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Religiosity and Mental Health Services: An Exploratory Study of Help Seeking Among Latinos

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In this qualitative study, we examine religiosity, coping with adversity, and facilitators of seeking different types of mental health services in a sample of 17 religious Latino men and women. Thematic analysis revealed that participants tended to cope with methods that were consistent with their religious practices. Most participants, especially those older in age, identified organized and informal religious and spiritual practices as important and preferred religious and spiritual coping methods when handling adversity. Additionally, many participants indicated a preference for religious counseling services that was consistent with their religious beliefs and complemented their extant ways of coping with adversity. Finally, our study found that there were several commonly held ideas about circumstances under which participants would seek formal mental health services, including feeling understood, experiencing serious mental health problems, and encountering problems that were thought to be biological in origin. Importantly, two contextual factors emerged as relevant in understanding these reasons, with participants who shared these views tending to be more acculturated and have more formal education. Results from this study highlight how religiosity is related to coping and attitudes toward formal mental health services among religious Latinos, as well as the importance of context in understanding these processes.

Keywords: religiosity, coping, mental health help seeking, help-seeking behaviors, Latinos

The Latino population is the largest minority group in the United States, comprising 15.1% of the total population (U.S. Census Bureau, 2010). Based on recent Census Bureau projections, approximately 30% of the population will be Latino by the year 2050 (U.S. Census Bureau, 2010). This population growth has been mirrored by a rise in the attention to the mental health needs of Latinos, which has been consistently marked by the underuse of formal mental health services as compared with non-Latinos (e.g., Alegría et al., 2002). To date, research among Latinos suggests that this underutilization is attributable to a variety of reasons, including logistical barriers to accessing health care (e.g., Nandi et al., 2008), attitudes toward mental health services (e.g., Berdahl & Torres Stone, 2009; Cabassa, 2007), as well as individual's levels of acculturation (e.g., Alegría et al., 2007; Sentell, Shumway, & Snowden, 2007).

However, one area that has received minimal attention with regard to the help-seeking process among Latinos is the role of religiosity. Studying the relationship between religiosity and help-seeking processes among Latinos has considerable potential since a growing literature has documented associations between religiosity and mental health outcomes among Latinos (e.g., Herrera, Lee, Nanyonjo, Laufman, & Torres-Vigil, 2009; Jurkowski, Kurlanska, & Ramos, 2010). Moreover, religiosity has been generally associated with negative attitudes toward help seeking (e.g., with African Americans, Chandler, 2010, and non-Hispanic White college students, Miller & Eells, 1998), which may in turn lead to less use of formal mental health services. Indeed, several scholars have argued for the importance of understanding the centrality of religious practices in the lives of many Latinos and their families, which may lead them to make less use of mainstream or formal mental health services (Comas-Diaz,

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2006; Falicov, 2009). However, few empirical studies have examined how religiosity may be associated with the mental health help seeking processes among Latinos in the United States, despite the fact that over 90% of Latinos in the United States report that they are religiously committed (Hispanic Churches in American Public Life national survey, 2003). In this study, we examine data from a qualitative study investigating the associations between religiosity and attitudes toward mental services among Latinos in the Northeast United States.

Defining Religiosity

In general, religiosity refers to the following of practices and rituals through an organized system of beliefs (e.g., a group of individuals who share a common notion and or worldview; Cervantes & Parham, 2005; Hill & Pargament, 2008). Religiosity may have overlapping practices with the construct of spirituality, as many religious individuals also self-identify as spiritual. However, scholars have noted that there are differences between these two constructs (Del Rio & White, 2012; Hill & Pargament, 2008). Some scholars note that because spirituality generally refers to a personal relationship with a transcendent being (e.g., God, Jesus, saints, or spirits), it does not require adherence to an organized religion (Cervantes & Parham, 2005). Del Rio and White (2012) have suggested that spirituality is a super ordinate category that includes religiosity within it. For the purpose of this article, we focus on the construct of religiosity, recognizing that many individuals who actively engage in organized and formal religious practices may engage in spiritual practices as well.

Religiosity and Mental Health

There is a long-standing acknowledgment of the interrelations between religiosity and mental health. For instance, scholars have noted that many religious groups and organizations attempt to shape the behaviors and lifestyles of their members, establishing norms concerning morals and human conduct. These moral codes often forbid behaviors that might pose risks to health and other types of problematic conduct (Hill & McCullough, 2008). Indeed, research has found support for this relationship between religiosity and mental health, with higher levels of religious commitment generally being associated with lower levels of psychological distress (e.g., Diaz, Horton, McIlveen, Weiner, & Williams, 2011; Sternthal, Williams, Music, & Buck, 2010).

A central premise that explains this positive relationship is that religiosity may assist individuals in coping with adversity (e.g., Bhui, King, Dein, & O'Connor, 2008). In particular, religiosity may help individuals manage difficulties through religious counseling, as well as social support among members of a given religious organization (Nooney & Woodrum, 2002; Pickard & Guo, 2008). In addition, religiosity may help individuals experience a better well-being and a higher life satisfaction (Ellison, Boardman, Williams, & Jackson, 2001; Pieper, 2004).

