MENTAL HEALTH CAUSAL BELIEFS, PERCEPTION AND ATTITUDE
DIFFERENCES OF MEXICAN IMMIGRANTS AND MEXICAN AMERICANS

A Project

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by
Joanna Gutierrez

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by

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Division of Social Work
Abstract

of

MENTAL HEALTH CAUSAL BELIEFS, PERCEPTION AND ATTITUDE DIFFERENCES OF MEXICAN IMMIGRANTS AND MEXICAN AMERICANS

by

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The study explored the differences in mental health attitudes, perceptions and causal beliefs between Mexican Americans born in the United States and Mexican immigrants born in Mexico through quantitative data gathered by the researcher. Primary data collected from fifty (50) participants was used to explore these differences via the Attitudes Towards Mental Health Problems Scale (ATMHPS) (Gilbert et al., 2007). According to mean scores on the ATMHPS, the Community External Shame (CES) subscale - concern about how one’s community views mental illness and how it would view them personally if they suffered from a mental illness, was of highest concern regardless of nationality, sex, income and education. For this reason, the researcher focused on examining the relationship between nationality, sex, income and education with Community External Shame (CES). The major findings from the study indicated no statistically significant difference between U.S born Mexican Americans and Mexican born immigrants in their concerns for Community External Shame (CES) (t(48)= -.571, p=.571). Like nationality, the researcher did not find a statistically significant affect of
sex (t(48)= 1.29, p= 0.203), income (t(48)= 1.05, p= 0.297) or education (t(48)= 1.53, p= 0.133) on Community External Shame (CRS), suggesting that in this small sample of participants of Mexican descent, nationality, sex, income and education did not influence their stigmatic mental illness beliefs about community external shame.

________________________, Committee Chair
Teiahsha Bankhead, Ph.D, L.C.S.W

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Date
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Joanna Gutierrez
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Chapter 1

Introduction

People of Mexican descent have been cited as displaying strong disparities in mental health care treatment rates when compared to other racial groups (Keyes, Martins & Hatzenbuehlet et al., 2012; Lee & Matejkowski, 2012; Berdahl & Torres Stone, 2009), which is concerning and must be addressed due to the prevalence of mental health problems in the Mexican population (Pate, 2010). Of those individuals who qualify as having a mental health disorder in the Latino population, only 22% receive mental health treatment (Wells, Klap, & Koike et al., 2001), regardless if they have insurance or not (Ojeda & McGuire, 2006). Low mental health treatment rates by individuals of Mexican descent is particularly a problem because of the rapid increase in population Latinos are experiencing in the United States. It is estimated that by the year 2050, the Latino population will account for one-fourth of the U.S population (U.S Census Bureau, 2014). This translates into a vast need that is not being addressed or met, which is concerning not only for the target population but also for the U.S at large.

Not only do Latinos underutilize mental health services, but they also display high rates of early termination if they enroll in mental health treatment (Pate, 2010). Research also shows that in addition to early termination rates, Latinos also showcase low rates of compliance to medications like anti-depressants (Ayalon, Arean, & Alvidrez, 2005). Early termination and low rates of medication compliance are problematic because they prevent individuals from attaining stability in their mental health and overall wellbeing.

Although Latinos display low mental health treatment rates, a high percent of
them seek mental health services from a general medical practitioner rather than a mental health specialist (Uebelacker, Marootian, & Pirraglia et al., 2012). This is also problematic because general practitioners are neither trained nor suited to treat mental health problems, leaving the patient with a lower level standard of care than is appropriate.

Underutilization of mental health services, treatment, and medication by a large portion of the population is problematic for many reasons. When a large segment of the population is living with untreated mental illnesses, it affects more than just the individual. It affects the individual’s stability and well being, but also their relationships with family and friends, their family dynamics, and the community as a whole.

Having untreated mental illness impacts the individual’s overall wellbeing by increasing suicidal ideations, negative thinking patterns, emotional distress, disorganized thinking, and risky behaviors like drug and alcohol use, among other things. These symptoms can be difficult and painful to live with so mental health treatment is imperative in soothing these distressing symptoms.

Untreated mental illness also affects relationships with family and friends. If a mental illness is left untreated, relationships with family and friends can suffer due to the strain and tension mental health symptoms may place on family and friends. Untreated mental illness is not only painful for the individual suffering from the illness but also for his or hers family and friends.
Untreated mental illnesses also put a strain on the family dynamics because it may interrupt communication styles and hinder positive relationships. It can cause such a strain that family ties may become severed or even broken.

The community as a whole may also suffer from untreated mental illness among its citizens. Implications like drug and alcohol use, disorganized social cohesion and criminal activity may result from untreated mental illnesses in the population.

Many barriers to treatment among Latinos have been cited in the literature ranging from legal status, education level, poverty rate, (Uebelacker, Marootian, & Pirraglia et al., 2012), and immigration history (Garcia & Saewyc, 2007). Although there have been many cited barriers, a particular barrier that will be under investigation for the purpose of this study is attitudes towards mental illness which include perceptions and causal beliefs. Attitudes towards mental illness are an important topic to explore because of their particular influence on help seeking behaviors. Although attitudes towards mental illness have been investigated in the past, this study will go beyond and compare attitudes, perceptions and causal beliefs of mental illness between Mexico born Mexican immigrants and U.S born Mexican Americans in the United States with the hopes of targeting their low mental health treatment rates.

**Background of the Problem**

Low mental health treatment rates among people of Mexican descent is the result of many commonly cited barriers, which in essence are the root of the problem. One of the most cited barriers to mental health treatment among those of Mexican descent is the stigma associated with mental illness (Zhang Hampton & Sharp, 2014; Jimenez, Bartels
& Cardenas et al., 2013; Caplan, Paris & Whittemore et al., 2011; Jang, Chiriboga & Herrera et al., 2011; Corrigan, 2004). Minorities like African Americans and Mexicans have been cited as perceiving more stigma from family, friends, and the community as a whole for mental health disorders, particularly depression (Nadeem, Lange, Edge et al., 2007). This perceived stigma is perpetuated by the community and the family, which then becomes internalized by individuals, making it an obstacle to treatment.

Some other commonly cited barriers to mental health treatment among Latinos in general have been perceptions of the cause of mental health illness (Zhang Hampton & Sharp, 2014; Jimenez, Bartels & Cardenas, 2013; Caplan, Paris & Whittemore et al., 2011; Gonzalez, Alegría & Prihoda et al., 2011; Jang, Chiriboga & Herrera et al., 2011; Ojeda & Bergstresser, 2008), language and cultural barriers (Ruiz, Aguirre & Mitschke, 2013; Keyes, Martins & Hatzenbuehler et al., 2012; Rastogi, Massey-Hastings & Wieling, 2012; Uebelacker, Marootian & Pirraglia et al., 2012; Berdahl & Torres Stone, 2009; Garcia & Saewyc, 2007) and lack of financial resources (Uebelacker, Marootian & Pirraglia et al., 2012). Other factors that contribute to low use of mental health services among Latinos may include the fear of breach of confidentiality where personal information like immigration status would be leaked (Uebelacker, Marootian & Pirraglia et al., 2012).

Another noteworthy explanation for low mental health service rates for Latinos is their historic preference for informal resources like family, friends, or spiritual and religious healers when addressing their mental health symptoms (Loera, Munoz, Nott et al., 2009). Alternate resources like spiritual and religious healers used by Latinos involve
healing the body, mind, and spirit through conventional practices like herbal remedies and body cleanses (Loera et al., 2009).

Negative attitudes about mental health and seeking treatment may also present as a barrier to treatment. Among negative attitudes may be the belief that mental illness, depression in particular, is not a disease (Perez-Zepeda, Arango-Lopez, Wagner et al., 2013). Not perceiving mental health disorders as organic diseases presents a problem; if the issue is not seen as a disease then one will not seek treatment or medication. More research is needed to examine the role of mental illness attitudes, perceptions and causal beliefs among Latinos to see if they do in fact play a role in their treatment seeking behaviors.

**Statement of the Research Problem**

Attitudes and perceptions towards mental illness and mental illness causal beliefs are critical themes to examine for the purpose of further understanding low mental health treatment rates among people of Mexican descent. The importance of funding psycho-educational programs about mental health symptoms and the importance of treatment cannot be denied. Although there is research information about barriers to mental health treatment, there are limited findings on the difference in these themes between U.S born Mexican Americans and Mexico born Mexican immigrants.

**Study Purpose**

The goals and objectives of this study are to explore the differences in attitudes, perceptions and mental illness causal beliefs among Mexican Americans and Mexican immigrants in the United States. It is important to identify differences in attitudes,
perceptions and causal beliefs among these two subgroups of Mexican individuals in order to provide culturally appropriate treatment to target low treatment rates by ensuring compliance with both treatment and medications. It is also important to study in order to encourage practitioners and agencies to explore, identify and implement culturally sensitive practices and interventions with this particular population.

**Theoretical Framework**

The theoretical framework this study follows is based on Acculturation Theory. Robins and colleagues (2011) state that Acculturation Theory is based on culture - the organized set of shared values, beliefs, and behaviors developed and followed by a group. Robbins et al. (2011) explain that acculturation is a process of cultural pluralism where an individual changes their original culture by incorporating elements of another to their own, which then results in a new culture that includes aspects of both. By doing this, an individual then achieves bicultural socialization, which is defined as a mastery of both cultures. A person who achieves bicultural socialization “integrates positive qualities of his or her culture of origin and the dominant society’s culture [with] the outcome… [being] a functional way of relating and surviving in both cultures” (as cited by Robbins, Chatterjee, & Canda, 2011, pg.147). Robbins and colleagues further state that by mastering both cultures, a biculturally socialized individual gains a new sense of power from the broad set of adaptive skills he or she possesses. This new sense of power may help individuals of Mexican American descent raise awareness on maladaptive mental illness attitudes, perceptions and causal beliefs among their Mexico born family members.
Taking Acculturation Theory into account, second and third generation Mexican American individuals may have a different set of beliefs than their first generation Mexico born family members. It is important to investigate this difference in terms of mental illness attitudes, perceptions and causal beliefs in order to address the underutilization of services by this particular population.

It is presumed that because immigrants typically have strong cultures immersed in tradition that result in beliefs that are rigid and unwavering (Robbins, Chatterjee, & Canda, 2011), Mexican immigrants may have more rigid sets of traditional beliefs that may influence their mental health treatment rates compared to Mexican Americans.

**Definition of Terms**

**Mental illness.** A medical condition that disrupts a person’s thinking, feeling, mood, ability to relate to others and daily functioning.

**Attitude.** A settled way of thinking or feeling about someone or something, typically one that is reflected in an individual’s behavior.

**Perception.** A way of regarding, understanding or interpreting something; a mental impression.

**Causal belief.** The attribution of the origin or reason for something.

**Mexican American.** An individual of Mexican descent born in the United States.

**Mexican immigrant.** An individual of Mexican descent who has immigrated to the United States from their country of origin- Mexico.
Acculturation. Cultural modification of an individual, group, or people by adapting to or borrowing traits from another culture; also, a merging of cultures as a result of prolonged contact.

Culturally sensitive/appropriate practice. Treatment and interventions that are sensitive to an individual’s culture.

Assumptions

The researcher of this study wish all readers to assume the following to be true:

- Participants will answer honestly and sincerely without fear of repercussions from the researcher, the community, or family members.
- Participants will not have ulterior motives to participate in the study.
- Participants have the competence to comment on their attitudes, perceptions, and causal beliefs on mental illness with regards to their culture.

Social Work Research Justification

Social workers have duty to advocate for and help individuals who are marginalized and overlooked in society. Research in this topic is of importance because of the repercussions associated with an untreated mental illness, repercussions that affect the individual, their family and friends, their communities, and society at large. Living with an untreated mental illness results in distressing symptoms such as suicidal ideations, negative thinking patterns, emotional distress, disorganized thinking, and risky behaviors that are difficult and painful to live with, and impact an individual’s overall wellbeing. Living with an untreated mental illness often results in homelessness, criminal activity, victimization and incarceration, episodes of violence and suicide, which all
impact our communities and society as a whole (Treatment Advocacy Center, 2015).

