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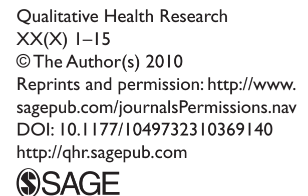

Help Seeking and Help Receiving for Emotional Distress Among Latino Men and Women

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Abstract

In this study, we examined help-seeking pathways and help-receiving experiences among Latinos, a population that has been shown to underutilize mental health services. We used the qualitative approach of dual mode of analysis to explore the experiences of 13 Latino men and women who utilized formal as well as informal treatment and support resources. We explored three specific themes: (a) individual and family help-seeking perspectives intersecting with Latino cultural norms; (b) referral source and style, needs identification, and prior help-seeking experiences as key motivational factors for help seeking; and (c) client–therapist match and client–therapist relational style as integral to mental health treatment satisfaction. We discuss clinical implications for efforts to improve the cultural sensitivity and accessibility of mental health services.

Keywords

culture; health behavior; interviews, semistructured; Latino/Hispanic people; lived experience; mental health and illness

In 2001, the United States Surgeon General published a supplement to the first-ever Surgeon General's report on Mental Health (U.S. Department of Health and Human Services, 2001). Echoing the burgeoning research evidence (e.g., Hough et al., 1987; Vega, Kolody, Aguilar-Gaxiola, & Catalano, 1999), the report highlighted troubling and pervasive mental health care disparities that affect individuals from racial and ethnic minority backgrounds. Of particular concern was the fact that, despite the existence of a variety of efficacious psychosocial and pharmacological treatments for mental disorders, significantly fewer ethnic minorities receive adequate mental health care than do non-Latino Whites.

Although there is evidence that mental health care disparities have been reduced for some ethnic groups (U.S. Department of Health and Human Services, 2005), health care disparities between the general population and Latinos seem to be widening, with lower mental health treatment rates continuing to be documented among Latinos (Alegría et al., 2002; Blanco et al., 2007; Peifer, Hu, & Vega, 2000; Vega et al., 1999; Wang et al., 2005). There are likely many systemic factors that contribute to these disparities, including the high cost of health care and access problems for primary Spanish speakers (Cristancho, Garces, Peters, & Mueller, 2008), fragmentation of health plans along socioeconomic lines (Smedley, Stith, & Nelson, 2003), and discrimination patterns that result in less care being provided to ethnic minority patients than to White patients (McGuire, Alegría, Cook, Wells, & Zaslavsky, 2006).

In addition to these systemic barriers, researchers continue to explore the differences in mental health service utilization between Latinos and non-Latino Whites that are attributable to the quality and appropriateness of clinical care and to patient preferences. Researchers have begun to identify cultural, demographic, and psychological variables that might contribute to Latinos' underutilization of mental health care (Echeverry, 1997; Snowden & Yamada, 2005). Nevertheless, we still know relatively little about how these variables influence the help-seeking experience itself, or the experience of receiving help once it is accessed (help receiving). These knowledge gaps impede efforts to increase Latinos' utilization of mental health services by preventing improvements based on access and treatment successes. Thus, research that elucidates the dynamic ways in which help seeking and help receiving unfold can help clarify the processes that contribute to successful help-seeking experiences.

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In this study, we investigated the experiences of a sample of Latino men and women who had utilized formal and informal treatment and support resources. Our objective was to illuminate two related phenomena: the dynamic help-seeking process and the formation of successful therapeutic experiences while receiving help. We explored help seeking and help receiving as socially and culturally enmeshed, by attending to the ways that relationships and culture were enacted by different participants in different circumstances. This goal arose out of a desire to interpret the particularized, lived experiences of individual Latinos in a way that recognizes the ever-present cultural contribution to individual perception and action while also refraining from presupposing a homogenous enactment of culture among members of a group who are quite diverse, despite sharing some cultural values (Quintero, Lilliott, & Willging, 2007).

Investigations Into Help Seeking and Help Receiving Among Latinos

Although researchers have generally found that Latinos as a group are less likely to seek formal treatment for emotional distress, there exists considerable variability in service use rates among Latino subgroups. In particular, Latino men (Ortega & Alegría, 2002; Peifer et al., 2000), Latinos from lower socioeconomic backgrounds (Sue, Fujino, Hu, Takeuchi, & Zane, 1991) and immigrant Latinos (Vega et al., 1999) appear to be especially unlikely to seek out formal mental health services. Although this research has helped raise awareness of the variability that exists among Latinos with regard to seeking treatment, it has provided little insight into the explanations underlying the disparate rates themselves.

In an effort to explain these disparities, researchers have explored how cultural characteristics, such as language and religion, and psychological characteristics such as treatment and disclosure beliefs, might influence help seeking among Latinos. For example, investigations into the role of language ability in accessing care have led to the finding that greater English language proficiency is associated with increased help seeking (Delgado et al., 2006; Vega et al., 1999), thereby underscoring the barriers faced by Latinos who are not proficient English speakers. Religious and cultural values might also be important in determining the type of help people seek. For example, Alvidrez (1999) showed that Latinos who believe that mental illness has a religious etiology might be less likely to seek treatment than those who attribute it to biological origins. Altarriba and Bauer (1998) showed that individuals who endorse high levels of *familismo,* which refers to the emphasis on family-level communication and decision making (La Roche, 2002), are less likely to seek help outside of the family.

Researchers have also identified a number of individual psychological traits positively associated with mental health service use among Latinos. These include trust in confidentiality (Echeverry, 1997), perceived need for mental health care (Albizu-Garcia, Alegría, Freeman, & Vera, 2001), and low levels of stigma about mental illness (Interian, Martinez, Guarnaccia, Vega, & Escobar, 2007). Client–therapist relationships also appear to be important. Cabassa and Zayas (2007) found that increased confidence in one's health care provider predicted future mental health service use. Other studies have shown that personal coping strategies such as social support (Golding & Wells, 1990; Pescosolido, Wright, Alegría, & Vera, 1998) and self-reliance (Ortega & Alegría, 2002) are inversely associated with treatment seeking.

