


Rural Hispanic Perceptions of Mental Health: A Qualitative Study

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Abstract

Introduction: In 2020, 18.4% of Hispanics experienced mental illness, yet only about a third received treatment compared with nearly half of non-Hispanic Whites. In Montana, where only 11% of the mental health needs are currently met, service utilization is low. The purpose of this study was to determine the perceptions of the Hispanic immigrant population in a rural state on mental health and professional service utilization.

Methods: Using a descriptive phenomenological approach, we conducted semi-structured telephone interviews in Spanish. Audio recordings were transcribed, translated to English, and analyzed for themes.

Results: We recruited a sample of 14 participants from Mexico, Ecuador, Colombia, and Venezuela ranging in age from 33 to 59. We identified five themes: definitions of mental health, maintaining mental health, *familismo*/socialization, stigma, and acculturation stress.

Discussion: Novel findings point to the need for Spanish-language services focused on reducing stigma around mental illness and incorporating the importance of social connections.

Keywords

mental health, Hispanic immigrant, stigma, barriers

Introduction

Approximately 44% of the 19.8 million immigrants in the United States identify as Latino/Hispanic (Batalova et al., 2021). According to the National Alliance on Mental Illness, 18.4% of Hispanics experienced mental illness in 2020, yet only 35% received treatment compared with nearly half of non-Hispanic White persons who received treatment (National Alliance on Mental Illness, 2021). In rural areas, where mental health issues tend to be higher but access to professional services is lower, these rates are likely worse. Montana is a large rural state where Hispanics make up 4% of the population (U.S. Census Bureau, 2019). Only 11% of the mental health needs are met by current providers, and the statistics for Spanish-speakers are even more dire (Kaiser Family Foundation, 2020).

Background

There are more than 60 million Hispanic persons in the United States, and they may be at high risk of mental illness. Part of this may be explained by the immigration process itself, which can be traumatic and involve dangerous travel (Breslau et al., 2017; Crocker, 2015). In addition, potential

trauma experienced in an immigrant's home country, which may have spurred the desire to migrate, can result in post-traumatic stress disorder (Sangalang et al., 2019). In a culture where family ties (*familismo*) are central, the loss of or weakened familial support system may make the stress of immigration particularly acute (Jimenez et al., 2020). Once an immigrant is in the United States, adapting to a new culture may also create anxiety and depression. The potential conflict of integrating one's cultural experience with the majority culture of the United States is termed acculturation stress (Berry, 2006). Acculturation stress can lead to mental illness as an immigrant learns the new culture and may experience isolation, loneliness, and feelings of loss (Bas-Sarmiento et al., 2017; Torres et al., 2018). Immigrants may struggle with discrimination, a lack of social support, and disappointment at the reality of their new life (Gómez &

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Castañeda, 2019; Olcoñ & Gulbas, 2018). Spanish-speaking immigrants can struggle with language and cultural barriers that make it difficult to access help when needed (Salami et al., 2019), particularly in a setting where minimal Spanish-language resources exist. Although urban settings often offer enclaves of other Hispanic persons from the same country, rural areas tend to be mostly White and lack diversity. Mental health services are limited in rural settings, with a pronounced lack of culturally sensitive options (Carpenter-Song & Snell-Rood, 2016). In Montana, only 11% of the mental health needs are met by current providers, and the statistics for Spanish-speakers are even more dire (Kaiser Family Foundation, 2020).

Studies show that Hispanics may underutilize mental health services. In an analysis of service use published in 2005, researchers found that non-Hispanic Whites were seven times more likely to access outpatient mental health services than Spanish-speaking Hispanics, due to language barriers and stigma of mental illness (Guarnaccia et al., 2005). The lack of Spanish-language services is a large barrier to care (Cancel-Tirado et al., 2018), and Spanish speakers often prefer bilingual providers rather than communicating through an interpreter (Bischoff et al., 2003; Millard et al., 2009; Ngo-Metzger et al., 2007; Pinedo et al., 2018; Villalobos et al., 2016). The role of stigma, which has been shown to limit a person's perceived need for services, their willingness to disclose their mental health status, and adherence to medications is a large factor (Benuto et al., 2018; Mendoza et al., 2015; Nadeem et al., 2007). Although researchers suggest stigma prevents some Hispanics from accessing professional behavioral health services, others suggest that stigma may result in an increased reliance on family, social ties, and religious leaders, which have beneficial effects on mental health (Martinez Tyson et al., 2019).