Among Latinos, a few studies have highlighted the importance of religious coping (Herrera, Lee, Nanyonjo, Laufman, & Torres-Vigil, 2009; Sanchez, Dillon, Ruffin, & De La Rosa, 2012). Herrera and colleagues (2009), in a study of predominantly Mexican American individuals, found that both private and external religious coping was associated with a decrease in psychological distress. Interestingly, their study also found that negative religious coping, which the authors describe as blaming God for problems or feeling that God is punishing the individual, was associated with greater psychological distress. Sanchez and colleagues (2012) also found evidence for the mixed effects of religious coping. They conducted a study of 527 recently immigrated Latinos and found that those Latinos who engaged in more external religious coping before immigration tended to experience more acculturative stress after their immigration. There was no association between internal religious coping and acculturative stress, however. The authors speculated that the immigration process may have made it more difficult for the participants to remain connected to their external religious coping resources, thus making them more vulnerable to acculturative stress.

Religious Involvement and Formal Mental Health Services

The nuanced findings reported by Herrera and colleagues (2009) and Sanchez and colleagues (2012) are of particular interest given the evidence that religiosity has also been associated with more negative perceptions toward

and less use of formal mental health treatments (e.g., Harris, Edlund, & Larson, 2006). For example, Ng and colleagues (2011), in the National Mental Health Survey, found that compared with those with no religious affiliation, elderly people of all religious affiliations and regardless of race/ethnicity, reported less frequent treatment by health care professionals. Similarly, Miller and Eells (1998), in a sample of 463 undergraduate students from a Christian university, found that participants with higher levels of religiosity were less likely to have confidence in the efficacy of professional services and had less perceived need for psychotherapy.

There are several possible explanations for the negative association between religiosity and attitudes toward formal mental health services. First, religious individuals may be more likely to explain symptoms of mental health problems as caused by supernatural, spiritual, or mystical factors (e.g., Caplan et al., 2011; Landrine & Klonoff, 1994). This explanatory model of illness may decrease the likelihood of seeking professional mental health services when in distress. Alvidrez (1999) examined this question in a sample of 187 women, among which were included 84 Latinas, and found support for this possibility. She noted that endorsement of religious or supernatural causes of mental illness was associated with lower rates of mental health service use. A second possible explanation is that religious individuals may experience a mismatch between some of their religious beliefs and practices and the practices and recommendations of mental health professionals (e.g., Gall et al., 2005). Some scholars have noted that this mismatch may contribute to a reluctance to seek counseling from providers who may not share their worldview and belief system as well as increase the likelihood of early drop out when religious individuals work with a therapist with different beliefs (e.g., Worthington, Hook, Davis, & McDaniel, 2011). Mitchell and Baker (2000) found support for this notion in a qualitative study of Christian individuals living in the United Kingdom, many of whom viewed mental health professionals as relatively ineffective and neglecting of their religious concerns. Thus, religious individuals may prefer religious counseling over formal mental health services, given the likely greater match in belief system and worldview.

Although there has been an increase in research examining the role of religiosity in the help-seeking process for individuals from racial and ethnic minority backgrounds, only minimal attention has been given to Latinos. In particular, apart from the Alvidrez (1999) study, there have been very few empirical studies that have directly investigated these issues among Latinos. In one qualitative study of 40 religious individuals, of whom 10 were Puerto Rican Latinos, Levkoff et al. (1999) noted that for Latinos, religious and ethnic factors might both aid and impede seeking help from formal caregivers. That is, religious and ethnic beliefs seem to facilitate caregiving in that they pointed the way to an agency with ethnic/religious affiliations and provided emotional sustenance through prayer or shared decision-making among family members. Conversely, religious affiliations also were perceived as failing to assist in the help-seeking process through a lack of family or church support. Additionally, Postolache and colleagues (1997), in a small quantitative study of 41 Latinos in New York City, found that those Latinos who engaged in religious practices like confession perceived psychotherapy as less helpful than counseling from their priests. Despite the strengths of these empirical studies, there remain many gaps in our understanding of these issues among Latinos. In particular, little is known about other relevant factors, such as religious individuals' preferences for different types of coping strategies and their perceptions toward different types of mental health services.

Purpose of the Study

Thus, in this article, we present findings from a qualitative interview study investigating religiosity, coping strategies, and facilitators of seeking mental health services (i.e., religiously affiliated mental health services, like religious counseling, and formal mental health services). Given the lack of research on how religious involvement may be related to perceptions and factors that may facilitate seeking such services among Latinos, three main questions guided this research: 1. Among religious Latinos, what forms of coping with adversity are most commonly endorsed? 2. Among religious Latinos, what facilitates seeking religious counseling? 3.

Among religious Latinos, what facilitates seeking formal mental health services?