Collectively, this literature has helped identify several characteristics that affect Latinos' utilization of mental health services. However, although it is helpful to know who is more or less likely to seek help, efforts to increase service utilization demand an improved understanding of the process by which certain factors inform help seeking. Adequate attention to such process-level description is lacking from the culturally focused help-seeking literature. Examples of process-level description might include knowing how family support impedes or facilitates help seeking, how cultural values influence help receiving for clients of different genders, ages, and language abilities, and how providers address stigma about mental illness. Our intention with this study was to elucidate these kinds of processes. We hoped not only to identify the cultural, family, and psychological factors that influenced help seeking among our participants, but also to capture how individuals enacted these factors in their particularized context.

A Qualitative Analysis of Help Seeking and Help Receiving

Whereas quantitative help-seeking studies begin by identifying variables believed to be associated with help seeking, we employed a qualitative approach, beginning by listening to participants' lived experiences, and building theory about the dynamics of help seeking. This approach has been proposed as particularly well suited to help-seeking research, in that it enables a contextualized understanding of help seeking that highlights the complexities inherent in the decision-making process (Yeh, McCabe, Hough, Dupuis, & Hazen, 2003).

Recent publications on help seeking and help receiving, although still underrepresented in the empirical qualitative

literature (for an exception, in a different cultural context, see Okello & Neema, 2007), have begun employing case-study and clinical-vignette designs to examine Latinos' help-receiving experiences. This research has enriched our understanding of how culture influences help seeking. For example, Anger-Díaz, Schlanger, Rincon, and Mendoza (2004) explored how a brief therapy model accommodated the concerns that many of their Latino clients had about therapy. Bracero (1998) proposed culturally informed approaches to address issues that arose around disclosure, hierarchy, and gender among Latino clients. A mixed method study by Cabassa (2007) described Latino immigrant men's perceptions of depression and depression treatment, help-seeking preferences, and perceived barriers to care. By thoroughly exploring the role of culture in help seeking among Latino populations, these studies indicate that directly attending to cultural attitudes and beliefs can lead to more satisfactory therapeutic experiences for the client.

The Current Study

The goal of this study was to provide an in-depth understanding of the help-seeking and help-receiving experiences of a small sample of Latino adults. We framed the analysis to emphasize both the particularized enactment of culture and the dynamic processes of help seeking and help receiving. Rather than treating culture as a static or monolithic variable, or limiting our exploration of mental health service use to a dichotomous outcome, we undertook this study with the intention of showing how individual perception, family dynamics, culture, and experience with the mental health system intersect to shape an individual's approach to coping with distress. We paid particular attention not only to the decision to seek care, but also to the choice of a particular kind of care, and to the evaluation of the treatment experience. This study has the potential to contribute to a knowledge base of the lived experience of help seeking and help receiving among Latinos, thereby helping mental health professionals better understand the complex process of coping with distress.

Methods

Sample

This research received approval from the Clark University Institutional Review Board. We recruited participants from social service agencies in two New England metropolitan areas, a Latino student organization, and a pool of participants who had previously participated in a research project investigating the efficacy of a depression prevention program for Latina mothers (Cardemil, Kim, Pinedo, & Miller, 2005). We posted fliers at the agencies, made an announcement at the student organization, and sent letters to former study participants. In addition, several study participants referred their acquaintances. We screened interested individuals using the principles of purposive sampling, which calls for identifying research participants with the goal of having a final sample with nonrandom variability (Patton, 1990). Of 19 individuals who contacted us to participate, we interviewed 8 women and 5 men, based on variability of age, gender, and country of origin. We excluded individuals whose demographic information closely resembled that of an existing participant. Nine participants had utilized formal mental health services. The remaining 4 participants discussed their experiences using informal coping strategies.

To properly contextualize the experiences of this sample, it is important to note that many of the participants had considerable problems at the time of our interviews. Of the 13 individuals, 5 were living with HIV, 3 had histories of substance abuse, 2 had lost custody of their children, and 2 had been incarcerated. Six of the 14 were currently working; the others were either collecting disability insurance or were staying home with young children. Five reported a history of depression, 2 said they had been diagnosed with depression and anxiety, and 2 said they had prior diagnoses of bipolar disorder. We do not suggest that this is a generalizable sample, or that the severity of illness or life stressors is representative of the Latino population. However, the fact that the majority of this sample demonstrated such need for mental health services makes it a rich source for describing the multiple factors related to help seeking and help receiving.

Data Collection

The first author, who is bilingual in English and Spanish, conducted in-depth, flexibly guided, in-person interviews between August 2006 and February 2007. Participants were given a choice of interview language and location; 7 participants chose English and 6 chose Spanish, and 10 of the 13 chose to conduct the interview in their homes; the remaining 3 were conducted at a university office. Participants were paid $20 for their involvement in the study.

After participants provided informed consent, we began the interviews with a request to consider a time within the previous couple of years during which the participants felt emotional or personal distress, and during which it was harder than usual for them to cope on their own. Although the order of and emphasis on specific topics varied, each interview included the following critical themes: (a) experiences with formal and informal service use and

self-care; (b) decision making around help seeking; (c) processes by which certain factors, such as family support, personal beliefs, or financial access impeded or facilitated help seeking; and (d) treatment or service experiences and issues related to treatment satisfaction. Interviews ranged in length from 32 to 92 minutes, with a mean length of 62 minutes. Following the interview, the first author or Spanish-speaking graduate student colleagues transcribed the audio recordings of the sessions in their original language using Transana software (Fassnacht & Woods, 2006). All participants received a card thanking them for their time and inviting them to contact the first author if they had any study-related questions.

