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Investigating Psychological Service Utilization Employing an Integrative Sociostructural, Cultural, and Behavioral Framework

Natalia Salinas-Oñate[1], Héctor Betancourt[1, 2], Patricia M. Flynn[2, 3], María José Baeza-Rivera[4], and Manuel S. Ortiz[1]

[1] Department of Psychology, Universidad de La Frontera
[2] Department of Psychology, Loma Linda University
[3] Department of Preventive Medicine, School of Medicine, Loma Linda University
[4] Department of Psychology, Universidad Católica de Temuco

Building on research that has identified factors relevant to psychological services utilization, this study examines some of those variables within the context of cultural beliefs about psychological care among primary care patients in Chile, a country with high rates of depression and low mental health services utilization. Guided by an integrative conceptual framework, the structure of relations among sociostructural, cultural, and psychological factors influencing mental health services utilization was tested. Participants included 201 women referred for colocated psychological services at 13 primary care centers. Cultural beliefs about psychological care were measured employing a scale developed using a mixed-methods cultural research approach to instrument development. Additional scales assessed sociostructural factors (age, ethnicity, socioeconomic status; SES), outcome expectations and emotions, and intention to utilize psychological services. A structural equation model including the hypothesized structure of relations among the study variables fit the data well (comparative fit index [CFI] = .99, $\chi^2[68] = 78.44$, $p = .18$; $\chi^2/df = 1.15$; root-mean-square error of approximation [RMSEA] = .03, 90% CI [.00, .05]). As proposed, cultural beliefs about psychological care predicted intention to utilize psychological services, directly and indirectly, through outcome expectations and emotions ($ab' = .07$, CI [.01, .14]). Specifically, positive cultural beliefs about receiving psychological care influenced outcome expectations ($\beta = .30$, $p = .00$) and positive emotions ($\beta = .43$, $p = .00$), which in turn predicted intention to utilize psychological services ($\beta = .23$, $p = .01$; $\beta = .18$, $p = .03$). Integrative approaches including sociostructural, cultural, and psychological determinants may result in more effective and culturally appropriate interventions aimed at reducing disparities in psychological services utilization. This research could contribute to the internationalization of knowledge on mental health services utilization.

Natalia Salinas-Oñate https://orcid.org/0000-0001-6451-4965
Patricia M. Flynn https://orcid.org/0000-0002-8701-8611
María José Baeza-Rivera https://orcid.org/0000-0001-7763-0148

Natalia Salinas-Oñate received her MS and PhD in psychology from Universidad de La Frontera, Chile. She is currently assistant professor, academic coordinator of the doctoral program, and director of the "Laboratorio de Cultura y Comportamiento," in the Department of Psychology, Universidad de La Frontera, Chile. Her areas of research interest include factors related to mental healthcare utilization in culturally diverse populations, the relation between culture and mental health, mental health stigma, and mental health literacy.

Héctor Betancourt received his PhD in Psychology from University of California Los Angeles (UCLA). He is currently distinguished professor in the Department of Psychology at Loma Linda University, USA. He also holds an appointment as adjunt professor at Universidad de La Frontera, Chile. His main area of interest is the study of culture and how it relates to psychological processes and behavior. His research focuses on understanding the structure of relations among sociostructural, cultural, and psychological factors as determinants of behavior, and applications to health care and social issues.

Patricia M. Flynn received her PhD in psychology and Master of Public Health (MPH) from Loma Linda University, USA. She is currently an assistant professor in the Department of Psychology as well as in the Department of Preventive Medicine, School of Medicine at Loma Linda University. She serves as the director of Health Disparities Research and Cultural Competence Training for medical trainees who provide primary care services at the Federally Qualified Health Center, San Bernardino, California. Her areas of research interest include the role of culture in health behavior and outcome, culturally competent care, and implicit bias in medical interactions.

María José Baeza-Rivera received her PhD in Psychology from Universidad de La Frontera, Chile. She was a postdoctoral fellow in cultural psychology at Universidad Nacional Autónoma de México (UNAM). She is currently an assistant professor and director of the "Laboratorio de Interacción, Cultura y Salud" in the Psychology Católica de Temuco, Chile. Her areas of research interest include health behavior, culture, healthcare mistreatment, patient–professional relationship, stigma, and barriers to health care.

Manuel S. Ortiz received his MA in Social Psychology from the Pontificia Universidad Católica de Chile and a PhD in Health Psychology from the University of California Los Angeles (UCLA). He is currently director of the doctoral program in Psychology at Universidad de La Frontera, Chile. His areas of research interest include health psychology, psychological stress, chronic diseases, metabolic syndrome, obesity, and psychometrics.

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Correspondence concerning this article should be addressed to Natalia Salinas-Oñate, Department of Psychology, Universidad de La Frontera, Avda. Francisco Salazar 01154, Casilla 54-D, Temuco 4780000, Chile. Email: natalia.salinas@ufrontera.cl

Public Significance Statement
The results revealed that patients who report more positive beliefs about psychological care are more likely to show higher expectations and more positive emotions about psychological treatment and, in turn, indicate a higher intention to adhere to the recommendation to pursue psychological services. These findings suggest that developing culturally sensitive interventions and addressing patients' cultural beliefs and outcome expectation concerning psychological care could have beneficial effects on patients' utilization of psychological services.

