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Coping With COVID-19: The Impact of the Pandemic on Latina Immigrant Women's Mental Health and Well-being

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Abstract

Introduction.—We sought to describe how Latina immigrants living in King County coped with the pandemic, including their attitudes and behaviors related to COVID-19, and the impact of the pandemic on their mental health and wellbeing.

Method.—We conducted surveys by phone with adult Spanish-speaking Latina immigrants ($n = 137$) in the summer of 2020.

Results.—Very few women had been infected with COVID-19, and 23% reported having been tested. Most frequent reasons for not being tested were not knowing where to go (14%), concerns over the cost (15%), and not wanting to know if they were infected (12%). Most participants had concerns about paying for housing (76%) and food (73%). Depression and anxiety symptoms were in the moderate range. Almost all participants were practicing recommended preventive behaviors.

Conclusion.—Although few participants had COVID-19 infection, the pandemic had significant impacts on their mental health and ability to meet basic needs.

Keywords

COVID-19; Latino; women; immigrant; mental health

Washington was the first state to report a case of the novel coronavirus disease 2019 (COVID-19) in the United States. While the pandemic has affected many people across the United States, Latinos have been particularly affected, experiencing higher rates of

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SARS-CoV-2 infections, hospitalizations and deaths than their White counterparts (Centers for Disease Control and Prevention, 2020; Podewils et al., 2020; Rozenfeld et al., 2020; Ruprecht et al., 2021; Vargas & Sanchez, 2020). In Washington State, Latinos were 3.5 times more likely to be infected, 5 times more likely to be hospitalized, and 3 times more likely to die than Whites (Washington State Department of Health, 2021). Latinos were also more likely to experience COVID-19 disease at younger ages, leading to a greater number of years of potential life lost (Podewils et al., 2020).

Longstanding social and economic inequities have contributed to increased exposure and barriers to testing and treatment among Latinos, especially those who are women and immigrants (Rodriguez-Diaz et al., 2020). Many work in low-wage industries that are considered essential and require close personal contact, yet have few worker protections (Karout et al., 2020; Rodriguez-Diaz et al., 2020). Latinas are also more likely to live in multigenerational households and areas of higher housing density limiting their ability to social distance or quarantine after being exposed (Rozenfeld et al., 2020; Ruprecht et al., 2021). Latina immigrants often have limited access to health care and are less likely to have health insurance, which affects their ability to seek treatment (Rozenfeld et al., 2020). Latina immigrants may also be unable to isolate and quarantine when exposed due to the need to work as a result of their low wages and a lack of paid sick time (Baquero et al., 2020).

The impact of the COVID-19 pandemic on Latinas extends beyond morbidity and mortality. Many Latina immigrants who do not perform essential work have experienced job loss, business closures, and challenges paying for basic needs such as food and housing (Vargas & Sanchez, 2020). Many have delayed care for non-COVID-19-related health issues to avoid clinics and hospitals (Vargas & Sanchez, 2020). Latina immigrants have also reported experiencing stigma and discrimination related to having the COVID-19 disease. These experiences can negatively affect mental health, especially for women who are at increased risk for stress, depression, and anxiety (Connor et al., 2020; Fitzpatrick et al., 2020). Latina immigrant women may also be at increased risk for poor mental health during the pandemic, in part due to increased caregiving expectations and limited social support (Connor et al., 2020; Park et al., 2020). In this study, we sought to describe how Latina immigrants living in King County coped with the pandemic, including their attitudes and behaviors related to COVID-19, and the impact of the pandemic on their mental health and well-being.

Method

Recruitment and Data Collection

Participants in this study were recruited as part of a larger study which sought to evaluate a mental health intervention for Latina immigrant women. Between 2018 and 2020, Latina immigrants ($N= 156$) were recruited for the parent study from two community-based organizations serving Latino immigrants in King County located in Washington State. Participants had to be at least 18 years old, Spanish-speaking, and identify as a Latina immigrant to be eligible for the study. Those with a score greater than 20 on the Patient Health Questionnaire–9, a measure of depressive symptoms, were excluded, as the study was not intended for individuals with severe depression. Between June and September 2020, study participants were contacted and invited to complete a phone survey related

to the COVID-19 pandemic. Out of the 145 participants that were reached, 137 chose to participate and provided informed consent. All procedures were approved by the University of Washington Human Subjects Division.