Method

Participants

Twenty Latinos (11 men and 9 women) participated in the current study. However, those individuals who described not engaging in religious practices were not included in the results presented below. Therefore, the final sample consisted of 17 Latinos (9 men and 8 women) who indicated that they engaged in organized religious practices. Participants in this study were 18 years and older, recruited from local stores, churches, and barbershops in a Northeastern state in the United States. Participants were compensated $20 for their participation in the study. This research received approval from the university's Institutional Review Board.

The sample was diverse in terms of national origin: 8 participants (47%) were from the Caribbean (e.g., Puerto Rico, Dominican Republic, etc.), 7 participants (43%) were from Central America (e.g., El Salvador, Honduras, Guatemala, etc.), 1 participant (5%) was from Mexico, and 1 participant (5%) was from Ecuador. The participants' average age was 39.5 years (SD = 14.63). With regard to religion, 38% identified as "Catholic," 33% identified as "Protestant Christian" (e.g., Evangelical, Pentecostal, etc.), and 24% identified as "other." Thirty-eight percent reported not finishing high school, 38% reported finishing high school or GED, and 19% reported having and college degree. In terms of annual income, 57% of both men and women reported earning <$25,000 a year and 76.2% reported having insurance coverage in Massachusetts (e.g., Mass Health Coverage).

Procedure

The study consisted of a semistructured interview that ranged in length from 30–60 minutes, The first author (Latino male) conducted all interviews in Spanish or English and in a private setting, either in the homes of interviewees or at university. After obtaining written consent, the interviewer began the interviews with a series of demographic questions that were presented in an informal, conversational style. The interviewer then asked participants about their levels of engagement with religious and spiritual practices in a given week.

To distinguish among individuals with different levels of organized religious involvement, interviewees were asked to identify their religious traditions and behaviors (e.g., attending church, praying, reading the Bible) and to describe the frequency with which they engaged in such practices. After the information regarding levels of engagement toward religious practices was collected, interviewees were then asked to describe their cultural preferences (e.g., acculturation) and values in their day to day living (e.g., language, costumes, traditions, relationships). Shortly afterward, a brief semistructured interview (see Appendix) was used to explore a recent time they experienced adversity, how they coped with this time of hardship, as well as help seeking behaviors and attitudes toward seeking help from particular services.

Data Analysis

A contextualist framework guided the analysis. A contextualist framework acknowledges how individuals make meaning of their experiences and also recognizes how broader social contexts can also influence those meanings (Braun & Clarke, 2006; Annis, 1978). In particular, a contextualist framework emphasizes the context (e.g., gender, age, views, SES) in which individuals express their statements and beliefs. That is, individual actions, statements, or expressions are understood relative to their surrounding context (Annis, 1978; Bronfenbrenner, 1986; Dixon & Lerner, 1992). Therefore, for the data analysis, we attended to the particular life contexts in which participants answered questions and focused on their statements and expressions relative to their context. We were particularly attuned to those contextual factors that have been previously identified in the literature as being particularly salient for many Latinos. For example, we attended to participants' acculturation level, their age, and their educational background and explored whether these contextual factors might be related to their approaches to coping and their help seeking behaviors.

All interviews were audiotaped and subsequently transcribed by the first author or an undergraduate research assistant. Interviews

were transcribed in the original language of the interview using Transana software (Fassnacht & Woods, 2006). Pseudonyms were assigned to protect confidentiality.

Thematic analysis was then used to analyze the data. Thematic analysis is a method for identifying, analyzing, and reporting themes within data; a theme is a cluster of linked categories conveying similar meanings (Bogdan & Biklen, 2003). We chose thematic analysis because it is a versatile qualitative technique in which the themes or patterns that emerge are strongly linked to the data and not primarily driven by the researcher's prior assumptions or theories. Thus, given the lack of research on how religiosity may be related to coping strategies, attitudes, and the underutilization of mental health care among Latinos, thematic analysis allowed us to search and explore through data to identify any recurrent patterns and emerging themes that may help with our understanding of the three main questions that guided this research.

Three coders (including the first author) independently analyzed the data, identified codes, and reported themes. Through a process of analytic triangulation, we ensured that multiple interpretations were considered (Patton, 2002). A line-by-line analysis was also conducted independently of each transcribed interview to generate initial theoretical categories (Charmaz, 2006). The three coders also met weekly and compared findings to identify similarities and differences with the codes and themes. In-depth discussions followed after differences in coding. At these meetings, codes were expanded and collapsed, ultimately verifying the most substantiated codes as the coding scheme emerged. These final codes became the basis for what we refer to as the final themes developed.

The three coders were the first author and two research assistants. The three coders were bilingual Latinos who identified as Christian, Catholic, and nondenominational Christian. Because the coders shared similar religious orientations, there is a risk that the interpretation of the data was biased in accordance with the coders' worldviews. However, special attention was given to diminish relevant biases during weekly coding meetings. Specifically, at these meetings, the three coders focused on common themes endorsed, and interpreted such findings with support from the data, keeping in mind their own potential biases. Further, the use of a contextualist framework assisted in this endeavor, as it allowed the coders to focus on the participant's contexts, which was described clearly in the interview data.