Keywords: culture, expectations, emotions, psychological services utilization

There are considerable shortcomings in the utilization of mental health services. For instance, according to research only about 11% of individuals seek help from a mental health professional within the first year of the appearance of a psychological disorder (Andrews et al., 2001). It is common practice in primary care settings to screen for psychological disorders and refer individuals who present symptoms to a mental health professional. Hence, it is important to understand the factors that influence whether or not individuals choose to utilize such psychological services. Delays in seeking psychological help and low adherence negatively impact treatment outcomes in many ways, limiting the effectiveness of interventions, enhancing the risk and severity of symptoms, and increasing healthcare costs (Swift & Greenberg, 2012).

Low utilization of mental health services is particularly problematic in the case of disorders such as depression, which has an estimated global burden of 322 million (World Health Organization, 2017). In the Americas, the prevalence of depressive disorders ranges from 3.7% in Guatemala to 5% in Chile, and 5.9% in the United States. In Chile where the present research was conducted, the rate of disability due to depression is 8.8%, which is higher than in the U.S. (8.4%). In addition, rates of depression are higher among Chilean women as compared to men and among individuals from lower levels of education and income (Ministerio de Salud; MINSAL, 2017). Concerning the utilization of psychological services, Chile reports a treatment gap that is particularly high. Only 13% of Chileans with a psychological disorder have received care from a mental health professional as compared to 21.7% in the U.S. (Kohn et al., 2018).

To address these mental health concerns, in 2005–2006 the Chilean government passed healthcare legislation that included depression as one of the priority health conditions mandated to receive full coverage from the national health system. As a result, the number of patients treated for depression doubled (Bitrán et al., 2010). Still, despite this level of access, many Chileans in need of psychological services do not seek care. For instance, only 21% of those who reported symptoms of depression were at that time in treatment (Markkula et al., 2017).

In La Araucanía, the region of Chile where the present research was conducted, the rate of depressive symptoms is 28.3%, which is one of the highest in the country. Still, the utilization of services for the treatment of depression is 6.7%, one of the lowest of all regions (Markkula et al., 2017). This region also has one of the highest rates of poverty and the largest concentration of indigenous people in the country. This reality highlights a need for research and interventions designed to increase the utilization of mental health services, particularly among populations with higher levels of depressive symptoms and in need of services.

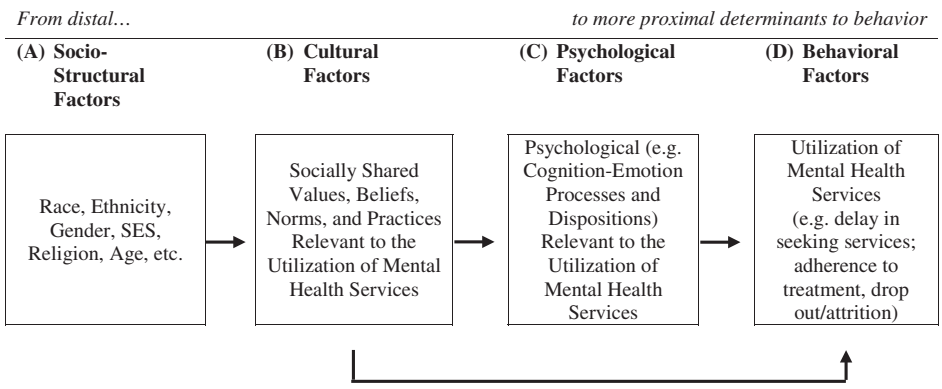
Research conducted predominantly in North America has identified multiple factors relevant to the utilization of psychological services, which can potentially inform research and intervention efforts in Chile. These include sociostructural, cultural, and psychological variables associated with outcomes such as intention to seek services, rates of utilization, and adherence to treatment. Still, much of that research focuses on the independent effects of one or more variables, with little attention given to how they relate to each other as determinants of the outcome of interest. This suggests that integrative theoretical frameworks can guide research and advance knowledge concerning the actual role of those multiple factors and how they relate to each other as predictors of seeking psychological services (Taylor & Kuo, 2018).

The present study was designed to examine the role of some of the variables found to influence seeking psychological services in North America, within the context of the sociostructural and cultural factors identified as relevant in Chile. This research was guided by Betancourt's integrative model of culture and behavior, which specifies the structure of relations among sociostructural, cultural, and psychological antecedents of behavior (Betancourt & López, 1993; Betancourt et al., 2010). The rationale for employing this integrative conceptual framework includes the emphasis on the role of cultural factors and its success at providing a more comprehensive understanding of the utilization of healthcare services (e.g., cancer screening, adherence to diabetes treatment, continuity of care) with diverse populations in the U.S. and Latin America (e.g., Baeza-Rivera et al., 2019; Betancourt & Flynn, 2019; Betancourt et al., 2011; Flynn et al., 2011, 2020; Salinas-Oñate et al., 2017). Although a number of other theoretical models, such as the health belief model (Rosenstock et al., 1994), the theory of planned behavior (Ajzen, 1985), and the model of healthcare utilization (Andersen, 1995) have also been used to predict health services use, these models do not specifically integrate aspects of culture and how they relate to sociostructural, psychological, and behavioral phenomena.

