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ORIGINAL PAPER

Understanding Service Utilization Disparities and Depression in Latinos: The Role of Fatalismo

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Abstract Research demonstrates a disparity between need and utilization of mental health services for Latinos. Cultural variations in perceptions of mental illness may be partially responsible for this discrepancy. Past research with Latinos has shown links between fatalismo, a cultural value similar to external locus of control, and both depression and lower service utilization in medical care, while links to psychiatric care have not been investigated. The current study therefore aimed to explore the associations between fatalismo, depression, and past year mental health service utilization by Latinos. A community sample of 83 Latino adults were recruited during local cultural events. Participants completed self-report measures of depression, fatalism, and past year service utilization. Analyses using structural equation modeling showed fatalismo was directly negatively related to past year medical service utilization ($\beta = -.35$). In contrast, the link between fatalismo and past year mental health service utilization was mediated by self-reported depressive symptoms (indirect $\beta = .19$, $p < .001$). We conclude that while fatalismo is associated with depression in Latinos, other barriers likely serve as more salient deterrents of service utilization.

Keywords Fatalismo · Latino mental health · Health disparities · Service utilization

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Background

Research has repeatedly demonstrated underutilization of mental health services by Latinos [1, 2]. Keyes et al. [3] found strong Latino ethnic identity and Spanish linguistic preference were linked with lower service utilization for Latino adults, even after controlling for disorder severity, time spent in the U.S., and age of immigration. This strong association between Latino ethnic identity, Spanish linguistic social preference, and low service utilization was extended to depression: A study by Alegría et al. [1] indicated 63.7 % of Latinos diagnosed with a depressive disorder in the past year did not utilize any mental health care services. Similarly, Lagomasino et al. [4] found that in managed primary care clinics, Latino patients experiencing depressive symptoms were less than half as likely as Whites to have received any depression care (i.e., antidepressant medication or specialty counseling) in the prior 6 months, even after controlling for other sociodemographic and clinical differences.

Some barriers to service utilization that Latinos experience are rooted in situational factors. For example, potential legal and social consequences of seeking mental health services, such as fear of deportation or social isolation, may discourage help seeking [5]. Limited access to health insurance, resulting from lower rates of full-time employment for Latinos compared to other ethnic groups, may be partially responsible as well [5, 6]. Kouyomdjian et al. [7] posit that cultural differences in beliefs and values may also play a role in service utilization disparities for Latinos, as perceptions of causes and viable solutions for mental health problems vary across cultural groups. It is likely that a reciprocal relationship exists between situational barriers and health beliefs, such that situational barriers influence and

reinforce health beliefs, while health beliefs also shape responses to these barriers.

Theoretical Framework

The Health Belief Model [8], adapted for mental health service utilization by Henshaw and Freedman-Doan [9], may help organize the myriad factors that relate to mental health service utilization in Latinos. The HBM proposes that demographic factors influence perceptions of illness threat (i.e., perceived susceptibility to and severity of mental health problems) and treatment expectations (e.g., the pros and cons of seeking care; self-efficacy to change), which in turn affect mental health care utilization.

The adapted HBM highlights the role of treatment expectations as a mechanism through which demographic variables, such as ethnicity, influence mental health care behaviors [9]. According to Kouyoumdjian et al. [7], mental health care may be perceived as culturally insensitive or simply ineffective by Latino families, which could be reinforced when Latinos who do utilize mental health services receive inadequate care.

Fatalismo and Service Utilization

Fatalismo (fatalism), a Latino cultural construct similar to external locus of control, emphasizes belief in the limited control of the individual over life events. *Fatalismo* is often associated with attributing explanations for events to a higher power, destiny, or luck [10]. Religiosity is often included in definitions of *fatalismo* (e.g. [10, 11]); Neff and Hoppe [12] described fatalism and religiosity as complementary personal and social resources. Strong adherence to fatalistic beliefs has been linked to high levels of psychological distress in general, and with depression in particular.