Relatively few studies address the perceptions of Hispanics related to mental health or the need to seek professional services, and the few that exist use small sample sizes and do not focus on immigrant populations (Breslau et al., 2017). Some research suggests that Hispanics and persons of color may fear microaggressions in therapy, contributing to their avoidance (Owen et al., 2014). Other studies suggest that fear of potential deportation may influence willingness to seek mental health services (Nichols et al., 2018; Vargas et al., 2019). The lack of information about the perceptions of mental health among Hispanics led to the current study to determine perceptions of the Hispanic immigrant population in a rural state on mental health and the use of mental health services.

Method

Research Team and Reflexivity

Personal Characteristics. A bilingual, bicultural undergraduate research assistant trained in qualitative data collection conducted telephone interviews using a semi-structured

interview guide. The study procedures were overseen by the principal investigator and first author, a PhD nurse. Throughout the process, to address potential bias, the researchers engaged in reflexivity by discussing with one another the potential influences of their own cultural background and their experiences working with the Hispanic population in other settings.

Relationship With Participants. No relationship was established with any of the participants prior to the study's commencement. The goals of the research were explained to each participant as part of the consent process. The interviewer introduced herself as an undergraduate nursing student from Puerto Rico who worked with the study team to identify perceptions about mental health among Hispanics.

Study Design

Theoretical Framework. Qualitative research is an approach used to understand perceptions, beliefs, and behaviors of individuals and is a useful method to employ when little is known about a subject (Pathak et al., 2013). We employed a descriptive phenomenological approach (Lopez & Willis, 2004) to understand the experience of mental health of Hispanic immigrants. The descriptive phenomenological approach focuses on the lived experience of participants solicited through interviews and uses thematic analysis to identify patterns of meaning (Sundler et al., 2019). We adhered to the COnsolidated criteria for REporting Qualitative research (COREQ checklist) for qualitative research (Tong et al., 2007). This checklist is used to help researchers ensure qualitative methodological rigor by reporting on aspects that may bias findings.

Participant Selection and Setting. The study sample included any Hispanic immigrant living in our county. We recruited participants initially during a community health event (Moyce et al., 2021) and asked participants to sign up if they were interested in further involvement with the research group. Twenty-nine persons indicated an interest in further participation. We contacted all 29 via phone calls, and 15 agreed to participate in the study. Due to restrictions imposed as a response to the coronavirus disease 2019 (COVID-19) pandemic, we conducted phone interviews. We were unable to reach 6 participants and used snowball sampling to create a sample size of 20 potential participants.

Data Collection

The research team generated a semi-structured interview guide based on a literature review and a community assessment. The interview guide included broad, open-ended questions designed to elicit views and perceptions of mental health (Table 1). A bilingual, bicultural undergraduate research assistant trained in research methods and qualitative data collection scheduled phone interviews with participants,

Table 1. Selected Interview Questions by Topic.

Topic	Example questions
Health Maintenance	How do you think people usually take care of their health? What are some resources people use to care for their health?
Mental Health Perception and Definition	When I say mental health, what do you think about? How would you describe the mental health of your community?
Treatment	How do people in the community feel about seeking professional help? Why do you think people are reluctant to seek help?
Causes of Poor Mental Health	What things affect someone's mental health? What are the things people in your community worry about?

explained the consent process, and collected verbal consent before initiating the interview. Interviews were audio-recorded, and the recordings were sent to a professional transcription service for transcription into Spanish. Anonymous transcriptions were translated into English by bilingual research assistants. All interviews were conducted in Spanish except for one conducted in both English and Spanish, and each lasted approximately 45 to 60 min.