The model depicted in Figure 1 is conceptually based on the integrative model of culture and behavior, which represents the structure of relations among sociostructural, cultural, and psychological factors as antecedents of behavioral phenomena relevant to mental health service utilization. An important underlying aspect of the model is that relations among the variables conceived as determinants of behavioral factors are structured from most distal to more proximal (moving from A to D), with proximity to behavior representing a greater impact. According to the model, behaviors (D) relevant to the utilization of mental health services are a function of psychological factors such as cognition–emotion processes (C), which are experienced at the individual level. These psychological processes are the most proximal antecedents to behavior and,

Figure 1

Betancourt's Integrative Model of Culture, Psychology, and Behavior (Betancourt et al., 2010, 2011; Flynn et al., 2011) Adapted for the Study of Mental Health Service Utilization



Note. SES = socioeconomic status.

therefore, are expected to have the greatest influence on mental health service utilization. Behavior (D) is also directly linked to culture, which is defined here in terms of aspects such as value orientations, beliefs, norms, and practices that are *socially shared* among individuals from a particular society, population, or community (B). These aspects of culture (e.g., socially shared beliefs about psychological care) can directly and/or indirectly influence behavior, through its impact on psychological processes and dispositions (C). Moving further away from behavior are sociostructural categories such as race, ethnicity, religion, gender, age, or socioeconomic status; SES (A), which represent sources of cultural variation. However, these sociostructural categories are more distal determinants and therefore may not necessarily relate to behavior (e.g., utilization of mental health services), other than indirectly through cultural and psychological factors.

Previous Research on the Utilization of Psychological Services

Previous research has examined a variety of factors relevant to seeking psychological services, from race/ethnicity, SES, and gender to beliefs, expectations, and emotions concerning psychological care. Generally, these factors have been investigated in relation to one or another measure of behavioral phenomena relevant to the utilization of mental health services, such as intention to seek psychological help, delay in seeking services, utilization rates, and adherence to treatment (Swift & Greenberg, 2012; Wierzbicki & Pekarik, 1993)

In relation to factors that may impact the intention to utilize psychological services, a significant body of research has focused on psychological determinants, such as expectations and emotions associated with treatment (Constantino et al., 2011). Specifically, outcome expectations, defined as a patient's perception of the likelihood that a particular treatment will help reduce mental health concerns, have been found to influence seeking psychological services and entering or continuing therapy (Constantino et al., 2011; Westra et al., 2010). Also, there is a body of research highlighting the impact of negative emotions associated with psychological care (Ballon et al., 2004; Barney et al., 2006). Shame, embarrassment, and fear (Ballon et al., 2004; Vogel & Wester, 2003) have been associated with lower rates of seeking psychological care (Edlund et al., 2002; Wang, 2007) and a greater likelihood of abandoning treatment (Barney et al., 2006). Although research on positive emotions is scarce, findings suggest that hope, relief, comfort, enthusiasm, gratefulness, and pride may play a positive role. In fact, one study revealed that positive but not negative emotions about psychological care were associated with help-seeking readiness (Israelashvili & Ishiyama, 2008).

Research on factors influencing intention to seek psychological care has also examined the role of beliefs concerning mental health. For instance, negative beliefs about psychotherapy (e.g., skepticism about its effectiveness) have been associated with negative attitudes toward seeking care (Elliott et al., 2015; Li et al., 2014). In general, findings in this area suggest that cultural beliefs about mental health, psychological disorders, and psychotherapy influence seeking and adhering to psychological care (Thomas et al., 2014; Vogel et al., 2007; Wong et al., 2010), and may also influence treatment outcome. This is particularly important for research and intervention with culturally diverse populations.

Studies with Latin American immigrants in Canada found that culturally based subjective norms and related attitudes predicted intention to seek psychological help (Kuo et al., 2015). Another study with African Americans found that cultural beliefs associated with seeking psychological care, such as the belief that seeking professional help implies a lack of faith in God or not being "strong," had a negative impact on seeking help (Taylor & Kuo, 2018). Still, few studies have examined the sources of those cultural antecedents (Acosta et al., 2013).

Research on cultural beliefs related to psychological services in Chile is limited. One of the few studies in this area suggests that Chileans hold rather negative cultural beliefs about psychological care, reporting concerns such as "fear of diagnosis" and "what other people might think" (Vicente et al., 2005). Nevertheless, the characterization of such factors and their role in seeking mental health services has yet to be addressed in Chile (Tapia et al., 2015), particularly among populations referred for these services.

To address the role of cultural beliefs concerning psychological care, a bottom-up cultural research approach to instrument development (Betancourt et al., 2010) was recently implemented in Chile,

to identify and measure socially shared (cultural) beliefs among primary care patients. An important advantage of this cultural research approach is that the population of interest provides the content necessary for the development of the cultural instruments, rather than relying on instruments developed for other populations that may or may not share similar cultural contexts. The implementation of this approach in Chile produced a psychometrically validated scale for assessing Chilean primary care patients' cultural beliefs about psychological care (Salinas-Oñate et al., 2017), which was used in the present study.

As observed in Figure 1, sociostructural factors such as SES, ethnicity, gender, and age are considered sources of cultural variation. Concerning the role of these factors, research shows that women are more likely than men to seek mental health services (Sheu & Sedlacek, 2004) and women hold more favorable outcome expectations and less negative emotions about mental health care as compared to men (Cohen et al., 2015; Israelashvili & Ishiyama, 2008). There is also evidence that individuals from lower SES are less likely to adhere to psychological care (Swift & Greenberg, 2012) and ethnic/racial minorities tend to underuse such services (Wang, 2007; Williams et al., 2005). Evidence is inconsistent concerning age, suggesting that it is related to both positive and negative therapy expectations (Tsai et al., 2014; Waas & Anderson, 1991).

The Present Study

Building on previous research and guided by the structure of relations specified in the integrative model described in Figure 1, the aim of this study was twofold. First, to examine the impact of local cultural beliefs about psychological care on intention to utilize mental health services among primary care patients in La Araucanía region of Chile. Second, to examine the structure of relations among these cultural beliefs, sociostructural, and psychological (emotions, expectations, intentions) factors identified in previous research as relevant to the utilization of services.

