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Latinas in Small Cities in Upstate New York: Health and Mental Health Issues

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Study Purpose and Background

The study presented in this report explored the health and mental health of Latinas in small cities in upstate New York focusing on specific health and mental health indicators. Latinas represent an appreciable and rapidly growing segment of the U.S. population comprising about 52% of the Latino ethnic group and projected to account for 25% of the total female population by the year 2050 (US Bureau of the Census, 2004).

Yet, little is known about their health and mental health (Aguirre-Molina, Abesamis, and Castro, 2003; Giachello, 2001). The available data specific to women's health seldom provide information based on ethnicity, and the limited available data on Latinos' health are not always reported separately by gender (Beckles, 2005). For example, heart conditions, cancer, and cerebrovascular diseases are the three top health related causes of death among Latinas, but data that depict the impact of these and other health problems on death rates and the prevalence of allied health conditions are scarce (Aguirre-Molina et al., 2003). Similarly, research that helps identify genetic, environmental, and cultural protective factors underlying positive indicators is virtually nonexistent. For instance, compared to the general population for Latinas septicemia is n ot a leading cause of death, and the proportion of those who die as a result of pneumonia, lower respiratory disease, influenza, or Alzheimer's is lower (Acevedo et al., 2007).

With regard to reproductive health, a key area for Latinas given their median age (26.6 years), which places them squarely in their childbearing years, the picture is mixed. Although Latino expecting mothers tend to experience lower rates of pregnancy-related hypertension (27.7%) compared to whites (41.0%), and report lower percentages of alcohol abuse (1.0 vs. 1.2) and smoking (4.0 vs. 16.2), the rate of maternal mortality for Latinas is 1.7 times higher than for whites (U.S. Department of Health and Human Services, 2007). Latinas are also less apt to receive regular mammograms and pap tests and suffer a disproportionate mortality rate from breast and cervical cancers (Ruskamp-Hatz, 2007). Recent efforts to document the gravity of chronic diseases such as diabetes in the Latino population have offered little insight for Latinas. This is troubling because diabetes is the fourth leading cause of mortality among Latinas (a mortality rate of 17.5 per 100,000 for all ages) while it is the eighth leading cause of death for women in general (Aguirre-Molina et al., 2003). For Latinas ages 45-64, the rate of diabetes is13.5% compared to 7.8% for white women, and for Mexican American women, it more than doubles (10.9%) that of white women at 4.5% (National Institutes of Health, 2001).

Evidence on the mental health status of Latinas is also limited. In addition, there is a lack of consistency in findings and a wide range of estimates of prevalence, which may be attributed to

methodological and sample differences as well as to the use of assessment instruments that may not be culturally applicable (Ramos & Carlson, 2004). For example, in the pidemiologic Catchment Area Study in Los Angeles, which collected data on Mexican Americas, 6.3% of the women reported major depression and 19.2% reported anxiety/somatoform disorders (Karno, Hough, Burnham, Escobar et al., 1987). Other research has found rates of depressive symptoms among Mexican American women as high as 64%, and in a comparison study more than half of the Latinas (53%) reported experiencing depressive symptoms in the previous week compared to Whites (37%) and African Americans (47%) (Giachello, 2001; Harris,1993). Latinas in the National Comorbidity Study, which included 719 English-speaking Latinos of various subgroups throughout the U.S., reported 12-month prevalence rates of 14.1% for any affective disorder and 6.6% for generalized anxiety (Kessler, McGonagle, Zhao, et al., 1994). Data suggest that Latinas are at a higher risk for depression than are Latinos, which is consistent with gender differences that have been found in the general population (Harris, 1993).

As a group, Latinas may be especially vulnerable to mental health problems as they often face a myriad of stressors associated with poverty, prejudice, discrimination, and resettlement. Additional risk factors include single parenting, traditional gender roles when practiced in oppressive environments, and domestic violence (Vasquez, 1994). For example, among Latinos in New York State, women are more likely to live in poverty than men (Bose, 2006). Overall, health and mental health information specific to Latinas and distinguished by gender and Latino subgroup is needed to inform professional and public awareness, and health and social policy.

Even less is known about the health and mental health of Latinas residing in small cities, although there are a number of environmental variations between small and large cities that could differentially impact their physical and emotional well-being (CEMHD, 2007). For example, Latinas in small cities may be embedded in environments with fewer economic resources where they comprise a small number of the local population, are less visible, and hold less political leverage. These differences may translate into fewer health and mental health programs, limited or no public transportation, greater alienation and marginalization, and fewer social supports from culturally prescribed sources. Similarly, family and social networks derived from the Latino community are often limited in small communities, where size and few resources impede them from developing into fully functioning ethnic enclaves.