Study procedures were approved by the Institutional Review Board at Montana State University.

Data Analysis

Data analysis occurred as an iterative process to ensure that we knew when data saturation was reached. The principal investigator, a graduate research assistant, and two undergraduate research assistants read through all transcripts as they were transcribed and translated. Data saturation was met when the participant comments became repetitive and no new information was learned with subsequent interviews. Transcripts were analyzed using thematic analysis to identify, organize, and describe common themes found in data (Nowell et al., 2017). The descriptive phenomenological approach helps the researcher identify patterns of meaning in the experiences of participants (Sundler et al., 2019).

The four investigators each read through a randomly chosen sample of four interviews to develop initial codes. Using an inductive approach, codes were identified by each investigator separately. Data were analyzed using NVivo 12 (QSR International, Melbourne, Australia). The team met to discuss the codes and to develop a master coding list. Discrepancies were discussed until consensus was achieved. This resulted in a total of 13 codes. Three investigators (the PI and the two undergraduate research assistants) each read through all of the transcripts and independently coded all of the interviews following the master coding list. When all interviews were coded, they were reviewed and compared for consensus or revision and categorized into themes based on similarities (Table 2). Results were presented to the full research team for validation and to a subset of five members of our sample for member checking.

Results

We conducted interviews with 14 participants (8 men, 6 women) before reaching data saturation. Participants were from Mexico, Ecuador, Colombia, and Venezuela and ranged in age from 33 to 59. Thematic analysis revealed five themes: *definition of mental health, ensuring mental health, familismo/socialization, stigma, and acculturation stress*. Themes are discussed below with English translations; original Spanish transcriptions are available in Supplemental Material.

Definition of Mental Health

Stress Management. Discussions of mental health need to be grounded in a common understanding of what is meant by the term. Participants in our sample associated mental health their relationship to stress—either its absence or the ability to cope with it. Mental health, for some, was synonymous with stress management. One participant explicitly stated, “Mental health for me has much to do with coping with stress” (43-year-old Mexican male), and another said, “Mental health is . . . when one does not have stress” (59-year-old Mexican male). Although the absence of stress contributed to mental health for participants, the management of stress was also important. Managing stress resulted in a feeling of calmness, contributing to overall mental health. One participant said,

It is like one's emotional state, how you feel, how you can handle sadness, handle happiness, handle all that. For me, that is mental health. (30-year-old Colombian male)

And another said,

Mental health? For one to be relaxed, without worries and I think about that, right? The tranquility before everything. (49-year-old Colombian female)

Some participants noted the difference in the lifestyle in the United States and their home country that contributed to elevated stress:

Table 2. Codes, Themes, and Definitions.

Code	Theme	Definition
Mental Power Fragility Stress	Definitions	Mental health as a pattern of thinking and the ability to manage stressful situations.
Food/Exercise Faith Positivity	Ensuring Mental Health	Protective health management techniques to maintain mental health
Family Support Social Connection	<i>Familismo</i> /Socialization	Fostering personal connections with others.
Judgment Language “I’m not crazy”	Stigma	Fear of perceptions of others or of judgment from health care provider
Acculturation Immigration	Acculturation Stress	Inability to understand and/or “fit in” to mainstream American society; feeling of being different.

Well I think that yes, because like I tell you, here is a routine country. So yes suddenly it feels as if one is like trapped in the routine, in the stress. (33-year-old Mexican female)

Mental Control. Similar to the ability to manage stress, many participants told us that mental health was dependent on not letting oneself become overwhelmed by a situation. Participants referred to mental health as a choice, dictated by one’s ability to control their own perceptions. For example, one participant described mental health as a decision rather than a state of being:

So, sometimes it is a question of not deciding that [things] are affecting you. So that it doesn’t affect you then. Because, well, yes, I think that it is a decision and you decide what affects you, and if not, well it isn’t going to affect you. (33-year-old Mexican female)

