School of Graduate Psychology   College of Health Professions

6-27-2014

"De poeta y loco, todos tenemos un poco": Conceptualizations of illness: mexican immigrants

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Recommended Citation

Nixon, Hannah (2014). "De poeta y loco, todos tenemos un poco": Conceptualizations of illness: mexican immigrants (Doctoral dissertation, Pacific University). Retrieved from:
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Abstract

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Degree Type
Dissertation

Comments
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"DE POETA Y LOCO, TODOS TENEMOS UN POCO": CONCEPTUALIZATIONS OF

ILLNESS: MEXICAN IMMIGRANTS

A DISSERTATION

SUBMITTED TO THE FACULTY

OF

SCHOOL OF PROFESSIONAL PSYCHOLOGY

PACIFIC UNIVERSITY

HILLSBORO, OREGON

BY

HANNAH NIXON

IN PARTIAL FULFILLMENT

OF THE

REQUIREMENTS FOR THE DEGREE

OF

DOCTOR OF PSYCHOLOGY

JUNE 27, 2013

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Acknowledgements

There are many people who provided me with assistance, knowledge, and support throughout all stages of this research project. First, I would like to thank Dr. Shahana Koslofky for her guidance and knowledge in the development of this research. With her help, this research was developed to keep cultural considerations at the forefront in both the methodology and analysis of the project. She provided invaluable assistance and direction in working with systemic research guidelines while at the same time respecting the cultural values of the participants that may be in incongruent with research guidelines. I would like to thank Dr. Genevieve Arnaut for assisting me in the development of this qualitative research. Without her help and attention to detail, this study would not have reached development. I am grateful for her words of wisdom and support during the analysis stage. Thank to Hana Nielson-Kneisler for her assistance in reviewing codes. Finally, thank you to my husband, Kasey Nixon, for the countless hours spent proof reading this dissertation. His support will never go unnoticed and I am forever appreciative for everything he has done to help me complete this research. Thanks again for all those who played a role in this study.

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Introduction

The Latino population is one of the fastest growing demographics in the United States, and currently accounts for approximately 16% of the U.S. population. This population is expected to double by the year 2060 (U.S. Census Bureau, 2010). Additionally, according to the U.S. Census Bureau (2012a), over half of the foreign born population in the United States is from Latin America or the Caribbean, making Latino immigrants the largest immigrant demographic. Although Latinos make up a substantial portion of the U.S. population, there is a large discrepancy between the demographic makeup of the general U.S. population and that of healthcare clientele in the United States. Latinos are substantially underrepresented in mental health care services (Alegría et al., 2002; Alvidrez, 1999; Cook, McGuire, & Miranda, 2007; Kouyoumdjian, Zamboanga, & Hansen, 2003). Researchers have identified multiple barriers that may explain this disparity, including socioeconomic status, lack of insurance, limited English proficiency, fear of discrimination, residency status, and cultural values (Alegría et al., 2002; Alvidrez, 1999; Cook et al., 2007; Kouyoumdjian et al., 2003; Rodriguez, Valentine, Son, & Muhammad, 2009).

Distinct conceptualizations of mental illness may as also be a barrier for ethnic minority populations seeking mental health services. Kleinman (1980) defined disease as biological pathology in physical and/or psychological functioning. Illness, however, is how an individual experiences, perceives, and responds to the symptoms of a disease. In short, illness is the subjective experience of a disease (Kleinman, 1980). In this paper, Maier and Straub's (2010) description of the concept of illness will be used. Maier and

Straub stated, "Concepts of illness usually include more than just the ideas about the cause of an illness; they also incorporate ideas about estimating the severity of illness, appropriate treatment, and the meaning of the illness" (p. 234). An individual's concept of illness is largely defined by that individual's culture, especially with regard to mental health (Ward, Clark, & Heidrich, 2009).

The American Psychological Association (2002) has defined culture as the norms, customs, practices, psychological processes, and social institutions that are influenced by a set of values and beliefs. Among Latinos, *espiritualidad* (spirituality)*, familismo* (strong identification and loyalty to one's family)*,* and *fatalism* (fatalism) have been identified as some of the values that may impact Latinos' concepts of illness (Kouyoumdjian et al., 2003). Therefore, when examining mental illness in the Latino community it is important to consider these specific cultural values. Failure to do so may result in considerable misinterpretation of Latino clients' behavior. Latino clients have historically been at risk of being interpreted as lazy, noncompliant, or uneducated when treatment progression is halted (Ailinger, Gonzalez, & Zamora, 2007). Rather than assume that a culturally diverse client is noncompliant with a proposed treatment, a consideration of the individual's unique conceptualization of mental illness may result in more culturally appropriate treatment and greater treatment gains.

In addition to an increased likelihood of treatment gains with culturally competent practice, mental health providers must follow distinct guidelines in order to provide culturally competent treatment. The American Psychology Association (APA) expects psychologists to adhere to the multicultural guidelines on education, training, research, and practice (APA, 2002). According these guidelines, psychologists are reminded of the

ways in which beliefs and practices can be influenced by one's social context inducing race, ethnicity, and social group membership (APA, 2002). Likewise, licensed counselors also have a specific set of guidelines to follow when working with culturally diverse clients. For example, Section E.5.b of the American Counseling Association (2005) code of ethics states, "Counselors recognize that culture affects the manner in which clients' problems are defined. Clients' socioeconomic and cultural experiences are considered when diagnosing mental disorders" (p. 12). The U.S. Department of Health and Human Services (2003) has also provided a comprehensive set of guidelines and recommendations for mental health providers to ensure culturally competent care. In order for clinicians to engage in culturally competent practices, an increased understanding of what constitutes these practices must be gained.

The focus of this research was to gain an increased understanding of Mexican immigrants' conceptualizations of mental illness in the Portland, Oregon, metropolitan area. A focus on the Mexican immigrant population was chosen based on the large percentage of immigrants hailing from Mexico in the Portland, Oregon, metropolitan area. Although results of this research cannot be generalized to the entire Mexican or Latino immigrant community, learning about this specific community will provide an important step in providing more culturally competent care for the Mexican and the larger Latino immigrant population. As noted previously, Latinos comprise over half of the foreign-born population in the United States. With the projected shift in U.S. demographics, understanding the conceptualizations of mental illness among Latino Immigrants will give healthcare providers the necessary information to increase quality of care as well as adhere to the APA Multicultural Guidelines.

<center>**Literature Review**</center>

In the following section, I review previous literature about multicultural conceptualizations of mental and physical illness as well as distinct variables prevalent in the Latino population that may affect the Mexican immigrant community's conceptualizations of mental health. First, and more specifically, previous research on multicultural concepts of illness with various cultural groups is described. Second, information about the disparity between the demographic breakdown of the Latino population and the Latino population in the healthcare system is identified. Third, distinct environmental stressors that place Mexican immigrants at risk for developing or exacerbating mental health problems are reviewed. Fourth, Latino values that may influence the Mexican immigrant community's conceptualizations of mental illness are described. Fifth, the benefits for researching and understanding multicultural conceptualizations of mental illness are highlighted. Finally, the purpose of this study is explained.

Multicultural Conceptualizations of Illness

In a westernized medical model, illness is often considered to be the result of a combination of environmental and genetic risk factors (Cooper, 2001; Jaffee & Price, 2007; Rutter, 1997). Hence, pharmaceutical or behavioral changes are corresponding remedies for such illnesses. Likewise, in regard to mental illness, pharmaceutical treatment and/or psychotherapy are often considered to be primary interventions (Wang et al., 2005). However, assuming this conceptualization is inherently shared across cultures would be detrimental to client care. Because cultures vary in values, practices,

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and customs, we cannot expect beliefs about mental illness to be homogeneous across cultures.

Several authors have outlined distinct conceptualizations of illness across diverse populations. Sabuni (2007) categorized beliefs about the causes of illness among participants native to the Democratic Republic of Congo into seven separate categories including (a) natural; (b) physical; (c) social; (d) breaking taboos; (e) heredity; (f) witchcraft, sorcery, and poisoning; and (g) punishment from ancestors. These beliefs about the causation of illness influenced preventative care and help-seeking behaviors of those who had fallen ill. For example, certain food and practices are prohibited among members or clans in the Nande and Bira tribes. Specifically, in some tribes, it is taboo for pregnant women to eat eggs because it is considered to be detrimental to the wellness of the baby (Sabuni, 2007).

In Nicaragua, a sample of women defined health as the ability to work, the ability to maintain healthy nutrition, have a happy or balanced disposition, and have a good appearance (Ailinger et al., 2007). Consequently, the women focused on maintaining a well-kept and sanitized home, seeking adequate nutrition, and obtaining medical interventions as preventive care. In a study out of Samoa and New Zealand, Norris, Fa'alau, Va'ai, Churchward, and Arroll (2009) found that many participants made distinctions between Samoan and European illnesses.

Maier and Straub (2010) investigated beliefs about illness and treatment expectations of traumatized migrants in Switzerland. The participants endorsed multiple explanations about the causes of their illness as well as their treatment expectations. Some of the participants held the belief that mental health symptoms were synonymous

with physiological symptoms and hence could be treated similarly to other medical problems via the use of medications. Others believed their symptoms would naturally decrease with time. Some participants believed their current distress was a result of prolonged political, economic, and social suffering in their country of origin and hence could not be cured due to ongoing knowledge of other family members still residing in those affected areas.

Bracken, Giller, and Summerfield (1995) exemplified how the conceptualization of illness informed help-seeking behaviors in research with female Ugandan rape victims. In this research, the authors studied the subjective concept of trauma in order to better understand the women's understandings of trauma and subsequent treatment needs. Although the women endorsed many of the symptom criteria for posttraumatic stress disorder (PTSD), the primary concern for the participants was somatic in nature. Specifically, a failure to conceive was a dominant complaint. Of note was the high value of fertility in Ugandan culture. The cultural value of fertility likely impacted the participants' conceptualization of illness. Hence, the participants' expectations for healing involved pain and fertility treatment. In that population, the westernized view and subsequent treatment for PTSD would have been incompatible with the participants' conceptualization of illness. Likewise, in Maier and Straub's (2010) research, many of the participants first sought care from their general practitioners. This pattern of help-seeking behavior suggests that these migrants conceptualized many of their symptoms as physical in nature.

The concept of *susto* is another example of how the conceptualization of illness is influenced by cultural beliefs. In the Latino population, *susto* is a cultural idiom of

distress that is typically caused by a traumatic or frightful event such as an assault, a family member's death, or a rupture in a social support system. *Susto* is believed to have taken place when the soul leaves the body. It is often accompanied by restlessness, weakness, weight loss, fearfulness, and decreased motivation (Falicov, 1999; Tseng & Mcdermott, 1981). To the westernized practitioner, a client with *susto* may appear to have anxiety, depression, or another physical ailment. Consequently, subsequent treatment would likely include medications or psychotherapy. However, the cultural congruent treatment of *susto* typically involves the help of a local healer who works to retrieve the lost soul (Tseng & McDermott, 1981). In many Latino cultures, *susto* is considered fatal if left untreated. Hence, failure to recognize the client's conceptualization may not only lead to a lack of treatment progress but may also contribute to increased suffering and serious consequences (Rubel et al., 1984; Tseng and Mcdermott, 1981).

These studies are not an exhaustive list of the cross-cultural research on the conceptualization of illness regarding mental health. However, they illustrates some of the varied conceptualizations about illness across cultures.

The Latino Population in the United States vs. the U.S. Healthcare System

The Latino population in the United States. Cross-cultural understandings of mental illness are becoming increasingly salient in the United States. In the 2010 census, the Latino population was the fastest growing demographic in this country. Between 2000 and 2010, the Latino population grew by 43%. In 2010, the Hispanic[1] population comprised approximately 16% of the total population (U.S. Census Bureau, 2010).

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[1] The use of the terms Hispanic and Latino are based upon the choices of previous authors in the original references.

Additionally, this population is expected to double by year 2060, suggesting that approximately 1 out of 3 U.S. inhabitants would identify as Latino or Hispanic (U.S. Census Bureau, 2012b). In regard to the Latino immigrant population and according to the 2010 Census, approximately 13% of the current U.S. population is foreign born (U.S. Census Bureau, 2012a). Of that 13%, over half (53%) of the immigrant population is from Latin America or the Caribbean (U.S. Census Bureau, 2012a).

The Latino population in the U.S. healthcare system. With the projected demographic change in the U.S. population, a comparable change with access to healthcare services is a reasonable expectation. However, the demographic breakdown in healthcare communities has historically been drastically dissimilar to the demographic breakdown of the general U.S. population (Kouyoumdjian et al., 2003). The Latino population continues to be significantly underrepresented in the health care system, even more so in the mental health care system (Alegría et al., 2002; Alvidrez, 1999; Cook, et al., 2007; Kouyoumdjian et al., 2003). In a recent study by Cook et al. (2007), Latinos were 38% less likely to have a mental health visit than were European Americans. This underutilization of services is alarming considering the unique mental health needs of the Latino population, and more specifically the Latino immigrant population.

Barriers to accessing U.S. healthcare. Barriers that prevent or inhibit Latino individuals' access to mental health care include socioeconomic factors, lack of insurance, limited English proficiency, fear of discrimination, residency status, cultural values, and different conceptualizations of illness (Algeria et al., 2002; Alvidrez, 1999; Cook, et al., 2007; Kouyoumdjian et al. 2003; Rodriguez, Valentine, Son, & Muhammad, 2009). A final barrier, and a focus of the current study, is the possible discrepancy in the

conceptualizations of mental illness between healthcare providers and clientele. Maduro

(1983) wrote:

Often overlooked is that culturally different patients such as Latinos who appear

for outpatient or inpatient health services bring with them preconceived ideas and

expectations about what constitutes illness, what kinds of treatment procedures

are effective and correct and what kinds of health services are most compatible

with their life styles. (p. 868)

Some authors have addressed this barrier in the Latino population. Carpenter-

Song, Chu, Drake, Ritsema, and Smith (2010) found that members from Latino and

African American backgrounds expressed resistance to mental health care. Some of the

Latino participants questioned the helpfulness of psychotherapy as well as other types of

treatment. Unfortunately, clients from nondominant cultures who may have different

views on mental illness are at risk of being interpreted as noncompliant, lazy, or

uneducated when treatment progression is halted or static (Ailinger et al., 2007).

Environmental Stressors in the Latino Immigrant Community.

Many environmental stressors affect the Latino immigrant community that may

cause individuals to develop or exacerbate mental health problems. As noted previously,

the foreign-born Latino population has increased substantially over the last 10 years and

is projected to continue growing. Hence, an awareness of the experiences and

conceptualizations of the Latino immigrant population is a growing need. The Latino

immigrant population has a higher susceptibility of encountering environmental stressors

not typically experienced by the dominant culture including political violence, adverse

immigration experiences, acculturation stress, and racism (Bryant-Davis & Ocampo,

2005; Fortuna, Porche, & Alegría, 2008; Pole, Best, Metzler & Marmar, 2005; Sztomka, 2000).