A clear distinction between *fatalismo* and external locus of control cognition is lacking in the literature; it is possible that fatalism may be comprised of multiple dimensions, something that has not been addressed by research. Typically, descriptions of *fatalismo* in research refer to inevitability and mastery components as representing external and internal locus of control, respectively [13]. However, Levenson [14] identified three dimensions of locus of control (one of which was internal and two of which were external): internality, powerful others, and chance. Levenson's research suggests external locus of control may be of two varieties: the belief that the world is completely chaotic and things happen entirely by chance, or the belief that the world is controlled by powerful others and one's ability to act willfully may be impeded in part by these external, but not random, forces. A commonly used unidimensional measure of *fatalismo*, the *fatalismo* subscale of the Multiphasic Assessment of Cultural Constructs-Short Form (MACC-SF), contains items that suggest the presence of both powerful others and chance perspectives on personal control. Furthermore, Roncancio et al. [15] found cancer fatalism was positively associated with health care provider control expectations, which could translate into *higher* service utilization rates for those with higher fatalism compared to those with low fatalism. Therefore, *fatalismo* may be thought of as sometimes promoting and other times inhibiting help-seeking behavior.

Research examining the relation between *fatalismo* and Latinos' help-seeking has been done in the medical health care domain. Espinosa de los Monteros and Gallo's [16] systematic review found *fatalismo* was inversely linked to cancer screening in 64 % of studies with Latina participants, after accounting for structural barriers. Although this systematic review provides preliminary evidence that *fatalismo* may be linked to lower service utilization, findings were mixed and fatalism was assessed with a wide variety of measures. This may be due to the complicated nature of the relationship between fatalism and help-seeking, as several qualitative studies have noted the coexistence of fatalism and agency in health care beliefs and behaviors [17–19]. For example, one such study found that women never discussed fatalism without also mentioning beliefs about self-efficacy in health care behaviors [17]. Bell and Hetterley [18] described fatalism as a way for infertile women to retain some control over their situation by choosing not to seek alternative methods for conception. Although researchers have hypothesized a negative association between *fatalismo* and mental health care utilization, no studies have specifically explored this prediction [7].

Study Aims

The present study examined the associations between *fatalismo*, depression threat perception, and medical and mental health care utilization in a Latino sample. The value in focusing on the role of *fatalismo* lies in its modifiability; studies have shown that experimental manipulations alter participants' control perceptions [20]. The adapted HBM includes recommendations to center psychological interventions on increasing understanding of mental illness susceptibility, symptom severity, therapy benefits; and decreasing perceived barriers to treatment [9].

This study intended to fill gaps in our understanding of the underlying processes that lead to lower mental health service utilization for Latinos. The first aim was to replicate research indicating a link between *fatalismo* and depression in Latino adults. Second, this study sought to examine how *fatalismo* relates to medical and mental health care utilization. We hypothesized that Latinos who more strongly endorse *fatalismo* would be more likely to

report personal depressive symptoms. We also hypothesized that there would be a similar negative relation between *fatalismo* and rates of service utilization in Latino adults [16].

Methods

Data Collection

Latino heritage participants were recruited by bilingual research assistants from a booth at a local cultural festival. Individuals were recruited from the study if they identified as Latino and said they were the parent of a child between the ages of 6 and 12. Recruitment was passive, as prospective participants approached researchers at a booth at local cultural events, and no record was made of participants who expressed interest in participating but did not meet inclusion criteria for the study. Measures were distributed in English or Spanish, at the participant's preference. Participants completed the Brief Symptom Inventory 18 (BSI-18), the affective problems scale of the Child Behavior Checklist, the *fatalismo* subscale of the Multiphasic Assessment of Cultural Constructs-Short Form (MACC-SF), and the Service Utilization Interview (SUI) [13, 21–23]. Only data from the following measures were used for the current study: the depression subscale of the BSI-18, the fatalism subscale of the MACC-SF, and the SUI [13, 21, 23]. Participants required about 20–30 min to complete self-administered questionnaires. Debriefing with participants after the study was completed consisted of a verbal description of study aims and implications, as well as provision of a handout with psychoeducation about depression. They were provided with a list of local resources for mental health services and received $10 compensation for participating in the study. This research was approved by the Institutional Review Board at the University of Arkansas.

Measures

In addition to answering demographic questions, participants reported on their depression, *fatalismo* beliefs, and past year service utilization for mental health problems. The depression subscale of the BSI-18 was used to evaluate past week depressive symptoms [21]. The depression subscale includes six items, such as "feeling blue" and "feeling no interest in things," which are assessed on a 5-point Likert scale ranging from 0 (*not at all*) to 4 (*extremely*). It has been shown to have good internal consistency reliability ($\alpha = .84$; [24]). Andreu et al. [25] found the Spanish version of the depression subscale of the BSI-18 had good internal consistency reliability ($\alpha = .88$), test–retest reliability ($\alpha = .82$), and convergent validity with the Beck Depression Inventory ($r = .83$) in a sample of people seeking outpatient psychological services in Spain. In the current study, the depression subscale of the BI-18 had good internal consistency ($\alpha = .80$).