Another participant defined mental health as the ability to put things into perspective or to handle negative thoughts or experiences. He said,

There are people who drown in a glass of water. They have a little problem, and then they are repeating and saying it. And there are people who are weakened by nerves. And sometimes, there are people who have more control over themselves, and they know how to endure, they know how to cope with their problems. (59-year-old Mexican male)

Another said,

The mind is very powerful. If you just let yourself bear the problems like that, then you’re not going anywhere. (40-year-old Mexican male)

Ensuring Mental Health

Finding Balance. Participants identified a variety of ways that they maintained their emotional well-being to ensure that they had optimal mental health, including a holistic mind-body

approach. Although these aspects of health were discussed separately, participants noted that when each of these was in balance, mental health was possible. For example, one person told us that maintaining mental health meant “that the person is good in all five senses” (59-year-old Mexican male).

Physical–Emotional–Spiritual Health. Many participants told us that ensuring mental health entailed maintaining a healthy body, emotions, and spiritual connections. Participants commented on the importance of food to their culture, which contributed to feelings of physical health. An emphasis on making healthy food choices for themselves and their families emerged as a way to maintain mental health:

And I say that to have mental health there has to be a balance, beginning with from your health, eat well, eat healthy. (59-year-old Mexican male)

Participants ensured mental health by focusing on emotional well-being, which took the form of positive thinking and optimism. One participant said,

If you are a happy person, if you have the capacity to be able to think and to know that in your moment if you have some problem how to make the decision or how to get out of any issue that you have about any problem and all that. (52-year-old Mexican female)

Spiritual health was identified as part of mental health, and a reliance on faith emerged as a common practice. When one relied on their relationship with God, mental health was sustained, and participants found comfort in their spiritual beliefs and the community created by their religious practices. Prayer was a form of maintaining spiritual health, and thus, mental health. For example, a 40-year-old Mexican participant said: “And one has to overcome, but like I tell you, one needs God’s help a lot.” Another participant said that not relying on God may lead to poor mental health:

[Someone] lets themselves bear everything that happens and does not put it in the hands of God and because of that so much happens, because they just bear the problems that has happened to them. (40-year-old Mexican male)

Familismo/Socialization. For many, family or social connections played a large role in their ability to maintain mental health. The social support from close relatives or other persons in their lives contributed to a feeling of being able to talk through problems. Participants did not rely on professional or external help in times of poor mental health, but relied on their family and friends. Within social networks, people found comfort and a place to talk through problems. For example, many relied on friends and family for support:

Well, I speak for the model of my family. We talk, we dialogue, we converse. And speaking. I think that communication in the family is very important. (59-year-old Ecuadorian female)

Socializing was presented as a way to combat the potential isolation and loneliness, which may lead to mental health concerns. One said,

I have told my mom, "Go out, walk, go to a shopping center or go to the supermarket, look, take pictures with the snow, do whatever it is, but don't stay, don't shut yourself in, because this here returns you to—anxiety, everything, everything." (30-year-old Colombian male)

Stigma

Judgment. Overwhelmingly, participants told us that people who may need professional mental health services rarely seek care in the mainstream health system. This was related to a stigma or a sense that mental illness was often ignored for fear of others judging them or that they would be perceived as "crazy." One person said,

The bad thing is when the person does not accept it. They don't accept any opinion, or they keep saying, "No, no, I am fine. I don't have anything; I am not crazy." (59-year-old Mexican male)

Another echoed this:

I also think that there is like a bad idea, that, for example, many people in the Hispanic community if you say—or especially the men, if you say, "You need to go to the psychologist." [They say,] "Oh, I am not crazy." (39-year-old Mexican female)

Participants noted that the stigma existed in the person's desire not to be viewed as "crazy," and in a fear that the service provider or professional would judge them negatively:

More than anything, we don't go to that type of help out of fear, out of embarrassment that they are going to talk, that they are going to judge us. (33-year-old Mexican female)

