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Stressors and Barriers to Using Mental Health Services Among Diverse Groups of First-Generation Immigrants to the United States

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Abstract This study examined stressors and barriers to using mental health services among first-generation immigrants in San Jose, California. Focus groups for 30 immigrants from Cambodia, Eastern Europe, Iran, Iraq, Africa, and Vietnam were audio-recorded, translated and transcribed. Two researchers coded the data and identified themes pertaining to mental health stressors and barriers. Six primary stressors were identified: economic, discrimination, acculturation due to language differences, enculturation, parenting differences, and finding suitable employment. Primary barriers included: stigma, lack of a perceived norm in country of origin for using mental health services, competing cultural practices, lack of information, language barriers, and cost. A conceptual model is presented that may be used to inform the design and implementation of mental health services for this population.

Keywords Immigrant · Mental health services · Stress · Barriers

Introduction

Specific immigration-related factors may affect mental health and create barriers to utilizing mental health services. Yakushko and colleagues (2008) found that stress associated with acculturation, maintaining cultural values and traditions, economic struggles, and oppression surrounding employment were the most significant concerns of immigrants. Research has indicated that the circumstances under which people migrate to the United States, English proficiency, and acculturative stress play a significant role in mental health (Hovey 2000; Oh et al. 2002; Pumariega et al. 2005; Takeuchi et al. 2007). In addition, stigma and a lack of awareness or understanding of services function as barriers to seeking mental health services (US Department of Health and Human Services 1999). For example, Nadeem and colleagues (2007) found that stigma-related concerns were significantly related to lower desire for mental health treatment for immigrant women from ethnic minority groups.

Both pre-migration risk factors, such as previous traumatic experiences, and post-migration stressors must be considered as important contextual factors associated with the mental health of immigrants (Pumariega et al. 2005). Pre-migration exposure to political violence is associated with emotional distress among recent migrants, regardless of immigration status (refugee, independent, or sponsored immigrant) (Rousseau and Drapeau 2004). In their population-based survey of recent migrants in Quebec, researchers found that although a higher percentage of refugees reported exposure to political violence in their homeland (60%), 48% of independent and 42% of sponsored immigrants also reported exposure. Notably, the level of emotional distress did not vary significantly across categories of immigration status (Rousseau and Drapeau 2004).

Pre-migration conditions of loss and trauma, common to many immigrant groups, are risk factors for mental health sequelae and also a factor predicting problems in

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resettlement. Many of the new immigrants to the United States are refugees or asylum seekers. The US Committee for Refugees and Immigrants reported that in 2008, the United States granted asylum to 20,500 individuals and resettled approximately 60,200 refugees from other countries. Persons who are forced to leave their countries as refugees, due to war, persecution, and human rights abuses face significant challenges in adjustment to living in a new country (Petevi 1996). Furthermore, previous torture and trauma, lower education, fewer social contacts, no occupation, and pain have been identified as significant predictors of emotional distress in refugees (Carlsson et al. 2006). Refugees resettled in western countries have been shown to be about ten times more likely to have post-traumatic stress disorder (PTSD) compared to age-matched general populations in those countries (Fazel et al. 2005). Fazel and colleagues (2005) found that 9% (99% CI 8–10%) were diagnosed with PTSD and 5% (4–6%) with major depression, with evidence of much psychiatric comorbidity. A background of severe life-threatening trauma and post-migration stress such as unemployment and lack of social contacts are seen as important factors in the long-term conditions of traumatized refugees living in exile (Lie 2002).

Post-migration disadvantages, such as inadequate English language skills, low socioeconomic status, and poor understanding of the new cultural expectations, are associated with the mental health challenges of immigrants (Porter and Haslam 2005; Pumariega et al. 2005). Researchers have noted that English proficiency is a key feature in the social integration of immigrants in important areas such as entry into the US labor force (Chiswick and Miller 1999; Stolzenberg and Tienda 1997; Takeuchi et al. 2007). Marshall et al. (2005) found a strong association of post-migration stressors (such as poor English skills, unemployment, being in retirement, or disabled and living in poverty) with high rates of PTSD and major depression in a US Cambodian refugee community.

