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Latino Immigrant Men's Perceptions of Depression and Attitudes Toward Help Seeking

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Perceptions of depression, attitudes toward depression treatments, help-seeking preferences, and perceived barriers to care were examined in a sample of 56 Latino immigrant men recruited from a primary health care clinic. Each participant was presented a vignette depicting an individual with major depression. Men described the vignette as a debilitating condition caused by social stressors that would improve with time. Men preferred counseling over medications and reported misconceptions about antidepressants. Faith in God and seeking help from family members were seen as important help-seeking strategies. Structural and financial barriers were prevalent among this sample of men. Implications for improving depression care for Latino immigrant men are discussed.

Keywords: *Latino immigrant men; depression; illness perceptions; attitudes toward depression treatments; help seeking*

It is estimated that about 6 million men suffer from depression each year in the United States and many do not seek professional care for this treatable medical condition (U.S. Department of Health and Human Services [USDHHS], 2001; Wang, Berglund, & Kessler, 2000). Latino immigrant men are especially vulnerable to not seeking timely mental health care for depression and, compared to non-Latino Whites, are less likely to receive

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guideline congruent care (Institute of Medicine [IOM], 2003). If untreated, depression leads to reduced functioning and quality of life and increased morbidity (World Health Organization, 2001). Little is currently known about how Latino immigrant men perceive depression and their attitudes toward help seeking.

Epidemiological studies of the U.S. general population have consistently found that women are 2 to 4 times more likely than men to be diagnosed with depression, yet men tend to report higher substance abuse than women and are 2 to 4 times more likely to commit suicide (USDHHS, 2001). Similar trends in the prevalence of these mental disorders have been reported in the U.S. Latino population (e.g., Centers for Disease Control and Prevention, 2004; Vega et al., 1998). These gender differences suggest that men may experience and express depressive symptoms differently than women (Rochlen, Whilde, & Hoyer, 2005). For example, men may be more willing to report fatigue, irritability, loss of interest in pleasurable activities, and sleeping problems rather than other common depressive symptoms, such as feeling sad, worthless, and excessive guilt (Cochran & Rabinowitz, 2000). Men also tend to externalize their depressive symptoms by becoming frustrated, discouraged, angry, and abusive (Cochran & Rabinowitz, 2000). These differences in symptom presentation may pose a challenge for clinicians to identify and diagnose depression among men (Rochlen et al., 2005). Substance use can mask depression among men. For some, the abuse of alcohol or drugs is used as a coping mechanism to self-medicate depressive symptoms and can distort the clinical picture making it harder for clinicians to recognize depression as a separate illness (Cochran & Rabinowitz, 2000; Möller-Leimkühler, 2002).

Men's perceptions and attitudes toward depression and its treatments as well as their help-seeking preferences are important factors that influence whether they receive timely and appropriate depression care. Men, particularly young adults (18 to 24 years old), are more likely than women to express more negative attitudes toward mental health treatments (Gonzalez, Alegría, & Prihoda, 2005) and are less likely to seek treatment for common health and mental health conditions, such as depression (Addis & Mahalik, 2003; Leaf, Bruce, Tischler, & Holzer, 1987; O'Brien, Hunt, & Hart, 2005). This trend in the underusage of mental health services seems to be more pronounced among Latino immigrant men and men from other racial and ethnic minority groups. Studies have found that after controlling for mental health needs, Latino men (e.g., Puerto Ricans, Mexicans, and Cubans) are less likely than Latina women to use mental health services from either the specialty mental health or general medical sectors (e.g., Peifer, Hu, & Vega,

2000; Pescosolido, Wright, Alegría, & Vera, 1998). These inequities in depression care for Latinos have been linked to structural and financial barriers (USDHHS, 2001). Other barriers to depression care include lack of knowledge about depression and its treatments, attitudes toward depression care, and not recognizing depression as a treatable illness (O'Brien et al., 2005; USDHHS, 2001). A small but growing number of studies examining Latino attitudes toward depression and other mental health treatments reveals that certain attitudes (e.g., being ashamed of discussing emotional problems with clinicians, not wanting to discuss emotional problems outside the family, believing that antidepressants are addictive, and endorsing self-reliant attitudes) may deter them from seeking mental health care (Alvidrez, 1999; Cooper et al., 2003; Givens, Houston, Van Voorhees, Ford, & Cooper, 2007; Ortega & Alegría, 2002). These attitudinal barriers have received little attention in the mental health literature and may provide new insights into the processes that create disparities in mental health care for Latino immigrant men.

