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Older Mexican Americans: Role of the Family and Mental Health Service Utilization

Introduction

Disparities in access and use of health and mental health services have led Latinos to be disproportionately represented among those most at-risk for chronic health and mental health illnesses and less likely to receive guideline-congruent care compared to non-Hispanic Whites (Blanco et al., 2007; Alegría et al., 2008; Cho, Kim & Velez-Ortiz, 2014; Mangadu, 2014). Latinos diagnosed with mental illness tend not to access or utilize mental health services available to them (Alegría et al., 2008a; Blanco et al., 2007; Cook et al., 2007; Jimenez, Cook, Bartels & Alegría, 2013). Alegría et al. (2002) examined disparities in utilization rates of *specialty mental health care* -- defined as treatment by a mental health professional such as a psychiatrist, psychologist, or psychotherapist -- in a specialty mental health setting, and found that a significantly higher proportion of non-Latino Whites (11.8%) received specialty care than African Americans (7.2%) or Latinos (5.9%). Similarly, Miranda and Cooper (2004) found that Latinos were less likely to receive specialty mental health treatment than African Americans or Whites (Chang & Biegel, 2017) and that the odds of Latino(a)s receiving any treatment for depression were lower than those for White patients. Further, Crystal, Sambamoorthi, Walkup, and Akincigil (2003) noted that among elderly cohorts who reported not ever receiving mental health care treatment, the rate was higher for Latinos and other ethnic groups compared to their White counterparts.

There are numerous barriers to health care, which separate racial and ethnic minorities including language, lack of appropriate information, a distrust of the delivery system, low income, and low education levels. Extensive research on service utilization has consistently documented the presence of economic, cultural, and structural barriers that contribute to the underutilization of health services by Latinos compared to the general population and other ethnic groups (Cho, Kim & Velez-Ortiz, 2014; Marin, Escobar, & Vega, 2006; Atdjian & Vega, 2005; Vega & Lopez, 2001; Villa & Aranda, 2000). Among these barriers are level of acculturation, language barriers, availability, affordability and accessibility of health services, lack of health insurance, familiarity with service delivery health systems, eligibility criteria, cultural insensitivity, practitioner's unfamiliarity with cultural nuances, and semantic equivalents critical in the diagnosis and treatment of illnesses. These barriers must be addressed because the U.S. Census Bureau (2012) estimated that Latinos will make up almost one-third of the U.S. population by 2060.

The United States has a population of diverse backgrounds. The multi-ethnic/racial population brings several challenges to health care. Differences exist among health beliefs and cultural practices when it comes to health care needs

(Trevino et al., 1991). Among Latinos, the family unit emphasizes culture. The family and the values of the culture influence help-seeking behaviors and adherence to medical recommendations. Given the importance of mental health and the growing population of Latinos, and increasing population of Latino older adults which will be the fastest among other diverse groups by 2050 (Alvarez, Rengifo, Emrani & Gallagher-Thompson, 2014; Kao, Lynn & Crist, 2013), it is essential to examine the relationship between the two. Since the purpose of this study was to explore the role of the family and social network of older Mexican-Americans on mental health services utilization, it is essential to examine existing literature related to these factors.

Literature review

Literature related to the utilization of mental health services by older, Mexican-American adults is limited; however, there are specific factors that are relevant. Researchers examined culture, family and service use as three of the most related factors to exploring the role of the family.

Culture

Culture is a factor that can serve as a barrier for older Mexican-Americans who need help in the mental health arena. Conversely, culture can also serve as a facilitator in accessing mental health services. According to Anthsel (2002), culture is important and has an impact on compliance with medical regimens. The culture of an older Mexican-American consists of the belief systems among the individual, their family, and their social networks. Older Mexican-Americans bring a diverse culture to the clinical setting.

Family

In the Latino culture, the family meets several emotional and psychological needs of their elderly family members. The family network is comprised of a nuclear family and an extended network of immediate and fictive members, bound by strong feelings of loyalty, identification, attachment, mutual support, and solidarity among its family members (Gonzales, German, & Fabrett, 2012; Organista, 2007). The immediate family usually takes care of older Latinos, with assistance from the extended family in their community. Older Latinos have a strong connection between their mental health and their health status. When their health status is stressed, their mental health is also impacted (Perez & Cruess, 2014; Caballero, 2011; Harris, 1998).