Trauma. Exposure to potentially traumatic events is an important consideration for clinicians in mental health care working with immigrant populations. In a study by Fortuna et al., (2008), an alarming 76% of immigrants in the United States endorsed exposure to at least one traumatic life event. Eleven percent of immigrants in this sample endorsed exposure to political violence. Over the last 60 years, refugees seeking a safe haven from war-torn countries have comprised a portion of the Latino immigrant population. Some of these refugee communities are the result of (a) high levels of guerilla activity in Columbia beginning in the 1940s; (b) civil war in Nicaragua (1982-1990), which resulted in an exodus of over 250,000 refugees; and (c) civil war in El Salvador (1972-1992) (Fortuna et al., 2008). Immigrants are also at increased risk of exposure to violence during the immigration experience, including physical assault, illness, immigration detention, and the loss of family or friends (Levers & Hyatt-Burkhart, 2011). The use of illegal travel bookers, known as coyotes, also places immigrants at risk for multiple forms of abuse. Upon arrival, immigrants may be met with adverse living conditions without adequate resources. In addition to decreased resources, settlement areas designed for refugee populations are susceptible to overcrowding (Foster, 2001). Many of those attempting to acquire refugee status are required to recount traumatizing events in order to prove the legitimacy of their persecutory fear and subsequent need for protection (Engstrom, 2004). Foster (2001) concluded that "premigration abuse/disaster; migration transit; asylum seeking; and substandard living conditions in the host environment all can serve as individual or cumulative assaults on human beings already

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stressed by having left behind the world they know" (p. 167). Taking into account the various and potentially traumatizing stages of the immigration process, Latino immigrants are at increased risk for needing specialized physical and mental health services.

Acculturation. The acculturation process is yet another hurdle that many Latino immigrants face upon arrival in the United States. The process of acculturation has been broadly defined as the cultural changes that occur in the encounter and interaction between diverse groups (Schwartz & Zamboanga, 2008). Although these encounters can induce cultural changes in both parties, in practice, acculturation has historically involved greater changes in the values, language, and behaviors of minority groups (Miranda & Matheny, 2000; Schwartz & Zamboanga, 2008; Torres & Rollock, 2007). Many variables contribute to the integration into a new culture with some of the strongest influences being language abilities, family cohesion, coping style, resources, and time spent in the new country (Miranda & Matheny, 2000; Torres & Rollock, 2007). The stress of adapting to a new culture can result in increased mental health symptoms, particularly depressive symptoms (Torres & Rollock, 2007). Exposure to racism may also hinder a healthy acculturation process (Levers & Hyatt-Burkhart, 2011).

Racism and discrimination. Members of the Latino community are at a heightened risk of encountering racism, which may elevate risk for psychological distress (Bryant-Davis & Ocampo, 2005; Flores, Tschann, Dimas, Pasch, & de Groat, 2010; Pole et al., 2005). In one sample, an alarming 94% of Latino adolescents reported experiences of racial discrimination. Even more disturbing, 21% of this sample endorsed frequent discrimination. Subsequently, 28% of this sample reported numerous symptoms of PTSD

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(Flores et al., 2010). Chronic exposure to racism has been speculated to be synonymous with chronic trauma, which can result in symptoms of fear, avoidance, hyperarousal, and helplessness (Carter, 2007).

Values in the Latino Community

Kouyoumdjian et al. (2003) discussed many traditional cultural values that impact Latinos' conceptualization of mental health and may subsequently result in lower utilization rates. The author highlighted how cultural values of *espiritualidad* (spirituality), *familism* (strong identification and loyalty to one's family), and *fatalismo* (fatalism) may influence mental health help-seeking behaviors in the Latino culture. For example, a Latino individual suffering from a mental illness may seek assistance from a spiritual leader, rely on family members for support, or feel as if he or she has minimal control over the situation. Although the above-mentioned values may very well result in beneficial coping skills, these values could also contribute to additional symptoms. For example, for an individual suffering from depression, a fatalistic viewpoint may result in the individual feeling as if he/she is being punished and result in increased feelings of helplessness and subsequently increasing the severity of depressive symptoms. Likewise, reliance on family is often a positive treatment indicator. However, in more extreme cases of mental illness, sole reliance on the family could result in additional negative consequences. A person suffering from mental illness may experience an increase in symptomatology as a result of going undiagnosed. The family may also experience additional systematic stress as the afflicted individual becomes increasingly reliant on the family system (Kouyoumdjian et al., 2003).

If a Latino immigrant is resistant to a mental health clinician's recommendations, there exists a chance that the provider will remain unaware of the client's hesitation or concern. In research about communication trends between Latino clients and mental health providers, Cortes, Mulvaney-Day, Fortuna, Reinfield, and Algeria (2009) found that many Latino clients did not question the clinician's conceptualization of illness. Additionally, some participants seemed either unwilling or unable to consider their treatment provider to be anything less than an all-knowing authority figure. One Latina woman in the study commented, "She is a psychiatrist, she went to school, she knows more than me. She is a professional" (Cortes et al., 2009, p. 145). This obedience and compliance is a common occurrence in ethnic minority communities where medical providers are considered to be all knowing (Maier & Straub, 2010). High levels of trust and reverence for medical providers is not inherently harmful for the client. The decision to follow the recommendations of treatment providers is generally considered to be appropriate and beneficial. However, if a clinician recommends a culturally incongruent treatment, the client is either left to ignore the treatment provider, an action that may result in the individual also feeling as if he or she has been disrespectful, or to act in contradiction to the client's own cultural norm that may place the client at risk of developing additional stress and health consequences. Therefore, when working with a Latino client who may demonstrate respect via passive acceptance or an unchallenging attitude towards the treatment provider, it is of utmost importance that the clinician seek to understand the client's conceptualization of illness before moving forward with treatment.

Treatment Benefits to Understanding Multicultural Conceptualizations of Illness

Stewart et al. (2000) sought a common understanding of individuals' physical health and illness by inquiring about participants' ideas about illness and determined that an increased understanding of clients' conceptualizations of illness can have beneficial influences on treatment, such as more positive health outcomes, increased efficiency of care, fewer diagnostic assessments, and fewer referrals. Clients are more likely to expect increased symptom improvement and better treatment outcomes when there is agreement about treatment and the perception of understanding on the part of the practitioner (Kaptchuk, 2002; Starfield et al., 1981).

Furthermore, when clients perceive or expect greater benefits from treatment, greater success and improvement in treatment is likely to occur (Eccles, 2007; Kaptchuck, 2002; Mayberg et al., 2002; Starfield, 1981). The connection between a belief in treatment and subsequent treatment benefits has been demonstrated in research about the placebo effect (Eccles 2007; Khan, Warner, & Brown, 2000; Lee et al., 2005; Mayberg et al., 2002; Van Cauwenberge & Juniper, 2000). Eccles (2007) described the placebo effect as "the therapeutic effect of any form of treatment that depends on the patient's belief in the treatment rather than on any physical or pharmaceutical properties of the treatment (e.g., faith healing, prayer)" (p. 100).

Kaptchuk (2002) wrote specifically about the placebo effect in the use of alternative healing practices that have, at times, produced dramatic and compelling treatment results outside the explanation of conventional medical treatment. The author cited the powerful influence of the client's belief in the treatment. Additionally, Kaptchuck (2002) noted the increased probability of treatment gains when agreement about the treatment approach is consensual between the client and treatment provider.

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Mental health providers could greatly enhance efficiency and quality of cross-cultural care by obtaining increased awareness into culture specific beliefs about illness. As mentioned previously, eggs are a taboo food for pregnant women in the Nande and Bira tribes (Sabuni, 2007). For many westernized cultures, eggs are a common source of protein used in many dishes. A naïve clinician may, with the best of intentions, suggest an increase of protein intake via eggs as part of a nutritional regime for a pregnant woman native to the Bira tribe. In describing the powerful effects of treatment beliefs, Eccles (2007) wrote, "A harmful or negative 'nocebo' effect is possible if that person believes that a procedure or treatment is harmful" (p. 103). A clinician who violates cultural beliefs during treatment may unknowingly subject the above-mentioned client to detrimental health consequences or social alienation as a result of breaking a cultural rule. Although knowledge about every culture's unique beliefs and taboos is implausible for clinicians, understanding that cultural differences exist may lead clinicians to search for each client's conceptualizations of mental illness in the diagnosing and treatment planning phases of treatment. By doing so, the practitioner decreases the risk of unhelpful or possibly detrimental care.

Summary

In conclusion, cross-cultural research on the conceptualizations of mental illness has increased as health professionals have increasingly recognized the importance of the client-practitioner agreement and alignment in treatment beliefs (Stewart et al, 2000). Although cross-cultural work is becoming an increasingly emphasized area of research and practice in the field of psychology, little research has been done investigating Mexican immigrants' conceptualizations of illness with respect to mental health. There

currently exists a stark discrepancy between the Latino representation in the U.S. population and the Latino representation in healthcare clientele, especially when considering the increased probability of environmental stressors often experienced in immigrant populations. One hypothesis to explain this discrepancy is a lack of understanding about the causes of mental illness and treatment goals on the part of healthcare providers resulting in services that are inefficient or detrimental to the client. Another explanation may be healthcare providers' lack of awareness about Latino immigrant help-seeking behaviors resulting in an underutilization of existing mental health services and a greater need for services in settings uninhabited by mental health care professionals.

Purpose of the Current Study

The goal of this exploratory research was to gain knowledge about concepts of mental illness in the Mexican immigrant population. Although researchers have increased the breadth of cross-cultural research, few, if any, researchers have focused on learning about Mexican immigrants' subjective experiences and perspectives on mental health. As previously stated, this area of research is especially important given the projected population increase of the Latino population. The more that mental healthcare providers understand the role of culture in healthcare, the better they will be able to effectively and efficiently meet the needs of the communities they are serving. As stated previously, many barriers may influence the Mexican immigrant population's underutilization of mental health care services. By investigating and increasing awareness of Mexican immigrants' conceptualizations of mental illness, clinicians can learn to provide more culturally competent treatment, and help reach out to more individuals in need. In order

to adequately research conceptualizations of mental health, a qualitative approach was selected due to the subjective nature of the material. Specifically, the following questions were investigated:

1. What conceptualizations of illness are held by Mexican immigrants seeking physical or mental health services in the Portland, Oregon, metropolitan area?

2. What kind of health help/treatment (medical or nonmedical) have Mexican immigrants already made use of for mental health concerns during their stay in the United States?

3. What perceptions do Mexican immigrants have about psychotherapy? Do they consider it an appropriate treatment for their current health problems?

4. How do Mexican immigrants experience and describe their perceived present distress?

Method

Research Design

A qualitative approach was selected for multiple reasons. First, the goal of qualitative research is to understand participants' subjective experiences rather than test a previously defined hypothesis (Montell, 1999). With this approach, I was be able to get a more in-depth understanding of how Mexican immigrants conceptualize health, a topic that I would have been unable to capture through the use of quantitative methods that require explicitly defined and measureable constructs. With qualitative approaches, researchers can help develop new topics for quantitative data to explore and measure as well as increase the validity of quantitative measurement tools (Fossey, Harvey, McDermott, & Davidson, 2002). In referring to qualitative methodology, Fossey et al. (2002) stated, "These methodologies are especially appropriate for understanding individuals' and groups' subjective experiences of health and disease; social, cultural, and political factors in health and disease; and interactions among participants and health care settings" (p. 718).

The second reason a qualitative approach was chosen to engage in the most culturally competent research practices. Unfortunately, more often than not, the Latino population has been studied with tools developed for measuring psychological phenomena in White populations (Dana, 2000). Further, although quantitative measures can provide useful information in a variety of settings, caution should be used when administering standardized assessments primarily with English-speaking populations to assess Spanish-speaking populations (Acevedo-Polakovich et al., 2007). Historically, the

Latino immigrant population has been understudied in psychological research. Not only has little research been conducted with Latino immigrant communities, but this community has also historically been difficult for researchers to access. Ojeda, Flores, Meza, and Morales (2011) reported:

> Unfamiliarity with research, prior experiences of being exploited or deceived for research purposes, concerns about language fluency, or fears that information they provide for a study will be reported to "immigration" may contribute to Latino immigrants' consideration of participating in research. (p. 189)

Many immigrant populations are excluded from research as a result of these barriers. However, when done in a culturally competent manner, qualitative research can help give a voice to the Latino immigrant population, a group typically excluded from research (Ojeda et al., 2011).

Finally, a qualitative approach offers increased opportunities to honor the cultural values of the Latino population. Integrating cultural values into research is of utmost importance in conducting culturally competent research (Ojeda et al., 2011). *Personalismo* is a cultural value in the Latino community referring to a style of communication that reflects warm and friendly exchanges in social interactions (Añez, Silvia, Paris, Jr., & Bedregal, 2008). In a research setting, the researcher must work to obtain personalismo in order to develop rapport and trust in the researcher-participant relationship. One way to demonstrate personalismo is by engaging in *platica*, or small talk (Arredondo, Bordes, & Paniagua, 2008). Ojeda et al., (2011) summarized:

> In addition qualitative research methods honor the Latino cultural value of *personalismo*, or interpersonal connections. Furthermore, given Latino

immigrants are understudied, qualitative methods allow us to generate theory

rather than testing theory as is typically done with quantitative research methods

from a Eurocentric lens. (p. 185)

During this study, personalismo was demonstrated by engaging in *platica,* or

small talk about family, work, weather, and health before commencing the study, in-

between filling out forms, and after the interview

For this study, a grounded theory approach was used. The overall goal was to

formulate an explanatory theory of the conceptualizations of illness (i.e., perspective of

health/illness, help-seeking behaviors, interactions with the healthcare system etc.) based

upon the various perspectives and experiences of members in the Mexican immigrant

community. Participants were invited to engage in a more in-depth and detailed

discussion of the subject matter through the use of broad and open-ended questions

(Charmaz, 2006). Consistent with a grounded theory approach, the role of the researcher

in the interview was to keep the participant on the proposed subject, explore themes,

inquire about the participant's thoughts and feelings related to the subject, paraphrase and

restate the participant's explanations, validate and express interest in the perspective of

the participant, and demonstrate respect for the participant in the interview process

(Charmaz, 2006). With this approach, interviews are conducted in an appropriate and

supporting manner, the participants can feel free to be the expert on the material in

question, reflect on their experiences, tell stories, choose what and how they share

information, and express thoughts or feeling not typically permitted in other contexts.