For these reasons, social workers must advocate for more culturally sensitive approaches and interventions to meet the needs of people of Mexican descent who are not receiving treatment for their mental health problems and to ensure they remain in treatment and are compliant with their medications. Along with advocating for culturally sensitive treatment comes the duty of advocating on the importance of terminating language barriers through matching clients with culturally similar providers, hiring more bilingual and bicultural providers, and providing certified interpreters when needed. Social workers must also advocate for more in-depth trainings on cultural competence in order to meet the needs of their culturally diverse clients. Not only must social workers demand more training but they must also advocate for psycho-educational programs in Latino communities that focus on the etiology of mental illness, symptoms of mental health problems, stigma around mental illness, appropriate treatment for mental illness, and the importance of medication compliance for their clients.

Further research into this topic could support advocacy efforts for the funding of more culturally sensitive training for practitioners, the need to hire bilingual and bicultural staff and psycho-educational programs for clients.

**Study Limitations**

There were several limitations of this study the researcher identified. One limitation was that the study sample was not randomized or generalizable to the population of Mexican individuals as a whole, both immigrants and Mexican Americans, due to the nature of purposive and snowball sampling procedures. The researcher used
her knowledge of the target population to recruit participants for the study, which impacts the generalizibility of the study’s results. Another factor that impacts the generalizability of the study’s results is that there were only 50 participants in the study so it was not a large-scale exploration of the topic. Another limitation the researcher identified is that the study is solely exploratory aimed at exploring the possibility of differences in mental illness attitude, perception and causal beliefs among the target population.
Chapter 2

Review of the Literature

The existing literature on mental health concerns for Latinos, specifically those of Mexican descent, primarily focuses on mental health treatment barriers through various studies that have cited common barriers to care such as perceptions of the cause of mental health illness (Zhang Hampton & Sharp, 2014; Jimenez, Bartels & Cardenas, 2013; Caplan, Paris & Whittemore et al., 2011; Gonzalez, Alegría & Prihoda et al., 2011; Jang, Chiriboga & Herrera et al., 2011; Ojeda & Bergstresser, 2008), stigma associated with mental illness (Zhang Hampton & Sharp, 2014; Jimenez, Bartels & Cardenas et al., 2013; Caplan, Paris & Whittemore et al., 2011; Jang, Chiriboga & Herrera et al., 2011; Corrigan, 2004), language and cultural barriers (Ruiz, Aguirre & Mitschke, 2013; Keyes, Martins & Hatzenbuehle et al., 2012; Rastogi, Massey-Hastings & Wieling, 2012; Uebelacker, Marootian & Pirraglia et al., 2012; Berdahl & Torres Stone, 2009; Garcia & Saewyc, 2007) and lack of financial resources (Uebelacker, Marootian & Pirraglia et al., 2012). Studies have cited low rates of mental health treatment among individuals of Mexican descent compared to other racial groups (Keyes, Martins & Hatzenbuehlet et al., 2012; Lee & Matejkowski, 2012; Berdahl & Torres Stone, 2009), which is a result of the commonly cited barriers in the literature. An area of study that is sorely lacking but will enhance the research on low mental health treatment rates among people of Mexican descent is the extent to which there are differences in the causal beliefs and attitudes towards mental illness between U.S born Mexican Americans and foreign born Mexican immigrants, and if these differences impact access to mental health treatment.
The literature has regularly cited attitudes towards mental illness as barriers in accessing mental health services for people of Mexican descent (Zhang Hampton & Sharp, 2014; Jimenez, Bartels & Cardenas, 2013; Caplan, Paris & Whittemore et al., 2011; Gonzalez, Alegría & Prihoda et al., 2011; Jang, Chiriboga & Herrera et al., 2011; Ojeda & Bergstresser, 2008), but differences among Mexican Americans and Mexican immigrants in their mental illness causal beliefs and their attitudes and perceptions need to be investigated further to assess the real impact they have on treatment rates; this is important to do because attitudes and perceptions about illnesses and their causes and treatments are important indicators of help-seeking behaviors. Although some studies have cited attitudes about mental illness as barriers to treatment (Zhang Hampton & Sharp, 2014; Jimenez, Bartels & Cardenas, 2013; Caplan, Paris & Whittemore et al., 2011; Gonzalez, Alegría & Prihoda et al., 2011; Jang, Chiriboga & Herrera et al., 2011; Ojeda & Bergstresser, 2008), there has been a lack of emphasis and understanding about the differences in attitudes, perceptions and causal beliefs of mental illness between U.S born Mexican Americans and their Mexican immigrant counterparts, which is a result of grouping all Latino groups into one in previous studies. Studies need to take into account that there are acculturative differences within Latino groups in order to accurately measure differences in mental illness causal beliefs, attitudes and perceptions between Mexican Americans and Mexican immigrants. There are several predominant themes in this literature review that delineate mental illness causal belief, attitude and perception differences among U.S born Mexican Americans and Mexican immigrants. The first theme of this literature review is the prevalence of mental health disorders among both
Mexican Americans and Mexican immigrants, which is important in outlining the true need for mental health treatment in both populations. Treatment rates is the second theme outlined in this literature review because it is the foundation of and informs this study while barriers to treatment is the third theme; barriers to treatment inform treatment rates so both are important themes to investigate. The final theme of this literature review includes the causal beliefs, attitudes and perceptions of mental illnesses, which are imperative in informing help-seeking behaviors and are the primary investigation of this study. Beginning with the historical background of the problem, this literature review includes studies that focus on the aforementioned themes with the intent of using them to guide the investigation of mental illness causal belief, attitude and perception differences between Mexican Americans and Mexican immigrants.

**Historical Background**

According to the United States Census Bureau, as of July 1, 2013 the Latino population was 54 million, making up 17% of the total U.S population. This statistic is only projected to grow further to approximately 27% of the entire U.S population by the year 2050. Although Latinos are a fast growing minority group and comprise a large portion of the population, they have low rates of mental health treatment when compared to other racial groups in the U.S (Keyes, Martins & Hatzenbuehlet et al., 2012; Lee & Matejkowski, 2012; Berdahl & Torres Stone, 2009). Accessing mental health care services is critical if an individual is living with a mental illness but studies on the prevalence of mental illness in the Latino population, specifically those of Mexican descent, have been mixed. Some studies have found that Mexican Americans have
reported higher rates of mental illnesses than their Mexican immigrant counterparts (Leung, LaChapelle & Scinta et al., 2014; Alegria, Canino & Shrout et al., 2008; Burnam, Hough & Karno et al., 1987). Other studies have found that Mexican immigrants with higher acculturation levels have a higher prevalence of certain disorders such as substance abuse, mood and anxiety disorders (Burnam et al., 1987), while contrary to Burnam et al.’s results, one study found that substance abuse disorders were higher in Mexican Americans compared to immigrants (Orozco, Borges & Medina-Mora et al., 2013). Reasons why there are mixed results in the findings of mental illness rates among Mexican Americans and Mexican immigrants may be logistical in nature such that sample sizes were too small or disorders were not assessed properly, but there may also be acculturation factors such as education, income, and societal pressures that impact the onset of mental illnesses. Regardless, concerns arise when a large segment of the population is living with untreated mental illness, so investigating the cause of such low treatment rates among people of Mexican descent has been a recurring area of study in the literature. Many studies have cited barriers to mental health treatment such as language and cultural barriers, stigma, and lack of financial resources and medical insurance (Rastogi, Massey-Hastings & Wieling, 2012; Uebelacker, Marootian & Pirragli et al., 2012). Attitudes and perceptions about mental health disorders and their treatment are also important barriers to care and although this subject has been incorporated into the literature, an area that is lacking is the investigation of the extent to which there are causal belief, attitude and perception differences between Mexican Americans and
Mexican immigrants. Although there is literature on the subject, investigating further is important because the subject of attitudes towards mental illness has been primarily explored with Latinos as a whole rather than examining the difference within Latino subgroups such as people of Mexican descent. Examining subgroups of Latinos differently is important because all differ immensely in terms of culture, beliefs and expectations.

**Prevalence of Mental Health Disorders**

The prevalence of mental illness among people of Mexican descent has been documented in the literature throughout the years (Leung, LaChapelle & Scinta et al., 2014; Alegria, Canino & Shrout et al., 2008; Hernandez, Plant, Sachs-Ericsson & Joiner, 2005; Burnam, Hough & Karno et al., 1987). Hernandez, Plant, Sachs-Ericsson & Joiner (2005) conducted a study to investigate the one-year prevalence of Axis- I psychiatric disorders in Hispanics and Caucasians in a large population sample ( N=4559, 52% female, 48% male, mean age= 42.6). Most of the participants were Caucasian (84.2%) followed by Hispanic (10%), who were predominantly of Mexican American descent. Participants were interviewed in their homes in a structured interview format by trained lay interviewers for a period of one year. The data collected in the interviews consisted of three scales- problems meeting basic needs scale, interpersonal functioning scale and Axis I- psychiatric disorders scale. Hernandez et al. (2005) found that Latinos were more likely to meet criteria for psychiatric disorders and had higher prevalence rates of several anxiety disorders such as phobias, Generalized Anxiety Disorder (GAD), and Obsessive Compulsive Disorder (OCD) when compared to Caucasians. According to the
researchers, high anxiety rates among Latinos were the result of the way in which they express psychiatric distress in the form of anxiety because it is socially acceptable in their culture. Latinos have been cited as manifesting mental health symptoms with traditional symptomatic patterns (Kim, Jang, Chiriboga et al., 2010), which is why anxiety may be overrepresented in this population. Hernandez et al. also found that there were high levels of alcohol abuse disorders among Latinos when compared to Caucasians, even after controlling for the protective factor of high interpersonal functioning. Lopez et al. (2012) also documented high depressive symptoms among people of Mexican descent when compared to Caucasians, reinforcing Hernandez et al. findings.

Prevalence rates of psychiatric disorders among Mexican Americans were also investigated by Burnam et al. (1987). Their study examined eight major psychiatric disorders as a function of acculturation level and country of birth—Mexico or the U.S. Burnam et al. administered direct survey interviews to a probability sample of adults in the Los Angeles area over the period of one year and seven months. A total of 3,132 adults were interviewed with an overall completion rate of 68 percent—of the total sample, 1,244 individuals identified as Mexican in ethnic origin. The surveys measured two variables; acculturation and psychiatric disorders. What Burnam et al. found was that U.S born Mexican Americans were more likely to meet the criteria for a mental health diagnosis compared to Caucasians. More specifically, Mexican Americans born in the U.S had higher rates of dysthymia, phobias, and substance abuse compared to whites. The researchers also found that there was a higher prevalence of affective disorders and anxiety disorders among Mexican Americans compared to Mexican immigrants,
concluding that immigrants had lower prevalence rates than Mexican Americans. This study did find however, that Mexican immigrants with higher acculturation levels had a relatively higher prevalence rate of substance abuse, but prevalence rates for other mental health disorders did not vary by acculturation level. This finding leads to the conclusion that acculturation levels may have an impact on prevalence rates which then impact treatment rates among this population.

The extent to which rates of mental health disorders differed among immigrant and U.S born individuals was also explored in a study by Alegría et al. (2008). In their study, Alegría et al. wanted to test the immigrant paradox, i.e., that foreign nativity protects against psychiatric disorders by comparing estimates of lifetime psychiatric disorders among immigrant Latino subjects and U.S born Latino subjects. By combining and examining data from the National Latino and Asian American Study and the National Comorbidity Survey Replication, the researchers found that the immigrant paradox was true because the risk for most psychiatric disorders was found to be lowest among immigrants compared to U.S born. Alegría et al. found that U.S born respondents reported higher rates of most psychiatric disorders but the rates of the disorders did vary when variables such as nativity, disorder type, demographics, and socioeconomic differences were controlled.

Although the aforementioned studies have suggested that U.S born Mexican Americans have higher prevalence rates of mental health disorders than their Mexican immigrant counterparts, both populations have stressors that contribute to negative mental health symptoms. In their study, Leung et al. (2014) attempted to investigate the
factors that contribute to high rates of depressive symptoms among Mexican Americans, both immigrant and U.S born. Leung et al. investigated what combination of variables best predict depressive symptoms among Mexican Americans by conducting a survey over the span of one year using a convenience sample of 90 respondents. What the team found was that those respondents who had concerns about discrimination were twice as likely to report depressive symptoms and those with concerns about access to medical care had a 94.8% increased likelihood of having depressive symptoms. Historically, people of Mexican descent have experienced discrimination in many aspects of their lives and Latinos in general are cited as having an uninsured rate of 30.4% - the highest rate of all racial groups (Leung et al., 2014), so these findings are significant and noteworthy.