Older Latinos are at the center of the family. When older Latinos are distressed, it disrupts the family since the older Latinos are at the core of the family. Other family members have to take up the roles and responsibility of the older person. The older Latino gives up the responsibility of being the caregiver to become the care receiver. The adult children take on the responsibility of caring for

their aging parent. This exchange of responsibilities sometimes leads to stress and distress for the family and for the family members involved. Family members that are female and from low socio-economic status who serve as caregivers, are more emotionally distressed and vulnerable. The burden of caring for older Latinos eventually falls on their children, particularly daughters. The children of older Latinos take on this caring role in addition to other responsibilities, like raising their own family and maintaining employment (Miyawaki & Miyawaki, 2016; Mendez-Luck, Geldhof, Anthony, Mangione, & Hays, 2016; Purdy & Arguello, 1992).

In such circumstances, many families' roles and responsibilities may even become interchangeable (Beyene et al., 2002; Becker et al., 2003). Characteristically, in these situations, the daughters are usually left to assume the primary caregiving role for older Latinos (Purdy & Arguello, 1992). Typically, Latino daughters, particularly the eldest sibling, assumes the primary caregiving role for a parent, an in-law or other elderly relative, which adds another role to their list of caring for their own spouse and children (Ayalon & Huyck, 2002; Connell & Gibson, 1997).

Keeping medical, mental health and other problems in the family is a norm that contributes to the reluctance of taking advantage of available health care services (Magilvy, Congdon, Martinez, Davis, & Averill, 2000). The family system does not take the problems of Older Mexican-Americans outside of the family system (Abramson, Trejo, & Lai, 2002). Latino elders are resistant to outside help, and have a strong sense of independence. They often are self-reliant, desirous of aging in place (their home), and dependent on family support and friends to meet health care needs. Similarly, the family system can be resistant to outside help with problems associated with older Latinos (Abramson et al., 2002). Family caregiving can be a double edged sword in times of need for health services. The family can be a great facilitator in helping older Latino family members access needed resources including mental health services (Chang & Biegel, 2017; Villatoro, Morales & Mays, 2014), yet at other times, the family can be a barrier to accessing services (Marquez & García, 2013).

Service use

Latinos' low usage of mental health services might be due to use of resources other than formal treatments, such as extended family (Evans, Coon, Belyea, & Ume, 2017; Marquez & García, 2013; Min & Barrio, 2009), spiritual/religious healers (Loera, Munoz, Nott, & Sandefur, 2009; Villatoro, Morales & Mays, 2014), *vergüenza* (shame), and no insurance (Chang & Biegel, 2017; Marquez & García, 2013; Min & Barrio, 2009). Family cohesion has also been found to be linked with low psychological distress among Latino older adults (Guo, Li, Liu & Sun, 2015) and their caregivers (Weisman, Rosales, Kymalainen, & Armesto, 2005). Villatoro, Morales, and Mays (2014) found that family support positively

influences the use of informal or religious services and also found that Latinos with high family support were significantly more likely to use informal or religious services as a form of mental health care.

Studies have shown that Latinos with highly supportive social networks are less likely to use formal mental health services than those with less supportive social networks (Golding & Wells, 1990; Hansen & Aranda, 2012; Miville & Constantine, 2006). This suggests that Latinos are more likely to trust and confide in reliable and supportive family and friends before considering mental health services (Villatoro, Morales, & Mays, 2014; Cabassa, 2007; Cabassa & Zayas, 2007). When older Hispanic adults need mental health care, those who receive support and encouragement from family and their primary care provider are more likely to use mental health services (Choi & Gonzalez, 2005). The relationship between the family and mental health service utilization is understudied; this study explores this relationship--the role of the family and social network in older Mexican Americans accessing mental health services.