Participants were asked to complete the *fatalismo* subscale of the MACC-SF [13]. The fatalism subscale contains eight true or false items. "True" items are summed to form a total score that ranges from 0 to 8. Higher scores indicate higher fatalistic beliefs. The authors found internal consistency reliability of .63 for the subscale [13]. In the current study, the internal consistency reliability for the *fatalismo* subscale was $\alpha = .64$.

The SUI [23] was used to assess past year help seeking for mental health concerns. This semi-structured interview assesses multiple types of service utilization, including seeking services from mental and medical health professionals, religious leaders, occupational therapists, and spiritual healers. For each type of service, information is solicited regarding frequency of utilization, reason for seeking services, and satisfaction with the services received. Any participant who endorsed having utilized a medical or mental health service for a psychiatric difficulty in the past year was coded as "yes" in two dichotomous service utilization variables. Bridges et al. [26] found medical service utilization rates, as assessed by the SUI, were significantly associated with current psychiatric diagnoses of Major Depressive Disorder, Generalized Anxiety Disorder, or Posttraumatic Stress Disorder in a sample of primarily immigrant Latino adults.

Analyses

Descriptive statistics and measures of bivariate associations (Pearson correlation coefficients, point-biserial correlations, and phi coefficients) were computed for all study variables using SPSS v. 21 (shown in Tables 1, 2, respectively). Structural equation modeling using AMOS v. 18 was used to explore study aims. While we considered using hierarchical logistic regressions, we instead opted for structural equation modeling because it permits the parceling out of error variance associated with measuring *fatalismo* and depression. Goodness of fit was assessed with the Chi square statistic (χ^2), the comparative fit index (CFI), and the root mean square error of approximation (RMSEA). Data were explored to determine that assumptions required for the study analyses were met. Histograms suggested significantly positively skewed distributions for adult depression. As analyses using transformed variables showed a similar pattern of results, the original data are reported. Examination of factor loadings revealed one item on the *fatalismo* subscale (*When I make plans, I am almost certain I can make them work*) did not load significantly on the factor; therefore, the item was removed.

Table 1 Means and percentages for demographic study variables

	n	*M* (*SD*)	% of respondents
Age	79	36.35 (6.83)	
Years in US	79	16.78 (7.44)	
Number people in household	82	4.73 (1.31)	
Number of children	83	2.87 (1.09)	
Religiosity (Likert 1–5)	73	3.36 (1.31)	
Gender	83		
Female	68		81.9
Male	15		18.1
Born in the US	81		
Yes	6		7.2
No	75		92.6
Country of origin	66		
Mexico	54		65.1
El Salvador	10		12.0
Guatemala	1		1.2
United States	1		1.2
Language of completed measures	83		
Spanish	45		54.2
English	31		37.3
Both languages	7		8.4
Marital status	82		
Married	59		71.1
Divorced/separated	11		13.3
Never married	8		9.6
Other	4		4.8
Employment	81		
Full-time	32		38.6
Part-time	13		15.7
Homemaker	29		34.9
Unemployed	7		8.4
Education	77		
Less than high school diploma	34		41.0
High school diploma	22		26.5
Some college	15		18.1
Bachelor's degree	4		4.8
Graduate degree	2		2.4
Religion	13		
Catholic	11		13.3
Baptist	2		2.4
Evangelical	1		1.2

Percentage values may not add up to 100 due to missing data and category overlap for some response items

Results

Participants were 83 Latino adults, ranging in age from 22 to 59 years ($M = 36.35$, $SD = 6.83$). Eighty-two percent were female; 71 % were married; 39 % were employed full-time and 16 % employed part-time; 35 % were homemakers. Many (41 %) participants had not completed high school; 27 % earned a high school diploma; and 18 % had attended some college. Only 7 % had earned a college degree. In terms of birth region, 93 % were born outside of the United States, primarily in Mexico ($n = 54$) and El Salvador ($n = 10$). The average time spent in the U.S. for foreign-born participants was 16.78 years ($SD = 7.44$). About half (54 %) of participants completed the study measures in Spanish.