Participants

Participants were selected using a purposive sample method. This method was chosen as a means of focusing specifically on Mexican immigrants who have had some form of interaction with the healthcare system in order to investigate beliefs and opinions about mental illness, treatment, and healing. I presented the aims of the study to participating clinics in order to increase collaboration with local agencies as well as increase the number of referring healthcare providers. Additionally, establishing and building relationships with leaders who have already established trust in the Latino community is an integral step to recruiting Latino immigrant participants. Ojeda et al. (2011) confirm "effective recruitment involves building relationships with key community leaders who have already established trust with the Latino immigrant community." Agencies that agreed to serve as referring entities included Lifeworks NW Services, Virginia Garcia Memorial Health Centers, Lutheran Community Services NW, and the Pacific Psychology Clinic. These clinics are located in the following Oregon cities: Portland, Beaverton, Hillsboro, Cornelius, and McMinnville. If referring providers believed a client to be eligible for the study, the provider offered the client a flyer outlining the study. Participants were notified that the decision to participate or not to participate in the study would have no bearing on the services the individual was currently receiving. It was important to ensure that participating in this study was made as easy and convenient as possible for the participants. For example, arrangements were made to conduct the interviews in the town or nearby geographical vicinity of each participant's home residence. Participants were given a direct phone number to contact the principle researcher to facilitate easy communication. Participant requests to allow young children (under age 2) to attend the interviews were acknowledged and permitted.

Additionally, each participant was reimbursed with a gift card for his or her time and effort to attend the interview.

In order to be eligible for the study, individuals had to be immigrants of Mexican origin who were independently seeking mental health services or those who had been referred by a primary care physician to a mental health care provider. This connection to mental health services was anticipated to influence the content of the participants' definition of the word 'complaints' in the interview in order to gain information pertinent to the mental healthcare system as well as the larger healthcare system. Participants were also required to be over the age of 18 and be either monolingual Spanish-speaking or bilingual English/Spanish speakers. Participants were not required to have a diagnosable mental health disorder in order to participate in the study. Finally, participants needed to be autonomous and able to consent independently in order to participate.

A total of eight participants engaged in the interview process. All of the interviews were conducted in a neutral room in the geographical location of the participant. Before engaging in the semi-structured interview, participants were asked to review and sign an informed consent form (Appendix A), participant contact form (Appendix B), and an audio recording release (Appendix C). Participants were then asked to complete a demographic form (see Appendix C & Appendix D). The participant demographic information is listed in Table 1. All participants were immigrants of Mexican origin.

Table 1

Study Participants

Demographic Characteristics	Sample

Sex	Female (6); Male (2)
Age	Mean 44; Range 24-68, SD 14
# of years living in the United States	Mean 18; Range 4-50, SD 14
Language spoken at home	Spanish (6); Spanish & English (2)
Language spoken at work/school	Spanish (2); Spanish & English (4); English (2)
# of academic years completed	3-6 years (3); 6-9 years (1); 9-12 years (4)

Materials and Procedures

Materials. Before data collection with a potential participant began, I explained the purpose of my study to potential participants and reviewed informed consent. I met with eight individuals, all of whom met criteria to participate in the study. The potential participant was informed that the interview would be recorded with an audio device. The individual was also given the option to refrain from answering any question that might make him or her feel uncomfortable or that he or she did not want to answer. The participant was informed that the general results of the study would be disseminated to local health care clinics. I addressed the participant's rights to confidentiality as well as the limits to confidentiality. I then discussed and clarified any questions the potential participant had about informed consent. Once knowledge of informed consent was demonstrated, the participant signed the informed consent document.

The participant was provided with a separate informed consent regarding the use of an audio recorder to record the semi-structured interview. The participant was

informed that identifying information and demographic information would not be recorded on the audio device.

The participant was given a participant contact form. On the participant contact form, participants could indicate whether he or she would like to obtain the general results from the study.

Participants were asked to fill out a brief demographic form that included information including each participant's name, date of birth, gender, education level, country of origin, and time spent in United States (see Appendix C & Appendix D).

A semi-structured interview was used in order to gain understanding of Mexican immigrants conceptualizations of illness (see Appendix E & Appendix F). The questions in this interview were based on questions developed by authors Maier and Straub (2010) who researched illness beliefs and treatment expectations in a sample of traumatized migrants in Switzerland. Written permission was obtained from these authors to use their semi-structured interview protocol. The interview was translated into Spanish by a native Spanish speaker with experience in mental health and subsequently back-translated by a different native Spanish speaker (who is a bicultural Spanish-language professor) to ensure consistency between English and Spanish forms. Participants were given the option of being interviewed in Spanish, English, or both languages. Five of the participant chose to conduct the interview in Spanish language, two participants chose to conduct in English language, and one person switched between Spanish and English language.

Interview protocol. The individual participated in the semi-structured interview that included a series of questions about the individual's view on health and

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conceptualizations of personal complaints. During the interview, the researchers

occasionally asked additional questions in order to clarify any participant responses that

were unclear. The semi-structured interviews ranged from 14-71 minutes, with an

average interview length of 30 minutes. Some participants included examples or stories

in their explanations whereas others answered in a more direct or brief manner. At the

end of the interview process, participants received a $20 gift card to Walmart as gratitude

for completing the interview process.

Data Analysis

Charmaz (2006) identified two main phases used to analyze data in grounded

theory. First, I developed initial codes by analyzing small segments of data, typically

through the use of line-by-line coding. During this first phase of coding, my goal was to

remain open to all possible theoretical categories elicited from the interviews. In the

second phase, the most frequent and significant codes in the initial coding process were

sorted and organized. This process allowed me to pinpoint and reflect on the most salient

pieces of information (Charmaz, 2006). A more detailed description of the phases is

provided in the following sections.

Phase 1. First, audio files from the interviews were transcribed into text

documents. Interviews conducted in Spanish and English were coded in the respective

language. Although difficulties existed in developing codes that can be representative

across languages, I believed there would have been greater challenges and information

lost if the material had been translated. Because language is engrained within culture,

problems in translating material can arse because some concepts are difficult to convey,

or are even nonexistent, in other languages (Yick & Berthold, 2005). Second, I engaged

in line-by-line coding to break down the data into smaller chunks. At this stage, I searched for both explicit statements as well as implicit messages (Charmaz, 2006).

Phase 2. In the second phase of analysis, I used a grounded theory approach to identify the most frequent and significant codes from Phase 1. In this step, I extrapolated data from several interviews and organized them into the respected categories, which were termed "themes" (Charmaz, 2006).

Once themes were created, I engaged in axial coding. Larger code families were organized into subthemes. Additionally, in the axial coding process, I identified relationships between the themes (Charmaz, 2006). Throughout this process, I used Atlas.ti qualitative software to assist in the organization of analytical themes (Scientific Software Developer GmbH, 2002).

Memo writing. Throughout the process of analyzing the interviews, I engaged in memo writing as a way to capture any thoughts or ideas that I had when looking at the data. Charmaz (2006) stated, "Memos catch your thoughts, capture the comparisons and connections you make, and crystalize questions and directions for you to pursue" (p. 72). Memo writing assisted me in the process of defining the codes, analyzing codes, and constructing possible categories from these codes.

A fellow psychology student with qualitative research experience and involvement with the Latino Bilingual track served as a second reader. The second reader evaluated the codes from three of the eight interviews and then independently derived categories and subcategories based on Phase 1 coding. Although there was a large degree of consistency between the reader's and my own analyses, any variations were discussed and agreed upon.

I kept a research journal in which I recorded any thoughts or feelings I had during the research process in order to increase objectivity and explore any potential biases I may have had during the research process. Specifically, I used my research journal to take notes immediately after all of the interviews in order to capture reflections or feelings I had during the interviews. I became interested in working with monolingual Spanish-speaking individuals after my first mental health practicum where I learned about the high need for healthcare providers with Spanish language abilities. I became more aware of barriers for immigrants of Mexican origin to access basic healthcare needs. As a White graduate student and member of middleclass society, I have not faced barriers accessing healthcare as the participants in this study. For example, accessing health insurance or worrying about whether doctors will understand my values have not been concerns I have had to entertain when experiencing health symptoms. Due to stark discrepancies between my own experiences with the healthcare system, and the participants' experiences with the healthcare system, comfort in sharing about dissatisfaction with White providers may have decreased. Although I identified as a psychology student researcher, my appearance and background may have placed me in a more expert role and created distance between myself and participants. At times I felt the desire to express dissatisfaction with access barriers and align with the participants' opinions in order to differentiate myself from any unpleasant healthcare experiences. However, as mentioned previously, I have not experienced barriers to access healthcare. Although efforts were engaged to communicate with participants in their native language, it is important to acknowledge that my own linguistic experiences may have influenced the interviews. I primarily learned Spanish-language during a study abroad experience in

Spain. Due to high regional and cultural differences in language, it is likely that these linguistic differences influenced data collection.

I wanted to conduct research to help decrease some of these barriers and improve delivery of healthcare services to this community. During the research process, I was able to learn about daily experiences of individuals who have had very different experiences within the healthcare system than myself. I often found myself wanting to advocate for participants who expressed barriers to accessing healthcare. I reflected on how this desire was a choice I am privileged to have being a member of White mainstream culture and U.S. residency status. I became humbled by some of the participants' willingness to express personal information and share part of their healthcare experiences with me. This experience of interviewing individuals increased my passions to provide culturally competent care and decrease barriers to the Mexican immigrant community.

Results

The eight interviews produced a large amount of detailed information. As mentioned previously, line-by-line coding was used to identify small and meaningful pieces of data. Axial coding was then used to organize the coded data into categories and themes. Five categories were identified as representative of the participants' conceptualizations of health complaints: Causal Factors, Phenomena, Strategies, Factors that Mediate Strategies, and Consequences. Quotes are used to further illustrate the various themes and give voice to the participants. Spanish language quotes were translated to English by myself, a non-native bilingual English/Spanish psychology student. My dissertation chair, a non-native bilingual English/Spanish psychologist with increased experience working with Spanish-speaking communities, assisted in the translation process. Attempts were made to ensure that various participants' views were expressed throughout the results section. Any identifying information, such as specific names of healthcare providers or clinics, was removed from the quotes to ensure anonymity.

As part of the requirements to participants, all of the participants from this particular study were referred by healthcare providers. Despite attempts in the interview to be vague about the definition of the word "complaints", the use of words such as "treatment", "clinic", "medications", "psychologists", and "healing" likely influenced participants to share healthcare-related complaints. Six of these eight participants had, at some point in time, obtained mental health services. Four participants were currently involved in mental health services. Additionally, I introduced myself as a psychology

student researcher. As such, many of the interviews were heavily laden with participants'

opinions and experiences with mental healthcare services and providers. Throughout the

interviews, many participants shared symptoms of both physical and mental health. It is

important the reader be cautious not to assume connections between physical health and

mental health symptoms. On the same note, assuming a disconnection between physical

health and mental health symptoms may also be an inaccurate assumption. Rather,

readers may benefit from considering a holistic approach when reading about healthcare

complaints.

Figure 1 offers a visual representation of the results. Arrows were utilized to

identify relationships between the themes. Finally, the themes with supporting quotes are

described in greater detail.

Category 1: Causal Factors

Familismo. The family context, or familismo was identified as a major theme of the

causes of complaints among the study participants. The traditional Latino value of

familismo places high importance on close relations within the family system and high

loyalty to the family system (Arredondo et al., 2008; Kouyoumdijian et al., 2003). Of the

eight participants, five identified some type of family-related variable or stressor that

served as a contributing factor to current complaints. Sometimes this meant the stress was

within the family (e.g., domestic violence, abuse) and sometimes it meant the stress was

associated with the family (e.g., being separated from or worried about the family. One

participant also stated that a cause of health complaints could be due to problems

stemming from birth, demonstrating more of a biological understanding of the causes of

illness or complaints. Another stated she did not currently have any complaints or

problems, whereas another participant was unsure about the cause of her current complaints. Of the five participants who cited family-based issues as a causal factor of current problems, participants talked about domestic violence and family isolation as problematic aspects of their past or current family unit. Participants largely discussed how life stressors affected the family unit which highlights the importance of family in every context of life. Three of the participants directly cited violence within the family system as a cause for complaints. In the interviews, participants referred to the impact that violence had on mental health problems. In response to a question about the cause of current complaints, Participant 1 stated, "Pienso que empezaron cuando estaba chica y mi papa golpear a mi mama." (I think they started when I was a young girl and my dad hit my mom.)[2] Participant 1 later added that this violence was not a single incident but rather a pattern that persisted throughout her childhood. Participant 2 described how parents with experiences of trauma often transfer their own trauma to their children through violence. Participant 2 commented, "Hay muchos niños que están pegado por sus padres que no tiene ayuda o recursos. Pero ellos tienen traumas, y después dan a sus traumas a sus hijos. "Ellos necesitan organizan sus ideas." (There are many children who are hit by their parents who don't have help or resources. But, the parents have traumas and they give their traumas to their children. They need help organizing their ideas.)

Three participants made reference to family isolation as a source of complaints. Family isolation captured both geographic separation and lack of emotional support or contact with family. One participant indicated that he experienced constant worry about what could happen to the family if the family were to become separated. Participant 5

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[2] I translated participant responses

identified "instability" as the cause for his current stressors. Upon asking to explain what

instability meant to him, Participant 5 added:

Figure 1.

