by a recently deceased relative) and perceiving presences (sometimes in the form of *celajes*) are relatively common and non-pathological experiences for some Latinos. These same symptoms get misinterpreted by mental health professionals as signs of psychosis. The cultural syndrome of *ataques de nervios* is a dramatic expression of deep sadness and distress among Caribbean Latinos. Some *ataques* that occur at culturally appropriate times such as at a funeral are culturally normative ways of expressing deep sadness; other *ataques* may signal the presence of an anxiety or depression disorder (Guarnaccia, et al., 1989, 1993, 1996; Lewis-Fernandez, 1996; Liebowitz, et al., 1994). The *DSM-IV* (APA, 1994) incorporates a "Glossary of Culture-Bound Syndromes" which provides some more detail on these experiences.

The *DSM-IV* also includes an "Outline for Cultural Formulation" (APA, 1994), which provides a framework for assessing the impact of culture on a client's psychopathology as well as the social and cultural context of the person. This Formulation includes questions to assess: the cultural identity of the client; their cultural explanations of the illness; cultural factors related to the psychosocial environment and levels of functioning; cultural elements in the client-clinician relationship; and an overall cultural assessment for diagnosis and care. While this Formulation is presented in a general way, and there has not yet been systematic research on its use, there have been a series of case reports presented in the journal *Culture, Medicine and Psychiatry* (since 1996) which illustrate the use of the Formulation with clients of different ethnic backgrounds and discuss the implications of the additional information collected in this way on diagnosis and treatment. Guarnaccia (Guarnaccia & Rodriguez, 1996) developed a more detailed set of assessment questions for Latino immigrants for use in bilingual/bicultural psychiatric inpatient programs [these questions are included as an appendix to this report]

The systematic adaptation and testing of treatments for Latinos is in its beginning phases. The most work has been done in adapting Cognitive Behavioral Therapy for Latinos (Organistra, 2000; Miranda & Munoz, 1994; Wells, et al., 2000), especially for the treatment of depression. CBT manuals have been successfully translated and adapted for Latinos and treatments have been shown to be effective. Organista (2000) provides a detailed discussion of the cultural issues in adapting CBT for Latinos in San Francisco and provides details on how they carried out the adaptation. He notes that family themes are predominant in the kinds of problems Latinos bring to mental health treatment. In addition, issues of stress and acculturation, particularly differential rates of acculturation between children and parents, are prominent areas to work on in therapy. Activity schedules, particularly identifying pleasurable activities accessible to low income Latinos, need to be modified from standard CBT protocols. Assertiveness training aspects of CBT need to be adapted to the cultural styles and gender issues prominent among Latinos. Organista also provides useful strategies for approaching cognitive restructuring tasks with Latino clients. CBT has been shown to work well for Latinos. A key issue is insuring that Latinos are offered therapeutic interventions in conjunction with medications.

Family interventions have been proposed to be particularly effective for Latinos because of the strong value placed on family ties, often glossed in Spanish as *familismo*. Much of the work on evaluating the effectiveness of family interventions has been carried out by Szapocznik and colleagues (1997) in Miami with Cuban American families. The focus of this work has been on helping families deal with intergenerational conflicts and acculturative stresses faced by adolescents and has been shown to be quite effective.

The other area of family work has been done with Mexican Ameri-

can families with a relative with schizophrenia (Lopez, et al., 2002). Much of this work has been informed by research on the role of expressed emotion in re-hospitalization of a family member with schizophrenia and on adaptation of mutli-family psychoeducational approaches. Jenkins (1988a,b) found that those Mexican American families who saw their family member's schizophrenia as a form of *nervios* were more likely to be more accepting of their relative's illness and less likely to express negative emotions towards their family member than European American families who identified the problem as mental illness. Lopez and colleagues (2002) found that expressed warmth was most protective for Mexican American relatives with schizophrenia, while lack of critical comments was most protective for European American family members. Lopez and colleagues (2002) identify a number of modifications which they recommend for developing culturally congruent family interventions for Latino families with a relative with schizophrenia. These adaptations include appropriate translation of family education materials both in terms of language and reading level; engaging families as helpers in improving outcomes for their ill relative; starting education about mental illness by eliciting families' understandings of the problem rather than with standard lectures on the medical model of mental illness; integrating biological and social dimensions of mental illness; and building supports for families and their ill relatives using naturally existing support systems in Latino communities rather than creating support systems among families who are strangers but share the problem of mental illness.

Ethnic matching, that is having Latino clients see Latino therapists, has been shown to be effective in some aspects of mental health treatment and for some Latino groups. The most comprehensive work has been done by Sue and colleagues (1991). Their work shows that when Latino patients are seen by Latino therapists who speak their language, they are more likely to return for follow up appointments and to remain in treatment over longer periods of time. This effect has mostly been studied for Mexican Americans in Los Angeles. The effects were most powerful for Spanish speaking clients. While the impacts on retention in these studies are clear, the effects of matching on outcomes are less strong, though part of the problem is identifying appropriate and sensitive outcome measures.