Method

The researchers conducted in-depth qualitative interviews to explore the role of the family and social network of older Mexican-Americans on mental health services utilization (Padgett, 1998; Spradley, 1979). The study consisted of a purposive sample of 20 older Mexican-Americans recruited from hospital-based, outpatient, mental-health programs for older adults located in Texas. Researchers included open-ended questions in the study informed by Kleinman's explanatory model (1980) to examine the role of the family and social network in older Mexican Americans accessing mental health services. Areas explored also included basic background demographic questions and open-ended questions regarding participants' treatment experiences, motivations for getting help, interactions with family, and family factors that contributed to participant decisions to remain in therapy/groups. The study team translated the interview guide into Spanish using back-translation methods to assure fidelity of the data collection process across the sample.

Sample Selection Criteria

After IRB approval, the study's Principal Investigator (PI) recruited the sample from acute care hospital-based, outpatient, mental health programs for older adults located in six urban and rural cities in Texas. The outpatient program offered cognitive behavioral therapy group interventions with a psycho-education component to manage mental distress. Using purposive sampling, eligible participants were screened and recruited by the hospital staff from the six programs using the assure inclusion criteria. The criteria required that eligible participants (a) had completed the hospital, outpatient, mental-health program in the past 12

months, (b) experienced a reduction of depressive symptoms, and (c) scored 24 or above on the Mini Mental Status Exam (MMSE). The MMSE is a test of cognitive functioning that provides an assessment of cognitive ability for participation in the program (Folstein, Folstein, & McHugh, 1975). The MMSE criteria was decided upon so as to include respondents in the study who were more than likely to have good recall of life events, ability to consent and participate in the interview, and provide in-depth information on their treatment experiences.

The PI managed recruitment and met with the agency staff to review the study's purpose and sample selection criteria. The staff accessed patient records to identify older Mexican Americans who met the sample selection criteria and contacted prospective participants to describe the research study. If interested, staff instructed prospective participants to contact the study PI to discuss participation in the one-time interview. Prospective participants received an information letter that described the study, research goals, and the informed consent form.

Once a participant contacted the study's PI, the PI reviewed the study objectives and informed consent by phone, and scheduled the interview at a time and location chosen by the respondent. Interviews lasted 60-90 minutes and took place primarily in the participants' homes. All interviews were audio recorded with field notes as part of the interviewer's subjective documentation of participant-observation. The researchers used memo writing to capture initial impressions, patterns, categories, and themes for further analysis (Saldana, 2009). The study PI, who is bilingual and bicultural, conducted the interviews in the preferred language of the participant, English or Spanish, or both. Analysis was conducted using an iterative process rooted in a theme-based content analytic approach (Grinnell, 1997). The analysis was conducted by an experienced team of researchers and clinicians in the field of gerontology and social work with expertise in depression management among older Latinos. To enhance trustworthiness in the analysis process, the researchers employed an audit trail and peer debriefing. The audit trail consisted of steps taken in data collection and data analysis as well as interview transcripts, field notes, notes from peer debriefing sessions, and coding and analysis (Creswell, 1998). The audit trail helped the researchers review the analysis process and decide on directions to inform the content analysis.

To begin the analysis, researchers used categories from the adapted open-ended questions regarding the participant's treatment experiences; motivations to getting help; interactions with providers; influence of treatment experience on individual functioning; and factors that contributed to participant decisions to remain in therapy/groups. The research team reviewed the transcriptions and recordings multiple times, coding common and unique themes separately, identifying keywords, phrases, meanings, and themes. The team held regular meetings throughout the data collection and analysis phase for peer data debriefing and ongoing analysis. Agreement that saturation was reached when no new themes

were uncovered in the analysis resulted in ceased recruitment efforts for the study (n=20).

Throughout the analysis process, the researcher reconciled coding and discrepancies. Adjustments to the interview protocol were not needed based on the initial results produced from the iterative analytic approach and review of the data. The debriefing sessions allowed for feedback on interpretations and an opportunity to explore new ideas for data analysis (Creswell, 1998; Padgett, 1998). In the next section, the authors present a description and interpretation of the themes, and quotations that reflected the resulting themes and the respondents' perspectives on the family and their role in helping respondents access and complete outpatient mental health treatment. The interviews were conducted in English, Spanish or a mixture of both languages, the analysis were conducted in the language spoken by the respondent. The findings were translated into English for purposes of publication.