There is a need to develop a better understanding of men's perceptions and attitudes toward depression and its treatments and their perceived barriers to care (Rochlen & Hoyer, 2005), particularly among Latinos and other men of color. This research has the potential to inform public health campaigns, community outreach activities, and provide clinicians with practical recommendations and strategies on how to engage Latino immigrant men into treatment. The present study used a mixed method design to describe Latino immigrant men's perceptions of depression, attitudes toward depression care, help-seeking preferences, and perceived barriers to care.

Methods

Sample

Data reported in this article come from a larger cross-sectional survey study of Latino immigrants recruited from a primary health care clinic in St. Louis, Missouri. Details about the sample and procedures of this larger study are reported elsewhere (Cabassa, Lester, & Zayas, 2007). Briefly, 152 consecutive Latino immigrants were approached at the clinic's waiting room and invited to participate in the study. A total of 130 participants (85%) were enrolled in the larger study. Ninety-five (74%) were current patients at the clinic and 35 (26%) were family members (e.g., spouse, partner) accompanying patients to their visits. A convenience sample of 56 Latino immigrant

men enrolled in the larger study was used for the present report. This sample of men was composed of both patients (n = 24) and family members (n = 32). No significant differences were observed in marital status, attendance at church, acculturation, depression, health status, and past service use for a mental health problem between these two groups. Male patients (M = 33 years old, SD = 13) on average were significantly older (t = –2.50, df = 54, p = .02) than male family members (M = 27 years old, SD = 5).

Procedures

All study procedures were approved by the Human Subject Committee of Washington University in St. Louis. Informed consent was obtained from all participants. A structured face-to-face interview that lasted on average 45 minutes was the main data collection method. A vignette adapted from the Mental Health Module of the 1996 General Social Survey (Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999) describing an individual meeting *DSM-IV* criteria for major depression was used to examine men's views of depression. Back translation techniques were used to translate the vignette into Spanish (Bravo, Woodbury-Farina, Canino, & Rubio-Stipec, 1993; Brislin, 1986). A prerecorded audiocassette was used to present the vignette. Men listened to the recording in their preferred language and the voice presenting the vignette was matched to respondents' sex. After listening to the vignette, respondents were presented with an array of measures described below.

Measures

Illness perceptions of depression. A modified version of the Illness Perception Questionnaire (IPQ-R; Moss-Morris et al., 2002) was used to assess men's perceptions of the vignette. Two open-ended questions (i.e., "What would you call the situation presented in the vignette?" and "What do you think caused this situation?") were used to measure men's views of the vignette. Interviewers recorded verbatim responses to these questions. A dichotomous variable (yes/no) was created to categorize whether the words *depresión* (depression) or *deprimido* (depressed) were used to describe the vignette. Twenty-one items derived from the IPQ-R were used to evaluate men's perceptions about how long the situation would last (e.g., acute, chronic, cyclical), their views about expected outcomes, and beliefs as to whether the situation could be controlled through treatment or personal efficacy. All items used a 5-point Likert scale, ranging from *strongly*

disagree to *strongly agree* and were translated into Spanish using back-translation techniques (Bravo et al., 1993; Brislin, 1986).

Attitudes toward depression treatments. Fourteen items from the short version of the Patients Attitudes Toward and Ratings of Care for Depression (PARC-D; Cooper et al., 2000) were used in the present study. This instrument measures primary health care patients' attitudes, beliefs, and knowledge of depression treatments using a 5-point Likert scale ranging from *strongly disagree* to *strongly agree*. A translated version of this instrument was made available by the developer (Andres Consoli, San Francisco State University, College of Health and Human Services, personal communication, June 2004).