In the present study, the point of contact was with patients from 13 primary care centers, who were considered at risk for depression as a result of a physician's clinical interview based on the International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) depression criteria and who were subsequently referred to colocated psychological services. Given that women are overrepresented among patients reporting depressive symptoms in Chile (Hojman et al., 2018; Ministerio de Salud, 2017) and that the majority of individuals who enter mental health treatment in the public system are women (Alvarado et al., 2005), the focus of the present study was on women referred for depression treatment.

Due to the large number of clinics involved in this research and the complexity associated with obtaining actual attendance data from the Chilean primary care centers, the study focused on intention to utilize those services as the outcome of interest. Although this is not the kind of behavioral phenomenon represented in the integrative model (i.e., D), intention is used in the present research as a psychological antecedent of behaviors associated with utilization of services. This choice of outcome measure is also conceptually grounded in attitude theory and research in the area of health promotion. For example, research and intervention based on the theory of planned behavior (Ajzen, 2020) identify behavioral intention as a critical antecedent and predictor of health behavior and behavior change (Fishbein & Cappella, 2006). A metanalysis study of 10 previous metanalyses, including a total of 422 studies examining the extent to which intention predicts behavior, revealed that intentions accounted for an average of 28% of the variance in behavior (Sheeran, 2002). This large effect size, suggests that intentions are strong predictors of behavior (Prestwich et al., 2015).

In a manner consistent with the integrative model of culture and behavior, it was hypothesized that cultural beliefs about psychological care would influence intention to utilize psychological services, directly and/or indirectly, through outcome expectations and emotions related to psychological care. As observed in Figure 1, it was proposed that a causal model including sociostructural (age, SES, ethnicity), cultural (socially shared beliefs about psychological care), and psychological factors (outcome expectations and emotions) as determinants of intention to utilize psychological services, would fit the data. Structural equation modeling (SEM) was employed to test the interrelations among the study variables on intention to utilize psychological services and shed light on the complexity of such relations. It was expected that in addition to advancing knowledge on the structure of relations among determinants of mental health services utilization, results may inform future culturally appropriate interventions.

Method

Participants and Procedure

Participants were 201 women recruited from 13 primary healthcare centers in the cities of Temuco and Padre Las Casas, in La Araucanía region of Chile. Inclusion criteria involved the following: to be 18 years old or above, to be able to read Spanish, and to have received a medical referral from a primary care physician or nurse for colocated psychological services related to depressive symptoms. Exclusion criteria were as follows: to have already attended a first appointment associated with the current referral for depression-related care, and to have a diagnosis of severe depression, psychotic symptoms, or any condition that would limit their ability to respond to the measurement instrument (e.g., illiterate, visually or cognitively impaired).

Concerning the detection of depressive symptoms, all Chilean primary care physicians and nurses are trained to conduct a brief clinical interview using criteria from the ICD-10 (Ministerio de Salud, 2013). Based on those criteria, patients that report "mild to moderate" symptoms are referred for colocated psychological care, within the same primary care center. These were the patients eligible to receive an invitation to participate in the present study. Those with symptoms greater than "mild to moderate" were referred for specialized services outside of the primary care system and therefore were ineligible to participate.

Potential participants who met the inclusion criteria were informed about the study by a medical professional (i.e., physician, nurse) at the time of referral for psychological services. They received a sealed envelope, which included an invitation to participate in the study, the instructions for participation, the informed consent document, and the measurement instrument. Those interested in participating took the envelope with them, to answer the scales at home. The time to complete the measures was approximately 30 min. Subsequently, they contacted the research team by

phone or email, and a research assistant picked up the instruments. Participants were provided with the equivalent of five U.S. dollars as compensation.

All scales included in the instrument were in Spanish, and written at a level of 2.3–5.8 years of education. Although the native language of the Mapuche people is Mapudungun, all of them attend Spanish-speaking schools. In fact, only 8% of the Mapuches speak Mapudungun (Centro de Estudios Públicos, 2016).

The research protocol was in compliance with the International Ethical Guidelines for Biomedical Research with Humans (Consejo de Organizaciones Internacionales de las Ciencias Médicas, 2016) and approved by the Ethics Committee of Araucanía Sur Health Services. Data collection occurred between February and June of 2015. Although attempts were made to have medical professionals track the number of instruments distributed to eligible patients, there was reluctance on the part of some clinics to add such responsibility to the load of physicians/nurses. As a result, it was not possible to reliably report the participation rate.

Measures

Cultural Beliefs About Receiving Psychological Care

The cultural beliefs about psychological care scale was developed and psychometrically validated (for details see Salinas-Oñate et al., 2017) using the mixed-methods cultural research approach to instrument development (Betancourt et al., 2010). This approach begins with specific observations relevant to an area of research (e.g., psychological care), which are derived through interviews from the population of interest (e.g., Chilean primary care patients), and evolves from these observations to the development of quantitative instruments.

The scale is comprised of 13 items with two subscales reflecting positive and negative socially shared (cultural) beliefs about receiving psychological care. The positive cultural beliefs subscale included seven items representing beneficial aspects of care (e.g., "psychological care helps patients love themselves more"). The negative cultural beliefs subscale included six items reflecting beliefs about psychological care being harmful (e.g., "psychological care aggravates the patient's problems"). Responses to all items were on 5-point Likert scales anchored at the extremes, from 1 "strongly disagree" to 5 "strongly agree." After eliminating one of the positive cultural belief items with a low item loading, confirmatory factor analysis revealed good model fit for the positive and negative cultural beliefs scales. Reliabilities for the positive (α = .89) and negative (α = .87) beliefs about psychological care subscales were excellent.