Measures

The survey included measures of health and health care access, COVID-19-related attitudes, behaviors, and impacts. Demographics characteristics were obtained from previous responses to surveys that been collected during the parent study or were collected during this survey.

Demographics.—Demographic information included age, employment status, household monthly income, household size, number of people older than the age of 65 years and younger than the age of 18 years living in their home, country of origin, and internet access.

COVID-19, Health, and Health care Access.—Participants were asked if they currently or previously had COVID-19, and whether their illness had been confirmed by a diagnostic test/medical provider. All participants were asked whether they had been tested for SARS-CoV-2 virus and, if not tested, their reasons for not getting tested. Participants were also asked about infection prevention behaviors, and the impact of COVID-19 on health services.

COVID-19 Impact.—Participants were asked about their COVID-19-related concerns, new caregiving responsibilities, and whether they had applied for or received temporary benefits or assistance since March 2020. Participants also noted their preferred sources for obtaining information about COVID-19. In addition, participants were asked about concerns paying for housing and food, changes in employment status, or changes in household income since March 2020. Depression was assessed using the Patient Health Questionnaire–9, a nine-item measure of the frequency of depressive symptoms experienced in the previous 2 weeks. Answers ranged from 0 (*never*) to 3 (*almost every day*) and were summed for a total score ranging from 0 to 27. Anxiety symptoms were measured using the seven-item Generalized Anxiety Disorders–7 scale which assesses symptoms over the past 2 weeks. Responses ranged from 0 (*not at all*) to 3 (*nearly every day*) and were summed to create a total score ranging from 0 to 21.

Data Analysis

We calculated the descriptive statistics using proportions for nominal or categorical data and mean and standard deviations for continuous data such as age and income. All data analysis was completed in STATA 14.2 (College Station, TX).

Results

The average age of participants in this study was 42 years, 81% were born in Mexico (Table 1), and almost half (48%) only spoke Spanish. The mean length of time the women had lived in the United States was 15 years and more than half (53%) stated they did not have legal permission to enter and/or stay in the United States, while 18% declined to answer.

The average monthly household income was around \$2,200 with an average household size of 4. Most participants (69%) had children younger than the age of 18 years living in the household.

The frequency of COVID-19 infections, testing, and the impact of the pandemic on routine health care and mental health is presented in Table 2. Only two participants had a confirmed COVID-19 infection and another three suspected they had been infected. Less than a quarter (23%) reported being testing for COVID-19. The most frequent reasons cited for not being tested was not knowing where to go (14%), concerns over cost of the test (15%), and not wanting to know if they were infected (12%). Over half of the participants used telemedicine for medical appointments (54%) and many had cancelled non-COVID-19-related medical appointments (41%) or postponed a medical procedure or surgery (15%).

Table 2 presents participants' concerns related to the COVID-19 pandemic and its impact. Many were no longer working or had their work hours reduced since March 2020. Most participants reported a lower monthly income (74%) and had sought or received temporary benefits such as unemployment security, food stamps, and/or cash assistance from a community organization or relief fund (81%). Most women said they had concerns about paying for housing (76%) and food (73%). Almost all women had concerns about family or friends getting sick with COVID-19, getting sick themselves, not being able to see friends, or not being able to get to work. Common challenges reported were increased costs of meeting basic needs (61%) and new child care responsibilities (46%). Scores for depression and anxiety symptoms were in the moderate range.

In terms of COVID-19-related preventive behaviors, almost all participants were practicing recommended behaviors, including staying home if they were sick (94%), washing their hands frequently (99%), and wearing masks and maintaining social distance (99%). Participants were also asked about trusted sources of information about COVID-19. The internet (61%) and television (55%) were the most common followed by community organizations (26%) and government sources (10%). However, 13% of participants reported not having access to the internet at home and 9% did not have access to the internet at all.