Demographic characteristics. Demographic variables included age, marital status, years of education, and attendance at church or religious services.

Acculturation. The Bidimensional Acculturation Scale (BAS) for Hispanics (Marín & Gamba, 1996) was used to measure acculturation. Half of the items measures a Hispanic domain (Cronbach's alpha = .78); the other half measures a non-Hispanic domain (Cronbach's alpha = .88). If men scored high in the Hispanic domain and low in the non-Hispanic domain, they were categorized as low in acculturation. A bicultural indicator was created if men scored high on both domains.

Clinical characteristics. The Center for Epidemiological Studies Depression Scale (CES-D) (Radloff, 1977) was used to measure men's depressive symptoms. High scores in the CES-D indicated greater symptomatology. Items were summed and a cutoff point of 16 or greater was used to identify individuals who experienced depressive symptoms in the past 7 days. The CES-D in our study had good internal consistency (Cronbach's alpha = .88). General health status was measured with a single question asking men to rate their current health status on a 5-point Likert scale, ranging from *excellent* to *poor*.

Lifetime use of services for mental health problems. Men were asked to indicate whether they had ever visited a mental health specialist (e.g., psychiatrist, psychologist, social worker) and/or a general medical provider for a problem with their emotions, nerves, or mental health in their lifetime.

Help-seeking preferences. Men were asked to rank order their top three help-seeking preferences for dealing with the situation presented in the vignette from the following seven choices: (a) deal with the situation by themselves; or talk to a (b) family member; (c) friend; (d) priest, minister, or rabbi; (e) doctor; (f) psychiatrist; or (g) other mental health professionals (e.g., social worker, psychologist). This measure was adapted from Angermeyer, Matschinger, and Reidel-Heller (1999).

Perceived barriers to care. Men were presented with a list of 11 common barriers to care and asked to choose which of these situations prevented them from seeking mental health services in the previous 12 months. This list of access barriers was developed from previous pilot work and from a measure developed by Manos et al. (2001).

Analyses

Qualitative data generated from the responses to the open-ended questions included in the IPQ-R were analyzed using the methodology of "coding, consensus, co-occurrence, and comparison" (Willms et al., 1992), an analytical strategy rooted in grounded theory (Glaser & Strauss, 1967). Two raters (study author and a trained research assistant) working independently read and coded at a general level these open-ended responses. During this process, segments of text were assigned codes based on emergent themes. In some instances, the same text segment was assigned more than one code. Each rater wrote analytical memos describing emerging themes, defined coding labels, and provided examples using respondents' quotes to illustrate how codes were applied. Once raters coded all of the data, three meetings were held to discuss analytical memos, code descriptions, and resolve through consensus disagreements in code assignments. A codebook was then developed and applied to the entire data set. NVIVO 2.0 (Fraser, 2000) was used to assist in the management and analysis of qualitative data. Means, standard deviations, frequencies, and rates were used to describe sample characteristics, men's illness perceptions, attitudes toward depression care, help-seeking preferences, and perceived barriers to care.

Results

Sample Characteristics

The 56 immigrant men who participated in this study had a mean age of 30 years and were predominantly of Mexican origin (see Table 1). On average,

Table 1
Sample Characteristics ($n = 56$)

	M (SD)	%
Demographics		
Age (years)	30 (9.43)	
Years of education	10 (3.27)	
Married		36
Place of birth		
Mexico		80
Central America		14
Caribbean		5
South America		2
Attendance at church or religious services (once a month or more)		59
Acculturation		
BAS Hispanic domain score	3.40 (.34)	
BAS non-Hispanic domain score	2.12 (.52)	
Years living in the United States	5 (5.10)	
Low in acculturation		73
Bicultural		27
Clinical characteristics		
CES-D score	11.54 (8.95)	
CES-D score ≥ 16 and above		18
General health status (poor/regular)		21
Lifetime use of services for mental health problems		
Mental health professionals		14
General medical providers		14
Nonprofessional providers		14
Identification with the vignette		
Imagine experiencing a similar situation		73
Know of family member or friend who has experienced a similar situation		38
Experienced themselves a similar situation		57
Had felt this way in the past		73
Currently feeling this way		27