There are a number of issues surrounding medication treatment for Latinos with mental health problems. One area of concern is that even when Latinos get into care, they do not receive the most recent medications at therapeutic levels (Marin & Escobar, 2001; IOM, 2002). Latinos appear to have significant concerns about psychotropic medications. These include both the strength and the addictive potential of those medications. At the same time, psychotropic medications may be more easily available in Latino's home countries. Those migrants who have been treated for mental illness in their home countries may continue to receive medications from relatives there; this is an important area for assessment

in initial visits with Latino clients. There is very limited information that some Latinos may respond differently to psychotropic medications, particularly anti-psychotics, than European Americans (Marin & Escobar, 2001; USDHHS, 2001). Latinos may metabolize some medications differently and be more sensitive to the side effects of medications than European Americans.

Overall, the studies show that once in treatment, Latinos benefit from it. The limited reviews of practice outcome research (Rosenthal, 2000; USDHHS, 2001; Wells et al., 2001) indicate that once Latinos are in care, they benefit greatly from both psychotherapeutic and medication interventions. The limited number of studies available show that the benefits accrue across several modalities, both those specifically adapted for Latinos and more standard approaches. The key issue appears to be getting Latinos into treatment and keeping them there. Getting them into treatment involves addressing the barriers discussed above. Providing bilingual/bicultural therapists to Latinos keeps them in care longer so that they can benefit from the range of modalities available.

APPENDIX A:
Social and Cultural Assessment of Hispanic Immigrants

Language Capabilities and Preferences

1. Basic skills in Spanish and English: Speaking, Understanding, Reading, Writing
   [1=fluent; 2=very good; 3=good; 4=poor; 5=no ability]
2. What language(s) were you raised in?
3. What language(s) did you speak and learn in school?
4. What language(s) do you currently speak with: family; friends; work associates; shopkeepers?
5. Levels of language ability
   A. languages the client understands
   B. languages the client functions in for day-to-day routine
   C. languages the client expresses emotions/feelings in
   D. language the client feels most comfortable with in interaction with doctor

Social Connections

FAMILY STRUCTURE:

1. Who is the core family? - Nuclear, extended, family of origin or marital family
2. Where is everyone living? - Is family separated between U.S. and home country
3. How long has family been separated? Are there plans to reunite family? How soon?
4. How often are you in contact with family? - In person, by phone, by letter
5. How difficult is it to maintain contact with family?
6. Do you have <u>compadres</u>? How often are you in contact with them?

SOCIAL SUPPORTS:

1. If you needed _____, do you have someone you could ask?

<u>Favor</u>	<u>Who would you ask?</u>	<u>Have they helped in the past?</u>
Ride to the doctor/hospital		
Loan of money		
Care of children		
Someone to talk to		
Place to live		
Use of telephone		
Help translating		

2. Who helped you get around when you first came to the United States?
3. Who do you turn to for advice about where to shop or to go for health care, how to get services?

4. Who do you turn to when you just need to talk to someone?
5. Who do you celebrate holidays with?
6. Who should we contact if there is an emergency?

Migration Experience

1. Where were you born? Where were your parents born?
2. How long have you lived in the United States? How long have you lived where you live now?
3. Why did you leave your home country?
4. Why did you come to the United States? Why did you come to the city where you live now?
5. Describe your trip to the United States?
   A. How did you travel?
   B. What countries did you pass through?
   C. Who helped you on your way?
   D. What problems did you encounter?
   E. Where did you sleep? eat? wash?
6. Did you travel alone or with others? Who did you come with?
7. Have you gone back to your home country? Why or why not?
8. Do you still have family and relatives in your home country? Who? Do they plan to come to the United States? Are you worried about their health or safety?
9. Do you plan to remain in the United States or return to your home country?

Religious Beliefs and Practices

1. What religion are you now? In what religion were you raised? If you changed religions, why did you change?
2. Do you consider yourself a religious person?
3. How often do you attend services and meetings of religious groups?
4. How often do you pray? Do you have an altar at home?
5. Beliefs in spiritual healing
   A. Have you ever heard of people who can heal through the use of spirits or saints?
   B. Do you believe people can heal with the help of spirits or saints?
   C. Have you ever consulted such a person, such as an espiritista, curandero, or santero?
   D. Has the treatment helped?
   E. Are you currently consulting such a person?
6. Have you or your family consulted a religious leader about your health problems? a healer?
7. Does your religion have any beliefs which might affect your treatment [not using certain medicines; accepting transfusions]?

Health Care Utilization

1. When you were sick in your home country, what did you do? Who delivered your babies?
Where did you go for medical treatment? Who did you talk to about what to do?
2. Since coming to the U. S., what health problems have you had? Where did go for treatment?
3. What do you call your current problem?
4. Since your current problem started, what kinds of care have you received?
   A. Have you done anything yourself? [Home remedies, teas, over-the-counter medicines]
   B. Who did you talk to for advice?
   C. What brought you here? Who suggested you come here?
   D. What are your expectations of treatment?
   E. Are you seeking any treatment from other providers?
   F. Have you talked to your priest or minister about your health problems?
5. Have you suffered from your current problem before? What did you do about it? Was the problem different in your home country?

[From Guarnaccia, P. J. And O. Rodriguez. 1996. Concepts of Culture and their Role in the Development of Culturally-Competent Mental Health Services. Hispanic Journal of Behavioral Sciences 18:419-443.]

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Henry Acosta, MA, MSW, LSW, Project Director
Changing Minds, Advancing Mental Health for Hispanics
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(609) 838-5488
(609) 838-5480 (Fax)
www.njmhi.org