Emotions Associated With Psychological Care

The bottom-up mixed-methods approach described above was also used for the identification of negative and positive feelings associated with psychological care. Items were piloted and psychometric analyses revealed a two-factor emotions scale. The negative emotions factor included three items assessing fear, worry, and embarrassment. The positive emotions factor included three items assessing feelings of tranquility, confidence, and enthusiasm. Participants were asked to indicate the extent to which they experienced these feelings when they thought about seeing a psychologist. Responses were based on a 5-point Likert scale anchored at the extremes, from 1 "not at all" to 5 "very much." The two scales had excellent reliability (positive emotions α = .88; negative emotions α = .86).

Outcome Expectations About Psychological Care

An abbreviated version of the treatment outcome expectations scale (TOES; Dew-Reeves & Athay, 2012), developed in the U.S. to assess youth (and caregiver) expectations regarding the outcomes associated with attending psychological counseling was employed. In comparison to other available measures of expectations that focus on "inaccurate" or "inappropriate" outcome expectations, the TOES was determined to have greater conceptual relevance to the cultural beliefs measured in the present study and hence was utilized for this reason. The TOES was translated into Spanish using the double-back translation procedure and pilot tested with Chilean primary care patients. The original eight items were reduced to five, as three of the items represented behavioral outcome expectations specific to youth and were not relevant to an adult population. The scale assesses personal (rather than socially shared or cultural) expectations about the outcomes associated with receiving psychological care (e.g., "psychological care will help me learn how to deal with thoughts that are bothering me"). Responses were based on 5-point Likert scales anchored at the extremes, from 1 "not at all" to 5 "very much," with higher scores reflecting greater outcome expectations associated with psychological care. The reliability for the 5-items scale was excellent (α = .88).

Intention to Utilize Psychological Services

Two items were used to assess intention to utilize and adhere to psychological care following a medical provider's referral. Participants were asked the extent to which they intended to: (a) go to the psychological appointment, and (b) attend all the prescribed sessions for psychological care. They rated their intentions on 5-point Likert scales anchored at the extremes, from 1 "not at all" to 5 "very much." Reliability for these items was excellent (α = .95).

Sociostructural Sources of Cultural Variation

Information regarding age, ethnicity (Chileans from indigenous vs. nonindigenous backgrounds), and SES was self-reported. Participants were asked if they were Mapuche, the indigenous population of La Araucanía, ("yes" or "no") and report their age in years. SES was measured based on an adapted version of the Subjective Social Status Scale (Adler et al., 2000; Operario et al., 2004). Participants were shown a picture of a ladder and asked to rate where they stood compared to others in Chile, based on their income, education, and occupation. After piloting the original scale, the image was adapted to include six rungs instead of the original 10. This scale has demonstrated adequate test–retest reliability and predictive validity in multiethnic populations in the U.S. and Latin America (Giatti et al., 2012; Operario et al., 2004).

Covariates

Participants responded to two questions regarding prior history of attending psychological care and use of medication for the treatment of anxiety or depression. These questions were based on prior research (Kuo et al., 2015; Rickwood et al., 2005).

Statistical Analyses

SEM with maximum likelihood (ML) estimation was used to test the study hypotheses via Equation 6.3 (Bentler, 2017). A review of the data revealed no missing data and four multivariate outliers, which were subsequently removed, resulting in a sample of 197 participants. Because normality expectations were not met, the robust ML estimation techniques were used to mitigate bias, by providing adjusted standard errors and indices of model fit. Adequacy of model fit was evaluated using robust fit indices, including: a nonsignificant Satorra–Bentler scaled χ^2, a χ^2/df ratio less than 2.0, a comparative fit index (CFI) of .95 or greater, and a root-mean-square error of approximation (RMSEA) of less than .08, with the upper limit of the 90% CI less than .10 (Kline, 2015). In conjunction with theory and conceptual reasoning, the Wald and LaGrange test statistics were reviewed to determine if eliminating or adding paths would improve model fit and if so, they were implemented in a stepwise manner.

A two-step model building procedure was used to first test the measurement model and then the full structural model. The measurement model included three latent factors: outcome expectations about psychological care (five indicators), positive emotions (three indicators), and negative emotions (three indicators). A test of the measurement model revealed an excellent model fit (robust model fit: CFI = 1.00, Satorra–Bentler scaled $\chi^2[41] = 40.40$, $p = .50$; $\chi^2/df = .99$; RMSEA = .00, 90% CI [.00, .05]).

To test the full structural model, sociostructural factors (age, SES, ethnicity) were included as manifest variables. Positive and negative cultural beliefs about psychological care were modeled as manifest variables based on the mean for each factor. Intention to utilize mental health services was modeled as a manifest variable based on the mean of the two items. Guided by the integrative model (Figure 1), the full structural model included paths from each of the sociostructural factors to positive and negative cultural beliefs about psychological care. Consistent with theory, error terms for positive and negative cultural beliefs were covaried a priori (see Hermida, 2015). There were also structural paths from positive and negative cultural beliefs about psychological care to outcome expectations, positive and negative emotions, and intention to utilize psychological care. Lastly, there were structural paths from outcome expectations, positive emotions, and negative emotions to intention to utilize services.

