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Utilization of Mental Health Services

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API women and Latina Americans may be considered unique client populations with special mental health needs. However, their service needs and utilization patterns remain largely a matter of conjecture due to the paucity of data for immigrant and refugee women on utilization rates, types of services received, and treatment outcomes. Nonetheless, study findings for the overall API and Latino and Latina populations consistently show that proportionally fewer individuals utilize mental health services compared to European Americans (Sue, Zane, and Young, 1994). One investigation, which used the 1986 National Institute of Mental Health national survey data of patient populations, found that APIs were three times less likely to utilize mental health services compared to European Americans (Matsuoka, Breaux, and Ryujin, 1997). Another study analyzed utilization patterns of five different Asian American groups who were treated in the Los Angeles County mental health system from 1983 to 1988 (Ying and Hu, 1994). Results showed variable utilization patterns and treatment outcomes across Asian American groups: Filipinos were underrepresented in this public mental health system relative to their overall county population, while Southeast Asians were overrepresented and reported the least improvement following therapy. In an earlier

study using the same Los Angeles County data set, Sue, Fujino, Hu, and Takeuchi (1991) found that Mexican Americans also underutilized public mental health services; these findings were in contrast to African Americans, who overutilized services.

Significant ethnic differences in the types of services received in public mental health systems also have been highlighted. For instance, Asian and Latino American clients used fewer emergency and inpatient services but more outpatient care compared to European American clients served in San Francisco and Santa Clara counties (Hu, Snowden, Jerrell, and Nguyen, 1991). Similar ethnic differences were found for clients who were being treated for severe mental illness at public mental health clinics. In examining mental health records for two large West Coast counties, researchers found that in one county, Asian and Latino American clients suffering from severe psychopathology and psychosocial dysfunction utilized more outpatient and supportive services, but fewer inpatient services compared to European Americans (Snowden and Hu, 1997). Asian and Latino American clients in the second county exhibited an opposite service pattern: they were more likely to be hospitalized compared to European American clients.

A broad range of variables have been identified to account for ethnic differences in utilization rates, treatment outcomes, and types of services: clients' demographic backgrounds, cultural values and norms, illness beliefs, help-seeking strategies, therapist characteristics, assessment and treatment techniques, and organizational and structural characteristics of the mental health agency (Echeverry, 1997; Uba, 1994). However, discussion of these variables often is devoid of a conceptual framework to understand their significance to the *process* of service utilization among immigrant and refugee populations. To this end, mental health service issues for these special client populations may be analyzed using a stage model of utilization that extends past discussions of utilization pathways (Howard and others, 1996; Saunders, 1993) and change processes (Prochaska, DiClemente, and Norcross, 1992).

The proposed stage model of utilization assumes that clients will progress through a series of identifiable and interrelated stages that characterize service utilization as a multilevel process involving numerous individual, organizational and structural,

and treatment variables: problem recognition, coping response, agency contact, and service engagement. The following discussion outlines the various issues in each stage for immigrant and refugee populations, with particular attention to sociocultural and structural barriers that may prevent API women and Latinas from accessing mental health care systems.

Problem Recognition

In this stage, individuals first become aware of their psychological distress and related symptomatology. They form initial illness attributions, which are contingent on their level of acculturation. API women and Latinas may view their presenting problems in culturally distinct ways that ultimately inform their coping strategies, including their decision on whether to utilize mental health services.

API women and Latinas may hold culturally embedded views of mental health that focus on a dynamic interaction between the mind and body (Chun, Eastman, Wang, and Sue, 1998). This, of course, is different from Western psychological perspectives, which primarily attend to mental processes. This was poignantly illustrated in the traditional health beliefs found in a community sample of immigrant Chinese women in San Francisco's Chinatown, who attributed major depression to both psychological (for example, "low/unstable mood") and physiological (for example, "heart problems") causes (Ying, 1990).

Latinas also may hold culturally distinct conceptualizations of psychological distress that may involve physical symptoms. For example, it has been suggested that *ataques de nervios* in immigrant Puerto Rican women is a permissible way for Puerto Rican women to express anger within their cultural milieu (Oquendo, 1994).

Coping Response

Individuals in this stage initiate coping strategies aimed at alleviating their psychological distress. They may attempt to resolve their problems individually or with the aid of resources in their socio-cultural environment. API women and Latinas may initiate multiple coping responses before considering mental health services

due to cultural conceptualizations of illness, availability of informal social support networks, cultural norms and values, gender role expectations, lack of awareness of the availability and nature of mental health services, and cultural distrust of agencies.