The findings in the abovementioned studies have found mixed results on the prevalence rates of mental health disorders in people of Mexican descent, both U.S and Mexico born but both have been cited to access mental health services at lower rates than other racial groups, (Keyes, Martins & Hatzenbuehlet et al., 2012; Lee & Matejkowski, 2012; Berdahl & Torres Stone, 2009), which is the next theme of importance in this study.

**Mental Health Treatment Rates**

Mental health treatment is underutilized by many minority groups but people of Mexican descent underutilize mental health care services at much lower rates than other racial groups (Keyes, Martins & Hatzenbuehlet et al., 2012; Lee & Matejkowski, 2012; Berdahl & Torres Stone, 2009). In their study, Berdahl and Torres-Stone (2009) attempted to study the roles that acculturation and attitudes towards care have on mental health
treatment rates among Latinos. Berdahl and Torres-Stone used data from the 2002-2003 Medical Expenditure Panel Survey (n=30,234)- a series of surveys based on clustered and stratified samples households that provide nationally representative estimates of healthcare use, expenditures, and insurance coverage for the U.S non-institutionalized population. Using this data, Berdahl and Torres-Stone found that only 4.5% of people of Mexican descent, both U.S born and Mexican born immigrants, accessed mental health care services compared to Caucasians and other Latino groups. They also found that only 1.8% sought out mental health care specialty services compared to other Latino groups and Caucasians. Regardless of the type of mental health care service, people of Mexican descent reported the lowest use of services and were found to be 53% less likely to use mental health care services compared to other groups.

Keyes et al. (2012) also investigated mental health service use among people of Mexican descent. They hypothesized that ethnic identity, language and ethnic homophily-a preference for co-ethnic social interaction, may be associated with mental health service use. After the authors controlled for disorder severity, time in the United States and age at immigration, they found that those respondents who reported stronger ethnic identity and a preference for the Spanish language were less likely to utilize mental health services. Keyes et al. also found that although people of Mexican descent were less likely to access mental health services compared to other Latino groups, service use was considerably lower for substance abuse when compared to anxiety disorders. These findings suggest that regardless of the type of mental health disorder, people of Mexican descent are less likely to utilize specialty mental health services when compared to more acculturated
racial groups.

The literature on mental health care service utilization by people of Mexican
descent has cited other alternate sources of care that are not specialty mental health
treatment. More specifically, there has been evidence in the literature that Mexican
Americans and Latinos in general access general medical providers for their mental
health needs at higher rates than they do specialty mental health service treatment (Kohn-
Wood & Hooper, 2014; Berdahl & Torres Stone, 2009). In their study investigating
factors that contribute to depressive symptoms among Mexican Americans and Latinos,
Leung et al. (2014) found that 47.8% of Mexican Americans visited a general practitioner
for their mental health problems vs. only 33.3% who sought help from specialty mental
health care professionals. These findings are troubling because general medical providers
may not be equipped with the necessary resources or competency to treat mental health
disorders, especially severe mental illnesses such as schizophrenia.

The literature has also touched on mental health treatment rate differences
between U.S born Mexican Americans and Mexico born immigrants. Although there
have been mixed results, some evidence has suggested that immigrants, particularly
undocumented ones (Orozco et al., 2013), are less likely to use mental health care
services when compared to their U.S born counterparts (Kim et al., 2010).

In one study, Kim et al. (2010) examined what factors were associated with
mental health service use in Latino immigrant elders. The authors drew data from the
National Latino and Asian American Study (NLAAS)-a nationally representative sample
that estimates the prevalence of mental health disorders as well as rates of mental health
treatment rates by Latinos and Asian Americans in the U.S. Hierarchical logistic regression analyses of mental health service use were conducted for 290 Latino immigrant elders. Kim et al. adopted Anderson’s Behavioral Health Model of Health Service Utilization (1995) and hypothesized that predisposing, enabling, and mental health need factors could be potential predictors for mental health service use. Predisposing factors such as being younger and female and mental health need factors such as having any mood disorder and/or poor self-rated mental health were significantly associated with higher mental health care service use among Latino immigrants. These findings suggest that Latino immigrants who are female, younger, and those who report poorer mental health are likelier to access mental health care services. Even though predisposing factors such as being young and female are associated with mental health care service utilization among Latino immigrants, self-rated poor mental health was the most powerful predictor in explaining mental health service use among this group. The only limitation in relating Kim et al.’s findings to the investigation at hand here is that the data the authors drew from did not solely consist of people of Mexican descent but was instead from a general sample of all Latino subgroups.

Ethnic and cultural factors have been cited as strong predictors of mental health service use by Keyes et al. (2012). In an attempt to investigate the role of ethnic identity and language/social preferences in mental health service utilization, Keyes et al. drew data from two waves (2001-2002 and 2004-2005) of the National Epidemiologic Survey on Alcohol and Related Conditions, focusing specifically on Latino respondents (n = 6,359). On average, Latino respondents were younger, more likely to be male, less
educated, have lower income, and less likely to be currently insured. After analyzing the data, Keyes et al. found that those who reported strong ethnic identity and complete Spanish language preference were less likely to use mental health services. This finding has significant implications for immigrants being that they may be likelier to uphold traditional values and beliefs that are concurrent with their ethnic identity (Robbins et al., 2011). Keyes and colleagues found that more recent immigrants that presumably have not had enough time to adopt cultural elements of the host society were less likely to use mental health care services when compared to immigrants who have been in the U.S longer. These findings suggest that language and culture are important predictors of mental health service use among Latino immigrants.

The findings in the Keyes et al. study were replicated by Folsom et al. (2007) in a study that explored if Spanish speaking Latinos differ from English speaking Latinos in their mental health service use rates. After examining the difference between Spanish and English speaking Latinos in the types of mental health services used, the authors found that preferred language may be more important than ethnicity and cultural factors when accessing mental health services for Latinos. There are limitations to the generalizability of these results however because Mexican Americans were not the only Latino subgroup from which data was drawn upon, which is the target population of this investigation.

Immigration related factors and mental health service utilization rates have also been investigated by Lee and Matejkowski (2012). In their study, Lee and Matejkowski also used data from the NLAAS to examine the extent to which U.S citizenship status was related to rates of mental health care service utilization. Like Kim et al. (2010), Lee
and Matejkowski also adopted Andersen’s Behavioral Model of Health Service Utilization (1995) and identified some predictors of mental health service use by non-citizen immigrants. These predictors included predisposing, enabling, need, and immigration-related factors. Predisposing factors included: gender, age, marital status, race and education. Enabling factors measured were: poverty status, insurance coverage, and social network characteristics (frequency of contact with relatives and friends). Need factors were measured by: the presence of psychiatric disorders as identified by a modified version of the World Mental Health Survey Initiative version of the Composite International Diagnostic Interview (WMH-CIDI). Finally, immigration-related factors included: U.S citizenship, age at immigration, English proficiency, and generational status. After controlling for these variables, the authors found that immigration-related factors like age of immigration had a negative association with any mental health service use, suggesting that immigrants who immigrated at an older age were less likely to use mental health care services. When the authors compared service rates between citizens and non-citizen immigrants, they found that non-citizens were 40% less likely than their U.S born counterparts to access mental health care services. Among non-citizen immigrants, those who were older, more educated, lived in poverty, had a psychiatric disorder, and immigrated at a younger age were more likely to use mental health services.

The findings in all studies mentioned above have found that Latinos of Mexican descent, both U.S born and immigrants, utilize mental health services at lower rates than other racial groups (Keyes, Martins & Hatzenbuehlet et al., 2012; Lee & Matejkowski, 2012; Berdahl & Torres Stone, 2009). Underutilization is concerning being that Mexican
immigrants and Mexican Americans constitute a large portion of the U.S population, making it troublesome that so many people are living with untreated mental illness. Low treatment rates among these groups have been cited as being the result of some frequently cited barriers, which is the subsequent theme in this literature review.

**Barriers to Mental Health Treatment**

Since people of Mexican descent have been commonly cited as accessing mental health care at low rates (Keyes, Martins & Hatzenbuehlet al., 2012; Lee & Matejkowski, 2012; Berdahl & Torres Stone, 2009), an investigation as to why they access services at such low rates and what barriers exist is important. Some cited barriers to mental health treatment among the Latinos have been cultural and language barriers (Ruiz, Aguirre & Mitschke, 2013; Keyes, Martins & Hatzenbuehler et al., 2012; Rastogi, Massey-Hastings & Wieling, 2012; Uebelacker, Marootian & Pirraglia et al., 2012; Berdahl & Torres Stone, 2009; Garcia & Saewyc, 2007), lack of financial means and health insurance (Rastogi, Massey-Hastings & Wieling, 2012; Uebelacker, Marootian & Pirraglia et al., 2012), and lack of information and knowledge about mental health disorders and how to get help as well as the stigma associated with mental illness have also been cited as barriers to treatment for Latinos (Uebelacker et al., 2012; Wright, 2010).

**Linguistic/cultural barriers.** Language and cultural barriers were cited as barriers to mental health treatment in a study by Uebelacker et al. (2012). In this study, the authors conducted four focus groups with 30 Latinos who endorsed having been depressed themselves or having had a friend or family member with depression to assess
barriers and facilitators to depression treatment. By conducting qualitative analyses of the focus groups, the researchers found language and cultural barriers as being a significant barrier to treatment. In terms of language, they found that negative experiences with interpreters such as having none available and concerns about the accuracy of translation vastly impacted service use. Another linguistic barrier respondents identified was the difficulty in receiving treatment from providers who do not speak Spanish.

An investigation into perceived barriers to mental health treatment by Latinos was also conducted by Rastogi et al. (2012). Their focus group sample consisted of 18 members who self-identified as Latino who were interviewed via five focus groups and one individual interview. Focus groups ranged in size from two to five participants, averaged about 90 minutes in length and were held in Spanish. Rastogi et al. found that although language barriers were not as emphasized as cultural barriers in this study, the respondents did report that they would prefer to seek a Spanish-speaking provider to meet their mental health needs.

Along with some linguistic barriers, cultural barriers were emphasized in both studies by Uebelacker et al. (2012) and Rastogi et al. (2012). The Uebelacker et al. focus groups identified cultural differences with service providers as potential barriers to treatment due to feeling a sense of difference from providers, describing a desire for cultural concordance, which suggested that respondents wished to encounter Latino providers to meet their needs. Provider responses to cultural differences were also cited as barriers, suggesting that respondents prefer providers be culturally competent to better suit their needs. Rastogi et al. had similar results with their focus groups; their
respondents reported a fear that providers would be culturally incompetent and insensitive and even racist towards them, which impacted their access to care.

Along with linguistic and cultural barriers to mental health care, Uebelacker et al. (2012) and Rastogi et al. (2012) have also cited lack of medical insurance and financial as barriers to care.

**Lack of medical insurance/financial means.** Lack of insurance and financial means were also cited as major barriers to mental health care for Latinos in Uebelacker et al. (2012) and Rastogi et al. (2012) focus groups. Participants in both focus groups reported that financial troubles and lacking financial means were of big concern when it came to accessing mental health care. Concerns over insufficient financial means are exacerbated when one is uninsured, which was also a major theme throughout participant responses in both focus groups. These findings are significant being that Latinos have been cited as having the highest rate of being uninsured compared to other racial groups (Leung et al., 2014). The participants reported strong feelings about not having sufficient insurance coverage and explained that the thought of needing long care treatment and not being able to pay for it was traumatic.

**Fear and mistrust/discrimination experiences.** Another major concern and barrier to mental health care treatment among Latinos was a general fear and mistrust of providers. The focus groups in the Uebelacker et al. (2012) study reported a general concern for the security of their private information and feared violations of privacy or breaches of confidentiality specifically regarding immigration status. This finding suggests that a lack of trust in provider discretion is a factor that keeps Latinos from
engaging in help seeking behaviors.

Concerns about provider discretion were also reported in the Rastogi et al. (2012) focus groups. Participants described an apprehension to seek services due to their immigration status and feared that they would be “deported” if they sought mental health services. Participants also reported that they felt they would not receive quality care due to their legal status, which also prevented them from seeking services.

These two studies show that lack of trust in provider discretion is particularly due to the immigration status of Latinos, but it may also be due to discrimination experiences in mental health care settings.