Note: Central America = Honduras, Guatemala, and El Salvador; Caribbean = Puerto Rico and Cuba; South America = Bolivia, Perú, and Venezuela.

most men had lived in the United States for 5 years. One fourth of the men in this study were categorized as bicultural, indicating that they were proficient in English and Spanish. Eighteen percent reported significant levels of current depressive symptoms (CES-D ≥ 16) in the previous 7 days, and 21% rated their general health as poor/regular. Past service use for a mental health problem among this sample was low. The majority of men identified themselves with the situation presented in the vignette.

Illness Perceptions

Thirty-nine percent of men used the word *deprimido* or *depresión* when talking about the vignette. Common symptoms of depression were used to describe the vignette, as exemplified by the following quote.

> *Pues se encuentra muy triste, tiene como una depresión. No quiere hacer nada. No quiere hablar con nadie. . . . Pues que se siente inútil, sin ganas de trabajar. No quiere hablar con nadie. Se siente cansado.*
>
> He is sad, he has like a depression. He doesn't want to do anything. He doesn't want to talk to anyone. . . . He feels worthless, without the will to work. He doesn't want to talk to anyone. He feels tired.

Depression was characterized by a constellation of symptoms and situations that engulfs the individual and chips away at their hope and self-esteem. In the middle of these issues, the individual feels trapped and cannot seem to find solutions to the problems and pressures confronted in their everyday life.

The most prevalent causes attributed to the vignette are presented in Table 2 along with illustrative quotes. These causes were not mutually exclusive and the majority of men endorsed multiple causes. Interpersonal problems related to the disruption of romantic or marital relationships were frequently mentioned as causal factors. These problems encapsulated issues of infidelity, breakups, separation, and divorce and were viewed to have an impact on the person's well-being. Economic strains were another common cause linked to the vignette. For some, the vignette described a man who is having a hard time making enough money or finding a job to financially support his family. These pressures were seen to exert a burden in the man's life creating the conditions for feeling depressed. *Sin apoyo* (lack of support) was also mentioned as a causal factor. This theme included issues of feeling or being alone, being away from their family, and lacking a supportive emotional system to cope with stressful situations. Some described the individual depicted in the vignette as someone who lacked a trusting friend or family member they could talk to about their problems.

Physical illnesses and substance abuse were linked to the situation presented in the vignette. Having an incurable or serious medical illness, such as HIV/AIDS or cancer, was seen as a contributing factor to depression. The abuse of alcohol or drugs as a failed coping mechanism to deal with family or economic problems was linked to the experience of depression.

Table 2
Causes Attributed to the Vignette ($n = 56$)

Cause	*N* (%)	Illustrative Quote
Interpersonal problems	27 (48)	*Algo muy mal que debe haber hecho. Como haberse metido con otra mujer y no se lo quiere decir a su mujer [Entrevistador: ¿Algo mas?] . . . algo trae entre manos. Algo esta pasando fuera de la casa, tiene otra mujer.* He probably did something very bad, like being with another woman and he does not want to tell his wife. [Interviewer: Anything else?] . . . he has something under his sleeve. Something is going on outside his home, he has another woman. *Cuando lo deja la novia, se desanima se siente sin ganas de vivir.* When your girlfriend leaves you, you feel dejected you feel you don't want to live.
Economic strain	14 (25)	*Problemas con el dinero. No tener suficiente dinero para poder sacar adelante a su familia.* Money problems, not having enough money to move one's family ahead.
Sin Apoyo (lack of support)	13 (23)	*Esta solo, sin familia. No tener amigos.* He is alone, without family. He does not have friends. *No tiene a nadie, no tiene la confianza de hablar con otras personas, por eso piensa de esta manera.* He does not have anyone; he doesn't have the confidence to talk to other people, that's why he thinks this way.
Physical illness	11 (20)	*Una enfermedad que no tiene cura.* An illness that has no cure.
Substance abuse	11 (20)	*Toma cerveza para alejarse un poco . . . de la realidad, de los problemas de trabajo.* Drinks beer to escape a little . . . from reality, from problems at work.
Immigrant pressures	9 (16)	*Llego con muchas ilusiones y se topo con una situación que no puede salir adelante por sus cuentas, no tener trabajo . . . todo esto lo desanima.* He came with many hopes and was confronted with a situation he could not move ahead because of many bills and being unemployed . . . all of this makes him feel dejected. *[Entrevistador: ¿Que causo esta situación?] No saber hablar ingles y no poder hablar el idioma. No es*