Results

Participants in this study described a variety of ways they handled adversity as well as factors that influenced their perceptions toward mental health services. We begin by presenting how participants handled adversity. We then examine factors facilitating use of religiously affiliated mental health services (like religious counseling). Finally, we examine factors facilitating use of formal mental health services.[1]

Coping With Adversity

Consistently across most Latinos, religiosity seemed to play an important role in shaping participants' styles of coping with adversity. Although other types of coping strategies were endorsed, religious and spiritual coping strategies were by far the most commonly endorsed across the majority of our sample (65% of sample endorsed engaging in religious coping and 82% of the sample endorsed engaging in spiritual coping). Contextual factors did not generally emerge as particularly salient in the use of these two forms of coping, with the exception of age as noted below.

Religious coping. Many participants in the study described coping with adversity through religious coping, including the use of religious counseling. Participants noted that they sought religious counseling because they held religious figures in very high esteem and expected to receive guidance in times of adversities. Further, most participants who sought advice from a religious leader also noted that this advice often encouraged the use of additional religious and spiritual coping practices (e.g., religious leaders encouraging more prayer). One of these participants was Angelica, a 55-year-old woman from Guatemala who identified as Evangelical Christian. Angelica described en-

[1] All quotes are presented in English. Those interviews that were conducted, transcribed, and analyzed in Spanish are noted with a comment at the end of the quotation: (Spanish).

gaging in multiple religious practices led by her religious leader in a given week. She spoke highly about her religious beliefs, practices, and especially her religious leader, describing him as the "*chosen man of God*" who shares "*wisdom, attributes, and knowledge*." She described how she prefers to seek religious counseling from him in times of adversity, stating the following:

> We received guidance from the pastor who helped us a lot [in times of adversity]. He encouraged us to seek more of God, and God was the one who indicated how to handle this situation. Because of my faith, it helped us [overcome the problem]. We are now fine. (Spanish)

From this quote, it appears that this religious leader's encouragement to seek help through more of these practices was important to Angelica and increased the likelihood that she would seek support from him in the future. Other participants shared similar perceptions as Angelica. These participants described engaging in various and regular religious and spiritual practices led by their religious leaders because they "*are used by God*." In general, participants who shared the notion that these religious leaders were wise "*men of God*" seemed to be more inclined to cope through this method. Interestingly, the majority of participants who shared such notions seemed to be older in age, with younger participants (i.e., under 35) not expressing as frequently this coping strategy.

Another commonly cited form of religious coping that emerged in the interviews was that of seeking social support within the church. Although receiving social support from family and esteemed friends emerged as a standalone theme, participants who described frequently engaging in religious practices noted receiving additional social support from others in their religious organization. One participant who provided insight into this form of coping was José, a 27-year-old Puerto Rican Christian man who was born and raised in an urban city in Massachusetts. José described living on his church's property. He also described his family and church members as playing an important role in his life. José further noted having daily interactions with these church members and sharing many similar personal characteristics with them. Thus, he felt that when he experiences adversity, church members express support as much as a biological family, which is due in part to their availability to one another. José stated the following:

> The only other people [besides biological family] we would talk to would be the people in the church, but they were always there. We are pretty much considered brothers and sisters. That's what we call each other, brothers and sisters in church.

Given that Jose lives on church property and is constantly engaged in daily interactions with members of his institutional church, it is understandable that he might be particularly inclined to cope through seeking support from these individuals. However, other participants also indicated engaging in frequent religious practices with other members of their church. These participants described how in times of need members of the church are the first one to support each other (e.g., encouragement and motivation) to remain positive and continue to cope through ways that were consistent with their religious beliefs.

Spiritual coping. Many of the participants reported using spiritual practices to help them manage adversity. One of the main strategies these participants cited was that of frequent prayer. For these participants, this spiritual practice helped create a connection with a transcendent being (i.e., God). Other commonly mentioned spiritual practices described by participants included reading spiritual books, reciting Bible verses, and participating in prayer groups in pursuit of a personal relationship with God. Through these spiritual practices, participants described remaining hopeful in times of hardships. One participant who provided insight into this theme was Alberto. Alberto was a 22-year old Pentecostal Christian who immigrated alone to the United States at age 15. He indicated that his two biggest stressors were his current undocumented status and the separation from his family, who remain living in Guatemala. When feeling distress because of immigration-related stressors, Alberto described praying to God. He stated the following:

> So [in times of adversity] we are crying out to God. We know that when praying to God constantly, we have faith that He will help us. It is He who is helping us, so we pray more. (Spanish)

Alberto believed that by praying to God, his prayers would be heard, and he would be "*protected from harm*." In addition, prayer seemed to produce a sense of hopefulness during his

difficult times, as he noted that after praying, he would feel more optimistic and feel that "*everything will be all right*." Other participants similarly described coping through spiritual practices as a way to create a secure attachment to their higher power, which would engender feelings of hopefulness toward their struggles.