Prior to testing the study hypotheses, an SEM examining the impact of the two covariates (prior history of attending psychological care and use of medication for the treatment of anxiety or depression) on the study variables revealed no significant effect and therefore they were eliminated from subsequent models. To test for the indirect effect of cultural beliefs about psychological care on utilization of services through psychological processes (outcome expectations and emotions), the product of coefficients methods was implemented (Hayes, 2017). In addition, bias-corrected bootstrapped confidence intervals (CI) were calculated based on the strategy discussed by Mackinnon and Lockwood (2014).

Results

Preliminary Analyses

Participants' mean age was 43.6 years old ($SD = 16.5$ years) and 28.4% self-identified as Mapuche. According to the subjective social status scale, approximately 0.5% of participants rated their income, education, and occupation at the top one-third of Chilean society, 40.6% indicated they were in the middle one-third, and 58.9% reported they were in the lowest one-third. Fifty-four percent reported utilizing mental health services previously, and 61.4% had taken medication for anxiety or depression symptoms. The means, standard deviations, and correlations among the study variables are reported in Table 1. Results revealed several statistically significant bivariate correlations among the study variables.

Test of Study Hypotheses

A test of the hypothesized theory-based relations among sociostructural (age, SES, ethnicity), cultural (positive and negative cultural beliefs about psychological care), and psychological (outcome expectations, emotions about psychological care) variables as determinants of intention to utilize psychological services provided a good fit to the data (robust model fit: CFI = .97, Satorra–Bentler scaled $\chi^2[104] = 124.12$, $p = .09$; $\chi^2/df = 1.19$; RMSEA = .03 90% CI [.00, .05]). The study variables accounted for 26% ($R^2 = .26$) of the variance in intention to utilize psychological services.

A review of the Wald test statistic suggested eliminating the paths from age to positive cultural beliefs about psychological care, from ethnicity to positive and negative cultural beliefs about psychological care, and from negative cultural beliefs to expectations. In addition, negative emotions about psychological care were eliminated from the model as they were not predictive of intention to utilize psychological services. A review of the LaGrange multiplier test statistic suggested adding a path from age to intention to utilize psychological services.

The resulting model (Figure 2) provided an excellent fit of the data (robust model fit: CFI = .99, Satorra–Bentler scaled $\chi^2[68] = 78.44$, $p = .18$; $\chi^2/df = 1.15$; RMSEA = .03, 90% CI [.00, .05]). The study variables accounted for 28% ($R^2 = .28$) of the variance in intention to utilize psychological services. As expected, there was a covariance between the error terms for positive and negative cultural beliefs about psychological care ($r = -.45$, $p < .01$). Consistent with the study hypothesis, positive and negative cultural beliefs about psychological care directly influenced intention to utilize psychological services (positive cultural beliefs $\beta = .18$, $p = .01$; negative cultural beliefs $\beta = -.13$, $p = .05$). In addition, positive cultural beliefs about psychological care exerted an indirect effect on intention to utilize psychological services through outcome expectations ($ab' = .07$, CI [.01, .14]). Namely, positive cultural beliefs about psychological care influenced outcome expectations ($\beta = .30$, $p = .00$), which in turn predicted intention to utilize psychological services ($\beta = .23$, $p = .01$). There was an indirect effect of positive cultural beliefs about psychological care on intention to utilize psychological services via positive emotions ($ab' = .08$, CI [.00, .16]). To this end, positive cultural beliefs about psychological care influenced positive emotions ($\beta = .43$, $p = .00$), which in turn influenced intention to utilize psychological services ($\beta = .18$, $p = .03$).

Results also revealed that age and subjective social status were significant sources of variation in cultural beliefs about psychological care. Specifically, higher subjective SES was associated with lower scores on negative cultural beliefs about psychological care ($\beta = -.15$, $p = .02$) and higher scores on positive cultural beliefs about psychological care ($\beta = .15$, $p = .04$). Older participants

Table 1
Correlations and Descriptive Statistics of Measured Variables

Variable	1	2	3	4	5	6	7	8	9
1. Age	—								
2. Subjective SES	.16*	—							
3. Ethnicity (Mapuche = 1)	−.17*	−.25**	—						
4. PCB	.03	.15*	−.08	—					
5. NCB	.12	−.13	.05	−.45**	—				
6. Outcome expectations	−.10	−.01	.08	.29**	−.16*	—			
7. Positive emotions	.15*	.01	−.06	.44**	−.15*	.23**	—		
8. Negative emotions	−.17*	−0.7	.02	.03	.08	.14*	−.21**	—	
9. IUPS	−.14	.03	−.04	.39**	−.30**	.35**	.31**	.02	—
M	43.64	1.26	.28	3.97	1.94	4.26	3.14	1.72	3.05
SD	16.50	.78	.45	.70	.80	.80	1.15	1.22	1.09