In New York State, where Latinos are the largest ethnic group, they remain numerically concentrated in New York City. Nonetheless, a shift toward geographic dispersion has resulted in their increased representation in smaller cities across New York State(Bose, 2006). These include the upstate cities of Albany, Schenectady, and Amsterdam located in a geographic area where the Latino population has increased 185% from 1980 to 2000 (City Data, 2005). According to the 2000 U.S. Census, Latinas comprise 52% of the Latino population in these three cities, and 66.7% of them self-identify as Puerto Rican. Among these Latinas, 62% have earned at least a high school diploma. Some 43.6% have never married; 43.1% are now married (of these for 66.1% the spouse is present in the household and for 33.9% the spouse is absent); 4.4% are widowed, and 8.9% divorced. The rate for female head of household is 15.9%. Their poverty rate is 38.9%, and the unemployment rate is 11.9%.

Research Questions

The specific research questions addressed by this study were:

1. What are some of the key health issues among Latinas in small cities?
2. What are some of the most important mental health issues among Latinas in small cities?

Analytical and Methodological Procedures

Study Design

The study used a cross-sectional survey design. Cross-sectional studies are a type of observational or descriptive epidemiology conducted on representative samples of a population. Unlike longitudinal studies which gather data through a series of measurements over a period of time, cross-sectional studies collect information at a single point in time (Abramson and Abramson, 2000). The results can be used for descriptive purposes as well as to determine relationships between variables at the time of study (Babbie, 1990). In this study, data were collected from a subset of community dwelling Latinas to ascertain a "snapshot" of the characteristics and frequencies of their health and mental health at the time.

Participants

This study used a purposive sampling method. The sample (N=287) was drawn from a three county area in upstate New York where the Latino population varies between 3% and 9%

(U.S. Census 2002). Potential participants were recruited through referrals, community based organizations, English as a Second Language classes, churches and workplaces. Women, 18 years and older who self-identified as Latina or Hispanic, completed a 30 to 40 minutes survey in English or Spanish, depending on the participant's preference. A bilingual researcher assisted women with low literacy. Participants received a $10 gift card as compensation for their time.

Survey

A survey, which included items on the respondents' health, mental health, healthcare, and demographics, was developed and pre-tested. For example, we asked about their health with the question "have you ever been told by a doctor or health professional that you have…?" which was followed by a list of 12 of the most prevalent health conditions among Latinas. For mental health, we asked "do you currently experience…?" and listed depression, anxiety, and panic attack. Respondents also had the option to complete an "other" category for both health and mental health. We asked respondents about their health insurance coverage and their experiences with the healthcare system. The demographic and screening questions were drawn from the National Health Interview Survey or/and the Behavioral Risk Factor Surveillance Survey.

Data Analysis

Data were entered, verified, and analyzed using the STATA 9.0 statistical package. Analyses produced basic descriptive statistics such as frequencies and percentages. For some of these analyses, we collapsed Latinas from various subgroups into one category, recognizing that collapsing diverse subgroups into a single category might obscure important differences (Vega, 1992). Given that Latinos as a group also share some sociocultural commonalities, collapsing the subgroups to emphasize these similarities seems conceptually appropriate (Ramos, Jaccard & Guilamo, 2003), especially where subgroup sizes are small.

Summary of the Results

Table 1 presents sociodemographic characteristics of the participants (N=287. Not all participants answered every question). Ages ranged from 18 to 81 with an average age of 45. Consistent with the geographic distribution of Latino subgroups in New York Sate, the majority, (56.6%) self-identified as Puerto Rican and 18.2% as Dominican. About 79% were born outside the continental U.S. either in Puerto Rico (43%) or in one of 14 Latin American countries. In this sample, respondents born outside the U.S. mainland were double the national figure (79% compared to 38%) with 76% immigrating at age 16 years or older. Interestingly, although an appreciable portion (42.3%) had less than a high school education, compared to more than 60% nationally, a considerable proportion of the participants had some college education (33.2%). Most participants (51.4% compared to 56% nationally) were married or living with someone, whereas 19% reported being single and 22% divorced. Respondents born in the U.S. tended to use both English and Spanish. Figures 1 and 2 depict the sample characteristics with regard to Latino subgroup membership and education.