Causal Factors
-Familismo

Phenomena
-Mental stress
-Physical pain

Mediating Factors
-Stigma
-Cultural Values
-Access barriers

Help seeking strategies
-Mental healthcare
-Physical healthcare
-Religious help

Consequences
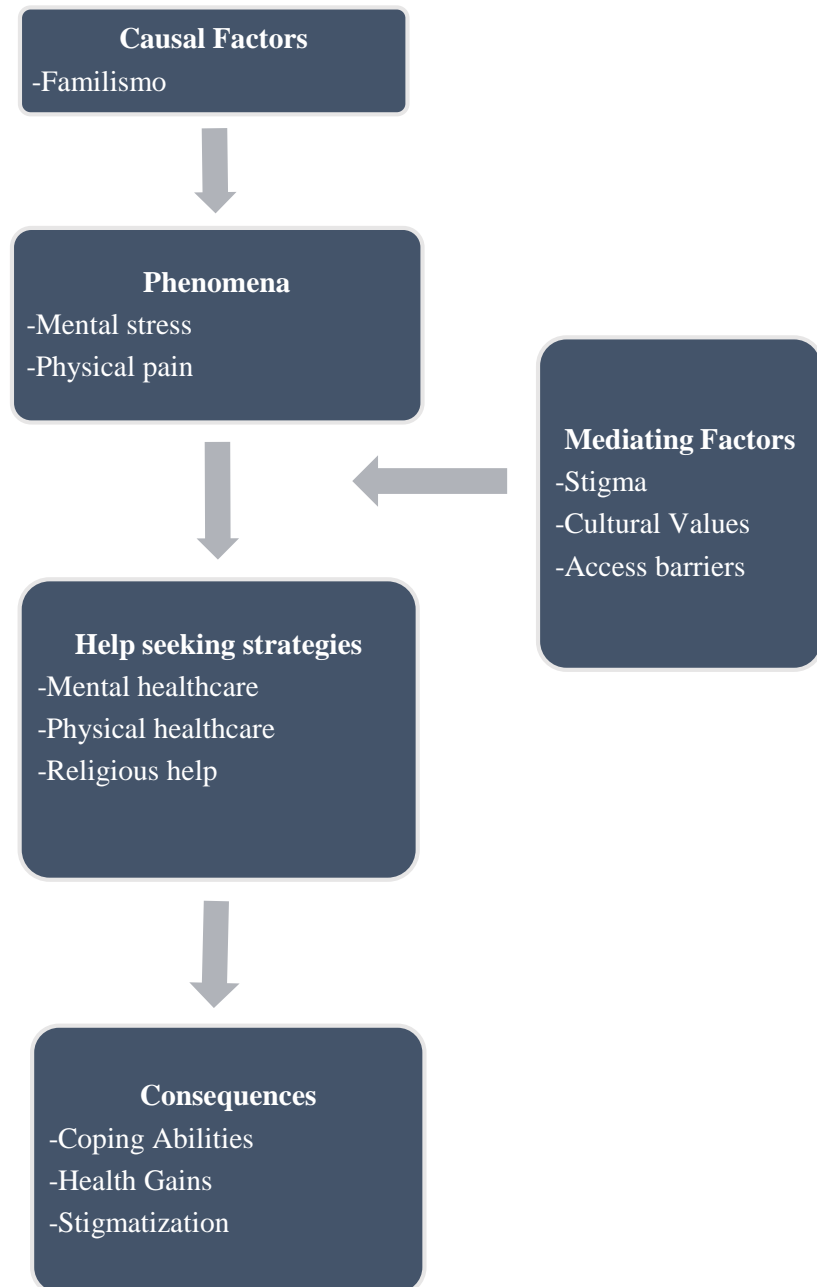-Coping Abilities
-Health Gains
-Stigmatization

Figure 1. Conceptualizations of illness, treatment decisions, and outcomes

Las causes son mis quejas son esos. Estamos preocupados o la quejas son lo que nuestro presidente no quiere firmarlo [proyecto de ley de inmigración]. Eso, eso es un preocupación fuerte. Quiero estar bien para poder bien con mis hijos. Ellos están en high school. Entonces me preocupa si algo pase me afecta mí y esposa (pausa) ellos [oficiales de gobierno] se queda muchas familias están separadas. Eso es inestable.

The causes of my complaints, we are worried, or my complaints is that our president won't sign it [immigration bill]. This, this is a stronger worry. I want to be good, to be able to be good for my children. They are in high school. Then I worry if something happens to me and my wife (pause). They [government officials] have left many families separated. This is unstable.

In this interview, Participant 5 referred to how immigration laws have impacted families in the immigrant community. He discussed his fears of not being able to be around for his children. Participant 6 also mentioned isolation from her family. Although there was not a substantial geographic barrier between herself and her family, Participant 6 explained that her in-laws created stress by acting as a barrier between herself and her family of origin, as well as her other social support networks. She explained:

My stress and my problem is my baby's dad. He was not able to be there for the oldest one. When we got together, his family was involved with everything. I used to live with them, just so much stressful, I could not see my family. I could not see nothing, I couldn't talk to people. I couldn't talk to nobody. It was the strangest thing, ya know, it was so stressful.

When asked about the causes of complaints, Participant 7 stated, "Pues, Yo pienso que a veces como falta de apoyo de familia." (Well, I think sometimes it is the lack of family support.) In all of the above-mentioned interviews, there was an overall theme about the role of family on the complaints, stressors, and health of the individual. Although individuals varied slightly in their opinions about the causes of complaints,

famiismo was identified as a theme for causal factors of complaints. As noted by Participant 5, even the fear of family separation was a significant stressor.

Category 2: Phenomena

Participants were asked to share how complaints affected them. Of the six participants who were able to identify how complaints were currently affecting them, participant responses varied between talking about their mental and/or physical health. Two participants were unsure of how they were being affected by their complaints.

Mental health. Five participants talked about how their complaints affected their mental health. In making reference to how historical domestic violence was affecting her current functioning, Participant 1 responded, "No puedo ser completamente feliz." (I can't be completely happy.) Participant 5 talked about how his complaints resulted in constant worrying and stress. He stated, "Puedo controlar mis emociones no es muy fácil porque… si no estoy trabajando, mi preocupado. Trato de relajarme." (My ability to control my emotions is not easy…. if I am not working, I worry. I try to relax.) Participant 4 also talked about wanting help to calm her mind and reduce time spent thinking about her problems. Participant 8 made reference to a historical time in her life when complaints were affecting her mental functioning. Participant 8 reflected "I felt helpless. I felt alone, because you feel alone when you don't understand why you are thinking that way, or why you are feeling a certain way."

Physical pain. Of the eight participants interviewed, five talked about the physical effects of complaints. Three of these participants specifically cited pain in the cranial region. When asked about the how complaints affected him, Participant 5

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responded "Me afectan en el aspecto de dolor de cabeza." (They affect me in the aspect of head pain.). Participant 5 later went on to explain that the resulting head pain caused increased worry for his health, specifically fears about a future stroke. Participant 1 explained how past stressors and complaints have impacted her life: "Me duele, me duele en todo mi cuerpo. A veces me duele cada hueso, cada pedacito de mi cuerpo." (I hurt, I hurt all over my body. Sometimes every bone hurts, every piece of my body.) Participant 2 talked about difficulties with allergies in the spring, and then later added that these complaints did not affect him too much, other than annoyance during times of the year with high pollen.

Category 3: Strategies

Although all of the participants were known to have some form of contact with the healthcare system, participants were asked about the specific types of healthcare services that they had used both in Mexico and in the United States. Participants were also asked about beliefs in more traditional forms of healing in the Latino culture. These questions helped identify what strategies participants used to treat the phenomena of their complaints. Themes that developed under Help seeking strategies include mental health services, physical health services, and religious help.

Mental health services. Of the eight participants, five identified either past or current involvement in mental health services to help with complaints. Four participants stated they were currently engaged in mental health services. These four participants seemed to have similar beliefs that learning coping skills or exercises could help them control their thoughts and emotions in order to reduce stress or become more relaxed. When asked about expectations for treatment, Participant 4 responded, *"Ejercicios para*

me ayuda relejarse y para que no esté piensa en los problemas que tiene." (Exercises to help me relax and not think about the problems you have).

Participant 5 also talked about wanting to reduce stress in saying, "Necesito ayuda. Quiero buscar para controlar mis emociones, mis emociones de preocupación, de estrés, de desesperaciones. Yo vengo solo quiero mejorar." (I need help. I want to control my emotions, my emotions of worry, stress, and despair. I come only because I want to improve). Another two participants talked about wanting to learn or better understand their emotions. Participant 8 responded, "I guess to be helped to understand my feelings."

The above-mentioned participants seemed to share beliefs about the goals pertaining to psychotherapy services. These participants seemed to value the interventions available in a variety of therapeutic modalities aimed at understanding emotions, controlling stress provoking thoughts, and reducing stress. This familiarity with psychotherapy was expected given the eligibility requirements to have had either been currently involved with mental health services or referred to mental health services.

Physical health services. Five participants disclosed past or current involvement in physical health services to help with complaints. When asked about expecations for appropriate care for complaints Participant 2 stated, "Bueno, yo venido más que nada cuando me pega mis alergias en el primavera, es cuando más necesito. Venir a la clínica una vez al año solamente cuando es necesario." (Well, I come to the clinic more than anything when allergies strike in the spring, that's when I need it the most. I only go to the clinic when it is necessary.) Participant 6 talked about a historical visit to the hospital: "I was in the hospital for two weeks because I had gall bladder…. I had stomach pain,

they had to take my gall bladder out. I had ulcers. I had ulcers so they had to give me medicine."

Religious help. Five participants identified past or current involvement with religious help. Although five participants identified religious help as a source they had used or were currently using to help with complaints, only two participants commented on religion during the interview. Participant 1 stated, "Voy a iglesia pero no he platicado con nadie sobre este (participación en servicios de salud mental). Platico con El." (I go to church, but I haven't talked to anyone about this (participation in mental health services. I talk to God.) and "Yo busco ayuda en Dios." (I look to God for help). Participant 4 cited religion as a primary reason for not believing in more traditional and alternative healers in the Latino culture by explaining "Yo soy una persona religiosa y yo sé que yo no debo creer en estas personas." (I am a religious person and I know that I shouldn't believe in these people.)

Category 4: Mediating Factors

Mediating Factors included participants' strategies for treating the resulting phenomena of their complaints. Under this category, themes of Stigma, Cultural Values, and Access Barriers were developed. Although participants were not specifically asked what variables influenced decisions about healthcare, participants were asked about opinions regarding various medical providers and expectations for treatment which provided insight into the thoughts and feelings behind help-seeking behaviors. Additionally, many of the participants offered spontaneous insight into their healthcare experiences and decision-making process.

Stigma. Although no questions were specifically directed at inquiring about stigma, six of the participant talked about common use of the word *loco* or "crazy" 'to describe mental-health-related complaints. All of these participants described the negative connotation of the word "loco" or "crazy" in the context of mental health. Three of the participants who were currently receiving mental health services affirmed that they did not talk to family or their community about their current complaints. Comments indicating avoidance or fear of telling family or friends about personal mental health symptoms and services were identified as areas of stigma regarding mental health. Participant 6 described stigma within the Mexican community:

> I was thinking sometimes you need a counselor. I mean, I think everyone needs a counselor, but especially when you're younger you're like "I'm not crazy. I'm not going to go to a counselor", and a lot of people say you have to go, but I'm not crazy to go to a counselor.

As mentioned previously, four of the participants were engaged in mental health services at the time of the interviews. Participant 4 shared reluctance to tell family about complaints. She explained:

> Yo soy una persona muy reservada y nunca le confeso a mi familia o mis amigos que estoy tomando este tipo de terapia. Platico con una de mis amigos…le digo, voy a [clínica local]. Hay miedo lo que me diga ¿Oh es loca?

> I am a very reserved person and I never confessed to my friends or family that I'm doing this type of therapy. I speak with one of my friends. I tell them I'm going to [local clinic]. I'm afraid she will say Oh, are you crazy?

Another participant talked about how her family's opinion about mental health problems resulted in her feeling upset. Participant 1 explained, "Mi hermana, ella antes me decía, por cualquier cosa, me decía "¿hay que tú estás loca?" y ese palabra me dolía. Me dolía mucha. Esa palabra es muy fuerte." (My sister, before she would say, for

anything, she would say, "Are you crazy?" and this word would hurt me. It hurt me a lot. This word is very strong.)

Participant 5 also shared his attempts to avoid involving the whole family in his complaints and treatment. Participant 5 seemed to want to protect his children from being burdened by his complaints. He explained:

> Bueno, en mi familia en casa, mi esposa, nuestros hijos. Prácticamente nuestros hijos aún son pequeños. El más grande solamente tiene 17 años, el más pequeño diez. Así que tratamos de no, no sé si está correcto, pero tratamos de no tenga preocupación de nuestras quejas porque no queremos de ellos también empieza a afectarlos.

> Well, in my family home, my wife, and our children. Our children are still pretty young. The oldest is only 17 years old and the youngest is 10. So we try not to, I don't know if this is correct, but we try to not to worry ourselves with our complaints because we don't want it to also start to affect them.

Almost all of the participants who were engaged in mental health services made efforts to avoid telling friends or family about their treatment. Participants did not express avoidance in disclosing physical symptoms from family or friends. This avoidance may be viewed as mental-health-related stigma that exists within the Mexican immigrant community and, in turn, can inform help-seeking behaviors.

Cultural values. Throughout the interviews, participants were asked their opinions regarding various aspects of healthcare such as medical providers, medication, and treatment approach. These opinions were largely influenced by both individual and cultural values of the community. Five participants expressed opposition towards medication use. One participant had a more neutral "if you need them, you should take them" viewpoint on medication use. Four of the eight participants responded that they did not want to take medications for mental-health-related complaints. Participant 4 stated:

Mi opinión es que a mí como que no me servido los medicamentos, porque me duele más la cabeza. Mis nervios son se hacen más como piezas y este no me ayudado en cierto manera la medicina. Más bien como los ejercicios, las palabras.

My opinion is that medications didn't help me because they made my head hurt. My nerves become more like pieces and the medicine didn't help me in this way. The exercises and words are better.

Participant 1 gave a similar response: "No me gusta porque me siento que me arterias son muy adictas medicamentos y prefiero a hacer las charlas con un persona." (I don't like them because I feel that my arteries are very addicted to drugs and I prefer to chat with a person.)

Participant 8 made references to medication use when sharing dissatisfaction about medical services and medications that she had received in the past. Participant 8 recalled:

All they wanted to do is give me pills and I'm not a pill popper and if they give me narcotics, forget it, I'm flying. I can take pain, a lot of pain. I can't take drugs. I'm flying, I'm flying all day long.

Participant 2 had talked about needing medicine at times to help deal with his allergies in the spring. However, despite this need to help control his allergies, Participant 2 shared "Cuando estoy trabajando me sentir que estoy drogado, muy lentamente, y pues es una medicina que no me gusta" (When I am working I feel that I am drugged, very slow, and well, it is a medicine that I do not like.)

Overall, five participants shared that medications were not the primary form of desired treatment for health services. Four of these participants discussed the topic of medication within the context of mental health services. These participants held a preference for obtaining help through communicating and learning skills with a therapist or another person to help deal with their mental health related complaints.

Participants were asked about perceptions of various treatment providers in order to gain insight into how the values and experience of both the participant and the provider impact decisions to seek healthcare services. Participant 8 talked about how her family values impacted her willingness to obtain healthcare services. When talking about her children and grandchildren, Participant 8 stated:

> They think I don't complain. They think I don't take good care of myself, and in a way it is true. I wait. They have to drag me out of here. They think I should be more active in my health care, and my mental healthcare, everything. But they were raised here, and my mother didn't raise me that way.

Four participants shared how specific cultural values of the provider characteristic mediated healthcare decisions. Participant 5 shared positive opinions regarding U.S. treatment providers. He explained that his positive feelings towards the providers he had worked with were a result of providers' cultural competency. Participant 5 stated:

> Ah, por lo menos la mayoría de ellos son muy efectivos por la razón de que han estudiado también en México y eso es lo que los ayuda a hacer un poco más, más efectivos por esto razón, conocen la cultura.

> Ah, at least the majority of them are very effective because they also studied in Mexico, and this is what helps make them a little more effective, more effective for this reason, they know the culture.

Participant 8, who had become more familiar and comfortable with healthcare services in the United States, also shared about cultural dissonance as a factor influencing her desire to go to the doctor. Participant 8 stated, "Some doctors are very rude, they don't understand us as Mexicans, ya know." Participant 2 explained dissatisfaction with a provider's mechanical approach with his child. Participant 2 had also reportedly switched primary care providers as a result of how the medical provider treated her baby.