Barriers to Care. Many participants told us about potential barriers to accessing professional mental health care, especially in the context of the immigration experience, including cultural barriers and the discomfort of talking to someone who did not understand their culture. Cost of care was another barrier, especially for those who do not have health insurance. The language barrier was the most commonly identified problem, and this was not mitigated by providing a Spanish interpreter:

It's not the same, because, you know, when you are about to cry or talk about what you feel, you speak it from your heart and so, when someone else is translating the words for you, you forget how you feel, you forget what you wanted to say. So, I totally believe it's better to have that same language when it comes to mental health so you can say what you're feeling. [English interview] (35-year-old Mexican female)

Acculturation Stress

Participants viewed the sources of poor mental health as part of a cultural context, situated in a desire to acculturate into the majority culture. This theme emerged as participants told us that they struggled to fit in or that they experienced loneliness and a feeling of not being accepted into the majority culture despite desires to belong. For some, this unease presented as a feeling of disorientation, but for others, this was more personal:

Feeling a little less than the native people here in the United States. I mean, I arrive, and I feel that they turned me around to look ugly. (45-year-old Mexican male)

Often, feelings of not fitting into the mainstream culture resulted in isolation and an awareness of loss resulting from the immigration experience. Those who immigrated to the United States and Montana for work opportunities relayed a feeling of sadness because of the lack of family support in this new country. One noted,

And more than anything, that the Latino community who is here, I mean, if they come here, it is because they are working, right? But they don't have any help from anyone. That is, here nobody has their family members. (30-year old Colombian male)

The acculturation stress was felt on many levels, owing to the number of differences between the mainstream culture and their home culture. For example, one participant discussed these differences in terms of the climate in relation to the social dynamic:

Because mostly in this place that we are in, here in Montana, it is completely different from where we come from. The majority of Latinos come from places that have warmer climates. And a more sociable environment too. For example, in my town, we are accustomed to everyone greeting you, everyone says to you,

“Hi, good morning. How are you?” You talk with a child just as with an adult or the elderly. You walk with anyone for a moment, and you get distracted. And those things don’t happen here. (43-year-old Mexican male)

Another echoed these thoughts:

It’s like isolation because, well, in winter there aren’t many activities, you are in your house, you go shopping for groceries, you go to the mall. But there aren’t many things to do outside. For example, I tried to learn how to ski, but no, it is very difficult, it makes me scared and I say, “No, I can’t.” I know that this is a nice sport for the American culture because it is a way to distract yourself and enjoy the winter. But as Hispanics, no, that is not given to us. (39-year-old Mexican female)

Discussion

We describe the perceptions of mental health among a sample of Mexican, Ecuadorian, Colombian, and Venezuelan immigrants living in a large, rural, border state. Despite the mix of nationalities and immigration experiences, common themes about mental health emerged. Most participants defined mental health in relation to stress—either in not having stress or in successfully managing stress. Mental wellness was described as a positive attitude, which helped participants meet challenges, be optimistic, and control anxiety (Matel-Anderson et al., 2019; Wurm & Benyamini, 2014; Zvolensky et al., 2016). The sense that the mind is in control of a mental health outcome, as expressed by participants, may be one of the factors contributing to the underutilization of mental health services. If the community believes a change in mindset can alter the presence of a mental illness, they may be more likely to attempt to alter thought patterns on their own rather than seek care from a professional.

Participants identified other ways they maintained their mental health, including a focus on the physical, emotional, and spiritual aspects of health. Other research has identified the holistic view of health in the body, mind, and spirit in Hispanic persons (Greder & Reina, 2019; Jurkowski et al., 2010). Faith can be a protective factor against mental distress (Curtin et al., 2019; Haney & Rollock, 2020). Positive religious experiences can buffer anxious thoughts and provide a sense of comfort in times of distress (Caplan, 2019), which was echoed in our findings. Religious attendance may mitigate some of the negative effects of acculturation stress in Mexican immigrant communities (Moreno & Cardemil, 2018).