TABLE 1
Demographic Characteristics of the Participants (n=286)

CHARACTERISTIC	N	%
Birthplace		
United States	59	20.6
Puerto Rico	122	42.7
Dominican Republic	47	16.4
Mexico	12	4.2
Other	46	16.1
Age		
<25 yr	33	11.7
>25 to <35yr	60	21.3
>35 to <65yr	151	53.6
>65	38	13.5
Age at Immigration		
<15 yr	48	24.0
>15 yr	152	76.0
Education		
Lower than High School	121	42.5
High School Diploma	69	24.2
Associate	49	17.2
Bachelor Plus	46	16.1
Marital Status		
Married/Lives with partner	147	51.4
Single	54	18.9
Divorce/separated	63	22.0
Widow	20	7.0

FIGURE 1
Educational Attainment (n=285)

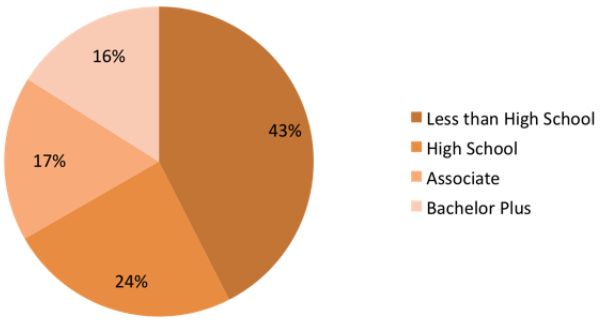
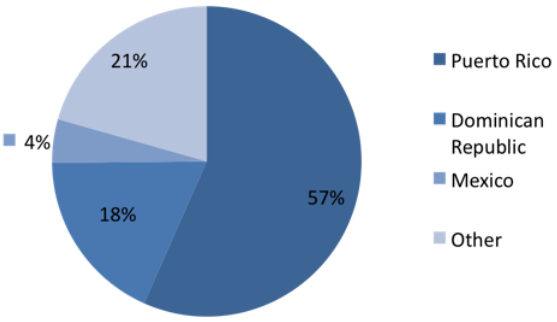


FIGURE 2
Latino Subroups (n=285)



As shown in Table 2, 33.6% of the respondents reported hypertension, 27.6% high cholesterol, and 14.3% diabetes. Nationally, Latinas report rates of 22% for hypertension and 13.5% (ages 45-64) for diabetes (Health, US, 2007; National Center for Chronic Disease Prevention, 2004). For mental health conditions (Table 3), respondents reported 39.2% depression and 42.3% anxiety. These findings are somewhat inconsistent with the limited evidence on the mental health status of Latinas at the national level indicating a depression rate of 53% for adult Latinas (U.S. Department of Health and Human Services, 2007).

TABLE 2
Most Commonly Reported Health Condidtions

HEALTH CONDITION	%
Hypertension	33.6
High cholesterol	28.0
Diabetes	14.3

TABLE 3
Most Commonly Reported Mental Health Condidtions

HEALTH CONDITION	%
Depression	39.2
Anxiety	42.3
Panic Attack	19.3

Table 4 presents sample data on healthcare insurance and utilization. Here, 69.7% reported delaying seeking healthcare during the past year and 83.3% have had a Pap smear test within the past three years. For other screening procedures, 84.2% have had a mammogram, 83.8 % a cholesterol check, and 94.2% a blood pressure test within the past two years. Each of these figures is above the national rate for Latinas (James, et al., 2007; U.S. Health, 2007). With regard to health insurance, 39.8% had Medicaid, 12.7% Medicare, and 35.6% private insurance. In this sample, 12% had no insurance.

TABLE 4
Healthcare Questions

HEALTHCARE QUESTIONS	%
Delayed seeking healthcare past year	69.7
PAP test within last 3 years	85.3
Mammogram within last 2 years	84.2
Cholesterol test within last 2 years	83.8
Blood pressure test within last 2 years	94.2
Healthcare Insurance	
Medicaid	39.8
Medicare	12.7
Private	35.6
None	12.0

Limitations of the Study and Future Directions

The results and interpretations presented need to be considered in the context of the methodological limitations of the study. The sample was not randomly selected and, therefore, it is not representative of all Latinas. It was biased toward younger, slightly more educated Latinas born in Puerto Rico. We also collapsed the sample into one category, which might have obscured important subgroup differences. As with any study based on self-reporting, the potential for recall bias is increased. Thus, the findings are primarily descriptive and may have only limited generalizability to all Latinas. Despite these limitations, this study adds to the limited literature on the health and mental health of Latinas. Furthermore, it provides a glimpse into these concerns among Latinas living in small cities, a sub population seldom studied. The findings can inform the development and implementation of action oriented strategies to address health and mental health concerns for Latinas.