Translation

The first author led the data analysis in the original interview language, and collaborated with the second and third authors as the analysis progressed. Quotations selected from Spanish interviews for inclusion in this article were translated independently by the first and second authors and two graduate students who are native Spanish speakers. When there was disagreement among the four translations, the translators decided on the final translation by consensus. Space restrictions precluded the inclusion of the original Spanish quotes in this article, but they are available on request. We have indicated each quote that came from a Spanish interview by adding "(Spanish)" after the quote.

Data Management and Analysis

In this study, we followed the data collection and analytic principles of dual mode of analysis (Falmagne, 2006), a qualitative methodology that enables knowledge generation based on both particularized and generalized (group-level) modes of analysis. It is based on the idea of concrete generality, which addresses the dialectic between two goals associated with qualitative research: understanding individuals as particular social agents in particular locations and contexts, and generating data that contribute to knowledge beyond the level of the individual (Falmagne, 2006).

Dual mode of analysis involves two concurrent modes of analysis. One phase is affiliated with grounded theory, a qualitative approach to generating theory from data, originally introduced by Glaser and Strauss (1967). More recently, practitioners have developed grounded theory in a more interpretive direction, focusing on in-depth and interpretive data to illuminate the individual meaning making and human interactions that form the basis of human behavior (Charmaz, 2006; Strauss & Corbin, 1990). The second phase of analysis involves generating narrative profiles for each participant. With these profiles, which resemble case studies, we particularized each participants' social location and cultural history, as well as the ways that each participant instantiated the phenomena of interest in different situations. The two modes of analysis thus address the tension inherent in the concept of concrete generality. Grounded theory analysis is given a concrete context by the application of the narrative profiles and, conversely, individual meaning making that emerges from the narrative profiles is given greater significance when viewed through the lens of grounded theory interpretation (Falmagne, 2006).

We based the data analysis for the grounded theory mode of analysis on the principles outlined by Charmaz (2006). The first stages of analysis involved several steps of coding, or assigning labels of meaning to descriptive or inferential information shared by participants. This process began with line-by-line open coding, and progressed to increasingly refined codes based on multiple rereadings of the transcripts. Ultimately, we condensed the original codes into focused codes, which are more directed, selective, and conceptual than the initial open codes (Charmaz, 2006). We used Atlas.ti software (Scientific Software Development GmbH, 2007) to organize the analysis.

The narrative profiles developed for each participant allowed us to contextualize the participants by explaining their immigration histories, family constellations, and social location, including community, employment, and economic circumstances. Most importantly for this study, the profiles enabled a description of the salient aspects of participants' experiences with help seeking and help receiving for emotional problems. We referred to the profiles throughout the analysis, so as to ground the interpretations in the particularities of participants' descriptions of their own lives. Space constraints prevent us from including the narrative profiles in this article, but we will provide them on request.

Results

This study revealed that help seeking and help receiving are networked and culturally informed processes, and that the intersecting influences of relationships, context, culture, and mental health care options informed help-seeking and help-receiving processes in particularized ways. Three themes emerged from the data and illustrate these intersections. First, participants integrated personal, family, and cultural perspectives to shape their ideas about suffering and healing. Second, three distinct factors influenced what kind of help participants decided to seek. These were referral source and style, need, and prior help-seeking experiences. Third, in gauging their satisfaction with treatment, participants reflected on client–therapist

match and client–therapist relational style. In the results that follow, we provide detailed descriptions of each of these themes.

Integrating Personal, Family, and Cultural Perspectives to Shape Ideas of Suffering and Healing

Personal perspectives. Participants considered various options for help when they found themselves struggling with emotional distress. These options were informed by individual perspectives on the origin and changeability of suffering. For example, Gonzalo,[1] a participant who believed that his distress had a clear causative agent, and that the progression of his suffering could be halted by a specific intervention, spoke about help as a curative intervention. Gonzalo was a 55-year-old Puerto Rican widower with a long history of depression and anxiety, who had arrived in the mainland United States 4 months before our interview. He said that many members of his family had suffered from mental illness, and he believed that treatment would prevent his symptoms from becoming more severe. Gonzalo's beliefs about mental illness as hereditary, progressive, and treatable informed his treatment preference: in his case, medication:

> So, what happens is that my dad, my dad loses his mind too, that is, he went crazy. Now he's calm. And then after my father, then my sister, we had a sister who even went to the United States—she went crazy, and was sent to the asylum and she died there, she died in the asylum, outside. Currently, we have a brother in Puerto Rico, who has also lost his mind. So that thing, there is like a family inheritance or something and we wanted to see if there was a psychiatrist who could give us support before—my mind has never broken, never. Calm. I've always been calm. (Spanish)

Other participants viewed suffering differently. Luisa, a 38-year-old Puerto Rican working mother of six who had lost custody of her four youngest children to Child Protective Services because of accusations of abuse, believed that suffering arose from negative and painful circumstances. She described how emotionally overwhelmed she became when her children were taken from her:

> Oh my god, anxiety, depressed, just everything, like your emotions are like all over the place. . . . I guess I was ashamed, too, you know,' cause I was—just to me there was just embarrassment to having your kids taken away, especially [because of] a man.

Because her emotions were so bound to her situation, Luisa relied on psychotherapy to help her accept her circumstances and end the cycle of self-blame:

> I had to work on not feeling guilty, because I felt really guilty about the whole thing. . . . [My therapist] reassured me that it wasn't my fault, you know, and that um, on an every day-to-day basis there was children being taken away for, you know, abuse and I was not the only one, that I wasn't alone.

Still another perspective came from Ryan, a 20-year-old college student of Colombian descent, who believed that depression resulted from constricting one's emotions. He believed that he had avoided depression by releasing his emotions through physical exercise:

> Just like probably if they hold their feelings inside. I've heard a lot of people can become depressed that way. Or just—they bottle them up, like kind of like I said I did, but . . . for some reason I just got my aggression out.