Findings

The family was involved with respondents throughout the process of help-seeking and accessing mental health services. Family members helped respondents recognize their mental distress by noticing behavior signs and working with their physician. The family shared feedback with the doctor to help facilitate the respondent making the decision to go to treatment. The family motivated respondents by recognizing and acknowledging changes and progress in the treatment program.

Family and Problem Recognition

Respondents reported that family members noticed their mental distress. Thirty-five percent of respondents said their families told them they were depressed. The family members included husbands, daughters, sons, a sister, a daughter in law, and a nephew. One respondent described how her family noticed the change in her behavior and were glad that she acknowledged her problem. Two nieces lived with the respondent at the time. The nieces and the respondent's daughter could see her depression. The family grew tired of making plans with the respondent who would then change her mind and refuse to participate. Her nieces saw results as the respondent began the treatment program.

I think they were tired of me moping around and not wanting to do anything. After the first two weeks, they said, you know we can tell the difference. We can tell the difference, you are coming alive again. I said, "I think you are right."

Another respondent described that her daughters could see that she was having problems. She was adjusting to eye surgery and losing her eyesight. She tried to make a cup of coffee and had an accident. Her daughter could see her in

distress. The daughter contacted her sisters, and they told the respondent, “Mama, you need to do something.” Her daughters had seen respondent have problems with depression in the past, and knowing her history, contacted her doctor for help.

One respondent said her sister told her she was depressed. She had suffered a heart attack, which had affected her independence. She was adjusting to doing things with assistance. *I didn't want to believe her because why would I be depressed? I didn't have a reason or could not figure out what I was depressed from.*

She felt angry about losing her independence, and she did not want to believe that she was depressed. Her sister contacted their nephew, who is a physician in the community. Her nephew was familiar with the treatment program. He talked with the respondent and told her she needed the treatment program and that it would help her.

Family and Treatment Program

The family helped respondents get to mental health treatment in several ways. The family provided support and encouragement as respondents attended the treatment program. The family gave respondents feedback after noticing progress, such as behavioral changes, in them. The family helped with decision making by holding family meetings.

Decision making

The family helped respondents make the decision to go to the treatment program as well as other decisions. One respondent talked about her daughters helping her make the decision to get help for her depression and go to the treatment program. They helped her understand the treatment program and overcome any doubts she had. They helped her “to make the decision and [showed] how I would benefit.”

Another respondent said she makes her own decisions and her children provide support. If she needs help, she asks her children for help, particularly with big decisions. *They tell me they respect me; they have always supported me. Now I make my own decisions. Everyone used to leave everything to me. Not anymore. I am me. I make more of my own decisions. If I need anything, they help me.*

Family meetings are one way that families helped respondents make decisions. One respondent talked about having Sunday dinner with her son and his family. At this dinner, the son and his family bring dinner to the respondent. *In general, it is my children who help me make decisions. My son (and his family) come visit me on Sunday. They bring food, and they eat here with me. We call my other son. After dinner, they call her son who lives in another city. Both sons give her feedback.*

Support

Twenty percent of respondents reported that their families did not know about the treatment program. Mental health treatment was new to some families as was the idea of a program for older adults. Families supported the respondents' decision to attend the treatment program. One respondent shared that her husband, son, and daughter supported her decision to get help, "...my husband, my son and my daughter."

Once the respondents started the program and the family noticed changes, they became supportive of the respondent attending the treatment program. One respondent reported her family did not know the program existed, but once they learned of the treatment program, they were supportive of respondent's participation, and they were happy that she was getting help. *They didn't help me because they didn't know either about the program. When they found out about this program, they agreed. They were happy for me to get that kind of help.*

Respondents talked about their family offering encouragement of their attending the treatment program. The family continued the support after they could see progress in the respondent. One respondent shared that her family could see the treatment program helping her. The family noticed the difference in her. *When they found out about this program, they agreed. They were happy for me to get that kind of help. The first time they visited me, they noticed the difference in me, from one day to the next. They said, "Mom, you look good."*

Noticed progress

Respondents talked about how their families recognized the behavioral changes in them. The family observed respondent getting back to being their usual self and their usual behavioral functioning. One respondent said her family noticed the changes quickly. The family could see that she was looking better and was back to doing things like going out, cooking, and watching television. *My family noticed the change in me. Now I will watch television and make dinner. I still pray. I haven't forgotten my sister.*

Another respondent said her family, "...saw that I was OK. I have more energy, I am not as anxious." One respondent talked about getting motivation from her family because they noticed the change in her, "Well, they just helped me stay motivated."