Of the eight participants, six held opinions and values of disbelief in curanderos. Two participants were unsure whether they would ever visit a curandero. When asked to explain her disbelief in curanderos, Participant 8 stated:

> I think because my mother used to go and she'd pay money and money for people to rub her legs and I didn't see no difference. Honestly I thought they were just making a fool of her and taking her money. That's what I used to tell her.

Participant 7 commented, "Pues hay unos que dicen la verdad y otros que nada más es un chantajista." (Well, there are some that tell the truth and others that are nothing more than a blackmailer). After stating that she would never go to a curandero, Participant 4 went on to explain:

> Yo no creo porque yo soy una persona religiosa y yo sé que yo no debo de creer en esas personas. Lo que pasa es que yo escuchado los testimonios de personas que han ido a curanderos y nada más este les quitan el dinero pero no los han ayudado en sus problemas.

> I do not believe because I am a religious person and I know that I shouldn't believe in these people. What happens is I listened to the testimonies of people who went to curanderos and they didn't do anything but take your money, but they didn't help you with your problems.

In this sample, participants seemed to values services offered in the U.S. healthcare system, with the caveat that certain treatment providers are more effective when they approached treatment with consideration of the client's culture and social norms.

Access Barriers. Five participants cited lack of finances as a barrier to accessing healthcare services. One of the participants specifically discussed how financial difficulties impacted his ability to obtain mental health care and others made more general statements about an inability to access all types of healthcare. The statements below highlight some of the participants' views about how the lack of finances impeded

their ability to receive healthcare services. Participant 2 stated, "La verdad es que el tratamiento es mucho dinero y si no puedo pago porque no tengo trabajo." (The truth is that treatment is a lot of money and I'm not able to pay because I don't have a job.)

Participant 2 later added how the lack of finances specifically affected his and others' ability to access mental health services:

> Pues sí, espero que hay más clínicas para la gente que tienen problemas mentales. Hay muchas con traumas en sus vidas, y allá no hay psicólogos que vaya o un hospital que puede platicar- si tienes suerte, y si tiene más dinero. Si no tienes, hay menos opciones, entonces como te digo, yo necesito un psicólogo y yo buscado. No hay mucho.

> Well yes, I hope there are more clinics for the people that have mental problems. There are many with trauma in their lives, and there aren't psychologists that you can go to or hospitals where you can talk- maybe if you are lucky or if you have more money. If you don't have it, there aren't many options. Then, as I said, I need a psychologist and I looked. There isn't much.

Participant 7 also cited a lack of finances and resources as a primary reason for avoiding medical care, *"Aquí, a veces la gente no ve al doctor porque de falta de recursos porque es muy caro. Es el mismo problema. La gente tiene miedo de visita el doctor porque es muy caro."* (Here, sometimes people do not see the doctor because of lack of resources, because it is expensive. It is the same problem. People are afraid to visit the doctor because it is expensive.)

Two participants also specifically talked about how lack of finances impeded treatment in their country of origin. Participant 8 was discussing her childhood in Mexico when she stated, "If you have money, you can go to good doctors; if you don't have money, you can die in the streets."

Of the five participants who identified financial barriers as a barrier to accessing medical services, two participants additionally cited an inability to obtain health

insurance as a problem pertaining to the healthcare system. While discussing a specific

medical clinic in the local area, Participant 5 added, *"Allí no tenemos seguranzas. En mi*

lugar no hay seguranzas cuando uno va a doctor." (There we don't have insurance. In my

place, you don't have insurance when you go to the doctor.)

Participant 2 also shared frustration with an inability to obtain medical coverage.

In his discussion of financial barriers and healthcare coverage, Participant 2 shared how

inequalities between the immigrant community and those with citizenship affected the

ability to access services:

> En realidad, si todos tuviéremos derechos, los mismos beneficios que toda la
> gente, podemos pagar para un psicólogo. Americanos no preocupa para nada si no
> tiene seguros médicos, y empieza los problemas. Yo sé que todo cuesta, pero
> necesitamos servicios médicos para psicólogos. Este es la meta.

> In reality, if we all would have rights, the same benefits as we could all pay for a
> psychologist. Americans do not care at all if you do not have medical insurance
> and the problems start. I know that everything costs money, but we need medical
> services for psychologists. This is the goal.

These statements highlight an important and unresolved problem for many

immigrant communities in the current healthcare system. It is important to note that none

of the participants talked about needing more money to enjoy materialistic items in life

such as designer clothing, nice vehicles, or money for eating at restaurants. Money

concerns were shared within the context of needing basic living and healthcare costs.

After describing treatment progress, Participant 4 concluded "Dinero isn't what would

make me feliz. It doesn't make people happy. No es solucion. I want my health more than

$5 in my pocket." (Money isn't want would make me happy. It doesn't make people

happy. It isn't a solution. I want my health more than $5 in my pocket.) Participant 5 also

expressed opinions regarding finances when expressing healthcare goals. Participant 5

stated:

> No es posible acá dejar pagar un mes de rento porque tenemos problemas.
> Tenemos que pagar un fee, y yo sé que todo el mundo no tiene casa o rento, pero
> acá vivo. Eso es la realidad. Hay muchas ayudas pero a veces nosotros no
> quilificamos por lo mismo.

> It isn't possible here to not pay rent for a month because we have problems. We
> have to pay a fee, and I know that not all of the world has a house or rent, but I
> live here. This is the reality. There is a lot of assistance (social support services),
> but sometimes we do not qualify the same.

> He later added "Dinero no es la felicidad pero es necesario para vivir." (Money

isn't happiness, but it's necessary to live.) These responses may represent common

barriers in the immigrant community for those who desire or need medical treatment, but

who are unable or afraid to face the financial burden that would ensue should they

receive treatment.

Category 5: Consequences

Participants were asked to reflect on any consequences or changes they had

experienced as a result of the above mentioned help-seeking strategies. As mentioned

previously, all eight participants had some form of current or past contact with the

healthcare system. Four of these participants stated they were currently engaged in

mental health services. Among the four participants who were engaged in mental health

services, themes of health gains, coping skills, and stigmatization were developed. The

participants who were not involved in current mental health services, but who had other

forms of contact with the healthcare system did not identify current complaints in need of

current medical care. However, this lack of medical necessity among the four participants

not currently involved in healthcare services may also be the result of previous treatment gains.

Health gains. All four participants who were currently engaged in mental health services identified health gains as a result of seeking healthcare services. Participant 1 confirmed, "Pienso que es lo mejor. Ahorita han ayuda sentir la vida." (I think it is better. Now they have helped me feel life.) Participant 4 explained "Ahora, no tengo (quesjas). Mis doctores son preocupados con mi salud, y salud mental y de todo. No tengo ninguna queja. Todo es positivo." (Now I don't have any [complaint]). My doctors are concerned about my health, mental health, and everything. I don't have any complaints. Everything is positive.) Participant 8 reflected on her treatment experience by adding "I'm doing pretty good. Right now I'm in a place with a clinic and a therapist. Even though she gives me medicine, I realize that I need it."

Coping skills. Three of the four participants involved in mental health treatment specifically discussed how acquiring coping skills assisted in their ability to relax and experience health gains. When talking about relaxation exercises he had learned during group therapy, Participant 5 confirmed, "Cuando vengo al grupo, nos dice que si posemos capacitar de estar tranquilar durante la hora y media. Es posible que podemos practicarlo en nuestra vida fuera y poder este poco a poco controlarlo." (When I go to group, they say that we possess the capacity to be calm during the hour and a half. It is possible to practice this in our life outside and to be able to control this [stress] little by little.) Participant 1 also shared certain skills she had learned in treatment to help with her complaints. She explained:

Aprendo a relajarse y pues encontrar la forme que me ayuda. Por ejemplo, a me ayuda caminar. Bueno, ante me ayudaba caminar con mis perritos y ahora me ayuda está platicando con mi bebe… Me siento relejado. Me siento major.

I learn to relax myself and then to find what helps me. For example, walking helps me. Well, before I would walk with my dogs, and now it helps talking to my baby…I feel relaxed. I feel better.

Stigmatization. As mentioned previously, high levels of stigma pertaining to mental illness and treatment were observed in this sample. Of the four participants who were engaged in mental health services, three chose to conceal their complaints and treatment with family and friends. Participant 1 and Participant 4 disclosed that they did not want to tell family or friends because of a fear that they would be called crazy. Participant 5 withheld talking about complaints to his family so as not to worry his family members. Participant 8 shared that many people in her community would not go get mental health care because it was understood by the Latino community that you must be crazy to need mental health treatment. Stigmatization was included as a potential consequence for participants who used strategies of mental health services due to the high levels of avoidance in telling family and friends about mental health symptoms and treatment. Participants expressed potential stigmatization from community members despite personal beliefs and health gains through their treatment.

Findings and Implications

  The emerging categories from the interviews are discussed below. Many of the categories and themes are consistent with existing research. The semi-structured interview questions were intentionally vague and open-ended in order to capture the participants' subjective conceptualizations about healthcare. As mentioned previously, there are many variables that likely impacted to content of the interviews including terms used in the interview, past healthcare services used by participants, and position of myself as a psychology research student. Although participants shared physical health symptoms and experiences, the interview content was more heavily laden with mental health symptoms, experiences, and treatment goals.

  The theoretical model, "Conceptualizations of Health", identifies the stages of the participants' health complaints and journey towards health gains. In this model, causal factors are first identified. The Latino value of familismo was developed as a primary theme which led to the development of phenomena mental stress and/or physical pain. For example, one participant shared how worries about family separation resulted in constant worrying and head pain. The experienced phenomena resulted in various forms of help-seeking behaviors. Participants in this study sought treatment through a combination of mental health services, physical health services, and religious help. Participant decisions to engage in specific treatment strategies were mediated by variables including stigma, cultural values, and access barriers. Participant 7 summarized how access barriers continue to influence help-seeking strategies in her community when

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she stated "La gente tiene miedo de visita el doctor porque es muy caro." (People are afraid to visit the doctor because it is very expensive). Participant 6 talked about not believing in mental health treatment at a younger age as a result of thinking that individuals were "crazy" if they visited a mental health counselor. This response reflects on-going stigma pertaining to mental health services and may continue to influence treatment strategies used in the Mexican immigrant community. In this theoretical model, consequences of health gains, coping abilities, and stigmatization were observed. Participants identified various coping skills they had learned to help manage phenomena of mental stress and physical pain. Participants in this sample experienced reduced symptomology and improvement in overall health as a result help-seeking strategies. However, consequences of continued stigmatization were also observed during the interviews despite confirmation of health gains. In this study, it was possible for participants to experience treatment satisfaction and subsequent health gains while also managing ongoing stigmatization for certain help-seeking strategies.

Within this model, participants are observed to have engaged in externalized help-seeking strategies to deal with complaints of mental stress and/or physical pain. This help-seeking approach is consistent with previous research on Latino values in viewing healthcare providers and leaders within religious communities as having increased knowledge, respect, and power (Cortes et al., 2009). Participants who sought mental healthcare, physical healthcare, and religious help seemed to approach treatment with expectations that these providers would offer knowledge or solutions for their current complaints. After engaging in treatment, participants were observed to internalize

recommendations from their provider and experienced health gains and coping abilities as a result.

It is possible that consequential health gains and coping abilities resulted in increased tolerance to deal with family-based stressors. Additionally, increased health gains might also result in less stress on the family unit. As a result of individual health gains and increased coping abilities, it is possible that participants acquired greater tolerance to deal with stress pertaining to the family unit. Individual health gains may also result in more positive family relationships. Both of these consequences likely result in decreased mental health and physical health symptoms. However, personal health gains might also be compromised if increased levels of stigmatization among family and community members continue to impact the individual.

It is important to note that this model was developed with a sample of participants who had experienced health gains as a result of various healthcare treatment. This model is likely not representative of those individuals who have not sought healthcare treatment for complaints nor for those individuals who did not experience health gains as a result of various healthcare treatments.

Familismo was identified as a causal factor for complaints. This category is an important and interesting finding as it is slightly incongruent with the westernized medical conceptualization of mental illness. In the current westernized medical model, illness is often considered to be the result of a combination of environmental and genetic risk factors (Cooper, 2001; Jaffee & Price, 2007; Rutter, 1997). Social relations, socioeconomic stress, occupational stress, racism, and acculturation are just a few variables that U.S. providers may define as environmental risk factors for the Mexican

immigrant population. Additionally, U.S. healthcare providers typically acknowledge a biological vulnerability to mental illness. Willerton et al. (2008) noted that many physicians have historically been trained to emphasize biological components and minimize social components of health.

However, none of the participants cited financial stress, work, racism, or larger sociopolitical issues as environmental causal factors in describing their complaints or illness. Although financial and occupational difficulties were shared when discussing barriers, none of the participants seemed to conceptualize their current or past complaints as the result of financial stress. This finding highlights the impact that cultural values can have in the conceptualization of health and illness. Specifically, this result identifies the importance of family among participants, which is consistent with previous research on Latino values (Arredondo et al., 2008; Comas-Díaz, 2006; Edelson, Hokoda, & Ramos-Lira, 2007; Gannotti, Kaplan, Handwerker, & Groce, 2004; Kouyoumdjian et al., 2003). The value of *familismo* is conceptualized as an individual's strong identification, attachment, and loyalty to one's family (Kouyoumdjian et al., 2003). In discussing the value of familismo, Comas-Díaz (2006) stated that"collectivist persons understand themselves through others, emphasize family, social, and emotional bonds and prefer communal goals above individual ones" (p. 438). In cultures in which high value is placed on family support, loyalty, and interdependence, dissonance between the ideal value of familism and the actual family system may create increased stress for individuals within the family system.

As a result of listed complaints, participants in this study were observed to experience both physical and mental health symptoms. Mental health stress was typically

the result of stress caused by the family unit, whether by domestic violence or a small support network. In a recent study investigating the impact of domestic violence between Latina and non-Latina women, Edelson et al. (2007) found that the Latina women experiencing domestic violence had significantly poorer outcomes on measures of trauma, depression, and self-esteem than did their non-Latina counterparts. Edelson et al., (2007) wrote, "Latina women who are victims of domestic violence may find themselves torn between their duty to preserve and maintain the family and their obligations to themselves" (p. 8).

The results of this study support previous research on the importance of familismo in the Latino culture, and its effects on health and wellness. Descriptors about pain throughout the body or pain specific to the head and neck region were common among participants. This result is consistent with previous research regarding prevalence of somatization and mental-health-related disorders in Latino populations (Crocket et al., 2009; Pina & Silverman, 2004; Tofoli, Andrade, & Fortes, 2011; Varela et al., 2004; Varela, Sanchez-Sosa, Biggs, & Luis 2008). Providers would benefit from learning culturally engrained descriptors of mental illness to avoid miscommunication and misdiagnosis. In addition, mental health referrals could be missed if healthcare providers fail to recognize descriptions of pain as potential phenomena of psychological illness.