Thus, individual ideas about suffering contributed to participants' beliefs about what would ease their suffering, thereby leading them to seek different coping strategies.

Family perspectives. In addition to personal perspectives, participants' pathways to help seeking were influenced by family perspectives about the appropriateness of disclosing problems to people outside of the family. The importance that many participants placed on their respective family's opinions about help seeking reflects the Latino value of familismo.

Participants reported differing views about help seeking among family members. Whereas some described family members as endorsing outside help seeking, others did not, and still others said that their family refused to acknowledge their suffering. Participants who received outside help and also reported having a supportive family noted that their family's endorsement reinforced the work that they did in support groups or therapy. For these participants, such as Luz, a 41-year-old Puerto Rican grandmother, family support was critical to the healing process. She said, "[My children] want me to do something for myself 'cause they know that I can do it. You know, they give me the strength to do it." Some participants said that their family dissuaded them from disclosing family problems to outsiders. As Luisa struggled with the loss of custody of her children, she said that several of her family members discouraged her from turning to a therapist for help: "My brother and my mother, they're like that, it's all in the family, it doesn't get out, family's

first and so you go to the family. You don't go to strangers. You don't go to other people."

When families discouraged outside help, participants' reactions varied according to how satisfied they were with the help they received within the family. For example, participants tended to express satisfaction with familial support when families acknowledged the seriousness of participants' suffering and helped them to cope. An example was Jacob, a 22-year-old U.S.-born college student of Dominican and Honduran descent. After Jacob learned that his father had been abusing his mother for years, and had on one occasion tried to kill her, he suggested finding a "mediator" to help the family heal. His mother and sisters opposed his suggestion. Instead, they reached out to Jacob and supported him themselves. This support proved critical in helping him to gain a sense of control:

> My family immediately . . . came down . . . and they like talked to me and stuff, which really helped. . . . I spent a month at home, which really, you know, I was able to focus again. I really needed that, to be surrounded by family and surrounded by people who understand, so I needed my community again, so once I was surrounded by my best friends, and like, my family again, that's when I calmed down, I was able to focus again.

For Jacob, the support of family and friends provided him with the help he needed. Other participants, however, reported receiving neither support from the family nor encouragement to seek help outside of the family. This situation resulted in one of two scenarios, which depended on the relationship between participants and their respective family, and illustrates the particularized influence of familismo on help-seeking decisions. For participants who expressed a strong sense of familismo, family dismissal of suffering might convince participants that their suffering didn't merit attention, leading them to deny the severity of their own problems. For participants with less expressed familismo, and more independence within the family, their family's opinion of their suffering was not as influential. These participants tended to look elsewhere for help.

Ryan's case is a good illustration of the first scenario. He came from a family in which "I don't think we really mentioned our problems." His family's reservations about expressing problems led him to minimize his own problems. Although he talked about feelings of resentment and anger throughout his life, he never considered utilizing mental health services, which would have been outside the family norm: "Going to a random person, you know, that you don't know, it's not like an idea—I don't really think they do that in Colombia, Latin America." Ryan explained his family's self-reliance by attributing it to a cultural norm, thereby reinforcing his family's practice and normalizing it for himself. At the same time, he said that he rarely discussed his problems, even within the family. His concession to cultured family beliefs thus led him to keep his problems to himself.

Luisa's situation is an illustration of the second scenario. She described her family as neither encouraging her to seek outside support nor providing her with support from within the family. Her family members' inability to listen impartially, coupled with Luisa's independence from family conventions, inspired her to look elsewhere for support:

> Luisa (L): Like my mom, and she was like one of the last persons I told, because she's just really hard to deal with . . . and my older brother . . . they're very judgmental. It's always, "I told you so, I told you so," instead of you know, trying to be supportive and say, "Okay it happened, let's see what we can do to rectify it."
>
> Interviewer (I): Okay. Was it easier for you to tell strangers, like to tell the counselors, than it was to tell your mom and your brother?
>
> L: Oh yeah, a lot easier, yeah. They didn't know me, you know, so they couldn't judge me for what I did or didn't do, you know. If, if it was even my fault.

This interplay of familismo and help-seeking decision making exemplifies how culture is a part of the help-seeking process, and not just a static variable. Furthermore, it shows how the influence of familismo is particularized. Rather than acting uniformly on behavior, familismo was enacted differently by particular participants in particular contexts. Specifically, when families dissuaded outside help seeking, a participant's degree of familismo pushed him or her closer to or farther from the decision to seek outside help.

In comparison to the variable influence of familismo, participants painted a much more uniform picture of how they enacted another cultural value, that of *marianismo*. Marianismo has been defined as an idea of female gender role that emphasizes nurturance and self-sacrifice (Arredondo & Perez, 2003). In relation to help seeking, it manifested as the tendency for female participants to take on so much responsibility that they felt burdened and, for both women and men participants, to want to alleviate their own mothers' burdens. For example, Rosalía, a 31-year-old married mother of two, cared for her children and her disabled mother, and was responsible for her institutionalized sister. She expressed her frustration at how her obligations precluded her from taking care of herself:

"I have to be mother, sister, mother, spouse, so, I'm there for everyone else but I'm not there for myself" (Spanish). Many participants saw their own mothers as equally overwhelmed, and noted that because mothers already suffered so much, it would be unfair to compound their suffering. For example, Ryan said, "She has enough problems of her own, so it's not like I should be there adding on top of hers." Ana Lucía, a 34-year-old married Ecuadorian and working mother of a teenaged son, said, "Sometimes I feel, mothers suffer. By telling her that I have problems, that I feel bad—I know that I would make my mom suffer, so no, I don't want to make her suffer" (Spanish).