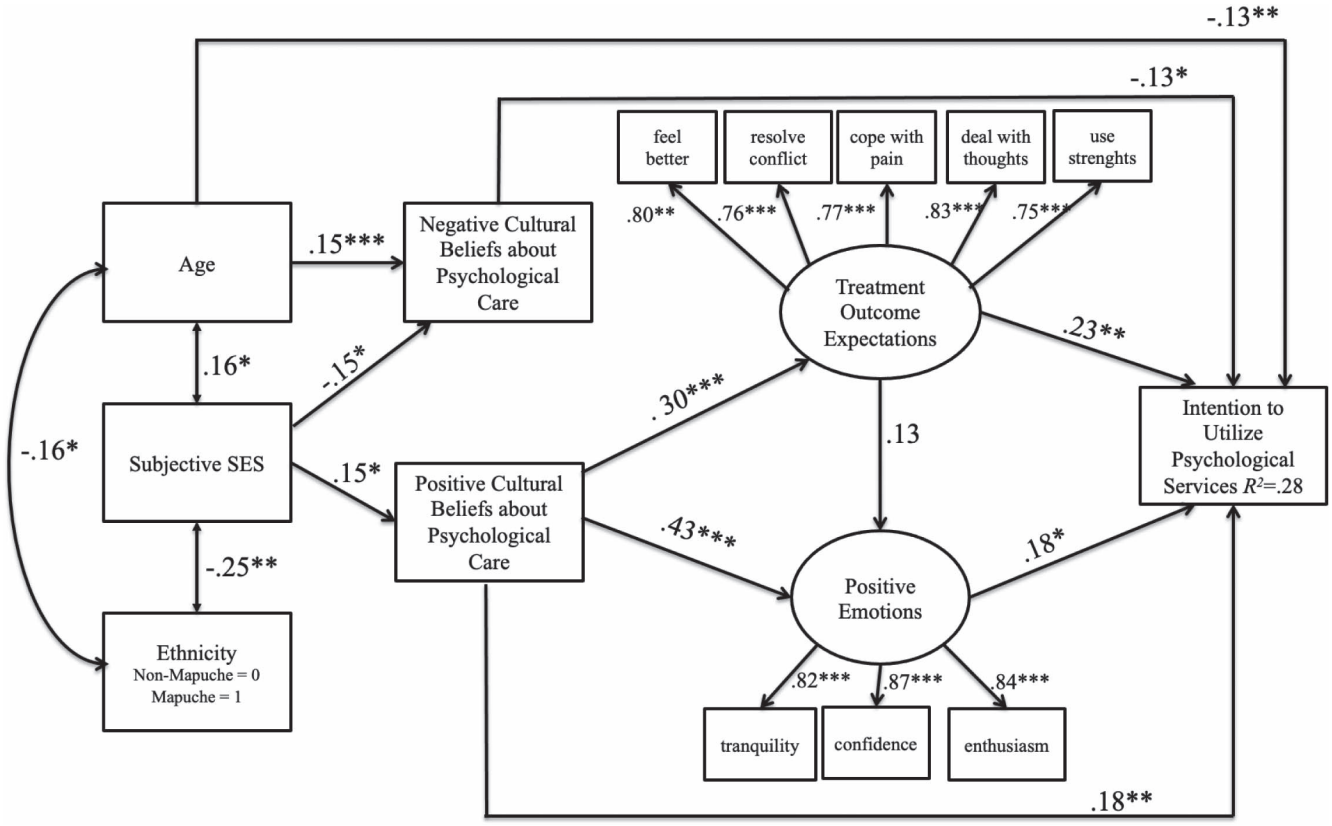
Note. SES = socioeconomic status; PCB = positive cultural beliefs about psychological care; NCB = negative cultural beliefs about psychological care; IUPS = intention to utilize psychological services.
* $p < .05$. ** $p < .01$.

reported higher scores on negative cultural beliefs about psychological care (β = .15, p = .00) and less intention to utilize psychological services (β = −.13, p = .01).

Discussion

This study represents an effort to move beyond the investigation of independent effects of either sociostructural, cultural, or psychological variables as predictors of mental health service utilization. To this end, the structure of relations among these multiple factors thought to influence utilization of psychological services which was examined. The research builds on previous findings and confirms the role of variables such as outcome expectations and emotions as predictors of psychological services utilization, within the cultural context and primary care system of Chile. The fact that this research was conducted in a Latin American country with high rates of depression and low mental health service utilization, adds significance and generalizability to the previous research findings.

Figure 2
Test of the Structure of Relations Among Sociostructural, Cultural, and Psychological Factors as Determinants of Intention to Utilize Psychological Services



Note. SES = socioeconomic status.
* $p < .05$. ** $p < .01$. *** $p < .001$.

By integrating variables originally investigated in other countries with positive and negative cultural beliefs about receiving psychological care that was identified as relevant to Chilean primary care patients, this research may also contribute to the internationalization of research on the utilization of psychological services.

From a conceptual perspective, it is important to note that Chilean primary care patients' cultural beliefs about receiving psychological care influenced intention to utilize those services in a manner consistent with the integrative model (see Figure 1). Specifically, SEM suggested that cultural beliefs about psychological care influenced intention to utilize mental health services in more than one way: directly, and indirectly, through their effects on psychological factors (i.e., outcome expectations and emotions). While the outcome variable was intention to utilize psychological services and not utilization rates per se, the present study findings concerning the role of culture are consistent with previous research which revealed that the impact of culture on actual health behavior, was indirect, through various mediating psychological processes (Amador et al., 2015; Betancourt & Flynn, 2019; Betancourt et al., 2011; Flynn et al., 2015, 2019). In fact, it is not unusual that cultural beliefs can impact multiple mediating psychological factors, such as in the case when cognitions impact emotions, which in turn, impact health behavior (Flynn et al., 2015). Given that research and theory highlight the robust and predictive effect of intentions on actual behavior (Prestwich et al., 2015), one might expect a similar impact of culture on actual utilization rates, through expectations, emotions, and intentions.

Findings from SEM are also consistent with the integrative model in that variations in cultural beliefs about psychological care were a function of sociostructural factors, such as age and SES. Interestingly, ethnicity (indigenous vs. nonindigenous Chileans) was not directly related to cultural beliefs about psychological care, but it was associated with SES, which was a direct predictor of those cultural beliefs. This has conceptual and practical implications, as low SES is often overrepresented among racial/ethnic minorities, but many times overlooked in research. As a consequence, behavioral phenomena, such as those related to intentions to utilize health services can be wrongly attributed to a person's race or ethnicity, when in fact they may be a function of SES (Flynn, 2005). This is not unexpected, as it is consistent with previous findings with diabetes patients of Mapuche background who were more likely to attribute their experience of healthcare discrimination to low SES than to ethnicity (Ortiz et al., 2016).