Discussion

In the summer of 2020, when these data were collected, King County had an increasing number of infections with an average of about 118 new cases each week. Local public health officials recommended several preventative behaviors, such as avoiding all nonessential contact, maintaining social distance, and frequent handwashing. At the same time, the Washington State mask mandate went into effect, legally requiring people to wear a face covering in both indoor and outdoor public spaces when unable to physically distance from others (Public Health–Seattle and King County, 2020b). Almost all participants in our study reported practicing these recommended behaviors, suggesting that these recommendations and policies were effective in reaching Latino communities. Few women in our study were infected with COVID-19 during this time, although some reported barriers to testing and obtaining health care. Some participants were also hesitant to be tested, likely out of fear about not being able to work or being discriminated against for having the disease.

At the same time, local public health officials recommended that everyone with COVID-19 symptoms and/or had been in contact with someone who has COVID-19 be tested. Community testing sites began rolling out in Seattle and King County; however, geographic disparities meant that some neighborhoods initially had limited access to testing (King County Hospitals for a Healthier Community, 2021; Public Health–Seattle and King County, 2020a). As it became clear that Latinos were experiencing large numbers of cases in the county, local health officials opened more testing sites in Latino neighborhoods and clearly communicated that the sites had Spanish-speaking providers, were offering free testing, and would not ask for identification or proof of citizenship. These outreach efforts likely led to increased testing over time. However, even when testing was provided at no cost in areas with large numbers of Latinos, they still faced barriers to accessing services (King County Hospitals for a Healthier Community, 2021). These findings highlight the importance of engaging community members to disseminate health information and deliver messages through trusted sources, such as *promotoras* (Montiel et al., 2021; Ornelas & Ogedegbe, 2021). Local public health officials must also provide accurate information in Spanish through social media, internet, and television programming to combat the continued spread of misinformation (Barua et al., 2020).

In terms of the impact of COVID-19, participants experienced significant losses to employment and income. Our findings were consistent with previous research documenting an increased burden of the pandemic on women, who are more likely than men to adjust their employment to take on increased caregiving responsibilities, due to school and child care closures (Hibel et al., 2021; Morgan et al., 2021; Reichelt et al., 2020). Because many immigrants were ineligible for federal government benefits, women in our study relied on temporary relief funds providing cash assistance. The City of Seattle also implemented a program to provide grocery vouchers distributed through community organizations. Residents were not required to provide proof of citizenship to receive these benefits (Washington Immigrant Solidarity Network, 2021). Future relief programs should continue to provide assistance without restrictions tied to immigration status and target outreach to Latina immigrants. In addition, programs should provide support for working Latina immigrant women such as child care, food assistance and affordable housing.

The pandemic also affected Latina immigrants' mental health. Levels of depression and anxiety symptoms among participants were moderate, on average, but much higher than levels reported among women in the parent study prior to the pandemic (Ryan et al., 2021). Similar studies have also noted higher levels of depression and anxiety symptoms among Latinos during the pandemic (Fitzpatrick et al., 2020). This population was already experiencing high levels of economic- and immigration-related stress prior to the pandemic (Ryan et al., 2021). COVID-19 only exacerbated these stressors, while also increasing caregiving responsibilities and social isolation. Similarly, the limited availability of bilingual mental health services was even further stretched due to increased demand. Our findings suggest the need for more affordable and accessible mental health services in Spanish to help Latina immigrant women cope with stress in healthy ways. There is also a need for policies to reduce the social and economic stressors that lead to mental health disparities.

As the pandemic continues, disparities persist in terms of access to COVID-19 vaccines. The proportion of Latinos receiving a COVID-19 vaccine has been much lower than Whites in the United States overall, and in King County (Bloomberg, 2021; Public Health–Seattle and King County, 2021). Reducing these disparities requires providing health information, testing, vaccines, and health care to Latino communities most in need. The pandemic provides an opportunity for public health and health care professionals to build the trust with Latino communities that will be needed to address both the current and future pandemics.