Spouses also helped respondents by giving feedback. One respondent talked about her husband who noticed changes in her. *He saw that I was not afraid any longer and said I was looking better; I'm no longer afraid. I am much better. My husband tells me he can see how I have changed.* Another respondent said that her husband was happy that she was better. He could see the change in her face, "He is

very satisfied (with the program) because he says he can see the difference in my face.”

Daughter

The daughters of respondents were instrumental in helping them get to mental health treatment. Seventy percent of respondents reported that a daughter or daughters helped them the most. Daughters helped by calling the treatment program and encouraging respondents to attend the program. Daughters also contacted programs, worked with physicians and went with the respondent to initial appointments. They explained the program to the respondent and helped get respondent to appointments and ran errands.

One respondent told about her daughter seeing her through her problem, to the extent that she took the respondent to the treatment program. She talked about her daughter being there for her and seeing her at her worst, through her anxiety attacks. *I felt so bad; I could not help having the anxiety attack. She saw it. She felt bad because she could not do anything for me. So, luckily, we got through it.* Her daughter was helpful in the respondent’s learning about, and ultimately, going to the treatment program.

One respondent talked about how her daughters, who live out of town, came to help her after she had moved to a different city. Two of her daughters took leaves of absence from their jobs to help her settle into her new place and find the treatment program for her. She took a leave of absence from her job. *I have four daughters. Then she went home and another daughter came for two weeks to help me.* After both of her daughters had left, two of the respondent’s granddaughters came to stay with her and help her out. One came from Colorado and the other from New Jersey. It was when “the last granddaughter left, [that] I entered into the program.”

Worked with physician

One respondent talked about his daughter working with his doctor to help him get help. His doctor called his daughter and recommended the treatment program for him. She then called the program to set up an appointment for him. *Well, (she) helped me a lot. I think it was the doctor who called my daughter. Then my daughter called me to tell me that a nurse would be going to her house to talk to me about the program. So, I went.*

Told her to go to treatment

One respondent said her daughter told her to go to the program; “She would tell me to go.” Another respondent talked about how all of her daughters preferred that she was attending the treatment program. “I have three daughters, and all three wanted me to go to the program.”

Called the treatment program

Daughters helped respondents by calling the treatment program and making an appointment for the initial assessment. One respondent said her daughter told her that a nurse would visit her. Her daughter told her to go to the program because it would help her feel better. "My daughter told me. And a lady came to visit and tell me about the program. And my son told me, 'Mom, maybe you should go so you can feel better.'" Another respondent's daughter was visiting from out of town and talked to the respondent about going to the program because of her depression. The daughter called and made the appointment for the respondent. That was how she started the program.

Helped until she was used to program

A respondent talked about her daughter going with her to the program at the beginning of treatment. Her daughter would drive her to the program and walk her into the agency. She did this until the respondent was used to attending the program, alone. *Me, I wanted to go. First, my daughter (went with me) until I was used to going by myself...At first, I didn't want to go in alone, and my daughter had to go in with me.*

Discussion

Respondents' relationships with their family members were significant because of the role of the family in their lives. The family was involved with respondents throughout the process of help-seeking. The family helped respondents by working with their physician. The family shared feedback with the doctor to help facilitate the respondent making the decision to go to treatment. Respondents' relationships with their families helped them get to mental health services. The family helped with recognizing the problems, some family members helped give the problem a label, and others assisted the respondent in going to the treatment program and seeing them through problem resolution. The family helped with making the decision to seek help, offered support and encouragement, and noticed progress as respondents felt better. Hansen and Cabassa (2012) found that family support and encouragement was influential in getting Latinos to treatment. Respondents also discussed the relationship their family had with their physician. Some family members were in direct contact with the respondents' physicians.