In addition to seeking treatment for complaints through primary care and mental health providers, some participants identified using religious means to help with the phenomena experiences as a result of complaints. Religion can be an additional source of healing for the individual. Many Latino families in search of help obtain guidance from a local priest before seeking help from a healthcare provider (Smith & Montilla, 2006).

Religious devotion may also serve as an additional area of support for Latino individuals. Culturally sensitive clinicians must understand how religion affects the daily life of individuals and not attempt to downplay the importance of religion within the community.

Mediating variables were observed to impact participants' help seeking behaviors. Stigma, cultural values, and access barriers were themes that influenced strategies used by participants to treat their complaints. Although none of the participants explicitly used the word "stigma" when discussing mental health, many of the participants commented on personal fear or reluctance to tell family and friends about their desire to seek mental health services. Participants referenced fears of being called crazy, even by close family and friends. Barrio et al. (2008) found similar results in research on the mental health service needs and barriers of the Latino population. In one interview by Barrio et al. (2008), a Latino mental health advocate stated, "The word clinic itself scares them [the patients], especially if it is mental, because then they say 'I do not wish to be called crazy'. It is well-documented in previous research that mental illness can be a shameful stigma for members of the Latino culture and can result in an underutilization in mental health services (Barrio et al., 2008; Frevert & Miranda, 1998; Kouyoumdjian et al. 2003; Rodriguez, et al., 2009). As a result of the ongoing stigma regarding mental health in the Latino community, providers should be aware of specific terminology or phrases that are stigmatizing when discussing psychological distress with clients. By using language that is nonpathologizing, clients may be more likely to continue with treatment.

Specific research was not found on Latino cultural values that influence decisions regarding medication use or preference for certain forms of treatment including

westernized treatment services or more traditional culture-specific treatment providers such as curanderos. Of those participants opposed to medication use, several were concerned about the side effects or potentially addictive qualities of some medications. Others shared preference for natural remedies or talking about complaints in psychotherapy. Because a majority of the participants in this study wanted to avoid medication for current complaints, these participants may have sought out psychological services. It is important for prescribing physicians to have a thorough understanding of their patients' opinions regarding medication and addiction before prescribing medication. Without agreement about the utility of medication, individuals may not adhere to the prescribed medication regime for a given ailment. Prescribing providers may also obtain greater medication compliance with more thorough patient education regarding the utility of certain medications. Alternatively, providers may see even greater results by referring individuals within the Mexican immigrant community to mental health providers or alternative healthcare options if their patient is against medication use.

Participants also shared how the values and approaches used by healthcare providers' impacted treatment. Providers who respected cultural values or engaged in cultural congruent social norms were identified as being able to understand me or are more knowledgeable about my culture. Three participants who were dissatisfied with treatment providers described not liking the "mechanical" or "rude" approach used by certain providers. This approach mentioned by participants may have been inconsistent with the value of personalismo. Providers who fail to respect cultural values may easily offend individuals from diverse backgrounds. Maduro (1983) stated, "even such a simple

thing as failing to shake a Latino's hand vigorously in an initial interview may convey the impression of a cold and distant attitude that will cost the physician a cooperative relationship" (p. 869). Whether intentional or not, actions or treatments that are incongruent with cultural norms can result in an avoidance of future healthcare or harm to the participant.

This finding is important to consider given increased efforts to reduce healthcare costs in the U.S. medical system. By providing more culturally competent care, healthcare consumers may be more likely to follow recommendations by their treatment providers and obtain greater treatment success, thereby reducing ineffective and costly treatments. Stewart et al. (2000) found that patient-centered practice was associated with greater patient health outcomes and more efficient care as demonstrated by reduced diagnostic tests and referrals. Likewise, Starfield et al. (1981) found that patient-provider agreement on the identified problems and treatment resulted in increased patient compliancy and overall better healthcare outcomes. As a result, providers with increased culturally competency and knowledge about patient culture may result in increased quality of care and reduced healthcare costs.

Six of the participants shared similar values pertaining to seeking services through curanderos. Of those who stated they did not believe in curanderos, four explained that their disbelief was rooted in their perceptions of curanderos being thieves or blackmailers, stating they "take your money" or "make a fool out of you." Religious values were also explained as incongruent with the services offered by curanderos. Although the results of this study suggest dissatisfaction with curanderos in the Mexican immigrant community, it is important to acknowledge that this view might be unique to

the participants in this study. For example, negative experiences with curanderos in the past may have resulted in participants seeking treatment within U.S. healthcare system. Those individuals who have experienced healing or success with curanderos may not have felt the need to seek contact with the current U.S. healthcare system.

Common responses acknowledging the high cost of services and inability to obtain health insurance led to the identification of access barriers as a mediating factor in help-seeking strategies. High medical costs and inability to obtain healthcare coverage are some of the most substantial barriers for member of the Latino population (Casey, Blewett, & Call, 2004; Cook, Mcguire, & Miranda, 2007; Kouyoumdjian et al., 2003; Rodriguez et al., 2009; Shattell, Hamilton, Starr, Jenkins, & Hinderliter, 2008). According to a recent report on income, poverty, and health insurance by the U.S. Census Bureau (2013), 29% of the Hispanic population in the U.S. did not have health insurance in 2012, compared to 10% of the non-Hispanic White population. Due to the census's inability to account for undocumented Mexican immigrants, it is a reasonable assumption that the number of uninsured Mexican immigrants is much higher than 29%. Not surprisingly, strong negative correlations have been observed between being uninsured and accessing mental health care (Cook et al., 2007). Shattell et al. (2008) further supported this, stating, "While having insurance does not guarantee access to mental health care or even quality care, not having insurance usually guarantees no care" (p. 360).

In this study, four of participants enrolled in mental health services to help manage emotions and reduce stress in order to become more relaxed. Among the interviews, there was an emphasis on psychoeducation and the desire to learn about

emotions and mental health. Additionally, four of the participants wanted to develop coping skills or exercises to assist in reducing stress and increase their ability to become more calm or tranquil. These participants who wanted help dealing with emotions and stress wanted specific options or solutions for their complaints. This approach seems to be consistent with previous research on viewing healthcare providers as all knowing and able to provide solutions for problems (Cortes et al., 2009). These findings suggest that psychological treatment approaches emphasizing psychoeducation and teaching skills aimed at reducing symptoms may result in more effective treatment in the Mexican immigrant community.

Participants in this study had either experienced past health gains or were currently experiencing improvement in physical and/or mental health symptoms. For those participants currently engaged in mental health services, there was an emphasis on the coping skills they had gained from group or individual therapy that led to the reduction of stress. None of the participants shared dissatisfaction in their personal progress or the resulting consequences from obtaining physical or mental health services. It is possible that the combination of participants' active help-seeking behaviors and their providers' recommendations resulted in personal health gains and reduced symptomatology. As mentioned previously, seeking treatments that are congruent with an individual's values system may have a positive influence on health consequences. Although half of the participants held beliefs that mental health services were helpful, it is important to recognize the ongoing stigma identified by these individuals within their community. As noted previously, fear of being called crazy impacted some of the participants' decisions to disclose help seeking strategies to close family and friends.

Mexican immigrants who are involved in mental health services may continue to experience stigmatization within their community despite personal health gains.

Healthcare Provider Recommendations

Recommendations for healthcare providers are offered based upon the results from this study. It is important to note that these recommendations are just a short list that may result in more culturally competent healthcare with the Mexican immigrant community. Future researcher may find alternative or additional suggestions for working with this community. Readers should continue to assess whether these recommendations are appropriate for individual clients or patients in the healthcare setting.

1. *Healthcare providers should assess Mexican immigrants for physical health and mental health symptoms through a family systems perspective, especially during times of high family stress or when relocation has resulted in a decreased social support system.*

Familismo was identified as a primary theme for causal factors of complaints. Social support can serve as a buffer against illness in individuals from any population, especially mental illness. This buffer may be especially pronounced in collectivist cultures that place high value on family ties. The traditional Latino value of familismo places high importance on close relations within the family system and high loyalty to the family system (Arredondo et al., 2008; Kouyoumdijian et al., 2003). Just as a strong social support system can protect an individual against stress-related illnesses, a lack of a social support system or dysfunctional family relationships can have the opposite effect. Mexican immigrants who do not belong to or have access to a cohesive and functional

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family unit may be at risk for increased stress due to inconsistencies with their idealized

cohesive family unit (Keefe, Padilla, & Carlos, 1979).

2. *Medical providers would benefit from learning culture-specific descriptors of*
   mental health symptoms Reports of pain in the head and neck areas should be
   further assessed to rule out additional mental health symptoms.

Participants in the current study listed both physical and mental health symptoms.

There is a well-documented history of comorbidity between physical illness and mental

illness (Croft & Parish, 2013; Mandersheid & Kathol, 2014; Sperry, 2013). Psychological

symptoms often masquerade as physical symptoms and/or can exacerbate current medical

conditions (Sperry, 2013). Mandersheid and Kathol (2014) noted that over 50% of

people with a chronic physiological disease also had comorbid mental health conditions.

Common physical symptoms that are often included in various mental health diagnoses

include fatigue, insomnia, changes in appetite, shortness of breath, nausea, chest pain,

and sweating. Mental health assessment may prove beneficial for Mexican immigrant

patients complaining of pain.

3. *It may prove beneficial to ask the client about the desired level of contact with the*
   family unit when assessing for mental health concerns.

As noted previously, familismo is a cultural value of many Mexican immigrants and

describes the importance of closeness and loyalty to the family system (Arredondo et al.,

2008; Kouyoumdijian et al., 2003). As such, it is not uncommon to include family

members in the treatment process. Inclusion of the family may play a central role in

treatment, and may prove extremely beneficial for individuals within the Mexican

immigrant community. Just as some of the participants in the current study noted that a

lack of support or contact with the family unit can be a source of illness, an increased level of involvement and support from the family in treatment may result in increased health gains. However, it will be important for the clinician to have a sense of the family's views of mental health and whether any stigma regarding mental illness exists. If there is a sense that the family may be opposed to any types of assessment or treatment related to mental health, it may be beneficial for the healthcare provider to assess for mental health individually with the client. Despite confirmation that participants valued mental health services, this value of mental health services was not always consistent throughout the participants' family system. In order to maintain respect for the cultural value of familismo and assess for mental health concerns, healthcare providers might consider a hybrid model of including the family and allowing time for individualized assessment.

4. *Medical providers should discuss patients' beliefs about medications before prescribing to patients of Mexican origin. Additionally, medical providers should consider referring patients to alternative or supplemental forms of treatment.*

Given the hesitancy towards medication use found in this study sample, healthcare providers should discuss the patient's beliefs about medications when working with an immigrant of Mexican origin before prescribing a medication. Increased medication education may also ease potential hesitancy regarding medication use. If the individual is opposed to or hesitant about the use of medications, the healthcare provider might then make referrals to treatments that are more consistent with the patient's beliefs about healing. This recommendation is not intended to undermine medical providers' recommendations, nor is the intent to withhold medications that may prove very

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beneficial to the patient. Rather, the goal is to increase the awareness of alternative treatment modalities that may prove useful for an individual given their cultural values about treatment, heighten the level of cultural sensitivity in determining treatment, and ultimately enhance the effectiveness of more medication treatment. For those instances when medication management is the first line of treatment, it is recommended that health providers assess and address the client's potential hesitancy in taking the prescribed medication.

5. *Healthcare policy makers and treatment providers should consider the effects of increased healthcare costs for communities with limited funds and barriers to accessing health insurance.*

The financial burden of healthcare services remains an ongoing topic of debate in government and healthcare reform. This financial burden remains the primary barrier for the Mexican immigrant community in obtaining both mental health and physical health services. Although there may not be a simple or problem-free method of reducing the financial burden of healthcare, there are some options that healthcare policymakers or private healthcare providers could consider when developing business models for healthcare. Student clinicians working under licensed providers in various healthcare fields may be able to provide reduced fee or free services. Unfortunately, there are few healthcare training programs in rural populations. As such, satellite clinics in rural communities may provide the Mexican immigrant community with greater access to healthcare. Satellite campuses can provide a mutually beneficial relationship for communities in need of low-cost services and student-clinicians in need of training hours. Government loan repayment programs for healthcare workers may also improve the

access for services in the Mexican immigrant community by providing incentives for

healthcare workers to work in rural areas. Increased trainings and job opportunities for

mental health advocates who could travel to more rural areas might be yet another source

of knowledge about healthcare service options.

Strengths and Limitations

Many strengths and limitations result from the qualitative nature of this study. An

inherent strength of the qualitative approach is the ability to gather information about the

participants' subjective experience rather than testing a previously defined hypothesis

(Montell, 1999). Charmaz (2006) confirmed that the goal of the grounded theory

approach in qualitative research is to view the world through the lens of the participant in

order to develop new theories. By allowing the participants to share their true opinions

and experiences in relation to the mental health and treatment, it was possible to gather

data that may have been missed if quantitative tools with pre-defined constructs had been

used. With the information gained in this study, it may be possible for future researchers

to develop new topics of research and create more culture-specific operational definitions

and valid quantitative tools (Fossey, Harvey, McDermott, & Davidson, 2002).

A second strength of this research design is the ability to gather rich and detailed

information about a specific target population. Historically, the Latino immigrant

population has been understudied in psychological research (Ojeda et al., 2011). This

lack of research is even greater when further narrowing the focus to a specific nationality

of immigrants, such as the use of participants of Mexican origin in this study. One of the

reasons for this scarcity is largely the result of researchers experiencing difficulties

accessing this community. As noted previously, Ojeda et al. (2011) cited unfamiliarity

with research, previous experiences of exploitation, concern about language fluency, and fears that personal information may be reported to immigration officials as barriers to accessing the Latino immigrant community for research purposes. The number of participants involved in this study provides a solid start to research in this area, considering the multitude of barriers to accessing populations that have often been excluded from research. With the projected growth of the Latino immigrant community and current emphasis on healthcare reform in the United States, it will be important for researchers to make efforts to understand the healthcare needs of the Latino community as well as the Latino immigrant community.

Another especially important strength of this study was the emphasis on culturally competent research methods. Although guidelines associated with research are not fully compatible with the values of all cultures, special efforts were made to ensure that cultural sensitivity was at the forefront of methodological decision-making during the development of this study. A qualitative methodology was chosen to eliminate some of the cultural biases inherent to many quantitative measures. Before the data collection process began, relationships with providers who consistently work with the Mexican immigrant community were formed. Efforts were made to adhere to the value of personalismo, a cultural value in the Latino community that emphasizes warm and friendly exchanges in social interactions (Añez, Silvia, Paris, Jr., & Bedregal, 2008). Ojeda et al. (2011) confirmed that upholding cultural values in research is of utmost importance in conducting culturally competent research.