lo mismo saber el idioma que te lo estén traduciendo. No saber el idioma te sientes frustrado, te siente alejado.

[Interviewer: What caused this situation?] Not knowing how to speak English and not knowing how to speak the language. It is not the same when you know the language than when someone translates for you. Not knowing the language, you feel frustrated, you feel isolated.

Note: Causes are not mutually exclusive, therefore *n* exceeds 56 and percentages add up to greater than 100.

Lastly, certain conflicts and pressures experienced by Latino immigrant men, such as being way from family members, feeling they have not fulfilled their financial obligations, and language barriers, were identified as causal factors. Some talked about how a push-and-pull tension in which they felt torn between having to work in a different country far away from their loved ones and wanting to be close to them may contribute to the situation in the vignette. Other men mentioned how not being able to meet financial obligations, such as securing a stable employment, having a steady income, making enough money to support themselves in the United States, and sending money back home to support their families, contributed to feeling depressed. Lastly, not knowing the language, having to rely on others to communicate could cause men to feel alone and disconnected.

Responses to the IPQ-R indicated that most men did not perceive the situation in the vignette as a chronic condition. Fifty-five percent *strongly disagreed* or *disagreed* that the situation would be permanent rather than temporary and 70% *strongly disagreed* or *disagreed* that the situation would last for the rest of his life. The majority of men (88%) *agreed* or *strongly agreed* that it would improve with time. However, men seemed ambivalent as to whether the situation in the vignette was an acute condition. Forty-one percent neither *agreed* nor *disagreed* that the situation would last a short time, whereas 46% thought that the situation would pass quickly.

Men's opinions about the cyclical nature of the situation were inconsistent. On the one hand, some men *agreed* or *strongly agreed* that the situation changed a great deal from day to day (57%), that it was very unpredictable (43%), and went through cycles in which it got better and worse (45%). On the other hand, men's views about whether the symptoms depicted in the

vignette came and went in cycles were almost evenly split between those who *strongly disagreed* or *disagreed* (32%), those who were ambivalent (34%) and those who *agreed* or *strongly agreed* (34%) with the statement.

Most men viewed the situation in the vignette as a serious condition that affected many aspects of a person's life. The majority *agreed* or *strongly agreed* that the situation was a serious condition (79%), had major consequences on his life (82%), had serious financial consequences (59%), and caused difficulties for those close to him (75%). The majority of men felt that the situation was amenable to personal and treatment control. Most men *agreed* or *strongly agreed* that there was a lot that could be done to control these symptoms (91%), and that ones actions determined whether the situation got better or worse (80%). Most men also reported that treatment would be effective in curing the situation (88%), that the negative effects of the situation could be prevented by treatment (82%), and that treatment could control the situation (86%).

Attitudes Toward Depression Care

The majority of men reported they trusted that doctors act in their best interest (93%) and felt doctors listen to them (98%). Most men reported a preference toward counseling over antidepressants. Ninety-three percent *agreed* or *strongly agreed* that counseling restored depressed individuals to their normal level of functioning, whereas only 54% reported the same attitudes toward antidepressants. Similarly, 79% reported they *agreed* or *strongly agreed* that counseling would help depressed individuals just as much as antidepressants. Items about attitudes toward antidepressants had higher ambivalent answers (i.e., neither *agreed* nor *disagreed*) than the ones related to attitudes toward counseling, suggesting men's opinions about counseling were stronger than for antidepressants. Misconceptions about antidepressants were common. Sixty-one percent *agreed* or *strongly agreed* that antidepressants were addictive and 41% had strong convictions that they made people feel drugged. Both of these items also had substantial ambivalent answers (29% and 31%, respectively).