Bivariate analyses of association (Table 2) revealed that fatalism was positively related to depressive symptoms and

Table 2 Descriptive statistics and bivariate associations for study variables

	1	2	3	4	5	6	*M* (*SD*) or *N* (%)
1. Female gender[a]	–						68 (81.9 %)
2. Age, in years[b]	−.25*	–					36.35 (6.83)
3. Religiosity[c]	−.25*	.20	–				3.3 (1.31)
4. Depression[d]	.13	.04	.19	–			5.39 (5.02)
5. Fatalismo[a]	<.01	−.14	.01	.33**	–		4.19 (1.98)
6. Past year medical service utilization[e]	.18	.03	−.17	.01	−.24*	–	40 (48.2 %)
7. Past year mental health service utilization[e]	−.01	.11	.17	.27*	.06	.09	6 (7.2 %)

* $p < .05$; ** $p < .01$

[a] 83 total respondents

[b] 79 total respondents

[c] 73 total respondents

[d] 82 total respondents

[e] 78 total respondents

inversely related to utilization of medical health services in the past year. *Fatalismo* was not associated with sex, age, religiosity, or use of mental health services in the past year. Depressive symptoms were positively associated with mental health service utilization in the past year, but were not related to sex, age, religiosity, or use of medical health services in the past year. The structural model examining *fatalismo,* depression, and service utilization provided good fit to the data; $\chi^2(83) = 97.47$, $p = .132$, CFI = .94, RMSEA = .05 (90 % CI .00–.08), explaining 23.9 % of the variance in depression, 12.5 % of the variance in past year mental health service utilization, and 9.1 % of the variance in past year medical service utilization (Fig. 1).

Our first hypothesis was that we would replicate previous findings showing a link between *fatalismo* and depression. As seen in Fig. 1, the standardized path between two factors was significant ($\beta = .49$, $p = .014$), providing support for our prediction.

Our second hypothesis was that *fatalismo* would directly and negatively relate to past year medical and mental health service utilization. We found support for a direct role of *fatalismo* in medical service utilization ($\beta = -.35$, $p = .049$) in the hypothesized direction. However, *fatalismo* did not have a significant direct contribution to past year mental health service utilization ($\beta = -.12$, $p = .469$); instead, *fatalismo* and mental health service utilization were indirectly related, via associations with depression (indirect $\beta = .19$, $p < .001$).

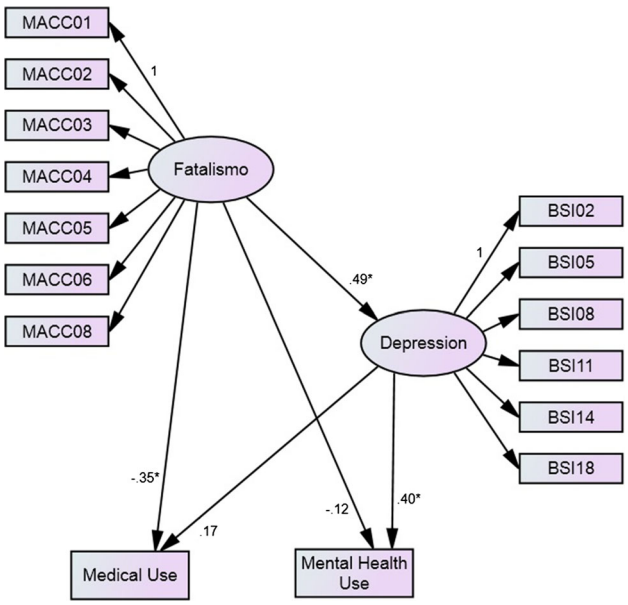

Fig. 1 Structural model predicting past year mental health and medical service utilization from fatalismo and depression.*$p < .05$

Discussion

The current study sought to examine the relations between *fatalismo*, depression, and help seeking for mental health problems in Latinos. Consistent with the HBM, study results showed *fatalismo* was related to increased depressive symptoms. *Fatalismo* significantly and directly predicted past year medical service utilization; however, *fatalismo* did not directly predict past year mental health service utilization, suggesting other factors may play a more influential role in determining mental health care help seeking in Latino adults. Instead, the link between *fatalismo* and past year mental health care use was mediated through depression.