Experiences of discrimination in the mental health care field may also serve as a barrier to treatment and play a role in low mental health service utilization rates among Latinos. In their literature review on racial disparities in the diagnosis and treatment of depression, Simpson et al. (2007) found that there are lower rates of treatment for African Americans and Latinos than for Caucasians. The findings in the Simpson et al. literature review were found to be true in the study Lê Cook et al. (2010) conducted on comparing methods of racial and ethnic disparities measurement across different settings of mental health care. The authors used a nationally representative sample of Caucasian, African American and Latino participants from the 2002-2006 Medical Expenditure Panel Survey and found that rates of total mental health care expenditures, which included inpatient, outpatient, and prescription drug expenditures, were significantly lower for Latinos and African Americans compared to Caucasians. One study found that among respondents with depression, minorities were significantly less likely than Caucasians to receive
adequate care with only 25% of Latinos predicted to access treatment and receive adequate care (Alegría, Chatterji, & Wells et al., 2008). Another study by Lopez et al. (2012) cited that minorities were less likely to receive case management services, which is essential for severe mental illnesses such as schizophrenia. Among those who did receive any psychotherapy or counseling services, Latinos were significantly less likely to receive an adequate level of care when compared to Caucasians (Harman, Edlund & Fortney, 2004). These findings reinforce the notion that minorities receive inferior mental health treatment when compared to Caucasians, which impacts their access to care. Lê Cook, Zuvekas, & Carson et al. (2014) found a disparity in the number of days in which mental health treatment was provided- Latinos received care for 228 days while African Americans received 230 days and Caucasians received 257 days of mental health treatment when they assessed racial and ethnic disparities in treatment across episodes of mental health care.

These findings suggest that disparities in service intensity may result in poorer quality mental health care for minorities. Discrimination experiences may hamper patient help seeking behaviors such that they could be associated with decreased utilization of mental health services (Kohn-Wood & Hooper, 2014) and may also influence a lack of trust in mental health providers and the mental health care system in general.

**Stigma.** Among the literature on barriers to mental health care in the Latino population, stigma is one of the most commonly cited barriers (Zhang Hampton & Sharp, 2014; Jimenez, Bartels & Cardenas et al., 2013; Caplan, Paris & Whittemore et al., 2011; Jang, Chiriboga & Herrera et al., 2011; Corrigan, 2004). Stigma is experienced when
society views an individual in a negative way because of a distinguishing characteristic or trait that is thought to be a disadvantage (Mental Health: Overcoming the Stigma of Mental Illness, MayoClinic.org, n.d). Corrigan’s (2004) study on how stigma interferes with mental health care delineates stigma as four social-cognitive processes that include cues, stereotypes, prejudice and discrimination. Cues help society infer mental illness, which then lead to stereotypes that society uses to categorize people and make generalizations about them. A common stereotype about people with mental illness is that they are dangerous or violent. Stereotypes like these result in prejudice behaviors which then lead to discrimination. These are the stages that lead an individual to feel stigma which then impacts their access to treatment. In order for people to avoid this process of stigmatization, they prefer to deny their status as a mentally ill individual by not seeking care from the institutions that mark them as such (Corrigan, 2004).

**Self-stigma.** Corrigan characterized self-stigma as stigma’s potential effects on an individual’s sense of self and their worth and esteem, explaining that it is common for people with mental illness to accept common stereotypes and eventually internalize them. Internalizing stereotypes then results in reduced self-esteem and stigmatic beliefs toward oneself.

Self-stigma was a topic in the Rastogi et al. (2012) focus groups in which some participants explained that “seeing a psychologist means you are crazy”, which is why they refrained from accessing treatment. This finding suggests that being labeled as “crazy” was a strong enough motive for them to leave treatment out as an option.

Zhang Hampton and Sharp’s 2014 study used a sample of 330 students that
consisted of one Native American, 19 African Americans, 76 Asian Americans, 17 international students, 63 Latinos and 154 Caucasians to measure the role gender and culture played in shame focused attitudes towards mental illness. In this study, Zhang Hampton and Sharp used the Attitudes Toward Mental Health Problem Scale (ATMHPS) to measure these shame focused attitudes on five different subscales, and found that Mexican American participants scored high on an internal shame (IS) subscale. The IS subscale measures the level of shame or stigma a person may feel about themselves if they have a mental health disorder. This result suggests that self-stigma is a big concern in the Mexican American culture and supports the notion that Latinos feel a great deal of self-stigma from mental health problems, which most likely plays a role in their low mental health treatment rates.

Stigma has a significant impact on mental health treatment among people of Mexican descent, which is evidenced by Jimenez et al. (2013) study on stigmatizing attitudes towards mental illness among racial/ethnic older adults. Jimenez et al. found that Latinos expressed greater shame and embarrassment about having a mental health disorder - 40.3% compared to 15.3% of Caucasians, which highlights the presence of stigma in the Latino culture and the need to address it in order to help low treatment rates.

**Family stigma.** Stigma from one’s family has also been cited as a particular barrier to mental health care for Latinos (Zhang Hampton & Sharp, 2014; Chang, Natsuaki & Chen, 2013; Rastogi, Hastings & Wieling, 2012; Uebelacker, Marootian & Pirraglia et al., 2012; Graf, Blackenship, & Sanchez et al., 2007; Weisman, Rosales & Kymalainen et al., 2005). There are mixed results in the literature about the role of the
family on help seeking behaviors. The literature points to the family as a resiliency factor to mental health disorders, showing that strong family bonds, known in the Latino culture as familismo, are correlated with low psychological distress among Latinos (Weisman et al., 2005). While additionally, the literature shows that strong cultural conflicts in the family that result in weak family cohesion lead Latinos to use mental health care services at higher rates than those Latinos with greater family cohesion (Chang, Natsuaki & Chen, 2013).

Zhang Hampton and Sharp (2014) found that Latinos scored high on family external shame (FES) subscales, which were intended to measure how individuals become focused on how their families may view them as a result of their mental health disorder. This finding suggests that there is a strong culture of honor around the family in the Latino population, which then results in the Latino perception that having a mental illness is a dishonor to the family (Graf, Blackenship & Sanchez et al., 2007). These perceptions then impact help seeking behaviors by encouraging Latinos to avoid treatment in order to avoid stigmatizing their families.

Family stigma was also cited as a concern and a barrier in accessing mental health care in the Rastogi et al. (2012) focus groups. Participants reported barriers at the family level, claiming that if they were to seek mental health services, their family might be stigmatized and family members would likely feel ashamed of them, fear social criticism because of them, and be afraid of what people would think of them.

Stigma, whether it is internalized self-stigma or stigma from one’s family, has been cited as a major barrier to mental health care treatment (Zhang Hampton & Sharp,
Barriers to mental health treatment for Latinos are of concern and must be addressed. Although there is literature on what factors play a role as barriers to care among Latinos in the literature, more research is needed to assess if other factors such as attitudes and perceptions about mental illnesses impact treatment rates.

**Attitudes and Perceptions about Mental Illness**

More research is needed on the causal beliefs, attitudes and perceptions of mental illness among people of Mexican descent, both U.S born Mexican Americans and their Mexico immigrant counterparts due to their continuous low mental health treatment rates. The literature shows that attitudes towards mental health treatment have a positive relationship with actual service use and help seeking behaviors (Jimenez, Bartels, Cardenas & Alegría, 2013; Gonzalez, Alegría & Prihoda et al., 2011); there are also cited ethnic and racial differences regarding the causes of mental illness (Jimenez et al., 2013), so it is important to investigate if Mexican Americans and Mexican immigrants have differing perceptions and attitudes about mental illness and accessing care in order to better meet both groups’ mental health needs.

Mental health conceptions, just like most other conceptions and beliefs, are typically a result of family tradition, personal experience and peer relations (Jimenez et al., 2013) These experiences combined with cultural and religious beliefs regarding the origin and treatment of mental health symptoms could impede decisions to access formal mental health care services (Garcia & Saewyc, 2007).
**Cultural beliefs.** When Garcia and Saewyc (2007) investigated the perceptions of mental illness among recently immigrated Mexican adolescents, they found that the adolescents’ cultural beliefs impeded them from accessing mental health care. Many acknowledged the presence of mental health symptoms but did not discuss the need to access the care necessary to address them, which suggests that perceptions of mental illnesses among immigrants who uphold their more traditional and conservative culture hold perceptions about illness that are more rigid in nature, which then plays a role in their help seeking behaviors.

In their study on the role culture and gender plays in attitudes towards mental health, Zhang Hampton and Sharp (2014) found a significantly higher cultural effect compared to a gender one among the 330 students they sampled. Zhang Hampton and Sharp measured shame-focused attitudes on five different subscales of the Attitudes toward Mental Health Problem Scale (ATMHPS) and found a significant culture effect rather than a gender one on all five subscales. These subscales included: Community External Shame (CES), Family External Shame (FES), Family Reflective Shame (FRS), Internal Shame (IS), and Self-Reflective Shame (SRS).

The literature has also cited the Latino cultural belief that health is a consequence that is personally, spiritually, and socially rooted such that it is often viewed as a person’s state resulting from luck, good behavior, or as a gift from God, while disease and illness are seen as a punishment (Garcia & Saewyc, 2007); these cultural views are most likely due to the presence religion, particularly Catholicism, has in the Latino culture (Caplan, Paris & Whittemore et al., 2011).
**Religious beliefs.** The literature also shows that religious values, which are strongly endorsed by Latinos, along with age and country of origin, significantly influence causal beliefs about mental illness (Caplan et al., 2011). Religion has such an enormous presence in the Latino culture that they are more likely than any other racial groups to believe that prayer and faith can help alleviate mental health symptoms (Caplan et al.).

In their study Caplan et al. (2011) wanted to explore causal attributions about depression and identify psychosocial factors associated with these beliefs among 177 self-identified Latino immigrants. Using the Causal Beliefs scale with the participants yielded three factors that were associated with causal attributions about depression: balance, and psychosocial and malevolent spirituality/transgressions. The authors described balance as a spiritual belief in the need to maintain equilibrium between emotions, behavior, and the environment; psychosocial factors were described as interpersonal, development and traumatic causal attributions of depression; and malevolent spirituality/transgressions was described as a belief in uncontrollable evil forces, social injustices and personal sinfulness. Results showed that malevolent spirituality/transgressions formed a significant part of Latino immigrants’ causal beliefs, suggesting that they endorse uncontrollable evil forces, social injustices, and personal sinfulness as causes of mental illness. There was also high endorsement of psychosocial explanations of mental illness however, suggesting that they also sanction traumatic, developmental and interpersonal causes of mental illness. Although these results are not generalizable to only people of Mexican descent, results did show that country of origin
was a salient factor in believing in malevolent spirituality/transgressions so there is a need for further research on the relationship between county of origin and mental health causal attributions and perceptions.

**Folk healing beliefs.** People of Mexican descent have been cited in the literature as using traditional methods of healing commonly known as curanderismo, which utilizes the practice of folk medicine and herbal remedies (Loera, Muñoz, Nott & Sandefur, 2009). According to Loera et al., curanderismo attempts to heal the unbalance between the mind, body and spirit because in folk healing, health is conceived as the interaction of these three dimensions. These three dimensions play a role in understanding illness conceptualizations among people of Mexican descent, but according to Zacharias (2006) the spirit plays the central role in understanding mental illness and psychiatric disorders. According to Zacharias (2006), the soul/mind is affected if ones spirit is weak and cannot perform its’ function- dysfunction of the soul is then displayed by intense emotion, which is typically characterized by feelings of rage, envy or an overwhelming sadness, all of which are emotions that can be easily misunderstood as being “pathological”. Not only do people of Mexican descent believe in folk healing traditions but many may also see severe mental illness as brujeria (witchcraft) or hechizos (spells) used for retaliation (Falicov, 1999). Just like they view illness or disease as a punishment from God (Garcia & Saewyc, 2007), they may also see severe mental illness as a spell cast on them by others in retaliation or as punishment.

These findings suggest a belief in traditional folk healing medicinal practices as an alternative to Western medicine among people of Mexican descent, but more research
is needed on whether or not these beliefs are different between both groups of people of Mexican descent- U.S born and foreign born, in order to determine and meet both groups’ mental health needs.

**Age and gender.** Age and gender may also play a role in mental illness causal beliefs and perceptions. One study by Gonzalez et al. (2011) found that a willingness to seek help in specialty mental health care differed by gender with men being half as likely as even women with low willingness to seek help, prompting the researchers to believe that attitudes are central to mental health service use. Gonzalez et al. also found that the comfort levels of talking to professionals varied by age with younger participants aged 18-34 years old having a greater likelihood of seeking treatment than older participants aged 50-64 years. These results indicate that younger participants had less negative views about mental health disorders and treatment and felt more comfortable talking to practitioners.