Generally speaking, the present results highlight the benefits of employing an integrative conceptual framework to elucidate the role of multiple factors relevant to the utilization of mental health services within the context of a culturally diverse society. The research also demonstrates the usefulness or advanced multivariate statistics (e.g., SEM) to unravel the complexity of interrelations among sociostructural, cultural, and psychological phenomena, above and beyond what single-variable studies can do. Such a statistical approach allows for the simultaneous investigation of these multiple variables and provides a means to differentiate the relative impact of each on intention to utilize mental health services.

This study points to interesting questions for future research. For instance, more research is needed to untangle the role of positive and negative emotions associated with psychological care, and under what conditions these emotions may be more effective in promoting the utilization of mental health services. Future research could also distinguish between emotions associated with treatment as compared to those associated with the outcomes of psychological care. In addition, longitudinal studies could shed light on how cultural and psychological factors impact the likelihood that patients will remain in therapy over time and their influence on mental health outcomes. Finally, research could examine other aspects of culture, such as socially shared norms, values, or practices potentially relevant to mental health utilization and associated with sources of cultural diversity, such as ethnicity, SES, religion, gender, or sexual orientation.

These findings may also have implications for clinical practice. Namely, this research revealed that both cultural and psychological factors were important determinants of intentions to utilize psychological services. To this end, patient with depressive symptoms could greatly benefit from interventions designed to simultaneously address the *socially shared* beliefs about psychological care (i.e., cultural beliefs) as well as their *personal* outcome expectations (i.e., psychological processes) associated with receiving mental health services. To this end, if a patient screens positive for depressive symptoms in the primary care clinic, a psychologist could be immediately invited to the room by the physician or nurse for a "warm handoff." At this time, the psychologist could briefly meet with the patient to explore the socially shared beliefs that their friends, family, and other community members have about psychological care as well as the patient's personal expectations about receiving care. This would give the psychologist the opportunity to address any stigmatized beliefs, that may be commonly shared in the community at large, while at the same time providing the patient with realistic outcome expectations, if they were to pursue depression treatment. Such a brief, culturally sensitive approach could increase the likelihood that the patient will return for colocated depression treatment.

The fact that La Araucanía region of Chile has the lowest rate of mental health services utilization in the country (Markkula et al., 2017) underscores the need for interventions to address barriers and facilitators to the utilization of services in the general population as well. To this end, findings from this study could contribute to more effective and culturally appropriate local-level public health interventions. For instance, the present study was guided by a cultural research approach to instrument development that identified both positive and negative socially shared beliefs about psychological care. To this end, public health interventions could include radio, television, and other community-level campaigns to enhance the mental health literacy of the general population, while specifically countering the negative cultural beliefs about psychological care and reinforcing the identified positive beliefs. Enhancing positive expectations and emotions about psychological care, could further improve the utilization of services and ultimately increase the likelihood that individuals with depressive symptoms reach out to their primary care providers for referral. Such an approach is particularly important from the perspective of increasing mental health service use among men in Chile, given their particularly low rates of utilization (Ministerio de Salud, 2017).

International research like this could also inform culturally based interventions aimed at improving psychological service utilization in other countries with culturally diverse populations like the U.S., where this is a public health imperative (Atasuntseva et al., 2020). Specifically, future research could utilize the bottom-up mixed-methods cultural approach (Betancourt et al., 2010) to identify and

measure cultural beliefs relevant to psychological care in any culturally diverse population. Once psychometrically appropriate instruments are developed, the impact of those cultural variables and mediating psychological factors on service utilization can be tested and used to develop more effective culturally based interventions for specific communities.

Despite the significance of the study findings, some limitations should be noted. For instance, participants were all women referred for depression care in a primary care setting. In Chile, rates of depression as well as use of mental health services are significantly lower for men (Encuesta Nacional de Salud; ENS 2016–2017), which limited the ability to recruit male participants for this study. As a result, the generalizability of findings to men or to individuals with other mental health concerns should be viewed with caution. In addition, the present study included a higher percentage of individuals who had previously received psychological services or taken medication to treat depression/anxiety as compared to national statistics concerning utilization rates. It is possible that individuals who had prior experiences with mental health services in the primary care system were more likely to enroll in the present study. Interestingly, despite this potential selection bias, these two variables (prior use of psychological services and medication) were not significant predictors of variables included in the integrative model. These findings suggest that intervention efforts designed to address stigmatized beliefs about psychological care are even more critical for the general population of individuals who are not regularly accessing the primary care system, which is the entry point for receiving psychological services in Chile. Finally, while the tested propositions are solidly grounded in theory, the cross-sectional design suggests caution in interpreting temporal relations.

In sum, the present study confirms the role of cultural beliefs and psychological factors such as outcome expectations and emotions as predictors of intentions to utilize psychological services among patients referred for depression treatment in a primary care center. The study had several strengths, including the use of a conceptual framework and advanced statistical procedures for addressing the multivariate nature of relations among potential sociostructural, cultural, and psychological determinants of mental health services utilization. Findings from this research provide several avenues for the development of culturally sensitive interventions at both the individual level as well as at the public health level. Finally, this research could further contribute to the internationalization of knowledge on mental health services utilization.

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