The hypothesis, which stipulated higher *fatalismo* would be linked with greater depression, was supported by current study findings. These results are consistent with past research showing a positive association between fatalism and

depression [12]. Although the study design did not allow for analysis of the temporal ordering of the relation between *fatalismo* and depressive symptoms, it is probable that cultural values (i.e., fatalistic beliefs) are developed prior to the onset of depressive symptoms. Consistent with research demonstrating an association between external locus of control and depression, one possibility is that a strong belief in the limited control of the individual over life events may enhance a person's feelings of helplessness when difficult life events occur, thereby enhancing depressive symptom development, severity, and longevity [27]. On the other hand, these fatalistic beliefs may be a result of challenging circumstances posed by situational barriers faced by Latino immigrants, such as limited employment opportunities and low English proficiency. In addition, the present-focused nature of *fatalismo* may highlight the discomfort of present difficulties, cast doubt on the likelihood of future improvement, and discourage behaviors that could ameliorate depressive symptoms (e.g., behavioral activation), thus resulting in greater depressive symptoms. *Fatalismo* may reduce not only attempts to cope with depressive symptoms, but also the ability to do so effectively [28]. Another possibility is that individuals who adhere strongly to fatalistic beliefs may be more likely to perceive they have depressive symptoms, even if they are not truly experiencing more symptoms, than individuals who show low adherence to fatalistic beliefs. While *fatalismo* appears to be specifically linked to greater depression, some researchers have suggested it can also function as a coping mechanism for managing uncertainty and stress in the face of health concerns [17]. Future research implementing a longitudinal design and incorporating behavioral indicators or collateral reports of depressive symptoms could help disentangle perceptions of depressive symptoms from true symptomatology and provide further insight into the direction of the relation between depression and *fatalismo*. Inclusion of variables assessing situational barriers may enhance clarity regarding potential origins or moderators of *fatalismo*.

While study analyses revealed *fatalismo* did not significantly predict mental health service utilization, they did suggest a link between *fatalismo* and reduced likelihood of personal use of medical services in the past year. This finding is consistent with past research suggesting *fatalismo* may be inversely related to medical service utilization [16]. Additionally, certain barriers may be larger deterrents for seeking mental health services than for medical health services, such as the higher stigma associated with mental health conditions. If medical problems are perceived as more severe than mental health problems, individuals may be more willing to risk financial or legal consequences to address them. Taken together, though findings and previous research suggest a possible relation between *fatalismo* and personal service utilization, it appears other factors may be at play. Conceptualizations of *fatalismo* as having a dual nature, at times hindering help-seeking and at other times promoting positive health care beliefs, are consistent with these findings [15, 17–19, 29]. Interpretation of these results in the context of the HBM suggests other barriers to treatment (e.g., limited access to insurance, fear of deportation, and stigma) play a more prominent role in determining service utilization outcomes than *fatalismo*.

Several limitations exist in this study. The sample size was small, which could have affected the stability of path estimates in our structural model, and the use of convenience sampling limits the generalizability of our findings, as individuals with significant depressive symptoms may be unlikely to attend a cultural festival and the pattern of results may be different for parents of young children than for other individuals. As a Latino-only sample was recruited for the study, findings regarding the relations between *fatalismo*, depression, and service utilization cannot be generalized to individuals of other ethnic groups. Additionally, the distribution of male and female participants was uneven and measures were very brief, taken during a noisy cultural festival, and limited in content. Another limitation of this study is the unimpressive internal consistency reliability of the *fatalismo* subscale of the MACC-SF obtained in this study; we removed one item to enhance reliability and it remained low [13]. It may be fruitful to utilize or develop a more internally reliable measure; however, prior to developing a new measure of *fatalismo*, it would likely be beneficial to assess how well a bidimensional measure of external locus of control explains depression in Latinos. It may also be useful to explore potential differences between fatalism and *fatalismo*; if significant differences are not identified, it may advisable to use an established measure of fatalism with better reliability. As cultural values can be difficult to constrain to clear and measurable definitions, improving measurement of the *fatalismo* construct may entail empirical exploration of several factors, including those mentioned above (e.g., dimensionality, relations to external locus of control, fatalism, spirituality). Future studies should incorporate behavioral as well as self-report measures of depression in Latino adults in order to disentangle perceptions from observable depressive symptoms. Further, research is needed to identify which barriers are more salient deterrents of service utilization by Latinos so that steps may be taken to ameliorate underutilization of services by Latinos experiencing medical or mental health problems. Recruitment of more diverse samples would provide insight into the possible generalization of trends identified in this study to members of other ethnic groups.

New Contribution to the Literature

In sum, we extend the research showing an association between *fatalismo* and decreased service utilization, finding that while it may be important for medical utilization, mental health symptoms are better predictors of mental health services use than *fatalismo* beliefs directly. *Fatalismo*'s relation to mental health service utilization is indirect, via its association with depression. Consistent with the HBM, results suggested *fatalismo* may shape perceptions of illness threat and therefore may be an important consideration for depression treatment for Latinos.

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