Another study by Jang, Chiriboga and Herrera et al. (2011) also found that age had a relationship with attitudes towards mental health and accessing care. In their study, they explored predictors of attitudes toward mental health services in a sample of 297 Latino older adults with a mean age of 76 years old who were living in public housing. Results showed that “unfavorable” or negative attitudes toward mental health services were predicted by advanced age, supporting the notion that age may have something to do with negative attitudes and perceptions about mental health and accessing care.

**Education and income.** Education and income may play a role in mental illness causal beliefs and the attitudes and perceptions that accompany those beliefs. In their
investigation on the correlates of psychosocial barriers to mental health treatment among adults reporting unmet need from the 2002 National Survey on Drug Use and Health, Ojeda and Bergstresser (2008) found that persons of lower income or educational status were less likely to report negative attitudes towards care.

Gonzalez et al. (2011) found that attitudes differed in their impact on mental health service use by education level. Contradictory to Ojeda and Bergstresser’s study, Gonzalez et al. found that a higher education level was actually associated with improved mental health attitudes leading to an increased use of mental health services for those with a higher education, whereas lower education levels were linked to the likelihood of seeking mental health services through primary care providers rather than specialty mental health providers.

The notion that education and income levels impact mental health attitudes and perceptions and hence service use is imperative in understanding the low service use rates of people of Mexican descent because of the income disparities that exist between people of Mexican descent and Caucasians, which typically results from the lower average educational attainment of people of Mexican descent (Allen & Turner, 2013). Using information from the 2012 Census, the U.S Department of Health and Human Services of Minority Health predict that 25.4% of Latinos live at the poverty level compared to just 11% of Caucasians. In terms of educational attainment, the department predicts that only 64% of Latinos compared to 92% of Caucasians have a high school diploma while only 13.8% of Latinos have a bachelor’s degree or higher compared to 32.5% of Caucasians.
Summary

Although there is evidence that people of Mexican descent suffer from a number of mental health disorders, research shows that both Mexican Americans and Mexican immigrants access mental health treatment at disproportionately lower rates when compared to other racial groups (Keyes, Martins & Hatzenbuehlet et al., 2012; Lee & Matejkowski, 2012; Berdahl & Torres Stone, 2009), so it is imperative to investigate what factors other than those cited in the existing literature act as barriers to treatment. Although the existing literature identifies some barriers to treatment such as cultural, linguistic and financial barriers, rates are still low suggesting that other factors are impacting them and need to be addressed.

An area that is sorely lacking in the literature and which needs to be investigated further are the ways in which mental illness causal beliefs and the attitudes and perceptions that accompany those beliefs impact treatment rates, but differences need to be measured among Mexican Americans and Mexican immigrants in order to assess and better serve their true mental health needs. Distinguishing between Mexican Americans and Mexican immigrants is vital when measuring causal beliefs, attitudes and perceptions because they differ greatly since both populations are culturally different as a result of acculturation patterns. Because attitudes and perceptions are significantly associated with help seeking behaviors (Jimenez, Bartels, Cardenas & Alegría, 2013; Gonzalez, Alegría & Prihoda et al., 2011), it is necessary to explore them as barriers to treatment in order to better serve the mental health needs of both populations and deliver culturally competent services that will aim to reduce and improve the low treatment rates. Without such an
exploration into the impact causal beliefs, attitudes and perceptions have on treatment rates, many people will continue to live with untreated mental illness, which has negative repercussions not only for those who live with the disorder but also for their communities, families and friends.
Chapter 3

Methods

This research study aims to discover the differences in attitudes, perceptions and causal beliefs towards mental illness in U.S born Mexican Americans and Mexico born Mexican immigrants in a very small sample from Solano County, a county in Northern California. The study methods are presented in terms of objectives, study design, sampling procedures, data collection procedures, instruments, data analysis and protection of human subjects. The study question that the researcher attempted to answer was: Is there a difference in attitudes and perceptions towards mental illness between Mexican Americans born in the United States and Mexican immigrants born in Mexico? The researcher hypothesized that U.S born Mexican Americans are presumably more acculturated and hence have more positive attitudes, perceptions and causal beliefs of mental illness compared to more traditional Mexican immigrants who were born in Mexico. A difference in acculturation levels among these two groups may be the cause of the low mental health treatment rates and increased rates of traditional folk care among immigrants in particular.

Study Objectives

The purpose of this research study is to explore the differences between mental illness perceptions among Mexico native born immigrants in the United States and their U.S born Mexican American counterparts. The researcher has hypothesized that since Mexican Americans born in the United States are presumably more acculturated, they will hold more positive views and attitudes towards mental illness in comparison to
Mexican immigrants who were born in Mexico and immigrated to the United States. The researcher focused on comparing mental illness perceptions, attitudes and causal beliefs among both U.S born and Mexican born individuals. This topic is important to explore in order to identify how culture plays a role in perceptions, attitudes and causal beliefs, which have been cited as influencing help seeking behaviors. Exploring this topic would also reveal the importance of funding educational programs about mental health symptoms and treatment among the Latino population, specifically those of Mexican descent who have been cited as receiving little to no mental health care treatment. The scope of research for this study was an exploratory analysis to gain insight on possible differences in attitudes, perceptions and causal beliefs towards mental illness among U.S born Mexican Americans and their Mexico born Mexican counterparts.

**Study Design**

This study has an exploratory quantitative design using data collected by the researcher. In general, exploratory studies aim to investigate and report the existence of an issue in order to pave the way for further descriptive or explanatory studies (Rubin & Babbie, 2013). An exploratory design works best with this study because such studies normally involve relatively small samples and are not concerned with the representativeness of the larger population (Rubin & Babbie). This study serves to simply uncover the existence of differences in mental illness perceptions, attitude and causal beliefs among two Latino subgroups - U.S born Mexican Americans and Mexico born Mexican immigrants. Because exploratory studies can pave the way for further explanatory research, further research will be needed to describe and explain these
Sampling Procedures

This study utilized purposive sampling based on the researcher’s knowledge of the target population and the purpose of the study. Snowball sampling was used in order to recruit participants due to the particular difficulty of recruiting people of Mexican descent who are immigrants. Like purposive sampling, snowball sampling is a non-probability sampling technique that is suitable to use in research when the members of the target population that are not easy to locate (Rubin & Babbie, 2013). The researcher used snowball sampling by enlisting the help of the participants that met criteria and had already agreed to participate from verbal invitations of the researcher. Participants helped the researcher recruit other subjects by providing information such as where to recruit more participants from their same population, as well as by informing their families and friends of the study and specific locations of recruitment.

Participants were recruited from Vacaville, CA, a Northern California city located in Solano County. Participants were recruited from local ethnic businesses, clinics, churches, community events and schools that are known to cater to the Latino population. Interested participants who met criteria were sought through verbal invitations from the researcher as well as word of mouth from preceding participants. Criteria for this study included the following: being either a U.S born Mexican American or a Mexico born immigrant aged 18 or older.

Participants were recruited from community events such as “Christmas Wish,” a program that serves Vacaville’s financially disadvantaged children and their families by
finding local sponsors who are willing to donate Christmas gifts. This event was held at schools so the researcher attended schools identified as catering to Latino populations; these schools included Padan, Markham and Hemlock Elementary. The researcher was not affiliated with the events, but instead invited participation from parents who were leaving the event.

Other community events participants were recruited from included Proyecto de los Padres (The Parent Project), a parenting class conducted in Spanish and events at the two local Catholic churches, including baptism classes and religious processions.

Participants were also recruited from several local ethnic businesses such as restaurants and markets and a community health clinic in Vacaville that are known to cater to Latino populations.

The researcher is not affiliated with any of the aforementioned organizations or events and simply recruited participants who were leaving or entering these events using verbal invitations. Participants were recruited from the period of late October of 2014 to late December of 2014.

Data Collection Procedures

There are fifty (50) participants in total in this study; twenty-five (25) Mexican born immigrants and twenty-five (25) U.S born Mexican Americans who were verbally recruited from late October of 2014 to late December of 2014 from local businesses, churches, schools, community events, and clinics that cater to the Latino population of Vacaville, CA. Data was collected over the same period through a self administered structured questionnaire that was directly given to the participant by the researcher upon
recruitment.

**Instruments**

The data collected for this study consisted of self-administered questionnaires with a total of 55 questions. Eleven questions measured participant demographics with questions such as age, sex, race, country of birth, education, income, employment and marital status. Two questions on the questionnaire measured familiarity with mental illness by assessing if participants were familiar with mental illness and if they had a close relationship with someone with a mental illness. The next 35 questions of the questionnaire were comprised of the already established Attitudes Toward Mental Health Problem Scale (ATMHPS) devised by Gilbert, Bhundia, & Mitra et al., 2007. This scale was embedded into the questionnaire of this study to measure shame-focused attitudes towards mental illness and mental health problems. The ATMHPS uses a 4-point Likert scale, with participants responding by choosing one of the following four choices: Do Not Agree At All, Agree A Little, Mostly Agree, Completely Agree. The ATMHPS has five shame-focused subscales, including Community External Shame or CES (items 1-4 and 9-13), Family External Shame or FES (items 5-8 and 14-18), Internal Shame or IS (items 18-23), Family Reflective Shame or FRS (items 24-30) and Self-Reflected Shame or SRS (item 31-35). The last seven questions of the questionnaire were developed by the researcher to assess mental illness causal beliefs and used the same 4-point Likert scale used in the ATMHPS. A sample question of the causal belief subscale is: “I believe mental illnesses result from a chemical imbalance in the brain.”
Data Analysis

The factors that were the focus of analysis from the data collected were demographic information, attitudes and perceptions towards mental illness and mental illness causal beliefs. The data analysis program used to analyze these factors was the Statistical Package for the Social Sciences (SPSS) program that is used to analyze data collected and performs a wide variety of statistical analysis.

SPSS was used to code participant responses of demographic information such as sex, income, education and nationality (Mexico vs. U.S born) and attitudes and perceptions towards mental illness and mental illness causal beliefs. Attitudes towards mental illness and mental illness causal beliefs were coded into the subscale variables mentioned above (CES, FES, IS, FRS, SRS) in order to test the relationship between them and particular demographic information. Each subscale was analyzed as the test variable via independent sample T-tests against various demographic variables such as sex, income, education and nationality as the group variable. By conducting independent sample T-tests, the mean of each subscale and demographic variable was tested and compared in order to discover a statistically significant effect between the demographic variables and each subscale.

By conducting independent sample T-tests, the hypothesis that there is a difference in how U.S born Mexican Americans and Mexican born Mexican immigrants view mental illness was tested.
Protection of Human Subjects

The application for the protection of human subjects for this study was approved by the California State University, Sacramento, Division of Social Work, Institutional Review Board (IRB) on October 14, 2014. The human subjects protocol # is: 14-15-025. The application for protection of human subjects ensured that there was voluntary participation and informed consent from the participants, no harm to the participants, no deception to the participants, and anonymity and confidentiality for the participants in order to abide by the ethical standards that social workers must recognize when conducting research. The social work profession requires that when social workers are conducting research, social workers need to recognize there are ethical standards and other mandates such as code of ethics that must inform our research.
Chapter 4

Findings

This chapter presents the findings from the study on the difference in mental illness attitudes, perceptions and causal beliefs between U.S born Mexican American individuals and Mexico born Mexican immigrants, with a small sample of fifty (50) surveys collected by the researcher in Vacaville, CA. The small non-probability sample size of fifty (50) limits the validity of the data, which therefore limits the ability for the researcher to generalize the overall research findings.

Overall Findings

All of the participants identified themselves as being of Mexican descent and being born in the United States or Mexico. Fifty percent of participants identified as Mexican American and the other 50 percent identified as Mexican immigrants. Sixty-two percent (n= 31) identified as female and 38 percent (n=19) identified as male.

Of the fifty (50) participants, 28 percent (n= 14) make less than $25,000 a year, 44 percent (n=22) make up to $50,000 a year and 28 percent (n=14) make more than $50,000 a year. Of the fifty (50), 8 percent (n= 4) had an education no higher than elementary school, 10 percent (n=5) had an education no higher than middle school, 54 percent (n=27) had a high school education and 28 percent (n=14) had some college education or a college degree.