Marianismo could shape help-seeking behavior by calling for women to respond to their family's suffering before they tended to their own. Although participants themselves did not use the term, it is possible that a phenomenon resembling marianismo might impede the help-seeking and help-receiving processes for both men and women in the following way: If one felt unjustified asking for help because of the desire to appear strong, and the fear of overburdening family members, the options for receiving help would drop off considerably. Thus, exploration of the role of individual and family perspectives on suffering showed how the decision to seek help was informed by participants' own beliefs about suffering, and how those beliefs stemmed from participants' particular experience with mental illness. In addition, participants showed that familismo and marianismo were not static variables. Rather, these norms influenced help seeking through processes that shaped and were shaped by individual experience and interpersonal interactions.

Determining What Kind of Help to Utilize

Once participants reconciled their personal and family perceptions of suffering to determine whether they wanted outside help, a number of additional considerations influenced the kind of help they sought. These considerations were the source and style of mental health referral, the match between participants' identified needs and the type of support to access, and prior experiences with treatment.

Referral source and style. Many participants identified the perception that psychologists and psychiatrists treat only extreme cases as a considerable barrier to utilizing formal mental health services. Teresa, Ruth, Asunción, and Alberto were all in long-term therapy at the time of the interview, yet each one commented that therapy was for "crazy people."

An important consideration in assuaging participants' discomfort about treatment proved to be the manner in which medical providers made the referral to mental health services. When they did so with sensitivity to the participant's concerns about treatment, participants were more receptive to the referral. Alberto, a 39-year-old married Puerto Rican father, was diagnosed with HIV while living in Puerto Rico, and originally declined mental health services to help him cope with the depression that followed his HIV diagnosis. Alberto's comment illustrates how his doctor understood the stigma that he carried with him, and ameliorated his fears about being considered crazy:

> I said, "I'm not crazy," and she laughed and said, "Think about what I'm telling you so that you can see what you said wrong." And I said, "It's just that in one's country, people say that people go to a psychiatrist if they're crazy." And she said, "No, Alberto, you go to a psychiatrist when you need help, need to resolve something in your life that affects you, that feels—feels sad and you can't tell the whole world. That's what psychiatrists and counselors are for." (Spanish)

The conversation with his doctor then precipitated a shift in Alberto's perception of mental health care that reflects the influence of his doctor's recommendation:

> I wasn't one of those people who liked to go to psychiatrists. No, I didn't have the trust to go to a psychiatrist and tell him everything that had happened in my life. Later, well, I matured a little. . . . Because it's for advice, it's not for crazy people, it's for people who feel depression, who feel anxiety, or who have some problem that they can't resolve on their own. (Spanish)

Thus, rather than dismissing his culturally grounded preconceptions, the doctor validated Alberto's concerns and helped him to be more accepting of therapy. The influence of the referral style on the decision to seek help, which is surprisingly absent from the help-seeking literature, underscores the critical role of the referring provider, particularly in relation to individuals with negative attitudes about mental health treatment.

Identification of needs. Most participants used some form of complementary care, including combining medication with therapy, participating in a religious community, or utilizing case management services, support groups, or alternative therapies such as acupuncture. These participants acknowledged that no single source of support could adequately respond to all of their needs. Enrique is an illustrative example. He was a 55-year-old Puerto Rican man who had lived in the United States since the 1970s. At the time of our interview, Enrique was connected to a wide range of services to help him to cope with past trauma and to manage in the present. Although our

discussion focused on his utilization of formal services that included therapy, case management, and substance abuse services, Enrique identified church participation as his "number one issue right now." Church was where he had a sense of community, and where he was able to forget his problems. That sense of normalcy was essential for him:

> When I go to church, I just—I feel happy. When I was around with those people, I don't feel depressed, I feel like, I don't know, normal people. When I'm around them, we're never talking about problems. . . . I feel like I'm around, around family. Everybody treats everybody the same, nobody expecting anything from you.

It is noteworthy that Enrique acknowledged the utility of both therapy and church. He recognized the purpose of addressing problems directly, and also the need to escape from them at times, and to be recognized as a "normal" person. Other participants emphasized different needs. Whether they prioritized maintenance of physical health, a sense of connection to nature, spirituality, or simply feeling useful to others, complementary sources of support or services helped them to achieve their goals. Participants regarded those needs as ones that mental health services could not fulfill.

Prior experiences. Many participants had had experiences with mental health services prior to those that they were utilizing at the time of interview. These prior experiences, whether positive or negative, informed their attitudes toward subsequent service use. The influence of prior experiences on treatment preference provides a salient example of the particularized and process-oriented nature of help seeking. Participants' preferences were shaped not only by their attitudes or beliefs, but by their reactions to particular experiences over time. Positive early experiences helped Ruth to view similar services as helpful later in life. Ruth was a 52-year-old divorced grandmother of Cuban and American descent who was placed in state custody as a teenager. She reflected, "I've gone into some kind of counseling since I was 15, off and on, because I was a runaway, and I had a real dysfunctional home, and so I've known—I always knew that it was helpful."

For others, negative experiences with one type of service might motivate them to explore other modalities. This was true for Teresa, a 49-year-old single mother. When Teresa first arrived in the mainland United States from Puerto Rico, she suffered from stress-related illnesses, so her doctor referred her to a stress management support group. Her negative experience with that group kept her away from subsequent group services, although she later used couples and individual therapy:

> Another thing that I have experienced in the past . . . was group therapy, and I hated it. I think it was because there were men in the group. . . . And I hadn't been in the U.S. for such a long time, and it felt so awkward—I don't know, maybe it was the [lack of] privacy.