Initially they may seek help from medical rather than mental health professionals (Canino, 1982; Lin, Carter, and Kleinman, 1985; Lin, Ihle, and Tazuma, 1985). They also may be more comfortable accessing coping resources that are more compatible with their cultural belief systems (Dworkin and Adams, 1987; Lee, 1997; Reeves, 1986; Uba, 1994). Within the Asian and Latin American cultures, this may include seeking help from indigenous folk healers or the church and clergy (Akutsu, Snowden, and Organista, 1996; Flaskerud, 1986; Garcia and Zea, 1997; Lee, 1997; Leong, Wagner, and Tata, 1995; Uba, 1994). For example, many Hmong and Mien refugees who have relocated to the United States continue to seek shamans and use traditional herbal remedies to treat their psychological problems (Westermeyer, 1988).

Historically, API women and Latinas have turned to informal social supports, such as immediate and extended family and close friends, when personal remedies for psychological distress are inadequate (Cheung, 1987; Lin, Inui, Kleinman, and Womack, 1982). Cultural norms that ascribe shame and stigma to mental illness may also contribute to underutilization of mental health services (Jayakar, 1994; Vargas-Willis and Cervantes, 1987). Personal disclosures of mental health problems to individuals outside the immediate and extended family often are seen as cultural taboos that bring shame and dishonor to the entire family. Similarly, mental health problems often are viewed as a sign of moral weakness or a lack of moral character (Echeverry, 1997). As such, API women and Latinas are more likely to strengthen their willpower and suffer in silence instead of seeking professional help (Bradshaw, 1994). Korean immigrants, for example, have taken great pride in their silent endurance and resiliency under the most adverse conditions in immigrating to the United States (Kim, 1994).

Cultural values of harmony and group cohesion may further discourage these women from disclosing their problems even to their own families. For example, one study found that Spanish-speaking Latinas infected with the human immunodeficiency virus (HIV) were less likely to disclose their seropositivity or HIV-

related worries with their family and friends, compared to African and European Americans and English-speaking Latinas (Simoni and others, 1995). Cultural norms such as *simpatica* (emphasizing harmonious social relationships) and "familism" (promoting family solidarity) may have inhibited these Latinas from disclosing to family and friends in order to avoid disruption of interpersonal relations.

Puerto Rican American women may adhere to *marianismo*, which incorporates Catholic beliefs surrounding the Virgin Mary. This gender role prescription maintains that women are spiritually superior to men, thereby allowing them to endure the suffering caused by men (Comas-Diaz, 1988). This notion of self-sacrifice may reinforce Latinas to cope with their problems on an individual basis. Such gender role expectations are seen in Asian American cultures as well. In the Japanese culture, the expression *shi-ka-ta-ga-nai* or ("it cannot be helped") encourages women to tolerate life's suffering without complaint or help from others.

Lack of awareness of available services and lack of familiarity with the nature of therapy further mitigate API women and Latinas' seeking professional help (Starrett and others, 1990; Uba, 1994). For example, a lack of awareness of community mental health resources has been found to contribute to lower utilization rates (Loo, Tong, and True, 1989). Researchers also have noted that many immigrant and refugee groups may be reluctant to seek psychotherapy because they are unfamiliar with the nature and benefits of this treatment modality (Uba, 1994).

Cultural distrust may inhibit Asian American–Pacific Islander women and Latinas from using mental health services even if they are aware of their availability. Invariably, there is a recurrent fear that services or information disclosed in therapy may not be confidential and may become a part of public record where families, neighbors, or the community at large are privy to highly personal information (Echeverry, 1997; Ishisaka, Nguyen, and Okimoto, 1985). This fear is particularly important for undocumented women, who may not seek services in a government-sponsored clinic because they assume it is affiliated with the Immigration and Naturalization Service (INS) and that they will be deported if their illegal status is disclosed (Echeverry, 1997).

Given these reasons, it is not uncommon for immigrant and refugee women initially to attempt to resolve their personal difficulties alone or within their immediate and extended families, including trusted friends. Next, they may seek consultation with an indigenous folk healer, spiritualist, clergy, or medical professional (Koss-Chioino, 1995), and if these resources fail to alleviate the problem, they may finally go to an emergency room or a mental health clinic when the situation reaches crisis proportion (Wallen, 1992).