Specific Findings

In this section, an overview of the significant findings will be discussed in order to determine whether the researcher’s hypothesis could be supported or negated. The
researcher hypothesized that there is a difference in mental illness attitudes, perceptions and causal beliefs between U.S born Mexican Americans and Mexico born Mexican immigrants due to acculturation. In addition, the researcher assumed that U.S born have more positive and less stigmatic beliefs towards mental illness than their Mexico born counterparts. The main variables that were analyzed were nationality (U.S born or Mexico born), sex, education, income and six subscales of the Attitudes Towards Mental Health Problems Scale (ATMHPS) which are listed below, by category:

- **Community External Shame (CES)**: nine (9) survey questions about a person’s perception of how their community sees mental health problems in addition to how their community would see them if they had a mental health problem.

- **Family External Shame (FES)**: nine (9) survey questions about a person’s perception of how their family perceives mental health problems in addition to how their family would perceive them if they had a mental health problem.

- **Internal Shame (IS)**: five (5) survey questions focused on internal shame and the negative self-evaluation of having a mental health problem.

- **Family Reflective Shame (FRS)**: seven (7) survey questions focused on the reflected shame and beliefs about how one’s family would be seen if one had a mental health problem.

- **Self-Reflective Shame (SRS)**: five (5) survey questions focused on the fears of reflected shame on one’s self due to a close relative having a mental health problem.
- Mental Illness Causal Beliefs (MICB): seven (7) survey questions focused on the etiology or causal beliefs of mental health problems.

The set of statistical tools used to measure the relationship between each variable and each subscale of mental illness attitudes, perceptions, and causal beliefs were Independent Sample T-tests.

Based on participant responses, the range of total scores of each subscale of Community External Shame (CES), Family External Shame (FES), Internal Shame (IS), Family Reflective Shame (FRS), Self Reflective Shame (SRS), and Mental Illness Causal Beliefs (MICB) ranged from 7 to 89 out of 99 total possible points. Lower scores suggest less stigma beliefs towards mental illness while higher scores suggest higher stigma beliefs towards mental illness. Table 1 shows the mean and standard deviation of each group’s total scale scores.

Table 1

<table>
<thead>
<tr>
<th>Total Attitudes Towards Mental Health Problems Scale Score Mean and Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nationality</td>
</tr>
<tr>
<td>Mexico Born</td>
</tr>
<tr>
<td>U.S Born</td>
</tr>
</tbody>
</table>

Table 1 shows the mean total scale score for Mexican born immigrants at 47.00 while the mean total scale scores for U.S born was 45.96, suggesting that there is little difference in negative mental illness beliefs between U.S born and Mexican born people of Mexican descent.
Furthermore, the researcher divided the total possible scale score of 99 on the Attitudes towards Mental Health Problem Scale (ATMHP S) into three equal score groupings of Little Stigma (scores 1-33), Medium Stigma (scores 34-66), and High Stigma (scores 67-99) to determine how many participants fell within each stigma category. With lower scores implying less stigmatic beliefs and higher scores implying higher stigmatic beliefs, scores of 1-33 implied little stigma towards mental illness, scores of 33-66 implied medium stigma towards mental illness and scores 67-99 implied high stigma towards mental illness.

Of the Mexican born participants, 36 percent (n=9) expressed little stigma towards mental illness (scored 7-33 on ATMHPS), 36 percent (n=9) expressed medium stigma towards mental illness (scored 34-66 on ATMHPS) and 28 percent (n=7) expressed high stigma towards mental illness (scored 67-99 on ATMHPS). Interestingly, these percentages imply that there is no significant difference between little, medium and high stigma towards mental illness among Mexican born participants because their views are more or less equally spread out between each category.

Of the U.S born participants, 28 percent (n=7) expressed little stigma towards mental illness (scored 1-33 on ATMHPS), 60 percent (n=15) expressed medium stigma towards mental illness (scored 34-66 on ATMHPS) and 12 percent (n=3) expressed high stigma towards mental illness (scored 67-99 on ATMHPS). This suggests that based on their total scale score on the Attitudes towards Mental Health Problems Scale (ATMHP S), U.S born Mexican Americans expressed higher little and medium stigma than they did high stigma so their attitudes are not equally spread out between each
category like Mexican born participants. Figure 1 below shows scale score percentage frequencies for Mexican born and U.S born participants.

![Figure 1. Bar chart of the attitudes towards mental health problems scale stigma levels.](image_url)

The researcher also compared the mean scores for each subscale of the Attitudes Towards Mental Health Problems Scale (ATMHPS) by nationality (U.S born vs. Mexico born). As can be seen in Table 2 below, the mean scores for each subscale by nationality were at the low level with the mean scores for the Community External Shame (CES) being the highest followed by the Family Reflective Shame (FRS) subscale. This suggests that people of Mexican descent, both U.S and Mexico born, expressed more community external shame as the mean score for both groups were highest on this subscale. The Family Reflective Shame (FRS) subscale followed closely, suggesting that both groups expressed family reflective shame in addition to community external shame. When means were compared for CES between nationalities, Mexico born participants expressed more CES than U.S born participants, suggesting that Mexican born
participants had higher concerns with community external shame than their U.S born counterparts. Interestingly, U.S born Mexican Americans expressed more Family Reflective Shame (FRS) than their Mexico born immigrant counterparts, suggesting they have more concerns about the shame of having a mental illness reflect on their families.

Table 2

*Means and Standard Deviations of External, Internal, Reflective Shame and Mental Illness Causal Belief Subscales by Nationality*

<table>
<thead>
<tr>
<th>NTNY</th>
<th>CES M</th>
<th>SD</th>
<th>FES M</th>
<th>SD</th>
<th>IS M</th>
<th>SD</th>
<th>FRS M</th>
<th>SD</th>
<th>SRS M</th>
<th>SD</th>
<th>MICB M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S</td>
<td>13.20</td>
<td>8.08</td>
<td>6.28</td>
<td>6.82</td>
<td>6.48</td>
<td>3.62</td>
<td>9.44</td>
<td>5.10</td>
<td>3.68</td>
<td>4.05</td>
<td>6.88</td>
<td>2.51</td>
</tr>
<tr>
<td>MX.</td>
<td>14.44</td>
<td>7.26</td>
<td>6.40</td>
<td>7.37</td>
<td>5.84</td>
<td>4.46</td>
<td>8.64</td>
<td>6.16</td>
<td>4.56</td>
<td>3.47</td>
<td>7.12</td>
<td>2.44</td>
</tr>
</tbody>
</table>

*CES= Community External Shame; FES= Family External Shame; IS= Internal Shame; FRS= Family Reflective Shame; SRS= Self Reflective Shame; MICB= Mental Illness Causal Beliefs; Ntny= Nationality; U.S= U.S Born Nationality; MX= Mexico Born Nationality.*

When nationality (U.S born: M= 13.20, SD= 8.08 and Mexico born: M= 14.44, SD= 7.26) was analyzed in an independent samples T-test with Community External Shame (CES) to test the true relationship between the two, no statistically significant affect of nationality on participant concern with community external shame was examined ( t(48)= -.571, p= .571). Table 3 below displays independent samples T-test results for nationality and CES.
Table 3

Independent Samples T-test of Nationality and Community External Shame

<table>
<thead>
<tr>
<th>What is the level of Community External Shame (CES)?</th>
<th>Levene's Test for Equality of Variances</th>
<th>T Test for Equality of Means</th>
<th>95% confidence interval of the difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>Sig.</td>
<td>t</td>
</tr>
<tr>
<td>Equal Variances Assumed</td>
<td>2.63</td>
<td>0.11</td>
<td>-0.571</td>
</tr>
<tr>
<td>Equal Variances not assumed</td>
<td>5</td>
<td>1</td>
<td>-0.571</td>
</tr>
</tbody>
</table>

Nationality (U.S born: M= 9.44, SD= 5.10 and Mexico born: M= 8.64, SD= 6.16) and Family Reflective Shame (FRS) were also analyzed via an independent samples T-test to test the relationship between both variables, with results showing no statistically significant affect of nationality on participant concern with FRS (t(48)= .320, p=.619). Table 4 below displays results of the independent samples T-test for nationality and FRS.

Table 4

Independent Samples T-test of Nationality and Family Reflective Shame

<table>
<thead>
<tr>
<th>What is the level of Family Reflective Shame (FRS)?</th>
<th>Levene's Test for Equality of Variances</th>
<th>T Test for Equality of Means</th>
<th>95% confidence interval of the difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>Sig.</td>
<td>t</td>
</tr>
<tr>
<td>Equal Variances Assumed</td>
<td>1.010</td>
<td>0.320</td>
<td>0.500</td>
</tr>
<tr>
<td>Equal Variances not assumed</td>
<td>0.500</td>
<td>46.374</td>
<td>0.619</td>
</tr>
</tbody>
</table>
Another demographic variable used in analysis to compare with each subscale was income. The income variable was re-coded from a range of income levels to less than $50,000 a year and more than $50,000 a year to make the analysis simpler. With the recoded variable, education level percentages were changed to 72 percent (n= 36) making less than $50,000 a year and 28 percent (n= 14) making more than $50,000 a year.

When income was used to compare means for each subscale, the means scores were at the low level, with the exception of Community External Shame (CES) for both groups of participants who make less than $50,000/ year and those who make more than $50,000/ year. This suggests that people of Mexican descent, both U.S born and Mexico born expressed higher levels of Community External Shame (CES) regardless of income level. Community external shame had the biggest mean difference when compared between income groups as well, with people of Mexican descent who make less than $50,000 a year expressing more community external shame than those who make more than $50,000 a year.

Table 5

Means and Standard Deviations of External, Internal, Reflective Shame and Mental Illness Causal Belief Subscales by Income

<table>
<thead>
<tr>
<th>Income</th>
<th>CES</th>
<th>FES</th>
<th>IS</th>
<th>FRS</th>
<th>SRS</th>
<th>MICB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less $50K Per Year</td>
<td>14.52</td>
<td>7.77</td>
<td>6.25</td>
<td>6.22</td>
<td>4.06</td>
<td>5.37</td>
</tr>
<tr>
<td>More $50K Per Year</td>
<td>12.00</td>
<td>9.07</td>
<td>6.07</td>
<td>4.12</td>
<td>9.14</td>
<td>6.42</td>
</tr>
</tbody>
</table>

*CES = Community External Shame; FES = Family External Shame; IS = Internal Shame; FRS = Family Reflective Shame; SRS = Self Reflective Shame; MICB = Mental Illness Causal Beliefs
However, when income level and Community External Shame (CES) were analyzed via an independent samples T-test, the findings suggest no statistically significant connection between the two variables ($t(48)= 1.05, p= 0.297$), suggesting no significant affect of income levels of more than $50,000/ year ($M= 12.00, SD= 1.92$) and less than $50,000/year ($M= 14.53, SD= 1.29$) on Community External Shame (CES).

Table 6 below displays the independent samples T-test results for income and CES.

Table 6

<table>
<thead>
<tr>
<th>Levene's Test for Equality of Variances</th>
<th>T Test for Equality of Means</th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td>Sig.</td>
</tr>
<tr>
<td>---</td>
<td>------</td>
</tr>
<tr>
<td>0.143</td>
<td>0.707</td>
</tr>
</tbody>
</table>

Sex was also analyzed in comparison with each subscale of the ATMHPS. Mean scores for each subscale by sex were on the low level with Community External Shame (CES) being the highest, suggesting that regardless of sex, people of Mexican descent expressed higher levels of community external shame concerns. When compared between sexes, community external shame was higher for women than it was for men, suggesting women of Mexican descent express more community external shame than men.
Table 7

Means and Standard Deviations of External, Internal, Reflective Shame and Mental Illness Causal Belief Subscales by Sex

<table>
<thead>
<tr>
<th></th>
<th>CES</th>
<th>M</th>
<th>SD</th>
<th>FES</th>
<th>M</th>
<th>SD</th>
<th>IS</th>
<th>M</th>
<th>SD</th>
<th>FRS</th>
<th>M</th>
<th>SD</th>
<th>SRS</th>
<th>M</th>
<th>SD</th>
<th>MICB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>M</td>
<td>SD</td>
<td></td>
<td>M</td>
<td>SD</td>
<td></td>
<td>M</td>
<td>SD</td>
<td></td>
<td>M</td>
<td>SD</td>
<td></td>
<td>M</td>
<td>SD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>14.90</td>
<td>8.41</td>
<td></td>
<td>7.03</td>
<td>5.93</td>
<td></td>
<td>5.52</td>
<td>3.78</td>
<td></td>
<td>9.74</td>
<td>5.34</td>
<td></td>
<td>4.32</td>
<td>3.96</td>
<td></td>
<td>6.97</td>
</tr>
<tr>
<td>Male</td>
<td>12.05</td>
<td>5.93</td>
<td></td>
<td>5.21</td>
<td>5.06</td>
<td></td>
<td>7.21</td>
<td>4.32</td>
<td></td>
<td>7.89</td>
<td>6.00</td>
<td></td>
<td>3.79</td>
<td>3.47</td>
<td></td>
<td>7.05</td>
</tr>
</tbody>
</table>

*CES= Community External Shame; FES= Family External Shame; IS= Internal Shame; FRS= Family Reflective Shame; SRS= Self Reflective Shame; MICB= Mental Illness Causal Beliefs

However, when sex and Community External Shame (CES) were analyzed through an independent samples T-test, no statistically significant difference was found among the sexes (Men: M= 12.05, SD= 5.93 and Women: M= 14.90, SD= 8.41) in terms of their stance on community external shame (t(48)= 1.29, p=0.203). Table 8 below presents the independent samples T-test for sex and CES.