Madeline, a 35-year-old mother of Puerto Rican descent who was born on the mainland, also had negative experiences with therapy groups. She attributed her impression to concerns about confidentiality. Although Madeline received individual psychotherapy, she refused to attend groups that exclusively served Latino clients, because she feared that the closeness of the community could lead to a breach of confidentiality. This fear made disclosure seem risky to her:

> To be honest with you, I go to NA [Narcotics Anonymous] meetings and AA [Alcoholics Anonymous] meetings, Spanish, and I seen how, how the, it's so . . . divided, there's no unity, and people are always talking about you behind the, their back.

Thus, the role of prior services in participants' decision making underscored the particularization of help-seeking pathways, and contrasted with the belief that certain cultural groups necessarily prefer certain treatment modalities (e.g., the assumption that, because Latino culture is more allocentric than White American culture, group treatment would be the most appropriate modality). The preference for a particular modality might have a cultural element, but this element was individually enacted, and evolved over time.

Gauging Treatment Satisfaction

The final theme relates to participants' experiences with formal mental health services, particularly psychotherapy and psychiatry. Participants' levels of satisfaction with their treatment were largely influenced by their perception of the client–therapist relationship; in particular, the compatibility of the client–therapist match and the client–therapist relational style.

Client–therapist match. Client–therapist match played a significant role in participants' evaluations of their providers and of the therapy experience. Most participants valued having at least some similarities with their therapist. They described a range of matches, along the lines of ethnicity, language, age, and gender. Some participants reported that ethnic match was not particularly important, especially if the therapist was open to learning about Latino culture. For example, Alberto explained that what matters is "not that a therapist is from my own culture, but that [he or she]

knows about my culture" (Spanish). However, Teresa, who was bilingual and had worked with monolingual English-speaking therapists, referred to the comfort of a common cultural experience when she said she preferred working with Latina therapists: "It's nice when you have that opportunity. It's nice when there's things that are like, codes that you both understand in conversation." Ryan said he would prefer a Latino therapist, explaining that only a Latino male would understand his concerns about relationships. Incidentally, Ryan was the only participant who said he would prefer a male therapist:

> I would probably want somebody who was Latino. . . . They'd just know the general, like, man–woman relationship. There are a lot of Latin American countries are a lot different than man–woman relationships in like the U.S. . . . I feel that he'd be able to understand what I'm talking about.

Language match tended to be more critical than ethnic match, particularly for monolingual Spanish speakers. Ana Lucía adamantly stated,

> I think that it doesn't matter to me what country [a therapist] would be from, nor the race, nor the demeanor, nor the sex. The only thing that I would need is that [he or she] would speak my language. This, yes. (Spanish)

Age match arose as important for several clients, particularly for those who were older and had immigrated to the mainland United States as adults. Teresa, who was 49 years old, explained that when the therapist was older than the client, the client might feel restricted in his or her level of disclosure:

> With my therapist I was a little bit guarded because she's an older woman. . . . I guess it's a little big [sic] Latino culture . . . you really learn that elders, you have to be really respectful of older people.

Conversely, when the therapist and client were the same age, clients were more likely to believe they shared communication norms, and therefore felt freer to communicate openly, as with Enrique's description of his therapist: "She's so sweet, you know, and we [are] almost the same age, and when we [are] talking, you know like, I think she's, I don't know, like she's part of my family." The tendency for participants to defer to older therapists and to feel more comfortable with therapists of the same generation suggests adherence to the norm of *respeto,* which refers to the tendency to adhere to a hierarchical structure based on title and age, and to recognize individuals with greater seniority or status (Añez, Paris, Bedregal, Davidson, & Grilo, 2005).

When participants stated a preference for a therapist of a certain gender, most shared a general sense that confiding in a woman was easier than confiding in a man. This appeared to be the case for most of the women participants, but it was also true for some of the men. This greater ease in disclosure with women therapists might be attributed in part to the traditional Latino gender norm of *machismo*, which tends to undervalue emotional openness in men, and might make men feel awkward disclosing personal information to other men. For example, Jacob felt strongly that if he were to see a therapist, he would prefer to see a woman:

> Yeah, I'd be more comfortable with a female [laughs]. . . . Um, I just feel males, males are cocky, and with another male, it's like I don't want to share my problems, or not talk as much about them.

Ruth echoed a similar sentiment when she said she felt freer discussing whatever was on her mind with women therapists: "There's just some things I don't think I'd be able to tell a man."

Thus, the central issue with client–therapist match seemed to be that of comfort and ease of disclosure—provided that Spanish-language services or interpretation was available for those who needed it. Participants' main concern was being able to speak openly and truthfully. What is notable about these findings is that they illustrate the process by which cultural values might inform treatment satisfaction; a cultural match between participant and therapist led to the perception of a positive interpersonal bond, which would likely influence the participant's level of satisfaction with therapy.

Client–therapist relational style. The majority of participants defined their relationships with their therapists as successful when they were founded on warmth and high interpersonal regard. In this quote from Asunción, we see how she viewed her therapist as akin to a member of the family, and how that closeness helped her feel comforted:

> I tell you, I felt with her. Like she had even been part of my family or something, because of the way that she treated me. She hugged me, she—I was the patient, but she wasn't in it that way. She—like she was hugging her sister, her mother, or I don't know what. But one thing that she made me feel, like a comfort, something very, very beautiful. (Spanish)

When participants felt this type of warmth, they were more able to place trust in their therapist and to share their concerns, as Luisa related: "Oh my god this one is,

like, I don't know, and it's bad to say, but she's more like a friend, like I can really open up with this person."

This quality of warmth and openness in Latinos' personal and professional interactions is often described as *personalismo,* and has been identified as critical to the development of open and communicative relationships in many settings, including therapy (Comas-Díaz, 1996). However, like most of the cultural values hinted at by participants, it is not a universally preferred style. One participant, Ruth, said that she appreciated her therapist's more neutral stance, saying that it balanced her own emotive communication style: "She's not really emotional, and I'm very emotional, so she helps me to step out and look at things."