Agency Contact

Individuals in this stage make the initial step of contacting mental health agencies to determine the feasibility and relative merits of utilizing professional services. API women and Latinas may still harbor reservations about mental health care. Consequently, they may spend considerable time inquiring about agency services, structure, and policy, without making a commitment to utilization.

In order to improve mental health service use within Asian and Latina American communities, clinicians and researchers have emphasized the importance of hiring culturally competent and bilingual staff, improving accessibility to agencies, increasing availability of agency services, improving affordability of services and fees, and providing additional services targeting immigrant and refugee populations. Marin (1993) advises that culturally appropriate strategies must address some basic criteria for Asian and Latin American populations:

1. The intervention is based on the cultural values of the targeted group.
2. Intervention strategies reflect the subjective culture (attitudes, expectancies, norms) of the group.
3. The components comprising these strategies incorporate the behavioral preferences and expectations of the group's members.

Because Latinas and API women may be unfamiliar with mental health services, agencies should be staffed with culturally

competent individuals who are sensitive to their unique concerns and needs. This includes orienting staff to cultural expectations for psychological treatment among refugee and immigrant women (Acosta, Yamamoto, and Evans, 1982; Tien, 1994; Vargas-Willis and Cervantes, 1987). It is likely that these women will be contacting the agency after exhausting other culturally sanctioned coping responses, so it is critical to address possible feelings of guilt and shame immediately that may accompany their decision to seek services. This may require pretreatment client education on the nature and course of therapy, as well as the roles of the client and therapist. The provision of such information prior to treatment is associated with increased knowledge about psychotherapy and more positive attitudes toward treatment for API women and Latinas (Acosta, Yamamoto, Evans, and Skilbeck, 1983; Uba, 1994).

The availability of bilingual staff affects service utilization for APIs and Latinas as well (Echeverry, 1997; Uba, 1994). Most immigrant and refugee women clients who are primarily monolingual tend to prefer services offered in their native tongue or dialect. The inability of most therapists and staff to communicate effectively with clients who have limited English-language skills seriously compromises the quality of services (Bamford, 1991; Malgady, Rogler, and Constantino, 1987). This is especially evident during initial contact, where speaking to the agency receptionist in one's native tongue may be decisive in forgoing or pursuing professional help. Although children may act as translators for the family, this is not necessarily an effective method of communication (Chung and Lin, 1994), and the use of bilingual professionals in the field is preferred (Comas-Diaz and Greene, 1994).

Accessibility and geographic location of mental health agencies also influence service (Echeverry, 1997; Uba, 1994). Since many immigrant and refugee clients come from impoverished backgrounds, it is likely that they have to rely on public transportation, which means spending considerable time and effort traveling to seek professional help. A family also must have enough funds to pay transportation fares for several people. Reliance on public transportation can be a potential source of embarrassment for those traveling with a family member who may be visibly disturbed or difficult to manage (Echeverry, 1997).

Agency hours of operation or availability play a critical role in determining whether greater service use will occur. Work schedules for immigrant and refugee women may conflict with regular business hours, a significant obstacle for those who are primary caretakers of their children and other family members. In addition, many employed women of color are unable to take sick leave for mental health treatment (Echeverry, 1997; Uba, 1994). In response to these challenges, many culturally sensitive programs have increased their hours of operation to include evening and weekend hours.

High costs and service fees and lack of health insurance or benefits may further restrict access to mental health care (Ruiz, 1993; Wells and others, 1987). Many immigrant and refugee women and their families live below the poverty level and tend to have low-wage jobs that prevent them from utilizing mental health services (O'Hare, 1992). Newly arrived immigrants and refugees are particularly intimidated by the cost of mental health services, either because they lack health insurance or their health insurance is inadequate (Wong, 1985).

Service utilization may increase with the incorporation of mental health services into multiservice centers that provide legal and social services, as well as language programs that meet the unique needs of immigrant and refugee populations (Sue and Zane, 1987). This multiservice center option can diminish the stigma associated with mental health care by presenting psychotherapy as just one of many service options available to prospective clients (Uba, 1982).

Service Engagement

Once individuals have made an initial commitment to enter therapy, whether they will remain engaged in the treatment process depends on the client-therapist ethnic and gender match, culturally sensitive therapy techniques, and therapist credibility.