Reasons for Seeking Religiously Oriented Mental Health Services

Across most participants, religiosity also seemed to play an important role in shaping participants' perceptions toward and preferences for particular mental health services. With one notable exception discussed below, contextual factors again did not emerge as salient in our analysis of participants' reasons for seeking religiously oriented mental health services. That is, despite differences in acculturation, educational background, and age, participants tended to indicate preferences for counseling services that were consistent with their religious beliefs and complemented their ways of coping with adversity. Proximal reasons for this preference included an increased sense of trust and comfort with their provider, an expectation of similar beliefs and values, having existing relationships with providers, and increased accessibility. Of note, increased accessibility was the one reason where contextual factors did emerge as important. Each of these is now explored.

Trust/comfort. Among participants, one of the most prominent reasons given for the more positive attitudes toward religious counseling was the increased trust and comfort they felt toward their religious leader and members of their congregations. These participants noted that they believed their religious leader to be trustworthy and very dependable, and that it was this sense of trust and comfort that facilitated the use of religious counseling. One of those participants was Imelda. Imelda was a 27-year-old bilingual from Honduras. She identified as Baptist and reported pursuing an advanced degree. She described having a very positive rapport with her religious leader. Imelda further described relying on the church (especially her religious leader and his wife) to aide her when in distress. She explained that because she had no local familial support, her religious leader was an especially important source of aid for her when she experienced distress. When asked about preferred mental health services, Imelda stated the following about religious counseling:

> That is the person [religious leader] I think is most likely [to give better advice], I mean, other people can also give me good advice [referring to professional mental health services], but I feel more comfortable talking to him because he is trustworthy.

As can be seen, trust was a critical factor for Imelda in turning to her religious leader for help. The importance of trust was heightened for her since she had no familial support in the area. The responses of other participants were consistent with this theme that high levels of trust toward their religious leaders was an important factor in influencing their preference toward religious counseling.

Similar beliefs. Another prominent explanation given by participants for the generally more positive attitudes toward religious counseling was the sense of shared beliefs and values they had with their religious leaders. These participants described how it was critical to have similar world and political views, especially when seeking help for mental health problems. They also expressed more positive attitudes and preferences toward religious counseling because religious leaders would use methods that are similar to their beliefs as compared with nonreligious health providers. David was a 41-year-old from El Salvador who described practicing Catholicism. He acknowledged the utility of mental health services in the United States, but indicated that one reason he prefers religious counseling is that he shares similar religious beliefs as his provider:

> I mean, a psychologist can advise and counsel you, but a padre [religious leader] can counsel and inject more of our spiritual beliefs [in the therapy process] . . . that is something I like and is important. (Spanish)

For David, the ability of religious leaders to incorporate some values and beliefs he shares into therapy is crucial when determining which mental health services to seek out. He had also described coping through spiritual methods, and so he found it difficult to consider using mental health providers who do not share his same views. This idea of "injecting more of our spiritual beliefs" into therapy was shared by other participants when describing their preference for religious counseling.

Preexisting relationships. Some participants also noted that having a preexisting relationship with their provider played a crucial role in helping them decide which type of services they should seek. Participants stated that a preexisting relationship made it easier for them to trust these providers and have open communication with them. One participant who shed light on this theme was Martha. Martha was a 47-year-old from El Salvador who described herself as a Jehovah's Witness. Martha indicated that one reason that members of her church are open with each other and with their religious pastor is because they already have very positive relationships with one another. Martha stated the following:

> I felt more comfortable because he was the [religious] leader. Even before the problem, there was a very strong friendship with my family. My kids also had a very close relationship with the pastor's family. It was a pretty good relationship we had then. When I realized the situation I was going though, I felt that his wife and him were the people we were closest to [and so could] talk about [our problem]. They were already like family. (Spanish)

For Martha, this mutual and positive relationship was important for her. Further, the fact that Martha's family had a positive rapport with the pastor and his family seemed to also increase her positive views of religious counseling services. Like Martha, many participants described these relationships as very positive because they typically know each other for many years through a variety of regular religious practices (e.g., going to church together, attending to bible groups together, etc.). Therefore, participants felt that they would benefit more from a religious leader compared to a professional because they already had a close relationship, even before they experienced distress.