Most participants said that a more formal relational style made them feel less comfortable with disclosure, and therefore made them less likely to view therapy as successful. This was evident from Rosalía's description of her dissatisfaction with clinicians who seemed cold and distant:

> Don't try to talk to a patient like, "I went to University, I know everything, and all that.". . . In regard to the question you asked me [about whether I would prefer to see a] counselor, psychiatrist, or psychologist, I consider that I've had the same disillusionment in all three. That we sit down, so let's talk, okay, so I'll see you on such and such a day, what time is the appointment? So you're left like, "Oh my God." So, sometimes I, I feel more professional than them, because only I talk to myself, only I answer myself. (Spanish)

A warm relational style, therefore, helped most participants to feel comfortable with the whole therapy endeavor. It reassured them that instead of labeling them as crazy or dismissing them as just another case, their therapist respected them enough to engage with them as individuals.

Discussion

The in-depth, qualitative approach used in this study enabled us to gain valuable insight into the particularized experience and process of seeking and receiving help. We showed that help seeking involves an intersecting array of personal meanings, cultural value systems, and circumstances, and elucidated the experience of help receiving among Latinos by demonstrating how participants selected services and gauged their satisfaction with mental health treatment. We also showed how the process of help seeking does not end with the decision to seek care. Rather, participants who receive mental health care continue to evaluate their experiences and the interpersonal relationships that emerge from them. This ongoing process shapes their satisfaction with the care they receive.

In addition, we demonstrated a useful method for analyzing the role of culture in help seeking and help receiving. We showed how cultural constructs emerged from family and therapeutic relationships, and influenced help seeking and help receiving as they were individually enacted within particular contexts. This view of culture accommodates the complex, lived ways in which individuals deploy culture. It is consistent with conceptions of culture as dynamic, fluid, and dependent on individual context (e.g., Hays, 1996; Lakes, López, & Garro, 2006). We now provide a synopsis of key findings, and a discussion of their significance and clinical implications.

The first theme we explored related to how participants integrated personal and family perspectives to shape their ideas about suffering and healing. Participants described how individual and family perspectives on suffering informed their perceptions of their own suffering and their views about disclosure. They also demonstrated how an individual's particular enactment of the Latino cultural value of familismo was both informed by family and cultural norms, and implicated in help-seeking choices. Notably, we discussed how an individual's adherence to the norm of familismo influenced the decision to seek help outside of the family when that person's family dissuaded him or her from doing so. High adherence to the norm of familismo meant that the individual would likely not seek help, whereas participants with lower adherence to familismo were more likely to seek help, regardless of their respective family's disapproval.

We also discussed the role of marianismo in regard to attitudes toward seeking help. Women participants who expressed beliefs associated with marianismo often felt ambivalent about tending to their emotional health. Indeed, in writing about the "10 commandments of marianismo," Gil and Vazquez (1996) noted, "Do not put your needs first," "Do not ask for help," and "Do not discuss personal problems outside the home." Someone who endorses these values might have deep reservations about seeking help. Thus, our findings about the influence of cultural values on help seeking have important implications regarding who might or might not seek treatment, and suggest that it might be beneficial for clinicians to gauge clients' comfort with treatment from the outset, so that they can address any ambivalence clients might have.

Exploration of the second theme demonstrated how referral source and style, needs identification, and prior help-seeking experiences influenced participants' help-seeking choices. First, participants described the importance of the mental health care referral. When referring providers were sensitive to and respectfully addressed participants' reservations about treatment, participants reported

feeling willing to follow up on the referral. This finding showed that it was not only family and friends who influenced help-seeking decisions, but health professionals were also key members of an individual's network, with the capacity to influence utilization outcomes. Because most individuals with mental health care needs access medical providers before mental health providers, this finding has important implications for medical providers who want to help their patients access treatment. Directly addressing the stigma around mental health care and correcting any erroneous preconceptions about treatment might make the difference in a patient's decision to seek care.

Second, even those participants who utilized mental health care discussed how important it was for them to attend to their psychosocial needs through other means. Participants discussed a wide variety of coping strategies outside of mental health care, such as religious involvement. It is important that mental health professionals recognize and encourage these strategies, because participants discussed how mental health services were unable to meet all of their needs. By endorsing complementary coping strategies, clinicians empower their clients toward self-care. Furthermore, by actively supporting institutions such as churches in their efforts to address their members' mental health needs, clinicians make themselves and their services more familiar to those in need, and potentially reduce the discomfort associated with mental health services (Quintero et al., 2007).

Third, participants' prior help-seeking experiences influenced their current treatment preferences. Participants discussed how negative experiences in a certain modality, such as group therapy, led them to avoid that particular modality for subsequent care. This finding underscores the importance of inquiring about past help seeking so that clinicians can be aware of any preconceptions that patients bring with them to therapy.

The last theme we explored pertained to participants' evaluations of formal mental health treatment. The client–therapist relationship was paramount in deciding whether to continue treatment. For example, our data showed that the concept of *personalismo*, which has been identified as an important concept for therapists to understand and respect (e.g., Andrés-Hyman, Ortiz, Añez, Paris, & Davidson, 2006), was enacted in a particular way in the case of the client–therapist relational style. Most participants expressed a preference for a client–therapist relationship that was warm, caring, and personable, and in which they felt valued as a person, not just as a client. As applied to the therapeutic interaction, personalismo relates to the therapeutic alliance, particularly to the element of the alliance known as the "development of bonds" (Ackerman & Hilsenroth, 2003; Bordin, 1979); that is, the presence of positive interpersonal qualities between therapist and client, such as mutual trust, acceptance, and confidence. In addition, although personalismo included these features, it also emphasized the manner in which they were expressed—specifically, through warmth and openness that transcended the professional relationship. Understanding the process whereby personalismo influenced the therapeutic relationship could thus be critical in helping therapists develop a trusting relationship with their clients.