Most men showed confidence about their expectations and knowledge of depression treatments. Forty-six percent felt they knew what to expect from treatment and more than half (52%) felt they had enough information to cope with depression. Most men *agreed* or *strongly agreed* that faith in God would heal depression (79%) and that asking God for forgiveness would help heal depression (68%). Lastly, when queried about their access to care, 39% reported that they could not afford depression treatments.

Seventy-nine percent felt their health insurance would not cover the costs of depression care.

Help-Seeking Preferences

Few men reported dealing with the situation presented in the vignette by themselves without anyone's help (13%) or ranked formal sources of help (18%) as their first help-seeking choice. Their first choice was to rely on informal sources of help (70%), particularly family members. Their second choice was split between informal sources (52%), mostly friends, and formal sources (48%), mostly other mental health professionals (e.g., social worker). The third choice was also evenly split between informal (48%) and formal (46%) sources of help relying again on family members and other mental health professionals. Few men picked their doctors or a psychiatrist as sources for help.

Perceived Barriers to Mental Health Care

Table 3 presents Latino immigrant men's perceived barriers to mental health care. Financial barriers, such as lack of health insurance and inability to pay for services were the most prevalent barriers endorsed followed by language problems and lack of knowledge of where to seek services. Other barriers included not being able to take time off work, long waiting times at clinics, and being fearful of seeking services because of immigration status.

Discussion

Many of the men in this study had personal experiences with depression. However, only 39% labeled the vignette as depression. This finding suggests that public health campaigns and community outreach activities are needed to raise Latino immigrant men's awareness about the common signs and symptoms of depression. These efforts can help empower Latino immigrant men with the necessary information that will enable them to make informed decisions about how to identify depression and their options for treatment.

The majority of the men in this study described the vignette as depicting an individual experiencing an array of life stressors. External stressors (e.g., interpersonal problems, economic strains) were seen as the main causal factor for depression. For many, the experience of depression was rooted in social problems associated with their everyday life and not with chemical imbalances or other biological mechanisms. Discussions about causes of

Table 3
Perceived Barriers to Mental Health Care ($n = 56$)

Perceived Barriers	%
Lack of health insurance	73
Inability to pay for services	64
Language problems	63
Do not know where to seek services	57
Not being able to take time off work	50
Long waiting times at clinics	43
Fearful of seeking services because of immigration status	41
Operating hours of services not convenient to patients	36
Child care	24
Not having someone to accompany you to the appointment	23
Lack of transportation	11

Note: Perceived barriers are not mutually exclusive, therefore percentages add up to greater than 100.

depression revealed that men did not attribute depression to one salient social problem but instead depression was seen to arise from a constellation of interrelated events that affected men's moods, behaviors, and coping capacities. The inability to effectively cope with these mounting stressors was seen to be a key feature of depression. Treatments, such as problem-solving therapy (Nezu, Nezu, & Perri, 1989), aimed at the acquisition of problem-solving skills to cope and manage with life stressors may be an appropriate approach to treat depression among Latino immigrant men.

Men in this study did not perceive the vignette as a chronic long-lasting condition and were ambivalent as to whether this was an acute or cyclical situation. They viewed depression as a serious debilitating condition that would improve with time and could be controlled through either personal efficacy or treatment. These findings suggest that some Latino immigrant men hold complex views of depression that may shape and influence their coping and help-seeking behaviors and may be at odds with clinicians' medical model of depression. Studies have demonstrated that the quality of care a patient receives may be compromised when patients and clinicians have dissimilar interpretations of the disease being treated (e.g., IOM, 2003). Clinicians treating Latino immigrant men for depression should consider actively eliciting perceptions about the causes, course, consequences, and perceived controllability of the illness. Clinicians can use these perceptions to negotiate and develop a treatment plan that is congruent with men's views of their depression. For example, if a Latino man views his

depression as linked to interpersonal troubles, the clinician can then formulate a treatment plan that addresses these interpersonal problems through interpersonal or family therapy as a choice for treatment.