Acculturation stress was not surprising especially given the homogeneous nature of this predominantly White rural state where the sense of being an outsider may be aggravated. Participants described the anxiety that results from attempting to integrate one’s own culture with that of the dominant group. While not all immigrants experience acculturation stress, it has been associated with poor mental health, overeating, substance abuse, and other negative health outcomes (Alamilla et al., 2020; Simmons & Limbers,

2019; Sirin et al., 2019). Participants highlighted some of the challenges they experienced integrating their home culture with that of the majority culture, particularly in relation to the routine nature of the United States and the differences in climate between Latin America and Montana.

The stigma of mental illness in the Hispanic population is well-documented (DeFreitas et al., 2018; F. R. Gonzalez, 2020) and is likely to contribute to underutilization of services. Although shame and a desire to not appear “crazy” contributed to underutilization of professional services, it did not prevent people in our sample from discussing mental health issues with one another. Indeed, the reliance on socialization and seeking support from both social and religious networks was a protective factor in our study. *Familismo* is often viewed as a protective factor in studies of mental health in Hispanics (Caplan, 2019; Corona et al., 2017; Piña-Watson et al., 2019). *Familismo*, a cultural value that emphasizes the role of the family, may provide an emotional support network that can extend beyond blood relatives and into other social connections (Flores et al., 2021). These connections can be capitalized upon by nurses and other health professionals attempting to address mental health in Hispanic populations.

Implications for Nursing

The interpersonal connection that nurses have with patients can benefit those experiencing negative mental health outcomes, and nurses participate in mental health screenings, support patients in adhering to treatment protocols, and act as emotional support when patients express their concerns (Hartley et al., 2020). Therefore, nurses who understand the perceptions of Hispanics may help reduce potential mental health disparities. Nurses and other mental health providers must seek to first understand the Hispanic culture and the variety of experiences with acculturation stress, as nationality, immigration experiences, and other factors influence its potential impact. Capitalizing on the importance of faith and the protective factors of socialization, mental health providers may be able to provide services within faith-based settings in a group context. The role of peer support in behavioral health has promising outcomes, particularly when members of the community are trained in providing behavioral health services (A. Gonzalez et al., 2021; Moon, 2021; Sternberg et al., 2019). Including families in appointments, with the patient’s consent, may increase the comfort level in the provider’s office (O’Mahony & Clark, 2018).

The pervasive stigma around mental health and seeking additional support must be addressed. Community education programs designed to normalize mental illness may help. Culturally tailored interventions, such as *telenovelas* or storytelling narratives designed for health education messages, have been successful in reducing stigma (Benuto et al., 2018; Unger et al., 2013). Improvement in providers’ cultural sensitivity may also increase service utilization, including the

involvement of natural healers or *curanderas* in mental health treatment (Marquez & Ramírez García, 2013).

Limitations

Although qualitative work is not meant to be generalized, some limitations of this research should be noted. The first is the sampling method. We sampled from a faith community, which may influence our results and overstate participants' reliance on faith. Moreover, while we attempted to include persons from various nationalities represented in the local Hispanic population, we do not have equal representation from all Latin countries. As with national trends, the majority of our sample was Mexican. The immigration and acculturation experiences of persons from different countries are likely to be different and influence perceptions on mental health and access to care. Finally, while our research team is comprised, in part, of persons from multiple Hispanic nationalities, we recognize our potential bias in the interpretation of our findings as integrated members of the dominant culture.

Conclusion

We present the exploratory findings as the first to examine this issue among Hispanic in a rural, new immigrant community. This study and others like it point to the need for mental health services tailored to the Hispanic community. Although participants identified a number of ways they maintain mental health, we highlight the need to address stigma to improve service utilization. Understanding the impact of acculturation stress on immigrants may provide opportunities for increased outreach and screening efforts. Nurses who are aware of the potential mental distress of the immigration and acculturation process will be better able to serve their patients.

Authors' Note

All relevant data are included in the manuscript.

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Supplemental Material

Supplemental material for this article is available online.

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