Age and authority also emerged as themes with clinical implications as they related to the concept of *respeto.* For example, Teresa was never able to let down her guard and speak openly, because the bounds of respeto led her to treat her older therapist with more formality than she felt was useful in the therapeutic context. Therapists who are aware of the implications of age and hierarchy disparities will be better equipped to examine how the disparities might affect treatment, and to communicate accordingly with their clients.

The final theme, that of gauging treatment satisfaction, demonstrated that culture informs the help-receiving experience by influencing the client–therapist relationship. This is a salient finding for two reasons. First, prior research has tended to treat cultural variables as static predictors of service use, without elucidating the process whereby culture influences utilization outcomes. We highlighted this process, showing that culture influences outcomes via its effect on the therapeutic relationship. Second, this finding also has significant clinical implications, because it can inform clinicians about beliefs and expectations that Latino clients might bring to therapy, thereby preparing clinicians to address those issues in treatment.

Taken together, the three themes we explored demonstrate how interpersonal networks and adherence to cultural values are critical to help seeking and help receiving. This finding dovetails with the help-seeking frameworks proposed by Rogler and Cortes (1993), Pescosolido (1991, 1992), and Pescosolido, Gardener, and Lubell (1998). Rogler and Cortes proposed that culture mediates the pathways to care by shaping an array of factors associated with help seeking, such as the social desirability of distress, norms around the acceptability of help seeking, and the relative openness of different cultural networks. Pescosolido, Gardener, et al. (1998) developed a help-seeking framework that emphasized the role of social networks in help seeking. Their framework conceived of help seeking as a series of coping attempts undertaken in negotiation with one's social and community network, which includes family, friends, and community.

Our findings combine the salient points of these two frameworks by showing how culture and interpersonal networks interact and together influence help seeking. In addition, this research expands on the existing frameworks

in three ways. First, we demonstrated that not only do culture and networks influence the decision to seek care, but they are integral to the decision about what care to seek, as well as to an individual's intention to continue receiving formal treatment. This is a critical finding, given that Latinos are more likely than non-Latino Whites to terminate psychotherapy prematurely (Harman, Edlund, & Fortney, 2004). Second, our findings demonstrated that Latinos engage in multiple help-seeking efforts in complementary and simultaneous ways, rather than sequentially, with concurrent utilization of multiple sources of care (e.g., church involvement, therapy, and drug rehabilitation groups). This reality is often overlooked in service utilization research, but it has important implications for any provider who suggests mental health care for his or her clients or patients. Even when clients initially seem unreceptive to mental health care, if clinicians encourage alternative coping strategies, clients might revisit the suggestion of mental health care when they are ready.

Third, we underscored the importance of considering both process and an individual's particularized experience when examining the influence of culture and networks. This conclusion has important clinical implications, because there is a risk of making cultural assumptions about Latino clients without exploring whether and how the assumptions apply to a given individual. Recognizing that all cultural norms will be enacted in particularized ways, if enacted at all, will likely benefit the therapeutic experience by building understanding and rapport between client and therapist. Furthermore, recognizing that culture and networks act via decision-making processes and relationships, and not as static variables, enables a dynamic and fluid interpretation of help seeking and help receiving, as well as a dynamic interaction with clients.

Notably, this study self-selected for individuals who were comfortable talking about their experiences seeking help for distress. Nonetheless, it is important to acknowledge the positive experiences that most of them had with treatment and formal support. This contrasts with the commonly held assumption that Latinos have less favorable impressions of mental health services, and supports prior work documenting that, in fact, favorable opinions are more common than might be presumed (e.g., Bein, Torres, & Kurilla, 2000; Miranda, Azocar, Organista, Muñoz, & Lieberman, 1996).

Strengths and Limitations

The use of qualitative methodology and bilingual interview and data analysis enabled a detailed examination of particularized experience, as told by participants in the language with which they were most comfortable. Extrapolating from existing research that suggests that native Spanish-speaking clients represent themselves more authentically when they speak Spanish in therapy (e.g., Altarriba & Santiago-Rivera, 1994), we can surmise that Spanish-speaking participants were able to do the same when interviewed about help seeking and help receiving in Spanish.

This approach enabled an in-depth exploration of help seeking and help receiving among people who utilized formal mental health care. However, we were not able to explore the experiences of those who have not sought formal services in as much depth. This is likely attributable at least in part to the nature of the study; that is, those with experience speaking about their distress to a stranger would be more likely to volunteer for a study asking them to do just that. Thus, we obtained less data about exclusive self-care than we did about formal mental health care. We were also limited in our ability to investigate barriers to care (Andersen, 1995; Bernal & Sáez-Santiago, 2006), given that all participants who wanted formal treatment had obtained it. Future exploration of the processes by which these need factors and barriers to care influence help seeking and help receiving among Latinos would provide an important complement to the current findings.

Conclusions

The term *cultural competence* refers to the ability to understand how clients enact culture within the therapeutic context, and the ability to use this knowledge to provide sensitive and appropriate care. We conducted this study to explore participants' decisions to seek particular sources of care, the conflicts they faced in accessing therapy, and the salient criteria by which they assessed therapy's effectiveness. Within each of these themes, clients enacted culture in particular ways. By focusing on the elements of successful interventions, we have shone the spotlight on opportunities for increasing clinicians' cultural competence. What is needed is a commitment to particularizing each client's cultural identity and their expression of that identity; that is, remaining cognizant of the person within the culture, rather than making assumptions based on cultural stereotypes. When clinicians are able to view culture through a particularized lens, they become better equipped to accommodate the role of culture for an individual client, and to provide appropriate care. Thus, culturally competent services will translate into more acceptable and satisfying mental health services and, ultimately, might help promote greater utilization of mental health care.

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Note

1. We used pseudonyms to protect participant confidentiality.

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