In addition to immigration related factors, cultural factors intrinsic to different immigrant groups play a role in help seeking behaviors. Mental health is understood differently by diverse immigrant populations on account of cultural differences and the availability of mental health services in their countries of origin. In many cultures mental illness is highly stigmatized. In their review, Leong and Lau (2001) emphasized that the concern of stigmatization hinders the help-seeking behaviors of Asian Americans. For example, among Chinese American female immigrants, the cultural value placed on the avoidance of shame acts as a barrier to using mental health services (Tabora and Flaskerud 1997). Additionally, there may be folk or traditional concepts for understanding mental illness. Immigrants may exhibit somatic complaints which they do seek medical care for, but their physicians may not be aware of the possible psychological roots of the complaints (Leong and Lau 2001; Ritsner et al. 2000). Often, poor cross-cultural understanding and a lack of awareness or understanding of services impede the utilization of mental health services (Abe-Kim et al. 2007). Stigma, combined with the complicated network of problems common to all immigrants, affects access to care and consequently impacts resettlement. Pumariega et al. (2005) report that, "Mental health factors, most of which go unrecognized and untreated, can adversely affect the immigrant's successful adaptation and functioning after immigration" (p. 590).

Immigrants are a complex and diverse group. Assessing their needs and identifying the best way to meet them is a challenging undertaking for mental health professionals. Immigrants may be prevented from obtaining mental health services as a result of specific barriers to treatment. To address such issues, focus groups were conducted at the Center for Survivors of Torture (CST)[1] in San Jose, California. CST provides mental health interventions for severely traumatized immigrants, refugees and asylum seekers from diverse regions worldwide. This study aimed to identify the sources of stress and barriers to utilizing mental health services among these diverse groups of first-generation immigrants.

Methods

Participants

Santa Clara County has become an epicenter for refugees and immigrants in Northern California. According to the 2000 US Census, over 608,000 (34.1%) of the projected 1.78 million residents of Santa Clara County are foreign-born. The California Department of Social Services—Refugee Program Bureau data show that since 1975, Santa Clara County has resettled 63,186 refugees, the largest number of refugees resettled in Northern California (4th county in the state to accept refugees after Los Angeles, Orange and San Diego counties). During November 2008 to February 2009, CST conducted six focus groups with a convenience sample of 30 immigrants from Cambodia ($n = 5$), Iran ($n = 4$), Iraq ($n = 5$), Vietnam ($n = 6$), African regions ($n = 5$), and Eastern European regions ($n = 5$), who were drawn from the community and residing in Santa Clara County, California. One focus group was conducted for each ethnic group, but in some cases

[1] Center for Survivors of Torture (CST) is a program of Asian Americans for Community Involvement (AACI), a large nonprofit organization located in Santa Clara County.

multiple sessions were held to cover all of the material. These ethnic groups were identified based on their significant populations within Santa Clara County and the large documented incidence of trauma experienced in their countries of origin.

Inclusion criteria for recruiting participants were age 21 years or older and membership in one of the identified ethnic immigrant groups. Exclusion criteria for focus group participants included previous and current enrollment at the Center for Survivors of Torture. Being a torture survivor was not an exclusionary criterion, however clients of a torture treatment center were excluded due to the extensive services they receive that are linguistically and culturally consonant, which is exceptional in the community. Some participants recruited in this study may have been exposed to torture in the past, but exposure information was not collected. The Health Services Institutional Review Board of the Santa Clara Valley Health and Hospital System approved the informed consent protocol and study design.

The CST staff recruited 4–6 participants from each ethnic immigrant group through referrals from community resettlement agencies (African and Iraqi participants), the Adult Mental Health Program at AACI (Cambodian and Vietnamese participants), and outreach at local adult education schools and the community (Eastern European and Iranian participants). There were 30 participants, 14 males and 16 females. The groups had median ages of 40–49, minimum ages of 21–29, and maximum ages of 70–79 years. See Table 1 for more information about participants' demographic characteristics.