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Table 1.

Participant Characteristics ($N = 137$).

Demographic	N or M	% or SD
Age in years (<i>M, SD</i>)	42	10.6
Years in the United States (<i>M, SD</i>)	15	8.6
Country of birth ^a		
Mexico	111	83%
Other ^b	22	17%
Language		
Monolingual Spanish	66	48%
More Spanish than English	54	39%
Bilingual Spanish/English	17	12%
Education		
Less than high school degree	47	34%
High school diploma	52	38%
More than a high school diploma	38	28%
Immigration status		
Citizen or current visa/permission	40	29%
Entry and/or stay without permission	72	53%
Preferred not to or did not answer	25	18%
Mean monthly income in U.S. dollars ^c (<i>SD</i>)	\$2,243	(\$1,842)
Health insurance		
Any form	35	26%
None	102	74%

^aProportion reported is of those who reported their country of birth ($n = 133$).^bOther countries of birth include the following: El Salvador ($n = 6$), Colombia ($n = 4$), Guatemala ($n = 4$), Honduras ($n = 2$), Venezuela ($n = 2$), The United States ($n = 2$), Ecuador ($n = 1$), and Peru ($n = 1$).^cEight participants did not report their income.

Table 2.

COVID-19 Infections, Testing, and Impact.

	N	% or SD
COVID-19 infection		
Confirmed infection (test or diagnosis)	2	1%
Unconfirmed infection ^a	3	2%
No COVID-19 infection	132	96%
COVID-19 testing		
Performed	32	23%
Positive tests ^b	2	6%
Results inconclusive, negative, or unsure ^b	29	91%
Missing	1	3%
Reasons for not having a COVID-19 test ^c		
Did not know where to go	15	14%
Worried about financial cost of testing	16	15%
Did not want to know if infected	13	12%
Impact on seeking health care		
Appointments held via telemedicine	74	54%
Avoided clinics and/or hospitals	54	54%
Appointment(s) cancelled	56	41%
Procedure or surgery was postponed	20	15%
Have not been able to get medications	11	8%
Changes in employment		
No longer working	39	28%
Had work hours reduced	51	37%
Started a new job, had an increase in hours, or no change in employment	47	34%
Changes in household income		
Lower income	101	74%
No change in income	29	21%
Higher income	7	5%

	<i>N</i>	<i>% or SD</i>
Financial and employment benefits received		
Any	111	81%
Cash assistance from a community organization or relief fund	62	45%
Food stamps/Electronic Benefits Transfer	31	23%
Unemployment benefits	7	5%
Concerns about paying for housing		
None	33	24%
Almost every day ^d	39	38%
More than half the time ^d	17	16%
Concerns about obtaining food		
None	37	27%
Almost every day ^e	23	23%
More than half the time ^e	27	27%
Sometimes ^e	50	50%
Worries related to the pandemic		
Friend/family member(s) getting sick	125	90%
Getting sick	123	91%
Not being able to see family/friends	121	88%
Not being able to get to work	122	89%
Being treated poorly due to being Latina	92	67%
The isolation of family members	56	41%
Challenges due to COVID-19		
Increased costs	83	61%
New child care responsibilities	63	46%
Transportation	41	30%
Mental Health ^f		
Depression symptoms	14.8	5.4
Anxiety symptoms	11.8	4.2

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^aSelf-reported COVID-19 infection in the absence of a diagnostic test or medical diagnosis.

^bNumber and percentages shown of those with a COVID-19 test ($N = 32$).

^cNumber and percentages shown of those without a COVID-19 test ($N = 105$).

^dPercentage shown is of those who answered that they had concerns about paying for housing ($N = 104$).

^ePercentage shown is of those who answered that they had concerns about obtaining food ($N = 100$).

^fMean and standard deviation shown.