Table 8

Independent Samples T-test of Sex and Community External Shame

<table>
<thead>
<tr>
<th>Levene's Test for Equality of Variances</th>
<th>T Test for Equality of Means</th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td>Sig.</td>
</tr>
<tr>
<td>3.587</td>
<td>0.064</td>
</tr>
<tr>
<td>1.403</td>
<td>0.46933</td>
</tr>
</tbody>
</table>

The education variable was also recoded into an education higher than high school and one lower than high school variable in order to make the analysis simpler.
Seventy-two percent (n=36) participants identified as having an education lower than high school and 28 percent (n=14) identified as having an education higher than a high school diploma.

When the mean scores for education were analyzed with each subscale, the mean scores were also highest for Community External Shame (CES) and Family Reflective Shame (FRS). When community external shame was compared between education groups, participants who have an education higher than a high school diploma expressed higher community external shame than participants who have a high school diploma or lower, suggesting that participants of Mexican descent who have a higher education express more concern about how their community would view them if they were perceived as having a mental illness. Table 9 presents the means and standard deviations for each subscale by education.

Table 9

<table>
<thead>
<tr>
<th></th>
<th>CES</th>
<th>FES</th>
<th>IS</th>
<th>FRS</th>
<th>SRS</th>
<th>MICB</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Education</strong></td>
<td><strong>M</strong></td>
<td><strong>SD</strong></td>
<td><strong>M</strong></td>
<td><strong>SD</strong></td>
<td><strong>M</strong></td>
<td><strong>SD</strong></td>
</tr>
<tr>
<td>High School Or Less</td>
<td>12.81</td>
<td>7.67</td>
<td>5.69</td>
<td>6.70</td>
<td>5.94</td>
<td>3.62</td>
</tr>
<tr>
<td>Some College Or Degree</td>
<td>16.43</td>
<td>7.12</td>
<td>8.00</td>
<td>7.82</td>
<td>6.71</td>
<td>5.06</td>
</tr>
</tbody>
</table>

*CES= Community External Shame; FES= Family External Shame; IS= Internal Shame; FRS= Family Reflective Shame; SRS= Self Reflective Shame; MICB= Mental Illness Causal Beliefs

When an independent samples T-test was conducted to test the relationship between education (less than a high school diploma: M= 12.81, SD= 7.67 and higher than a high school diploma: M= 16.43, SD= 7.12) and Community External Shame (CES)
more closely, results did not show a statistically significant difference between education level and degree of community external shame among the participants \( (t(48)= 1.53, p=0.133) \). Table 10 below shows results of the independent samples T-test for education and CES.

Table 10

**Independent Samples T-test of Education and Community External Shame**

<table>
<thead>
<tr>
<th>What is the level of Community External Shame (CES)?</th>
<th>Levene's Test for Equality of Variances</th>
<th>T Test for Equality of Means</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>Sig.</td>
</tr>
<tr>
<td>Equal Variances Assumed</td>
<td>2.62</td>
<td>0.611</td>
</tr>
<tr>
<td>Equal Variances not assumed</td>
<td>-1.58</td>
<td>0.126</td>
</tr>
</tbody>
</table>

An independent samples T-test was also conducted to test the relationship between education level and Family Reflective Shame (FRS), which also showed no statistically significant affect of education level \( (less than a high school diploma: M=5.69, SD= 6.70 and higher than a high school diploma: M= 8.00, SD= 7.82) \) on participant opinion regarding family reflective shame \( (t(48)= 1.04, p=0.302) \). Table 11 below shows results of the independent samples T-test for education and FRS.
Table 11

*Independent Samples T-test of Education and Family Reflective Shame*

<table>
<thead>
<tr>
<th>What is the level of Family Reflective Shame (FRS)?</th>
<th>Levene's Test for Equality of Variances</th>
<th>T Test for Equality of Means</th>
<th>95 % confidence interval of the difference</th>
<th>Lower</th>
<th>Upper</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equal Variances Assumed</td>
<td>F 0.795  Sig. 0.377  t -1.04  Df 48</td>
<td>mean difference 0.302  std. error difference 2.21024  95 % confidence interval of the difference -6.7495  2.13843</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equal Variances not assumed</td>
<td>F -0.974  Sig. 20.853  t 0.341  Df 48</td>
<td>mean difference -2.30556  std. error difference 2.36820  95 % confidence interval of the difference 7.23262  2.62151</td>
<td></td>
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Chapter 5

Discussion

The purpose of this research study was to explore differences in attitudes, perceptions and mental illness causal beliefs among U.S born Mexican Americans and Mexican born immigrants. The researcher hypothesized that due to the impact acculturation levels have on attitudes and beliefs, U.S born Mexican Americans would hold more positive views towards mental illness than their Mexican immigrant counterparts. This chapter reports the summary, implications for social work, recommendations, limitations, and conclusion that resulted from the analysis of data collected for this study.

Interpretation of the Findings

It is important to note that the findings are not to be generalized to the larger Mexican population due to the small sample size of this study. Nevertheless, conducting research on this topic can establish a platform for dialogue in identifying the particular mental health needs of this underserved population. Additionally, the findings gathered from this study can assist in bringing this topic into public interest for further research and to begin addressing policy and program development.

The results show various findings. First, there is not a statistically significant difference in negative mental illness attitudes, perceptions and causal beliefs as tested via the Attitudes Towards Mental Health Problems Scale (ATMHPS) (Gilbert et al., 2007) between U.S born Mexican Americans and Mexico born Mexican immigrants, which negates the researcher’s hypothesis that a difference would exist due to acculturation.
Results for nationality and each subscale of the ATMHPS include: Community External Shame (CES): t(48)= -.571, p=.571, Family Reflective Shame (FRS): t(48)= .320, p=.619, Internal Shame (IS): t(48)= .444, p=.580, Family External Shame (FES): t(48)= -.060, p=.953, Self-Reflective Shame (SRS): t(48)= .260, p=.413 and Mental Illness Causal Beliefs (MICB): t(48)= .798, p=.733. Because no significant difference was observed, this implies that mental health service providers may not need to address attitudes and perceptions about mental illness among both groups differently in order to attain successful treatment rates. This is not to say that providers should not address this population’s stigmatic mental health beliefs but instead that there is no need to address them differently or in more extent between U.S born and Mexican born because there is no significant difference in their mental illness attitudes, perceptions, and causal beliefs.

Among both U.S born and Mexico born participants, community external shame was highest in comparison to all other subscales on the Attitudes Towards Mental Health Problems Scale (ATMHPS). This implies that both U.S born Mexican Americans and Mexico born Mexican immigrants both expressed high levels of concern for community external shame, which is defined as their perception of how their community sees mental illness and how their community would see them if they personally suffered from a mental illness. Interestingly, Mexico born participants scored higher than U.S born on the community external shame subscale, implying that Mexican immigrants have higher concerns than their U.S born counterparts. This is important for mental health service providers to note in order to better advocate for their clients among the communities that their clients live in and view as particularly stigmatizing.
A close second to community external shame for both U.S born and Mexico born was family reflective shame. Although both groups scored higher on this subscale than the others (besides community external shame), U.S born participants scored higher than Mexican born participants. This suggests that both groups expressed concern for the reflected shame their families may suffer and how ones family would be seen if the individual suffered from a mental illness, but U.S born expressed slightly higher concern. This is also important for service providers to note in order to better serve their clients by addressing their concerns about the shame a mental illness may have on their families.

Among all variables analyzed- nationality, sex, income and education, community external shame had the highest score of each subscale on the Attitudes Towards Mental Health Problems Scale (ATMHPS), suggesting that regardless of the participant’s nationality, sex, income and education, all expressed high community external shame.

Furthermore, the researcher grouped total scale scores for the Attitudes Towards Mental Health Problems Scale (ATMHPS) into three groupings of Little Stigma, Intermediate Stigma and High Stigma based on each participants score, lower scores meaning little stigma and higher scores meaning higher stigma. Interestingly, 28 percent (n= 7) of U.S born participants fell into the Little Stigma category compared to 36 percent (n= 9) of Mexican immigrants, suggesting that Mexican born participants express more ‘little stigma’ than U.S born. Sixty percent (n= 15) of U.S born fell into the Intermediate Stigma category compared to 36 percent (n= 9) of Mexico born, so U.S born expressed more ‘intermediate’ stigma than their Mexican immigrant counterparts. Lastly, 12 percent (n= 3) of U.S born fell into the High Stigma category compared to 28 percent
(n=7) of Mexico born so Mexican immigrants scored ‘higher stigma’ than their U.S born counterparts.

This finding suggests that Mexican born participants expressed more even stigma between little, intermediate and high stigma while U.S born expressed most ‘intermediate stigma’ and very little ‘high stigma’. Mexican born participants scored higher ‘high stigma’ than their U.S born counterparts, which may support the researcher’s hypothesis that U.S born Mexican Americans have less stigmatic beliefs about mental illness than Mexican born immigrants.

**Summary of Findings**

The overall and specific findings of this study note that there are no significant differences in mental health attitudes, perceptions and causal beliefs among U.S born Mexican Americans and Mexico born Mexican immigrants in a small sample of fifty (50) participants. Results for nationality and each subscale of the Attitudes Towards Mental Health Problems Scale (ATMHPS) (Gilbert et al., 2007) include: Community External Shame (CES): t(48)= -.571, p=.571, Family Reflective Shame (FRS): t(48)= .320, p=.619, Internal Shame (IS): t(48)= .444, p=.580, Family External Shame (FES): t(48)= -.060, p=.953, Self-Reflective Shame (SRS): t(48)= .260, p=.413 and Mental Illness Causal Beliefs (MICB): t(48)= .798, p=.733. Although no statistically significant differences were noted, U.S born and Mexican born scored differently on the ATMHPS, with U.S born expressing more intermediate stigma than Mexican born but Mexican born expressing more high stigma compared to U.S born.
Among all the variables analyzed, community external shame was the highest subscale score, implying that regardless of nationality, sex, income and education, all participants were most concerned with how their community sees mental illness and how their community would view them if they suffered from a mental illness. These findings are helpful for service providers to identify ways to target low mental health treatment rates among this population, starting by addressing the impact that community stigma has on an individual of Mexican descent.

**Summary of Study**

The major findings from the study included that there is not a statistically significant difference in mental illness attitudes, perceptions and causal beliefs among U.S born Mexican Americans and Mexican born Mexican immigrants. Among both groups, community external shame was highest, even when analyzed by sex, income and education, suggesting that this population expressed most concern about how their community views mental illness and similarly, how their communities would view them if they personally suffered from a mental illness regardless of nationality, sex, income and education. Interestingly however, the researcher did find that participants who are U.S born expressed less ‘high stigma’ than their Mexican born counterparts, speaking to the researchers’ hypothesis that U.S born have less stigmatic beliefs about mental illness than Mexican immigrants.

**Implications for Social Work**

The importance of addressing stigmatic beliefs among this population in order to target their low mental health treatment rates is demonstrated in this study. Although
there is research on treatment barriers for this population, there is minimal data on how to address a particular barrier—stigmatic beliefs. Addressing this social need is important in the field of social work because the profession prides itself on values and principles such as service, social justice, equality, and dignity and worth of the person, among others.