Table 1 Demographic characteristics of participants ($N = 30$)

Demographic variable	*n* (%)
Gender (%)	
Female	16 (53)
Male	14 (47)
Age range (%)	
21–29	6 (20%)
30–39	5 (17%)
40–49	6 (20%)
50–59	5 (17%)
60–69	6 (20%)
70–79	2 (7%)
80+	0 (0%)
Country of origin (%)	
Bosnia	4 (13%)
Cambodia	5 (17%)
Eritrea	3 (10%)
Ethiopia	1 (3%)
Iran	4 (13%)
Iraq	5 (17%)
Russia	1 (3%)
Sierra Leone	1 (3%)
Vietnam	6 (20%)
Year of immigration*	
Mean (SD)	1998 (8.0)
Range	1982–2008
Immigration status	
Asylum seeker	2 (7%)
Permanent resident	10 (33%)
Refugee	12 (40%)
US Citizen	6 (20%)
Other	0 (0%)

* $n = 29$ for year of immigration

Focus Group Procedures

Each session was facilitated by a skilled moderator and a co-researcher who kept notes of participant comments and significant behavioral observations. Each session lasted 2.5–3 h. With the exception of the African focus group, which was conducted in English, all the remaining groups were conducted in their native languages by interpreters who are immigrants themselves and active members of their respective communities. The interpreters each had several years of experience working with refugees and immigrants in either a mental health or case management capacity. Prior to conducting the focus groups, the interpreters were provided a copy of the focus group questions and received extensive training regarding the intent and meaning of the questions.

At the beginning of each focus group, the interpreter/co-researcher read the informed consent form verbatim to the study participants. They were informed that the purpose of the focus groups was to identify the needs of ethnic minority immigrant groups residing in Santa Clara County, that their participation was voluntary, and that they could choose to stop at any time without any consequences. Participants were then given consent forms in their language of choice, and written consent to participate in the study was obtained. To protect participant confidentiality, participants were instructed not to use any names and to refer to themselves and other participants by their assigned numbers instead. The moderator also explained the limits of confidentiality and questions were answered. At the end of each group session, participants received in their language of choice a referral list of local community based organizations and health and mental health clinics where they could obtain further information and/or assistance.

Data Analysis Procedures

Participant statements during the six focus groups were audio-recorded, translated in session, and transcribed. First, the transcripts were thoroughly read by the research team. Through discussion, the team applied an approach for analyzing qualitative data known as thematic analysis (Maxwell 1996) to identify major themes pertaining to mental health stressors and barriers to treatment that were discussed in the focus groups.

Two researchers systematically reviewed the transcripts to identify the material pertaining to mental health stressors and barriers to seeking mental health services. Then they identified themes that emerged from considering this material and coded the participants' statements into these themes. Using Maxwell's (1996) interactive approach for analysis, the themes could be altered or refined as the coding proceeded. This entailed reconsidering the statements that had already been coded related to that theme to determine whether they fit the refined version of the theme. During the process of evaluating the statements, the research team revised and refined the definitions of the themes to best examine similar statements.

The data were analyzed at the focus group level, rather than at the individual level within the groups, as the purpose of this study was to understand general stressors and barriers faced by immigrants after resettling in the United States, rather than specific stressors and barriers faced by a particular group. Due to the size of the groups and the way that data were collected, a within-groups analysis that tallied the number of participants who endorsed a particular viewpoint was not a meaningful way to analyze the data. Not all of the individuals within each focus group addressed each issue that was discussed. If one person described a particular type of stressor, for example, a group leader would often acknowledge that person's contribution and then move the discussion to another issue. Therefore, the group, rather than the individual, became the unit of analysis.

To evaluate the inter-rater reliability of the coding system, a second person recoded the discourse units without knowing the themes to which they had been assigned. The number of agreements was then recorded. The two raters obtained a high level of agreement throughout coding each of the twelve themes (95%). Within the six themes describing types of stressors, the level of agreement was 34/36 (94%), and within the six themes describing types of barriers to use of mental health services, the level of agreement was 25/26 (96%). After conducting these checks for inter-rater reliability, the three discrepancies were resolved through discussion to yield a final coding for each statement that was satisfactory to both coders and the research team.

Results

Using thematic analysis (Maxwell 1996), we identified the following stressors noted in the focus groups: economic, discrimination, acculturation due to language differences, enculturation, parenting differences, and finding suitable employment. We also identified six barriers to utilization of mental health services: stigma, perceived lack of mental health services in native country, competing cultural practices for addressing mental health needs, lack of information about local mental health services, language barriers, and cost. Table 2 shows the number of groups that reported a statement consistent with each theme. The number of groups that gave a statement corresponding to a particular theme varied from three groups to all six groups reporting it. Thus, not all groups endorsed every stressor or barrier that was identified in this study, but every theme mentioned was identified for multiple groups. For each theme, we provide representative quotes from the transcripts to illustrate the identified theme.