As a result of the strengths described, this researcher observed a degree of empowerment in many of the participants. The design of this study placed high value on

the opinions and beliefs of the participants. Sentiments of empowerment and gratitude among the study participants are exemplified in statements made by participants at the conclusion of the interview. Several of these statements are listed below:

[Pues yo me siento muy bien. Me siento este, una persona, una mujer afortunada porque no todos tenemos este privilegio de que nos den estas citas para vi a lugar y al mismo tiempo yo me siento confortable al decirlo lo que siento, lo que yo pienso, lo que yo hecho, y lo que las personas están hecho por mí]

[Well I feel great. I feel like I am a lucky woman because not everyone has the privilege of receiving these appointments and having this place, and at the same time I feel comfortable to say what I feel, what I think, what I've done, and what people have done for me]

[Pues, solo espero que de algo sirva de algo ayude mí, (pause) pues mi experiencia o lo que o la respuestas que ayudado porque pues estoy aquí no solamente por el cupón, si no que, mi parece interesante, muy interesante que estudiantes como tú, se intrigan en buscar o estudiar más acerca de nuestras tal vez nuestras culturas, de lo que creencias porque ojalo eso ayude para que algún da pues no solamente de acá con México si no todo el mundo para que nos conozcamos bien.]

[I only hope that this help and that my experience or the answers are helpful because I'm not only here for the coupon. I find it interesting that students like you who are intrigued to find or study our cultural values and our beliefs. I hope this helps someday, not only for here with Mexico, but that all of the world can know us better.]

[Muy bien porque tu es muy buena persona y me siente uno como si fueras tu alguien conocido que ya conocía a una antes y que puede uno entre hablar uno conversación larga. Me relajo un poco más.]

[I feel good because you are a very good person and I feel as if you were someone I already knew and that I could have a long conversation with. I feel a little more relaxed.]

[There's times I feel like you made me feel very good. There's people that make you feel inferior or dumb or stupid, they look down at you, but they stereotype.]

Several important limitations of this study warrant consideration. Readers should be careful not to generalize the results of this study to the overall Latino population. According to the 2010 U.S. Census, there were over 50 million people of Hispanic or

Latino origin in the United States; these include people from a diverse set of regions including Cuba, Mexico, South America, Central America, or other Spanish Culture. Additionally, the results of this study are not generalizable to the overall Mexican population in the United States, which, according to the last census, consisted over 31 million people in 2010 (U.S. Census Bureau, 2010). Extreme caution should also be used when attempting to generalize these results to the Mexican immigrant population. Although it is difficult to determine the exact number of Mexican immigrants residing in the United States, it is estimated that this number is well over 11 million (Migration Policy Institute, 2008). As with any ethnic group, the Mexican immigrant community boasts large within-group variation that can be influenced by multiple variables including age, personal and family history, education level, acculturation level, region of origin, geographic residence, and diverse cultural values. A sample size of eight participants should not be used to portray the opinions and beliefs of a community with membership well over 11 million people. Participants in this study had some form of previous contact with the healthcare system and voluntarily signed up for this study following a referral from a healthcare provider. As a result, the sample may be biased and not representative of those with less experience or contact with the healthcare system. For example, those in contact with mental health services may have unique views regarding medications or the use of curanderos. Additionally, more positive experiences with healthcare personnel may have increased the likelihood of the prospective participants to follow through with a referral or to be more trusting of this study.

Although the design of this study was listed as a strength, there were also some limitations as a result of methodological guidelines. As with all research, ethical

guidelines for the research ensure that human participants are protected and well informed of their rights and responsibilities when participating in a research study. Inherent in almost all studies is the requirement of each participant to sign one or more forms indicating consent to participate. This study was no different. Each prospective participant was required to review and sign three separate forms before beginning the actual study. This process of completing paperwork and gaining informed consent can be time-consuming and potentially result in fatigue on the part of the research participant. As an example of this, one participant appeared to grow fatigued as the informed consent process transpired. The participant was vocal in sharing frustration with the seemingly repetitive paperwork and multiple signatures required as part of the study. I reminded the participant of the voluntary nature of the study and offered multiple opportunities to withdraw from the study in an empathic and supportive nature. However, the participant wanted to continue despite feeling fatigued. It is possible that the rigidity of research guidelines may be incongruent with the value of personalismo. There exists a certain amount of inflexibility when reviewing research documents that are likely not encountered on a regular basis, particularly for individuals who have had minimal contact with the healthcare system. The participant mentioned previously also questioned whether these documents were connected to the legal system. This participant's concern brings up another important consideration when conducting research with a population in which there may exist a certain level of fear or past experiences of exploitation connected to government or legal agencies. Respect and understanding for those with little exposure to research methodology should remain in the forefront when working with members of marginalized populations.

A final limitation is the effect of the researcher on data collection and analysis. Although I am bilingual and was able to communicate with the participants in their native language, ethnic and racial differences may have impacted the data collection process. For example, ethnic differences may have influenced the content or degree of sharing by participants. Some researchers have argued that the therapeutic alliance can be more easily formed when client and therapist are of the same ethnic background due to perceived shared experiences (Sue, 1988). Participants in this study may also have felt increased pressure to express positive experiences regarding U.S. healthcare providers due to this researcher's racial and cultural identification with White and mainstream U.S. culture. Likewise, participants may not have been as open regarding their beliefs and experiences with curanderos if it was assumed that this researcher was in disbelief of traditional healing practices. Flicker et al. (2008) found that Hispanic youths who were matched with a Hispanic therapist exhibited higher treatment gains compared to Hispanic youths who were matched to an Anglo therapist in the context of family therapy. Although efforts were made to adhere to a culturally competent research approach, ethnic differences between the principle researcher and participants remain a limitation as it is difficult to fully appreciate and understand how this variable may have influenced the content or degree of sharing by the participants.

In addition to the data collection process, the background and worldview of the researcher may also impact the data analysis process. Charmaz (2006) discussed that personal history and values allow the potential to influence data collection and analysis. In order to decrease bias and maintain objectivity, a research assistant engaged in cross-validation measures. The assistant first reviewed the coding process of three of the eight

interviews. The assistant then independently derived categories, themes, and subthemes based on my line-by-line coding. Overall, all of the major themes developed by the research assistant were consistent with the themes I derived. Any variations in content categories or labels were discussed and agreed upon. I also maintained a detailed research journal to help capture thoughts or questions related to the data. I wrote memos shortly following the individual interviews and during the coding process to assist in the development of themes and subthemes as well as identify any gaps in the data.

Future Directions

The goal of this exploratory research was to gain knowledge about the concepts of mental illness in the Mexican immigrant populations in the United States. As noted in the limitations section, the results found within this study sample cannot be generalized to the larger Mexican community or the larger Mexican Immigrant community. Further research could expand on this study by replicating this research with different generations of the Mexican immigrant community. Additionally, due to regional differences, further research might expand on this studying by replicating the research with Mexican immigrant communities in different geographical areas in the United States. The participants in this study had at least some form of previous contact with the healthcare community. Including Mexican immigrant participants who have not come into contact with the healthcare system may provide additional data. With the expected population growth of the Latino immigrant population, gathering data from various Latino communities may provide more culture-specific recommendations.

In order to effectively research conceptualizations of mental health, a qualitative approach was selected to help generate ideas as well as develop hypothesis for future

areas of research. Qualitative research can provide opportunities to develop more precise and effective measures amenable to a quantitative study. Likewise, quantitative research could be developed to validate the results from this study. However, caution should be used when developing research with the Mexican Immigrant community, or any other minority group. A lack of cultural consideration in research methodology can only serve to further alienate or oppress minority groups as well as lead to faulty results.

A final expansion on this research could be developing culture specific trainings for providers who come into contact with the Mexican immigrant community. The themes gathered in this study, in conjunction with the recommendations provided, may offer helpful information that could be expanded upon and developed into presentation format. Culture-specific trainings presented at clinical team meetings or for continuing education credits can serve as effective learning tools for those who might not seek out research like this study independently.

Conclusion

In this study, I explored and highlighted distinct categories contributing to conceptualizations of mental illness in the Mexican immigrant community including Causal Factors, Phenomena, Strategies, Mediating Factors, and Consequences. The family context or familismo was seen as a contributing factor to both mental stress and physical pain in many of the participants. Specifically, results from his study suggested that both stress within the family or lack of access to and worry about the family can contribute to health symptoms. As a result, multiple help-seeking strategies were observed including mental health services, physical health services, and religious help. Multiple variables were observed to mediate treatment strategies. As a result of treatment,

participants identified overall health gains despite ongoing stigmatization experienced by some participants. Many of the identified themes were consistent with previous research. Specifically, the Latino value of familismo was observed within many of the participants' conceptualizations of the causes and development of complaints. Participants identified barriers similar to those described in previous research. Results of this study support previous findings of mental illness and the associated stigma within the Latino community. Of those involved in mental health services, participants expressed a preference for being educated about their emotions and learning skills to help reduce stress. Results of this study indicate a decreased desire for medication use within the Mexican immigrant community. Participants were observed to have experiences health gains as a result of healthcare services. Based on the interviews collected in this study, recommendations are provided to healthcare workers to assist them in providing more effective, efficient, and culturally competent care. Future directions may include replicating this qualitative approach to other underserved communities, developing culturally sensitive quantitative measure to solidify themes identified in this study, or developing cultural competence trainings for treatment providers working with the Mexican immigrant community.

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1. Study Title

Hannah Nixon, MS is a student in the psychology department at Pacific University and is studying the opinions and explanations of mental illness among Mexican Immigrants. The title of the study is Conceptualizations of Mental Illness among Mexican Immigrants.

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2. Study Personnel

Name	Hannah Nixon, MS	Shahana Koslofsky, Ph.D	Hana Nielsen-Kneisler, MS
Role	Principal Investigator	Faculty Advisor	Research Assistant
Institution	Pacific University	Pacific University	Pacific University
Program	School of Professional Psychology	School of Professional Psychology	School of Professional Psychology
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Telephone	(208)-420-4261	(503)-352-2621	(503)-545-1445

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3. Study Invitation, Purpose, Location, and Dates

You are invited to participate in a research study about explanations of mental illness. You will be asked to explain your opinions about the causes and treatment of mental illness The interviews about the explanations of mental illness will be administered in a neutral room in the referring clinic between 11/15/2013-5/30/2014. The study will start following approval of the Institutional Review Board of Pacific University.

Participating Clinics:

Pacific Psychology Clinic	Virginia Garcia Memorial Health Center	Lutheran Community Services NW	Conexiones Center for Trauma Recovery
222 SE 8th Ave, Suite 212 Hillsboro, OR 97123	1151 N. Adair Cornelius, OR 97113	617 NE Davis St, McMinnville, OR 97128	3500 NE MLK Blvd, Portland OR 97211
1411 SW Morrison St, Suite 310 Portland, OR 97205	226 SE 8th Avenue Hillsboro, Oregon 97123		
	115 N.E. May Lane McMinnville, Oregon 97128		

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4. Participant Characteristics and Exclusionary Criteria

In order to Participate in the study it is necessary that:

1. You identify as Mexican.
2. You are over the age of 18.
3. You were born in Mexico.
4. You can speak Spanish
5. You were referred by a healthcare provider or self-referred.
6. You are autonomous.

5. Study Materials and Procedures

Participation in this study includes an interview with a student researcher. During the interview, you will be asked to respond to questions about your thoughts of mental illness and health. You will be asked to explain your opinions about the causes and treatment of mental illness. Examples of questions include (a) When you first visited our clinic, what kind of help did you expect?, (b)How do you perceive doctors and psychologists in the United States?, and (c) What is your opinion about medication? The interview will take approximately 60-105 minutes to complete. The interview will be recorded with an audio device.

6. Risks, Risk Reduction Steps, and Clinical Alternatives

a. Anticipated Risks and Strategies to Minimize or Avoid Risk

Your participation may come with certain risks.
1. If there is discomfort responding to questions in the interview, you can skip questions you do not want to answer or withdrawal from the study at any time. If there is a serious conflict during the interview, a research assistant or health provider will assist the participant to resolve any conflict.
2. If you feel pressured by your healthcare provider to participation in this study, you may withdraw. Withdrawal from this study will not affect the services you are currently receiving or future services at this clinic.

b. Unknown Risks

It is possible that participation in this study may expose you to currently unforeseeable risks. If you identify another risk, please inform the researcher immediately and means will be taken to guarantee your physical and psychological wellbeing.

c. Advantageous Clinical Alternatives

This study does not involve experimental clinical investigations

7. Adverse Event Handling and Reporting Plan

In the event that you become sick, injured, distressed, or otherwise uncomfortable as a result of your involvement in the research study, you may stop your participation immediately. If such an event occurs, promptly notify Dr. Shahana Koslofsky, Ph.D. at (503) 352-2621 or the Pacific University Institutional Review Board at (503) 352-2112. If the investigator(s) become aware of an adverse event, the IRB office will be notified by the next normal business day for minor events and within 24 hours for major events. If you experience or are directly affected by an adverse event, you will be given the opportunity to withdraw any data collected from you during the study up to 6/1/2014.

8. Direct Benefits and/or Payment to Participants

a. Benefit(s)

There may or may not be direct benefits for your participation in the evaluation. The findings of this study may help other health care providers understand the needs of the Mexican immigrant population in the system of physical and psychological health. The finding of this

study will provide critical support for the national effort to provide mental health services to Latinos. It is projected that the benefits will outweigh the risks for participating in this study.

b. Payment

You will be reimbursed with a gift card for $20 to Winco or Walmart if you complete the study (responding to at least 13 of the 17 interview questions). You will be reimbursed for your participation with a gift card for $10 to Winco or Walmart if you decide to withdraw early. You will be reimbursed after the interview.

9. Promise of Privacy

All of the data will be protected in accordance with state and federal laws. In order to protect the confidentiality of the participants, the name of each participant will be changed after the interview to ensure anonymity. The information will be kept in a locked case. Confidentiality will only be broken in cases of abuse of a minor, elderly, or disabled person, risk to the participant's life, or risk to the life of another person. Confidentiality won't be broken for immigration issues.

10. Medical Care and Compensation in the Event of Accidental Injury

During your participation in this project it is important to understand that you are not a Pacific University clinic patient or client, nor will you be receiving complete mental health care as a result of your participation in this study. If you are injured during your participation in this study and it is not due to negligence by Pacific University, the investigator(s), or any organization associated with the research, you should not expect to receive compensation or medical care from Pacific University, the investigator(s), or any organization associated with the study. If you are injured and it directly is related to your participation in this study as a research subject, please contact the Pacific University Institutional Review Board at 503-352-1478.

11. Voluntary Nature of the Study

Your participation in this investigation is completely voluntary.
Your decision whether or not to participate will not affect your current or future relations with the referring clinic. If you choose not to participate, you are free to withdraw at any time; withdrawal will not result in penalty with the referring clinic. Participation in this project is voluntary and the only other alternative to this project is nonparticipation. If you decide to participate, you are free to not answer any question or withdraw at any time without prejudice or negative consequences. The audio recorder used in this study will be deleted if you withdraw. You have the right to limit what is recorded.