Consistent with previous studies (e.g., Cooper et al., 2003; Dwight-Johnson, Sherbourne, Liao, & Wells, 2001), Latino immigrant men in the present study preferred counseling over medications. Men also reported serious misconceptions about antidepressant medications believing that these agents were addictive and made people feel drugged. These negative attitudes can prevent Latino immigrant men from seeking help and talking to their doctors about their depression. Deficiencies in clinician–patient communications, particularly not providing patients with information about depression and its treatments, are linked to Latinos nonadherence to antidepressant medications and may contribute to their premature termination of depression treatment (Sleath, Rubin, & Huston, 2003). To address these negative attitudes and improve treatment adherence among Latino patients, Lewis-Fernández, Das, Alfonso, Weissman, and Olfson (2005) recommend that clinicians explore patients' explanatory models of their illness, assess the social and financial barriers to adherence, discuss and help mitigate patients' fears and concerns about treatment, and use therapeutic contracting and playback to assess patients' understanding of their illness and treatment plan.

Latino immigrant men in this study had a strong conviction that their faith in God could help them cope with depression. More work is currently needed to understand the religious beliefs and practices that help Latino immigrant men cope with life stresses and emotional problems and how they interact with other forms of depression treatments.

Men also reported an array of structural and financial barriers that prevented them from seeking mental health care in the past 12 months. This finding is expected given that the study was conducted at a community health clinic serving mostly uninsured, low-income Latino immigrant families and reflects the lack of medical and financial resources available to the members of this community. Structural and financial barriers prevent many racial and ethnic minorities, particularly those who are poor and recent immigrants, from seeking and accessing mental health services (USDHHS, 2001). Increasing health care coverage among Latino immigrants, integrating primary health care and mental health services, and supplementing mental health care with case management services are some of the strategies that have been proposed to help reduce racial and ethnic disparities in access to mental health services (USDHHS, 2001).

Help-seeking preference findings suggest that Latino immigrant men begin their search for care within their own social networks (i.e., family members)

and then expand out to formal services. Social networks may exert an influential role in how Latino immigrant men cope with distress and can facilitate pathways that lead to the use of formal mental health care (Rogler & Cortes, 1993). But they can also delay and/or discourage the use of formal services (Pescosolido et al., 1998). To understand the influence that social networks have on Latino immigrant men's pathways to services, factors within the social network, such as their attitudes and beliefs about mental health and its treatments, knowledge of where to seek services, and financial resources and the involvement that network members have with different community organizations, need to be directly studied (Pescosolido, 1991, Rogler & Cortes, 1993).

Findings from this study must be interpreted in light of several limitations. Results may not be generalizable to other Latino immigrant men because the men who participated in this study were not randomly selected, came from one community primary health clinic serving predominantly low-income Latino immigrants, and were geographically confined to St. Louis, Missouri. The vignette methodology employed in this study provides an approximation of how men perceive and react to a hypothetical scenario that may not correspond to how they will react if they were experiencing depression.

Given the paucity of studies examining depression among Latino immigrant men, more research in this area is greatly needed. Future studies can draw more representative samples of the diverse Latino population to examine within group differences and similarities in depression rates and risk factors. Perceptions and attitudes are not fixed, instead they are transformed by the experiences individuals have through the course of their illness (Williams & Healy, 2001). Prospective studies that capture these changes can provide a better understanding of how these perceptions, attitudes, and preferences evolve over time and how they interact with other barriers to care to shape help-seeking and mental health service use. Understanding Latino immigrant men's experiences with depression as well as their perceptions and attitudes can inform the development of culturally tailored interventions aimed at dispelling misconceptions about treatment, reduce stigma, improve treatment engagement and adherence, and lead Latino men in need of mental health care toward recovery.

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