Sources of Stress: Six Themes

Stressor: Economic

Each of the six groups reported economic distress. The sources of stress were numerous and included difficulty paying for education, inadequate compensation at work, and high cost of living. An Eastern European participant stated, "In my country, I had everything. I had my own place. I owned my own place. I had my job. And I was able to support myself. When I came here, of course … I couldn't afford, which is the basics, like housing. I cannot live by myself. And I cannot support myself." A participant in the Iraqi group noted, "We didn't imagine the rent (would be so) expensive here."

Stressor: Discrimination

All six groups reported some kind of discrimination since moving to the United States. Discrimination occurred in numerous settings, such as in the school and in the workplace. A participant in the Eastern European group stated, "My son one day came and told me … His teacher told him like, 'Oh, you are—what religion are you?' And when he said he's like Muslim, he said, 'Oh! I heard that that's like a devil religion." An Iranian participant reported discrimination at work, as illustrated by the following quote: "I have somebody not work with me because of my accent." An African participant spoke of a stereotype that he encountered. He said, "In general, there is a cliché that whoever comes from Africa is lower in grade."

Stressor: Acculturation: Language Differences

All of the groups also encountered issues with differences in language from their country of origin to having to use English in the United States. This issue permeated many areas of the immigrants' lives and interfered with their ability to obtain medical services, find a job, and navigate public transportation. One Cambodian participant stated, "I have difficulty when I see the doctor … how to translate … my illness to the doctor." A member of the Iranian group encountered an issue with taking the bus: "We had brochures. But that brochure was in English. Which is everywhere you go in all the schools you have [a] dictionary; you will have [a] brochure in Chinese, Vietnamese, Spanish, why except Farsi?"

Stressor: Enculturation

Four out of six groups (Iraqi, Vietnamese, Eastern European, and Cambodian) noted enculturation as a source of stress, particularly the preservation of their native culture and the transmission of traditions and values to the next generation. One Cambodian participant stated, "We don't want to lose the Cambodian identity in here." A Vietnamese immigrant said, "I'm not sure about that. But say—little kids who were born and raised in America—for the next generation—I don't think they'll be able to keep our traditions and customs—once the first generation dies out; they won't be able to keep real traditions."

Stressor: Parenting Differences

Most of the participants stated that parenting in the United States was much different than in their native country. Five out of the six groups (Iraqi, Vietnamese, Eastern European, Cambodian, and Iranian) said this difference was a source of stress, particularly with respect to physical discipline. There was a disparity between the child discipline norms in the United States in comparison to those in the immigrants' country of origin. A participant in the Iraqi group stated, "Because, we came from a different culture where it is okay to shout at our kids and in our country. Here, it is not. So, maybe they will get into trouble. Field visits could help." An Eastern European participant said, "If there's children outside on the street and they get into a fight, the first neighbor that comes outside spanks all of them. And your father will never go to their neighbor and be like, 'Why did you spank my child?' He'd be like, 'You need to spank him harder next time.' Here, I mean, you don't really do—you can't do that to your own children, let alone your neighbor's children."

Table 2 Themes identified as stressors and barriers to seeking mental health services

Theme	*n* (%)
Stressors	
Economic	6 (100%)
Discrimination	6 (100%)
Acculturation: language differences	6 (100%)
Enculturation	4 (67%)
Parenting differences	5 (83%)
Finding employment matching one's qualifications	5 (83%)
Barriers	
Stigma toward use of mental health services	4 (67%)
Perceived lack of mental health care services in country of origin	3 (50%)
Competing cultural practices	3 (50%)
Lack of information about mental health services	6 (100%)
Language barriers	4 (67%)
Cost	5 (83%)

Stressor: Finding Suitable Employment Matching One's Qualifications

A significant source of stress for many of the participants was the inability to assume jobs in the United States that reflected their degrees and/or certifications. In most cases, degrees and certifications earned in their native countries were not recognized in the United States. As a result, many immigrants felt forced to take lower paying or less prestigious positions. Five of the six groups (Iraqi, Eastern European, Cambodian, Iranian, and African) cited this as a significant problem. An Eastern European participant stated, "I've actually seen doctors from the old country working as garbage-men here." An individual from the Iranian group said, "If they have certificates they not going to accept that certificate. Okay. The person who was a mechanic or was working with the cars, fixing cars, and stuff like that. He cannot find the same job here. For example, if you were a doctor in your country, you cannot be a doctor. You have to start studying, going to school. OK. That is going to take 10 years. If I am going to go to school full time, who is going to pay my rent? Who's going to pay everything for me?"