Accessibility. Many participants in the study noted that they preferred religious counseling because of the greater accessibility to such services, especially when they had no other mental health services in their community. A few participants further described how many Latinos do not access formal mental health services because they are not aware of such services or do not have the financial ability to use them or lack insurance that could facilitate access. One contextual factor that shaped perceptions of accessibility was acculturation, with individuals who were less acculturated more likely to describe barriers to formal mental health services that were present in their countries of origin. These barriers shaped their initial perceptions and contributed to the sense that religious counseling services are generally more accessible. One participant who described this experience well was Marco, a 39-year-old Latino from the Dominican Republic who reported practicing Catholicism. He described using religious and spiritual practices, rather than formal mental health services, in order to handle adversity because of his sense of the limits of formal mental health services in the Dominican Republic. Marco said the following:

> When you come from a country where you don't have a real system, the first thing is believe in God and hold on. It's something that you grew up with. This is what makes sense, and it's so hard to work away from that. Here in this society, someone has a problem, they go to a psychiatrist, they go to a psychologist, but we don't have those . . . we don't have those luxuries. We have to hold on to what we got and it's free, technically. We can't depend on chemicals like getting a prescription for depression, because we don't have the money. This is the way we've been raised.

Marco views mental health services as limited, not readily available, and expensive. Other participants also talked about viewing mental health services as a "luxury" that some Latinos do not have, especially in their native countries. Not being able to afford such "luxuries" then leads these Latinos to seek more practices and services that are religiously oriented. Further, the fact that religiously oriented services are accessible and typically cost-free, seems to be another salient influence to seeking such service that are religious oriented

Overall, these statements reflect how, like their preferences for coping methods, most of these participants indicated a preference for mental health services that is consistent with their religious beliefs. Additionally, religious Latinos tend to already have strong relationships within their religious community, trust their religious leaders, share similar beliefs and values, and have the certainty that this type of service is readily available. Some of these perceptions, particularly around issues of accessibility, were shaped by the participants' experiences in their countries of origin. Together, these factors seem to create positive attitudes and facilitate the use of religious counseling services.

Reasons for Seeking Formal Mental Health Services: Facilitators

Although most of the participants indicated that they did not prefer formal mental health services, several noted that there were some circumstances under which they would seek these services, including feeling understood by their mental health provider, experiencing serious mental health problems, and encountering problems that are thought to be attributed to biological origins. Interestingly, we found that contextual factors were more salient here, as participants who noted a willingness to use formal mental health services tended to be highly acculturated, with more years of formal education (typically some college or an advanced degree). Each of these is now explored.

Feeling understood. Some participants expressed more positive attitudes toward mental health services when they felt understood by their providers. These participants noted that it was important that their therapist understand their religious beliefs because their provider would be able to better understand their perspective. One of these participants was Juana, a 30-year-old U.S.-born Latina of Mexican descent. Juana described coming from generations of practicing Protestants. She explained that her family members never used formal mental health services, as they did not believe that mental health professionals understood them. She was ambivalent about seeking such services herself as a result of not being able to relate to the provider. Juana believed that most mental health professionals have different values, beliefs, and principles than her. Despite her beliefs, Juana indicated that she was not completely opposed to seeking help from a professional provider, stating:

> I would probably seek a psychologist who had a Christian background or understood my Christian faith.

Other participants also noted that having a provider who shared similar religious beliefs would help them feel better understood. Thus, believing that providers have similar religious beliefs played an important role in influencing some participants to seek professional mental health services.

Significant mental health problems. Some participants also indicated a willingness to seek formal mental health services if they were struggling with very difficult situations, which primarily consisted of chronic and severe mental health problems, such as major depressive disorder. For Sandra, a 47-year-old Puerto Rican who identified as Catholic, the severity level of such distress would influence the type of services she would seek out. She stated the following:

> Maybe if I have been depressed for a very long time and felt that I couldn't get out of it on my own. So if it meant long and stuck, or if I had some mental health symptoms that I have never had. If I ever heard voices before and stuff like that, I guess in some extreme circumstance that I would feel that way, then yeah. That is what they [mental health professions] are there for.

And so, for Sandra, she would consider seeking professional help if she were to experience significant mental health symptoms, like chronic depression or hallucinations. Interestingly, Sandra reported being born in Puerto Rico but being raised in an urban city in the Northeast since her childhood, thus identified as adhering to both Latino and U.S. cultures. Several other participants also described how severe distress would make it more likely that they seek out help from a mental health professional, instead of a religious counselor. Like Sandra, these participants tended to be more acculturated. Of note, despite this willingness to use services, most participants indicated that they would seek out these services as a last resort, after first turning to religiously oriented methods.

Problems attributed to biological origins. Relatedly, some participants expressed a willingness to use formal mental health services if they experienced psychological disorders that they attributed to biological origins (e.g., psychotic disorders such as schizophrenia, developmental disorders such as autism, or other disorders like depression), as they believed that scientific community had identified effective treatments for these types of disorders. These participants described how professional mental health providers (e.g., a therapist, a medical doctor) were more educated and trained to help in this area, compared to most religious counselors. One of these participants was Pablo. Pablo was a 26-year-old from Ecuador who reported practicing Catholicism. Pablo expressed a belief that formal mental health services are more efficacious for disorders whose

etiology is biological in nature. When asked for examples of disorders for which formal mental health services would be appropriate, he said that mental health professionals may be better able to assess if the psychological problem is related to a biological origin. Pablo elaborated on this point:

> Ok let's put it in depression terms. If at the state of depression that is, like, I've been depressed for over a year, and I can't find a solution myself . . . if I have tried . . . everything that makes me happy, and nothing makes me happy, then I would see . . . what is wrong with me in a biological sense."