Attention to gender issues is a key factor in service engagement for API women and Latinas. In the previously discussed study of psychiatric outpatients in the Los Angeles County mental health system, ethnic match between client and therapist was

positively related to the number of therapy sessions for Asian and Mexican Americans (Sue and others, 1991). Moreover, it contributed both to fewer premature terminations and positive treatment outcome for those who did not have English as a primary language. Another study, which used the same data, found that Asian American women who were matched with their therapist on both ethnicity and gender were twenty times less likely to drop out of treatment after one session compared to women who were not matched on either ethnicity or gender (Fujino, Okazaki, and Young, 1994).

Treatment benefits associated with client-therapist ethnic and gender match may be related to heightened sensitivity to cultural and gender issues in the therapy session. Although studies have yet to investigate the relationship of specific treatment variables to outcome for API women and Latina clients, culturally sensitive therapy techniques have been recommended. These have included a directive and active counseling style and attention to nonverbal communication and implicit social cues reflected in body language, eye contact, and tone of voice. For Mexican American women clients, in particular, *dichos*, or cultural proverbs, may be used to overcome discomfort with the psychotherapy process and promote change. Examples of such proverbs include "*Lo que pasó voló,*" or let bygones be bygones, and "*Al que le duela la muela que se la saque,*" which literally means that the person with tooth pain should pull it out, or "God helps those who help themselves" (Zuniga, 1991).

Culturally diverse immigrant and refugee women may be more likely to remain engaged in treatment if gender issues are addressed as well. In addition to exploring grief and loneliness stemming from the immigration and refugee experience, therapists should be aware that some women may feel guilt and shame if they fail to meet gender role expectations. This may represent a salient treatment issue for those who come to the United States alone, leaving family and children behind in their home countries (Espin, 1987). Therapy may incorporate feminist approaches of self-empowerment that allow immigrant and refugee women to redefine their social and family roles and develop self-acceptance and autonomy (Vargas-Willis and Cervantes, 1987). However, feminist approaches should be adapted to meet the sociocultural

experiences of ethnically diverse groups (Comas-Diaz, 1988; Sieng and Thompson, 1992). For instance, awareness, education, openness, and confrontation of sexual and cultural stereotypes may be an integral component of treatment (Chan, 1988). In addition, analysis of power relationships that are affecting the client's situation and identification of potential power may prove beneficial to ethnic minority women (Gutierrez, 1990). This may encompass identifying positive role models of adaptation in the community or in traditional folk legends, and developing support groups for women (True, 1990). The ultimate goal of these treatment considerations is to help immigrant and refugee women to integrate ethnic, gender, and racial components into their identity (Comas-Diaz, 1988).

Finally, therapist credibility may be considered more proximal to the goal of positive treatment outcome than ethnic match, gender match, culturally sensitive techniques, and attention to gender issues alone. According to Sue and Zane (1987), ascribed and achieved credibility is fundamental to treatment success. Ascribed credibility relates to the status that is assigned to the therapist prior to the therapy session, whereas achieved credibility refers to the therapist's actual skills and actions. In this context, API women and Latinas may ascribe high credibility to their therapists if they are women who share similar cultural backgrounds. Moreover, therapists can achieve credibility if they develop culturally appropriate conceptualizations of problems, problem resolution strategies, and treatment goals. Therapists who have low ascribed credibility initially may thus achieve credibility over time.

Conclusion

The stage model of utilization is intended to broaden past discussions that typically have been confined to one aspect of a multi-level process. Delineation of stages toward utilization allows for the systematic analysis of individual, organizational and structural, and treatment process variables and their relationship to the service needs and utilization patterns of immigrant and refugee women. A number of recommendations aimed at improving service utilization can thus be formulated for the different stages in this model.

First, in terms of problem recognition, it is important to gain a better understanding of emic constructions of illness in order to estimate the prevalence of psychological distress within immigrant and refugee communities. This will allow practitioners to understand the mental health service needs of specific cultural groups better. With regard to coping responses, it is imperative that mental health agencies implement culturally appropriate interventions that increase community awareness of available mental health care. To this end, mental health agencies may enlist the help of community leaders to serve as educators or lay counselors, who can provide information about services to fellow immigrant and refugee women. In relation to agency contact, the hiring of culturally competent, bilingual staff should remain a priority in light of the growing size of immigrant and refugee populations who require mental health care. Furthermore, agencies should continue to offer additional services, such as parenting support groups and public seminars on women's health care, to diminish the stigma associated with mental health service use. For the last stage of service engagement, continued research on specific process variables associated with therapist credibility will lead to improved treatment approaches for culturally diverse groups. The efficacy of modified feminist treatment approaches also should be examined to develop strategies for empowerment that incorporate the sociocultural realities of immigrant and refugee women.