Barriers: Six Themes

Barrier: Stigma toward Mental Health Services

As seen in Table 2, four focus groups (Iraqi, Iranian, Cambodian, and Eastern European) reported stigma associated

with seeking and utilizing mental health services. According to Fink and Tasman (1992), stigma refers to the marginalization and ostracism of individuals who are mentally ill and can lead people to delay seeking treatment or to conceal their illness to avoid the negative labels associated with mental health needs. These four groups noted the cultural unacceptability of seeking mental health treatment, as well as the label of "crazy" that is bestowed upon the person that uses such services. A participant from the Eastern European group stated, "People do resent, you know, the services, simply because people put titles very easily on people, so if you do need to see a therapist or psychiatrist or psychologist, it means that you are crazy. It's just either you are not if you don't, or if you do go there you are. And, I mean, it's just either/or; there's no in-between." Additionally, a man from the Iraqi group reported, "Here, if I am depressed, I can go talk to my psychiatrist. There it is not acceptable in our society."

Barrier: Lack of a Perceived Norm in Country of Origin for Using Mental Health Services

Three of the six focus groups (Cambodian, Vietnamese, and Eastern European) reported a lack of presence of mental health care/services in their native country. As a result of this scarcity, they did not have access to or experience with mental health services and so they lacked a perceived norm for using mental health services to address their psychological problems. A Cambodian participant stated, "Before I came to the United States I don't know what is it, the counseling, mean for me. I don't know because in Cambodia there doesn't hear about the counseling." A Vietnamese participant reported, "It (mental health care) is very new, so they just don't know about it."

Barrier: Competing Cultural Practices

Three of the six focus groups (Iraqi, African, and Cambodian) reported utilizing an alternative practice to the western concept of mental health. These alternative practices included performing rituals or using holy water to cure ills. A Cambodian participant stated, "(I) don't believe that for the counseling help. If I'm in Cambodia probably they bring me to blessing from the mind, the water. Blessing from the mind, yeah, from the spirit, you know, of the believer, cultural believer. To wear something that they tell you know. That is a part of the, well I don't know what to call, yeah to protect about the (inaudible) to protect for the all everything the spirit from the cultural." Also, an African participant expressed that "Yeah, instead of saying … in our country, we take them to the … we give him the right medicine … we take them to the holy place, the churches, and give them holy water. But, even then the mother takes hide from other people and then cures it. So you have to teach the mom then she cures her daughter or for herself. Otherwise, no she denies completely, 'No, my son …' We have a proverb in our country. Mother hides everything except … eye spot. She tries to hide everything even the eye spot. This is our culture. That's it."

Barrier: Lack of Information about Mental Health Services

In addition, all six focus groups reported that they had little, if any, information regarding mental health services offered in the United States. They reported that they were unaware of mental health services in general or they did not know the process by which to access these services. A Vietnamese participant stated, "Because the newcomer doesn't know anything so they have no clue where to go to get help." Also, an African participant reported, "I don't think they know anything about counseling. I don't think people know much about counseling, how to get into counseling. There are people there who need counseling who don't know how to go about and don't know that there is something called counseling." Furthermore, all of the groups reported not knowing any County based mental health programs available at low or no cost.

Barrier: Language

Four of the focus groups (African, Cambodian, Eastern European, and Vietnamese) revealed that language was a barrier to receiving mental health services. Language barriers included the inability to locate a clinician who speaks the native language and/or a limited command of the English language. According to a Vietnamese participant, "They have a difficult time to find counseling—necessary counseling because sometimes for her own experience she wants to find a counselor for herself—but it's very difficult because they have a counselor with the language differences—that it doesn't work out—cause she tried to look for the Vietnamese—the same language counselor but there were none available." A participant from the Eastern European group revealed that "The language barrier plays into this, where people can really express what problems they have and, you know, who to approach to answer that."