12. Contacts and Questions

The investigator(s) will be happy to answer any questions you may have at any time during the course of the study. If you are not satisfied with the answers you receive, please call the Pacific University Institutional Review Board at 503-352-1478 to discuss your questions or concerns further. If you have questions about your rights as a research subject, or if you experience a research-related injury of any kind, please contact the investigator(s) and/or the IRB office. All concerns and questions will be kept in confidence.

13. Statement of Consent

YES   NO

_____ _____ I am 18 years of age or over.

_____ _____ All my questions have been answered.

_____ _____ I have read and understand the description of my participation duties.

_____ _____ I have been offered a copy of this form to keep for my records.

                     I voluntarily agree to participate in this study and understand that I may
                     withdraw at any time without consequence.
_____ _____

_____ _____ I give permission for the investigator(s) to gather audio data for analysis.

Signature	Date

	Participant
Printed Full Name	Study Role

Signature	Date

	Researcher
Printed Full Name	Study Role

APPENDIX B

Informed Consent-Spanish

1. Título de la Investigación

Hannah Nixon, MS. es estudiante en el departamento de psicología de la Universidad del Pacífico y está estudiando las opiniones y explicaciones de las enfermedades mentales en los inmigrantes mexicanos. El título del estudio es Conceptualizaciones de Salud Mental en los Inmigrantes Mexicanos.

2. Personal del Estudio

Nombre	Hannah Nixon, MS	Shahana Koslofsky, Ph.D.	Hana Nielsen-Kneisler, MS
Rol	Investigadora principal	Consejera de la Facultad	Asistente de investigación
Institución	Universidad del Pacífico	Universidad del Pacífico	Universidad del Pacifico
Programa	Escuela de Psicología	Escuela de Psicología	Escuela de Psicología
Email	heid8961@pacificu.edu	skoslofskyphd@pacificu.edu	hanank@pacificu.edu
Teléfono	(208)-420-4261	(503)-352-2621	(503)-545-1445

3. Invitación; propósito, lugar y fechas de la investigación

Usted está invitado a participar en un estudio sobre las explicaciones de las enfermedades mentales. Se le pedirá a explicar sus opiniones sobre las causas y tratamiento de enfermedades mentales. Las entrevistas sobre las explicaciones de las enfermedades mentales serán conducidas en una sala neutra en la clínica indicada, entre 11/15/2013-5/30/2014. El estudio dará inicio después de la aprobación del Comité de Revisión Institucional de la Universidad del Pacífico.

Clínicas participantes:

Pacific Psychology Clinic	Virginia Garcia Memorial Health Center	Lutheran Community Services NW	Conexiones Center for Trauma Recovery
222 SE 8th Ave, Suite 212 Hillsboro, OR 97123	1151 N. Adair Cornelius, OR 97113	617 NE Davis St, McMinnville, OR 97128	3500 NE MLK Blvd, Portland OR 97211
1411 SW Morrison St, Suite 310 Portland, OR 97205	226 SE 8th Avenue Hillsboro, Oregon 97123		
	115 N.E. May Lane McMinnville, Oregon 97128		

| 4. | **Requisitos de los participantes** |

Para participar en el estudio es necesario que:
7. Se identifica como mexicano.
8. Tiene por lo menos 18 años.
9. Nació en México.
10. Habla español.
11. Su médico o proveedor de salud mental lo enviaron, o se ha referido a sí mismo.
12. Usted es autónomo.

| 5. | **Materiales y procedimiento del estudio** |

La participación en este estudio incluye una entrevista con un estudiante investigador. Durante la entrevista, se le pedirá que responda a preguntas sobre lo que piensa de la enfermedad mental y la salud. Se le pedirá a explicar sus opiniones de las enfermedades médicos. Ejemplos de las preguntas incluyen (a) ¿Qué clase de ayuda esperó usted recibir, cuando visitó nuestra clínica por primera vez?, (b) ¿Cómo percibe usted a doctores y psicólogos en los Estados Unidos?, y (c) ¿Cuál es su opinión acerca de medicamentos? La entrevista le tomará aproximadamente de 60 a 105 minutos y será grabada con un dispositivo de audio.

| 6. | **Riesgos, pasos para reducir los riesgos y las alternativas clínicas** |

a. Posibles riesgos y estrategias para minimizar o evitar riesgos
Su participación conlleva ciertos riesgos:
1. Si se siente incómodo al responder las preguntas durante la entrevista, puede saltarse las preguntas que no desea contestar o dar por terminado el estudio en cualquier momento. Si tiene un conflicto serio durante la entrevista, un asistente o proveedor de salud le ayudará a resolver cualquier conflicto.
2. Si siente presionado por su proveedor médico a participar en este estudio, puede retirarse. El retirarse de este estudio no va a afectar los servicios que está recibiendo actualmente o en el futuro, en esta clínica.

b. Riesgos desconocidos
Es posible que la participación en este estudio lo exponga a riesgos imprevisibles. Si usted identifica algún otro riesgo, avise al investigador inmediatamente, y se tomarán medidas para garantizar su bienestar físico y psicológico.

c. Alternativas clínicas ventajosas
Este estudio no incluye una investigación clínica experimental.

| 7. | **Manejo de eventos adversos y plan de divulgación** |

En caso de que usted se enfermara, se lastimara, se sienta angustiado o incómodo de alguna manera, como resultado de su participación en este estudio, debe detener su participación de inmediato y notificar a Shanana Koslofsky, Ph.D. al (503) 352-2621 y a la oficina del Comité de Revisión Institucional de la Universidad de Pacífico, al (503) 352-1478. Si las investigadoras son conscientes de un evento adverso, la oficina del IRB será notificada el siguiente día hábil normal en el caso de eventos menores y un plazo de 24 horas para eventos serios. Si está pasando o está siendo directamente afectado por un evento adverso, se le dará la oportunidad de retirar su información de la entrevista hasta el 6/1/2014.

| 8. | **Beneficios Directos y Pago a Participantes** |

a. Beneficios

Es posible que haya o no beneficios directos por su participación en la evaluación. Los hallazgos de este estudio pueden ayudar a otros proveedores de salud a entender las necesidades de la población de inmigrantes mexicanos en el sistema de salud físico y psicológico. Los hallazgos de este estudio proporcionarán apoyo crítico para el esfuerzo a nivel nacional de proveer servicios de salud mental a latinos. Se proyecta que los beneficios serán mayores que los riesgos por participar en este estudio.

b. Pago

Usted será remunerado por participar en la entrevista con una tarjeta de regalo de $20 en Winco o Wal-Mart si completar el estudio (responder por lo menos 13 de las 17 preguntas de la entrevista). Usted será remunerado por participar en la entrevista con una tarjeta de regalo de $10 en Winco o Wal-Mart si decidir terminar la entrevista temprano. El pago se le dará después de la entrevista.

9. Promesa de confidencialidad

Todos los datos serán protegidos de acuerdo a las leyes estatales y federales. Para proteger la confidencialidad de los participantes, será cambiado el nombre de cada participante después de la entrevista para asegurar su anonimato. Los datos serán guardados en una caja cerrada con llave. La confidencialidad se romperá sólo en casos extremos de abuso a un menor, un anciano o discapacitado, o que la vida del participante u otra persona estén en riesgo. La confidencialidad no se romperá por asuntos de inmigración.

10. Atención médica y compensación en caso de daños o lesiones por accidente

Durante la participación en este proyecto es importante entender que usted no es un paciente o cliente de la Universidad del Pacífico, ni recibirá servicios de salud mental como resultado de la participación en esta investigación. Si usted sufre algún daño durante la participación en esta investigación y no es por negligencia de la *Universidad del Pacífico*, o por los investigadores, o cualquier organización o agencia asociada con la investigación, usted no debe esperar que reciba compensación o atención médica por parte de la Universidad del Pacífico, los investigadores, o ninguna organización o agencia asociadas con la investigación. Si usted sufre alguna lesión que está relacionada directamente con su participación en este estudio como sujeto a investigación, por favor comuníquese con la oficina del Comité de Revisión de la Universidad del Pacífico al 503-352-1478.

11. Naturaleza voluntaria de la investigación

Su participación en esta investigación es completamente voluntaria.
Su decisión de participar o no en esta investigación no va a afectar su relación con la clínica participante, ni ahora ni en el futuro. Si decide no participar, usted es libre de abandonar el estudio en cualquier momento, sin represalias por hacerlo con la clínica participante. La participación en este proyecto es voluntaria y la única alternativa es el no participar. Si decide participar, es libre para no responder a cualquier pregunta o abandonar el estudio en cualquier momento sin repercusiones o consecuencias negativas. La grabación de audio será destruida si se retira del estudio. Usted tiene derecho a limitar lo que se grabó.

12. Información de Contacto y Preguntas

Los investigadores contestarán con gusto cualquier pregunta que usted pudiera tener, en cualquier momento, durante el estudio. Si no está satisfecho con las respuestas que se le dan, por favor llame a la oficina del Comité de Revisión Institucional de la Universidad del Pacífico al (503) 352-1478, para discutir sus preguntas o inquietudes con más detalle. Si tiene preguntas sobre sus

derechos como participante en la investigación, o si usted sufre lesiones o daños de cualquier tipo relacionadas con la misma, llame a los investigadores o a la oficina del IRB. Todos los comentarios y preguntas serán manejados de manera confidencial.

13. Declaración de Consentimiento

SÍ   NO

_____ _____ Tengo 18 años o más.

_____ _____ Mis preguntas han sido contestadas.

_____ _____ He leído y entendido la descripción de las responsabilidades de mi participación.

_____ _____ Se me ha ofrecido una copia de esta forma para mis archivos personales.

_____ _____ Estoy de acuerdo en participar voluntariamente en este estudio y entiendo que puedo retirarme sin que haya consecuencias.

_____ _____ Doy permiso a los investigadores para que recopilen información de audio para su análisis.

_____   _____
Firma   Fecha

     Rol del participante
_____   _____
Nombre completo   en el estudio

_____   _____
Firma   Fecha

     Rol del investigador
_____   _____
Nombre completo   en el estudio

APPENDIX C
Demographic Questionnaire-English

Identifying Code: _____

Age: _____

Gender: _____

Academic Level: "I completed… (select one)":

        Less than 3 years   3-6 years   6-9 years

        9-11 years   High School   College

Country of Birth: _____

Number of years living in the United States: _____

What is the primary language spoken at home:
_____

What is the primary language spoken at work/school:
_____

"Most of my friends are…." (select one):

      Latino   Latino and American   American

APPENDIX D

Demographic Questionaire-Spanish

La identificación de código: _____

Edad: _____

Sexo: _____

Nivel Académico: "Yo completé… (seleccione uno)"

                  Menos de 3 años   3-6 años   6-9 años

                  9-11 años   la escuela preparatoria   colegio/universidad

País de nacimiento: _____

Número de años de vivir en los Estados Unidos: _____

Cuál es el idioma que se habla en casa: _____

Cuál es el idioma que se habla en el trabajo o en la escuela:
_____

"La mayoría de mis amigos son…." (seleccione uno):

latinos   latinos y estadounidenses   estadounidenses

APPENDIX E

Interview-English

1. When you first visited our clinic, what kind of help did you expect?

     What should the help or treatment consist of?

     What types of treatment are you aware of for your complaints?

     What is your opinion about medication?

2. What main outcomes are you expecting from treatment at this clinic?

3. What is the position of a doctor (i.e., medical doctor, physician, psychologist) in your country?

4. How do you perceive doctors and psychologists in the United States?

5. Does it make sense for you to talk about your complaints with an expert (within the framework of therapy)?

6. We are interested in how you describe your own complaints. What are the words for your

complaints in your language?

7. In your opinion, what is/are the cause(s) of your complaints?

8. When did your complaints occur for the first time?

9. In your opinion, what is/are the reason(s) that your complaints occurred that first time? Since your illness started, have you experienced times without complaints?

10. What does your family think about your complaints? Your friends?

11. In what manner are your complaints affecting you? What are they doing to you?

12. How serious are your complaints?

13. Do you expect the complaints to persist or be transient?

14. What are the main consequences of your complaints?

      What has changed because of them?

15. What kind of help have you made use of up until now?

      General Practitioner

      medical specialist

      hospital

      psychotherapist

      social worker

      legal counseling

      alternative medicine

      spiritual healer

      religious support

b. In your home country

      public hospital

      private hospital

      walk-in clinic

      private doctor

      pharmacist

      wise man/woman

      folk medicine

      spiritual healer

16. Are there healers in your country? Do people go to healers? Do you personally believe in such practices?

17. What are your expectations for the future?

      Termination:

Would you like to add something?

How did you feel during the interview?

How are you feeling at the moment?

Thank you very much for this conversation!

APPENDIX F

Interview- Spanish

1. ¿Qué clase de ayuda espero usted recibir, cuando visito nuestra clínica por primera vez?

¿En qué consiste la ayuda y el tratamiento?

¿Qué clase de tratamiento sabe usted para sus quejas?

¿Cuál es su opinión acerca de medicamentos?

2. ¿Cuáles son sus expectativas del tratamiento en esta clínica?

3. ¿Cuál es la posición de un doctor (doctor médico, psicólogo) en su país?

4. ¿Cómo percibe usted a doctores y psicólogos en los Estados Unidos?

5. ¿Está de acuerdo de hablar con un experto acerca de sus quejas (conforme el cuadro de terapia)?

6. Estamos interesados en lo que usted describe de sus quejas. ¿Cuáles son las palabras de sus quejas en su lenguaje?

7. En su opinión, ¿cuáles son las causas de sus quejas?

8. ¿Cuándo fue que sus quejas comenzaron por primera vez?

9. En su opinión, ¿cuáles son, o fueron las razones de cuando empezaron sus quejas por primera vez? Desde que su enfermedad empezó, ¿ha experimentado tiempos sin quejas?

10. ¿Qué piensan sus familiares y amigos acerca de sus quejas?

11. ¿En qué manara le están afectado sus quejas? ¿Qué le están haciendo a usted?

12. ¿Qué tan grave están sus quejas?

13. ¿Usted cree que sus quejas serán persistente o pasajero?

14. ¿Cuáles son las consecuencias de sus quejas? ¿Qué ha cambiado a causa de sus quejas?

15. ¿Qué clase de ayuda a usado hasta el día de hoy?

    Doctor general

    Un especialista medico

    Hospital

    Psicoterapeuta

    Trabajador social

    Consejería legal

    Medicina alternativa

    Sanador espiritual

    Ayuda religiosa

b. En su país natal:

    Hospital publico

    Hospital privado

    Clínica abierta al público

    Doctor privado

    Farmacéutico

    Hombre o mujer sabía

    Medicina natural

    Sanador espiritual

16. ¿En su país hay curanderos (sanador)? ¿La gente va con los curanderos? ¿Usted personalmente cree en esta clase de práctica?

17. ¿Cuáles son sus expectativas para el futuro?

   Determinación:

   ¿Le gustaría agregar algo más?

   ¿Cómo se siento durante esta entrevista?

   ¿Cómo se siente en este momento?

Muchas gracias por tener esta conversación.