Daughters normally assume the primary caregiving role for older Latinos (Ayalon & Huyck, 2002; Connell & Gibson, 1997). In this study, the daughter was the most instrumental family member to respondents. Most respondents relied on their daughters with the family roles being reversed. The daughter became an educator and a liaison for their parent, often times speaking for the respondent.

Daughters were helpful to the respondents in several capacities including communicating with the physician and the treatment program, reducing stigma of mental illness and educating respondents on mental illness and mental health treatment, and helping their parent make the decision to go to the treatment program. Their assistance was the most important to respondents. Because of the paucity of literature on the topic of this study, it is difficult to compare our findings to other studies. This does present the need for more research on this topic.

As the findings show, family members have crucial roles in the entire process of mental health services utilization with older Latinos. The family supports accessing treatment programs, assist the older Latinos adjust to the treatment programs, and cooperate with the medical staff. The results of this study indicate the significant role of the clients' culture in the medical intervention process and the delivery of services. While recognizing and emphasizing self-determination as one of the social work values, family-determination should be added to the health delivery system as a Latino cultural element.

Recommendations

Education regarding mental illness and treatment services

One significant recommendation is for social work and health care providers to increase education about mental illness and services to older Latinos and their adult children and families. Providing education will help increase the understanding of mental illness and mental health services. For example, older Latinos and their families need education concerning insurance benefits, availability of mental health services, plus general information about mental health.

Another recommendation is educating medical professionals and staff on the facilitative role of family members' involvement in the treatment process of Latino older adults and encourage the professionals to integrate the family roles in the Latino older adults' treatment plans.

Latino families are willing to assist their older relatives; however, their needs should be recognized. Latino families need support, as well as, to encourage them to continue to support their older relative and prevent the family members' burn out. In this study, the role of daughters was significant; however, the daughters' needs and problems need to be considered as well. Supporting Latino family members is cost-effective and decreases health professionals' pressure and burden. It also might increase older Latinos adherence to treatment protocols and promote family well-being with low cost.

Cultural Distance

With the current population growth, the barriers and needs of older Latinos and their families will need ongoing assessment. Assisting older Latinos in identifying

the barriers they are experiencing is vital to these assessments. Older Latinos might not identify a challenge as a barrier. In working with older Latinos and their families, social workers need to consider the degrees of acculturation, language skill and preference as well as adherence to traditional customs, values, and norms of those being treated (Santiago-Rivera, 1995).

Professionals need to move beyond holding a simplistic view of culture (e.g. creating a physical atmosphere and hiring people who speak the language), to one that incorporates the multiple dimensions of culture in a more detailed way (Bernal & Castro, 1994). For social work professionals, some suggestions for moving beyond a simplistic view of culture include cultural competency training focused on the language and culture of the region. Professionals need to understand and learn that Spanish exists in different dialects, that Latinos come from different countries, and that Latinos have lived different lifestyles and have different life experiences. Understanding the language that older Latinos are using will improve services for both the provider and the patient.

To decrease this cultural distance, planners need to take into account both factors of the linguistic minority clients and the limitations of the professionals who will be working with them. Professionals need to understand the cultural distance for each individual client and their family, and to provide accurate assessments. Professionals providing treatment to linguistic minorities need to understand these considerations within themselves to do so effectively. Professionals also need to understand their level of cultural competency and improve as needed with each ethnic/minority group to help remove any biases etc. that may act as barriers. In a pilot study, Choi and Gonzalez (2005a) found contributors to access of older minorities included physician, social worker referrals, churches, former patients, and community outreach. They also noted having a supportive family, and the treatment agency having bilingual/bicultural clinicians were also contributors (Choi & Gonzalez, 2005).

Future research could also address the needs of the Latino caregiver family members. When older adult family members suffer from mental health problems, they are the center of attention and other family members try to support them. These family members' struggles should be explored as well.

Conclusion

Although the number of respondents was limited, the findings indicate that family members, especially daughters, play a significant role in the decision to utilize mental health services. When working with older, Mexican-American adults, professionals must recognize the significance of family roles and culture in order to increase compliance with treatment.

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