Barrier: Cost

Five of the groups (Iraqi, African, Cambodian, Iranian, and Vietnamese) also reported cost as a barrier to receiving mental health services. One main reason participants stated they could not afford services was because they had no insurance to cover the costly bills. And as stated above, all of the groups reported having no knowledge of any

community mental health care clinics that offer low or no cost treatment. A Vietnamese participant stated "It would be nice if there's some way the government can have, you know, those people who doesn't have a job right now get health insurance because she want to go to doctor but they're afraid what it costs and everything." In addition, a participant from the Iraqi group stated, "We will not be able to afford it. We are not covered by insurance."

Discussion

The results of this study suggest a conceptual model (as schematically represented in Fig. 1) that recognizes specific major life stressors of immigrants that may inform mental health services utilization, as well as other specific barriers that may impede this utilization. Although specific sources of stress identified in this study have been found in other studies with immigrants and refugees (Pumariega et al. 2005; Yakushko et al. 2008), these findings across a number of diverse ethnic immigrant groups also suggests a conceptual model that illuminates possible solutions for easing access to mental health care for this target population. This conceptual model highlights the salience of six specific sources of stress: economic, discrimination, acculturation due to language barriers, enculturation, parenting, and finding suitable employment. Because these stressors are potentially complicated by co-occurring mental health symptoms that highlight the importance of access to utilization of mental health services, it is important that barriers to such utilization also be considered in this model. Six such barriers are identified in this conceptual model: stigma, perceived lack of mental health services in native country, competing cultural practices, lack of information about local mental health services, language barriers, and cost. This model's inclusion of both stressors and barriers in a single conceptual model should be useful in guiding potential policy implications, as discussed below.

However, before discussing potential implications of these findings, we wish to put them in context by acknowledging several limitations to this study. This research is based on a relatively small sample of immigrants ($N = 30$), with even smaller numbers of participants in each of the ethnic subgroups. Therefore, this study was not able to examine differences between ethnic groups in mental health stressors and in the use of mental health services. For example, if only four out of the six groups report a specific stressor or barrier, this does not necessarily indicate that this same issue is not a problem for the other groups who did not happen to report it. Immigration status upon arrival to the United States, resettlement phase and differential degrees of acculturation of focus group participants were not examined prior to inclusion in the focus groups and not controlled for in this study. Some of the participants have been in the United States for as long as 20 years, and some for as little as 1 year. How long immigrants have been in the country and in what stage of resettlement they are (arrival, reality, negotiation, integration, and marginalization) may influence the responses given in the focus group sessions and thus should be systematically considered in larger studies on this topic.

Despite these limitations, this study's findings suggest that a greater interface between the mental health community and the immigrant communities is desirable, as the participants in this study were readily able to articulate

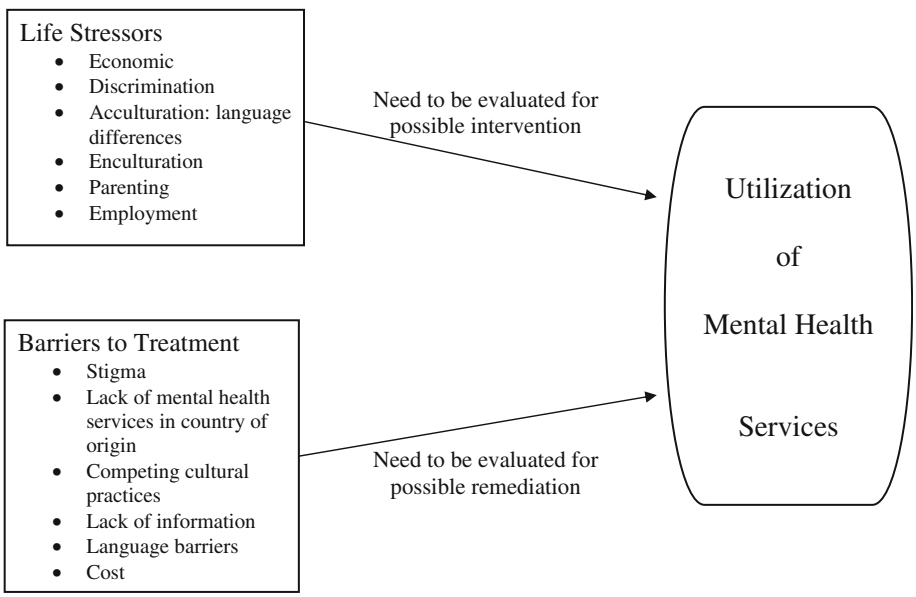

Fig. 1 A conceptual model of major life stressors and barriers to utilization of mental health services among first-generation immigrants resettled in the US