When examined in the context of national data, Latinas in the sample reported nearly double the rate of diabetes than white women and a higher percentage of hypertension compared to Latinas in California (Baezconde-Garbanati, et al., 2003). This is worrisome given respondents' relatively young age (mean of 45). The high number of respondents reporting depression and anxiety is intriguing and varies from national norms indicating further research is needed. Data from representative samples to document these and other health concerns as well as risk and protective factors among Latinas in small cities are sorely needed.

Not surprisingly, compared to white women, Latinas in this sample were more likely to be uninsured. Interestingly, for respondents the rate of uninsured was lower and the rates of screening practices higher than for Latinas nationally. Yet, a high number of respondents (69.7%) reported delaying seeking healthcare in the past year. Future research needs to examine the specific barriers to healthcare encountered by Latinas in small cities. It is apparent, at least for this sample of Latinas, that simply having healthcare coverage is often insufficient. Evidence-based, culturally responsive interventions that could effectively offset some of these healthcare barriers for this population of Latinas need to be identified. Perhaps, strategies shown to be successful in augmenting screening practices could be expanded to ensure follow-up and regular care.

Policy Recommendations

Recommendations for policy that are both specific to the population studied and Latinas as a whole can be drawn from the study findings and the literature. First, additional data collection, analyses, and reporting, under DHHS data systems, on the health and mental health of Latinas in small cities are needed to adequately identify and monitor prevalent conditions, and to better understand their etiology.

Second, federal and state funding should support research with Latinas in small cities to increase our understanding of risk and protective factors associated with health and mental health conditions, identify systemic barriers to healthcare, and test interventions specific to this population to inform policy and program development.

Third, existing and future national health, mental health, and healthcare data on the Latino ethnic group must be disaggregated by gender and place of residence with a concerted effort to over-sample small cities. It is important to be able to distinguish between the health and mental health conditions, as well as healthcare experiences, of Latinas in larger and smaller settings. This type of information should be included in periodically published Latino health fact sheets.

Fourth, public resources should be made available to foster and support Latino coalitions seeking to promote health and mental health through partnerships. Here, a coalition works in tandem with policy makers; local, state, and federal health agencies; universities; nonprofit and professional organizations; and businesses, civil leaders, consumers, and advocates. A recent project that drew upon these types of partnerships to address healthcare disparities in small cities found their use especially suitable. The partners' enthusiasm and commitment as well as the relatively short traveling distances facilitated the sharing of expertise and resources, regular personal interactions, meeting attendance, and sustainability (Ramos, Smith, & Jurkowski, in press).

Fifth, a necessary policy priority is to fully actualize policy recommendations targeted to address the health, mental health, and healthcare concerns of the Latino population, paying special attention to those concerns that are specific to Latino women in small cities. These carefully crafted recommendations have been previously generated from technical reports, summits, studies, task-forces, and special national initiatives during the last two decades (Aguirre-Molina, Falcon, & Molina, 2001). For example, scholars

have called for policies to reduce the distressingly high numbers of uninsured Latinos, increase healthcare access and utilization, and put in place mechanisms to ensure healthcare for undocumented immigrants, most of whom pay their taxes but are not eligible for many services (Acevedo, Gonzalez, Santiago, & Vargas-Ramos, 2007).

Similarly, educational programs designed to improve health and mental health status and reduce healthcare barriers must be linguistically and culturally responsive and provide basic health literacy, information on healthy lifestyles, and how to navigate the health care system effectively (Valdez & Posada, 2006).

Of utmost importance, it is critical to frame Latinas' health, mental health, and healthcare concerns as social justice issues and encourage legislators to catalyze political action in humanistic and justice-oriented fashion. The literature underscores the need to understand health and health systems from a broader perspective where health is considered a basic human right that entails more than the absence of disease with healthcare distributed equitably (Aguirre-Molina et al., 2001; Falcon, Aguirre-Molina & Molina, 2001). In U.S. society where opportunities and privileges are unequally distributed, Latinas are placed in a lower stratum characterized by multiple social inequities and socioeconomic stressors that negatively impact their health status and healthcare options.

The study presented in this report offers legislators, public agencies, community organizations, and the media some baseline, preliminary information for strategic discussions of the health and mental health needs of Latinas in small cities in Upstate New York. Indeed, it underscores the urgent need to address the historically invisible status of Latinas in the health policy arena.

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