Of note, Pablo holds an advanced degree from an American university and at time of the interview was completing his doctorate degree. Other participants with more formal education and who were more acculturated had the same perspective, even when describing themselves as religious. In contrast, this theme was not as evident among the participants with less formal education and less acculturated.

Overall, these statements reflect how there are some factors that seem to facilitate seeking formal mental health services. As described in some of these statements, participants noted that depending on the type of problems encountered, they would be more inclined to seek formal mental health services if they, or a loved one, were to experience a serious mental health problem, or encountered problems that they attributed to a biological origin. Further, participants also noted a disconnect between the provider and the client whereby they believed that mental health professionals would not understand their perspectives and not incorporate some of their religious and spiritual practices in therapy. Thus, incorporating these practices and feeling understood seemed to produce more positive perceptions toward type of services. Furthermore, contextual factors generally played large roles in participants' descriptions of their reasons for seeking formal mental health services. That is, when considering these factors, (e.g., acculturation and education), participants seemed to be more willing to seek formal health services compared to services within their religious communities.

Discussion

The purpose of this qualitative study was to examine religious participants' preferred methods of coping with adversity, as well as factors that facilitated the use of both religiously affiliated mental health services and formal mental health services among Latinos in the Northeast United States. Our results indicated that religious participants tended to cope with methods that were consistent with their religious practices. Most participants identified organized and informal religious practices, as well as spiritual practices, as important and preferred coping methods they use when handling adversity. In general, these themes are consistent with previous work in this area (e.g., Koenig et al., 2001). Most of these studies, however, have focused primarily on non-Latino populations and on very specific forms of adversity like serious medical illnesses. Our study supports and extends these findings by highlighting how religious Latinos, especially those who are older, also make use of religious and spiritual coping to manage a range of difficulties, including mental illness. Interestingly, the coping practices described by participants did not include examples of negative coping, as described by Herrera and colleagues (2009). It is possible that open-ended interview methods do not elicit descriptions of negative coping, particularly if the participants themselves are not currently experiencing significant levels of psychological distress. More research is needed to investigate these possibilities.

Our results also suggested that, with the exception of age, contextual factors did not generally emerge as particularly salient in the use of either religious or spiritual coping. That is, throughout our sample, older participants tended to cope more often with these methods than the younger participants. These findings differ slightly from those reported by Sanchez and colleagues (2012) in that acculturation did not emerge as a salient contextual factor. It is possible that those recent immigrants in our study had more success in connecting with local religious communities, allowing them to continue to successfully rely on religious coping as a means of managing adversity.

In addition, findings from our study further illuminate the different perceptions about particular mental health services held by religious individuals. Specifically, many of these participants indicated a preference for religious counseling services that is consistent with their religious beliefs. Contextual factors (e.g., accul-

turation, education, age) again did not emerge as salient in our analysis of participants' reasons for seeking religiously oriented mental health services. However, there were several expressed reasons for this preference, including an increased sense of trust and comfort with the provider, an expectation of similar beliefs and values, and greater accessibility. Of note, participants also described their preference for receiving help from mental health service providers with whom they have preexisting relationships. This is interesting, especially given the well-established guidelines held by psychologists regarding dual relationships (American Psychological Association, 2011). Although there are clearly many important reasons for discouraging psychologists from holding dual relationships with clients, these findings suggest that not all clients may share this perspective. It seemed clear that some of the participants in our study believed that the increased sense of trust they felt toward their religious counselors was directly due to their positive preexisting relationships. Therefore, we would do well to recognize this difference as we continue to explore how to best reach individuals who may not be using professional mental health services.

Relatedly, our study indicated that there are commonly held ideas about circumstances under which participants would seek formal mental health services. These included feeling understood by their mental health provider, experiencing serious mental health problems, and encountering problems that were thought to be biological in origin. Importantly, two contextual factors noted in previous literature did emerge as relevant in understanding these reasons, with participants who shared these views tending to be more acculturated and had more formal education. With higher acculturation and higher education, Latinos may acquire different causal explanations about mental illness, have less stigma toward help-seeking in the United States, experience fewer logistical barriers, and have better access toward formal help receiving in the United States.

Further, this study demonstrates how context plays an important role in participant's perceptions and preferences toward mental health services. Although the participants in this study were all Latino and self-identified as religious, we did not find a homogeneous set of attitudes and perspectives about coping, religious counseling services, or formal mental health services. Indeed, this study highlights how interpersonal networks, relationships with providers, adherence to religious and spiritual values, accessibility, and the severity and type of one's distress, as well as individual characteristics like acculturation, age, and education played important roles in the help-seeking and help-receiving process among religious Latinos.