their needs and barriers to using mental health services during the focus groups. Four of the six barriers to mental health care that were identified (*perceived lack of services, lack of information, language barriers, and perceptions about cost*) can be addressed through providing greater public education about available services and improving access to such services. Mechanisms within the mental health system may need to be further enhanced for greater effectiveness. For example, greater resources may be devoted to educating individuals in immigrant communities about how to access existing mental health resources. This will entail greater outreach by mental health service providers to new immigrant communities in languages that targeted communities understand and developing better relationships with the resettlement and clinical agencies that new immigrants tend to use for their basic needs. Furthermore, although the problem of lack of awareness of available services may be common across diverse ethnic groups of recent immigrants, specific outreach strategies for a given ethnic group may differ. For one group of immigrants, the most effective way to provide such outreach may be public service announcements over a particular radio station; for another group, it may be better to channel such outreach efforts by working with religious institutions in a given community. Additionally, the sources of stress identified in this study can be useful in helping to tailor such outreach messages. For example, messages can be tailored to advertise services to help immigrants who are struggling with finding suitable employment and managing related discrimination and economic stress. Alternatively, messages can be customized to advertise services for helping parents to communicate more effectively with their children.

For the remaining two barriers (*stigma toward use of mental health services and competing cultural practices for addressing mental health needs*), this study's findings highlight the need for providers to have more interactive communications with the target community to truly understand their cultural perspective on mental health stigma and its treatment, as stigma is a barrier that can be overcome once it is understood from a culturally sensitive perspective. The attempt to apply a Western mental health standard to a non-Western cultural group is culturally insensitive and can miss the root of the problem by focusing on Western approaches as the only viable solution. Failing to understand the culture of patients and their families is likely to be unsuccessful, as is so well illustrated in the nonfiction book, *The Spirit Catches You and You Fall Down* (Fadiman 1997). Participants in the study identified that alternative cultural practices take the place of Western mental health services in their communities, a theme that echoes the findings of previous research with immigrants. For example, the leaders of Tibetan refugees in India have stressed the importance of adhering to Buddhism and traditional healing practices for dealing with mental health problems (Mercer et al. 2005). This theme underscores the importance of understanding a client's cultural background, not only to increase the perceived credibility of the therapist but also to be able to incorporate the client's culture (e.g., religious, spiritual, ethnic) into the treatment approach when possible (Sue 2006).

In summary, this study suggests a conceptual model for understanding sources of stress and barriers to utilizing mental health services that should be considered in designing and promoting these services for diverse groups of recent immigrants to the United States. Although not all of these stressors and barriers will necessarily be applicable to any particular group of immigrants in a given community, we found that these problems were commonly identified by multiple immigrant groups, and therefore should be at least considered. The results of this study suggest that mental health administrators and staff who work with immigrants should inquire about exposure to ongoing life stressors that include economic, discrimination, language differences, enculturation, parenting differences, and finding employment matching clients' qualifications. In some cases, these topics may be the primary focus of counseling and psychotherapy. In other cases, these issues may need to be addressed in order to resolve other mental health problems, e.g., anxiety disorders that may be exacerbated by these life stressors. However, to address these mental health needs in immigrant groups, it will first be necessary to address any major barriers to utilizing mental health services. Our discussions with first-generation immigrants from diverse backgrounds suggest that major barriers to accessing services include immigrants' internalized sense of stigma toward use of mental health services, lack of a perceived norm in country of origin for using mental health services, competing cultural practices for addressing mental health needs, lack of information about mental health services, language barriers, and formidable cost. Further research is needed to evaluate best practices for overcoming these barriers and addressing these mental health needs with diverse groups of immigrants.

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