Limitations & Strengths

There are several limitations to this study worth noting. First, the sample was very homogenous in terms of religious affiliation (e.g., Roman Catholic and Protestant Christian backgrounds). Future research should investigate these questions with Latinos from different religious affiliations. Second, this Latino sample consisted primarily of individuals in a Northeastern state, limiting our understanding of this topic with different Latino nationalities in other geographic regions. Specifically, future research on this topic should seek to include Latinos across different regions of the United States. Third, because our research team shared similar religious background and worldviews, it is possible that our review of the transcripts missed some themes or contextual influences. This is an unavoidable aspect of qualitative research, and so replication of these findings would strengthen our confidence in them. Relatedly, the focus of the interview was on organized religiosity, and so we did not explore spiritual practices outside of traditional religious approaches. It would be interesting for future research to examine how engagement with traditional indigenous spiritual and religious practices might also be related to coping with adversity and help-seeking attitudes and behaviors.

Despite these limitations, this study has several notable strengths. First, the use of qualitative methodology and thematic analysis enabled a detailed and rich examination of our data, given the lack of research in this area. Second, having a bilingual Latino interviewer may have allowed native Spanish-speaking participants to represent themselves more authentically when interviewed in Spanish. In addition, although there is a growing body of literature that examines the relationship between religiosity, coping, as well as attitudes toward mental health

services, this is one of the few studies that has been conducted with a Latino sample. Finally, most of the previous research has focused on factors that may influence the underutilizations of mental health services, whereas this study examined facilitators that may increase our understanding of the utilization of preferred mental health services.

Given that more than 90% of Latinos self-identify as religious, clinicians who work with Latinos would do well to be knowledgeable about, and sensitive to, the context associated with religious issues that may be important to their clients. This knowledge and sensitivity could play an important role in developing and maintaining a strong therapeutic relationship with these clients, and could help reduce some of the mental health care disparities that affect Latinos.

Abstracto

En este estudio cualitativo, examinamos la religiosidad, el manejo con la adversidad, y facilitadores en la búsqueda de diferentes tipos de servicios de salud mental en una muestra de 17 hombres y mujeres Latinos religiosos. El análisis temático reveló que los participantes tendían a enfrentar problemas con métodos consistentes con sus *pr*ácticas religiosas. La mayoría de los participantes, especialmente los de mayor edad, identificaron las *pr*ácticas religiosas/espirituales organizadas e informales como métodos importantes y preferidos al manejar la adversidad. Además, muchos participantes mostraron preferencias hacia los servicios religiosos que eran consistentes con sus creencias religiosas y complementaban sus formas existentes de lidiar con la adversidad. Finalmente, nuestro estudio indica que había ideas comunes acerca de las circunstancias en las que los participantes buscan los servicios formales de salud mental, incluyendo sentirse comprendido, el experimentar problemas graves de salud mental, y el enfrentar problemas que se piensa son de origen biológico. Es importante destacar dos factores contextuales que surgieron relevantes para entender estas razones, que los participantes que compartieron estas opiniones tienden a ser más aculturados y a tener más educación formal. Los resultados de este estudio ilustran cómo la religiosidad está relacionada con el manejo de problemas y con las actitudes hacia los servicios formales de salud mental entre los Latinos religiosos, así como la importancia del contexto en la comprensión de estos procesos.

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Appendix

Interview Questions

"Now, I'd like to talk to you about the last time you had a difficult problem that you felt anxious, sad, or depressed, how you coped/handled the problem, as well as your views and attitudes toward it."

- "Can you tell me about your last difficult problem that made you feel anxious, sad, or depressed?"
- "Can you tell me more about it? Can you describe it?"
- "What were your reactions to the problem?"
- "How did this problem make you feel?"
- "When you were going through this difficult problem, how did you cope with it?
- How well did your coping work for you?
- "Did it help you feel better?"
- "Do you think that there is a 'right' way to handle these problems when things are difficult? If so, what is the right way?
- "When you were going through this difficult problem, did you talk about it with any members of the church, church staff (i.e., ministers), or your pastor/priest?"

If YES: "What role did this person have in the church?"

- "Why did you talk to this person and not the others?"
- "Was talking to this person helpful? Why?"
- "What did this person tell you?"

If NO: "If you were to discuss it with someone, who might that be?"

- "How do you think they would they respond?"
- "How you think talking to one of these people from the church might be helpful?

(*Appendix continues*)

"When you were going through this difficult problem, did you speak to a professional (like a counselor, psychologists, a psychiatrist, or a physician) *If NO*, "Did you think about it?"

- If you had a choice about getting psychotherapy, seeking professional help, taking medication, or coping through a religious way (i.e., going to church, praying, reading the Bible, and going to a priest) would you prefer one over another? Why?
- "What do you think about mental health services for depression/anxiety?"

"Those are all the questions I have. I want to thank you for taking the time to share your thoughts with me. Is there anything important about your religious views that we didn't talk about?"

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