Social workers are expected to practice in the scope of these values and must possess certain competencies in regards to social work practice, which are determined by the Council on Social Work Education (CSWE) EPAS Educational and Policy Accreditation Standards. The 2008 EPAS defines 10 competencies (EP 2.1.1-EP 2.1.10) social workers must possess, which are as follows: EP 2.1.1 Identify as a social worker and conduct oneself accordingly; EP 2.1.2 Apply social work principles to guide professional practice; EP 2.1.3 Apply critical thinking to inform and communicate professional judgments; EP 2.1.4 Engage diversity and difference in practice; EP 2.1.5 Advance human rights and social and economic justice; EP 2.1.6 Engage in research-informed practice and practice-informed research; EP 2.1.7 Apply knowledge of human behavior and the social environment; EP 2.1.8 Engage in policy practice to advance social and economic well-being and to deliver effective social work services; EP 2.1.9 Respond to contexts that shape practice; EP 2.1.10 (a)-(d) Engage, assess, intervene, and evaluate with individuals, families, groups, organizations, and communities; EP 2.1.10 (a) Engagement; EP 2.1.10 (b) Assessment; EP 2.1.10 (c) Intervention; EP 2.1.10 (d) Evaluation (CSWE EPAS, 2008).

By exploring mental illness attitudes, perceptions and causal beliefs among U.S. born Mexican Americans and Mexican born Mexican immigrants, the researcher brought
attention to an area in which social workers must apply critical thinking to inform and communicate professional judgments in order to advance human rights and social and economic justice by engaging in research-informed practice to then put this knowledge of human behavior and the social environment into practice. This is what the social work profession is about and how social work practice must be exercised in order to fulfill our core competencies and duties as a social worker.

Due to the fact that this population is underserved and marginalized in society, they are lacking the necessary services that would allow them to thrive and recover from mental health problems and live a satisfying life.

**Recommendations**

Based on the findings of this study and in order to target low mental health treatment rates among this population, the researcher proposes several strategies and recommendations on the micro, meso and macro levels.

The researcher suggests that on the micro level, social workers address stigmatic beliefs about mental illness among this population and the affect it has on their treatment through psycho-education with their clients. In order to do so however, more specific and less generalized trainings need to be added to existent cultural competence curriculum of social and human service agencies.

Another suggestion the researcher has on the micro level is the development of a psycho-educational program for the target population itself. The proposed program is a mental illness psycho-educational workshop for Latinos whose mission would be to address their low mental health treatment rates through comprehensive psycho-
educational services on the causes, symptoms, and treatment for mental illness in order to encourage wellness, promote their quality of life and increase their mental health literacy. A program like this would have a long term, overall goal of reducing low mental health treatment rates among vulnerable populations through the delivery of its psycho-educational workshops on the following topics:

- What is Mental Illness?- The Causes and Symptoms
- The Stigma Behind Mental Illness
- Cultural Barriers to Treatment
- Coping with Mental Illness
- Navigating the Mental Health Care System
- Locating Local Resources

Based on the finding that community external shame was of most concern to both U.S born Mexican Americans and Mexico born Mexican immigrants, the researcher suggests that on the meso level, social workers engage in collaborative efforts with influential community leaders and organizations through psycho-education in order to advocate for their clients and target the source of their stigma.

The last recommendation the researcher has applies to macro level practice and social policies. Since commonly cited barriers to treatment among this population include legal status and how it hinders their access to healthcare, the researcher proposes that social welfare and healthcare policies be reevaluated so that legal status is not a prerequisite for healthcare accessibility. Legal status defines what immigrants can and cannot do in this country but healthcare- including mental health care, should not be one
of them; healthcare is a human being’s fundamental right and legal status should not be a condition for it.

Although the researcher recommends ways to target low mental health treatment rates among people of Mexican descent, this is an area of study that needs further research and exploration. The researcher proposes that future research be conducted over a longer period of time in a longitudinal manner in order to control for changes in perceptions, attitudes, and beliefs over time. Such longitudinal research has the potential to contribute to the knowledge of ways in which attitudes and beliefs change over time and hence how to effectively engage, treat and retain clients in treatment regardless of the phase their attitudes and beliefs are in.

On the meso level, the researcher proposes that future research focus on ways to target negative stigma surrounding mental illness in the communities and support systems of this population. Future research on this topic may focus on the particular factors that contribute to stigma and ways to address the stigma.

The researcher also proposes for future research to be conducted in various locations locally and nationally to test for the possibility of geographical differences in mental health perceptions. Conducting the study nationally would also work to increase the sample size - another proposal the researcher has in order to improve the generalizability of the results.

On the macro level, the researcher suggests that future research focus on the affect that social welfare policies have on mental health treatment rates among this population. Such research can focus on how progressive or regressive policies surrounding healthcare
accessibility and legal status in particular would impact treatment rates.

**Limitations**

The study limitation the researcher identified includes the fact that there was limited data to determine mental health attitude, perception and causal belief differences between U.S born Mexican Americans and Mexican born immigrants due to the small sample size of fifty (50). Because this study was conducted on a small sample size of fifty (50), generalizibility of the results to the Mexican population as a whole is unlikely. In addition, the small non-probability of the sample size limited the validity of the data, therefore limiting the researcher’s ability to generalize the results further.

Also, the researcher did not explore the possibility of a geographical affect on mental health attitudes, perceptions and causal beliefs among people of Mexican descent. The study was conducted in the small northern California town of Vacaville, which does not have a prominent Hispanic population, so results are unlikely to be generalizable to people of Mexican descent in different geographic locations where their culture is more prevalent. The researcher only focused on analyzing factors such as nationality, sex, income and education versus geographic location and the affect of culture on the geographic location.

Another limitation to this study is the unequal number of men and women as well as the uneven distribution of ages among participants. When it came to sex, the majority of respondents were women, which may have had an influence on responses. In terms of age, the majority of participants were aged 25-34, which may have also had an influence on responses given that health attitudes are most likely to change as we age.
Conclusion

Based on the findings of the study, the following conclusions can be drawn. The study findings and this research demonstrated no statistically significant difference in mental health attitudes, perceptions and causal beliefs among a small sample of twenty-five (25) U.S born Mexican Americans and twenty-five (25) Mexican born immigrants.

The major findings from the study included no sex, income, and education affect on mental health attitudes, perceptions and causal beliefs regardless of nationality (U.S born vs. Mexico born). Community external shame was the highest expressed concern regardless of nationality, sex, income and education, suggesting that all participants expressed high community external shame in regards to mental illness and mental health problems. This means that all participants expressed concern of how their community views mental illness and how their community would specifically view them if they suffered from a mental illness. The second highest expressed concern was family reflective shame, suggesting that regardless of nationality, sex, income and education, all participants expressed concern for how their family would be viewed if they personally suffered from a mental illness, implying that family reputation is of importance for people of Mexican descent.

Another major finding of this study is that although no statistically significant difference was found between U.S born and Mexican born participants, more U.S born participants expressed higher ‘intermediate stigma’ and lower ‘high stigma’ scores on the Attitudes Towards Mental Health Problem Scale (ATMHPS) developed by Gilbert et. al, 2007 compared to their Mexican born counterparts. Mexican immigrants expressed equal
stigmas between ‘intermediate’ and ‘little’ stigma and higher ‘high’ stigma than their U.S born counterparts.
Appendix A

English Questionnaire

Part I- Demographic Information

1. How old are you?  
   a. 18-24  
   b. 25-34  
   c. 35-44  
   d. 45-54  
   e. 55-64  
   f. 65 or older

7. How many children do you have?  
   a. 0  
   b. 1-2  
   c. 3 or more

8. Employment Status:  
   a. Employed  
   b. Out of work, looking  
   c. Out of work, not looking  
   d. Homemaker  
   e. Retired

2. What is your race?  
   a. Non-Hispanic White  
   b. African American  
   c. Asian/Pacific Islander  
   d. Native Indian or American Indian  
   e. Hispanic or Latino

3. If you answered Hispanic or Latino please specify:  
   a. Mexican  
   b. Cuban  
   c. Puerto Rican  
   d. Other

9. What category best describes your annual income?  
   a. Less than $24,999  
   b. $25,000 to $49,999  
   c. $50,000 to $99,999  
   d. $100,000 or more

4. What is your gender?  
   a. Female  
   b. Male  
   c. Other

10. Were you born in the U.S?  
   a. Yes  
   b. No

5. What is the highest degree or level of school you have completed?  
   a. No schooling  
   b. 12th grade or less  
   c. Some high school, no diploma  
   d. High school, diploma  
   e. College degree

11. Were you born in Mexico?  
   a. Yes  
   b. No

Part II- Familiarity with Mental Illness

12. Are you familiar with mental illness?  
   a. Yes  
   b. No  
   c. Don’t Know
6. What is your marital status?
   a. Single, never married
   b. Married, domestic partner
   c. Widowed
   d. divorced, separated

13. Do you have a relationship with someone with a mental illness?
   a. Yes
   b. No
   c. Don’t Know

PART III- Attitudes towards Mental Illness

Please use the following scale:
0= Do not agree at all; 1= Agree a little; 2= Mostly agree; 3= Completely Agree

For this next set of questions, please think about how your community and family view mental illness

14. My community sees mental illness as something to keep secret
15. My community sees mental illness as a personal weakness
16. My community would tend to look down on somebody with mental illness
17. My community would want to keep their distance from someone with mental illness
18. My family sees mental illness as something to keep secret
19. My family sees mental illness as a personal weakness
20. My family would tend to look down on somebody with mental illness
21. My family would want to keep their distance from someone with mental illness

External Shame

For the next set of questions, please think about how you might feel if you suffered from a mental illness.

22. I think my community would look down on me
23. I think my community would see me as inferior
24. I think my community would see me as inadequate
25. I think my community would see me as weak 0 1 2 3
26. I think my community would see me as not measuring up to their standards 0 1 2 3
27. I think my family would look down on me 0 1 2 3
28. I think my family would see me as inferior 0 1 2 3
29. I think my family would see me as inadequate 0 1 2 3
30. I think my family would see me as weak 0 1 2 3
31. I think my family would see me as not measuring up to their standards 0 1 2 3

Internal Shame
For the next set of questions, please think about how you might feel about yourself if you suffered from a mental illness.

32. I would see myself as inferior 0 1 2 3
33. I would see myself as inadequate 0 1 2 3
34. I would blame myself for my problems 0 1 2 3
35. I would see myself as a weak person 0 1 2 3
36. I would see myself as a failure 0 1 2 3

Reflected Shame 1
For the next set of questions, please think about how you might feel if you suffered from a mental illness. Consider how worried you would be on the impact on your family.

37. My family would be seen as inferior 0 1 2 3
38. My family would be seen as inadequate 0 1 2 3
39. My family would be blamed for my problems 0 1 2 3
40. My family would lose status in the community 0 1 2 3
41. I would worry about the effect on my family 0 1 2 3
42. I would worry that I would be letting my family's honor down 0 1 2 3
43. I would worry that my mental health problems could damage my family's reputation 0 1 2 3
Reflected Shame 2

For the next set of questions, please think about how you might feel if one of your close relatives suffers from a mental illness. Consider how worried you would be on the impact on you.

44. I would worry that others will look down on me
45. I would worry that others would not wish to associated with me
46. I would worry that my own reputation and honor might be harmed
47. I would worry that if this were known I would lose status the community
48. I would worry that others might think I might also have a mental health problem

Gilbert et al., 2007

PART V - CAUSAL BELIEFS

For the next set of questions, please think about what you believe causes a mental illness.

49. I believe mental illnesses result from bad events from the past such as abuse or traumatic events
50. I believe mental illnesses result from a chemical imbalance in the brain
51. I believe mental illnesses result from certain genes inherited from the family
52. I believe mental illnesses are due to personal sinfulness & sinful thoughts
53. I believe mental illnesses are due to witchcraft and spells
54. I believe mental illnesses are due to uncontrollable evil forces
55. I believe mental illnesses are due to weak character and are punishment for being a bad person
Appendix B
Spanish Questionnaire

PARTE I- Información Demográfica

1. Cuántos años tiene?
   a. 18-24
   b. 25-34
   c. 35-44
   d. 45-54
   e. 55-64
   f. 65 o mayor

2. Que raza es?
   a. Americano
   b. Afroamericano
   c. Asiático
   d. Indio Nativo
   e. Hispano o Latino

3. Si su respuesta es Hispano o Latino; especifique:
   a. Mexicano
   b. Cubano
   c. Puerto Riqueño

4. Sexo?
   a. Femenino
   b. Masculino
   c. Otro

5. Cuál es su máximo nivel de estudio?
   a. Ninguna escuela
   b. Primaria
   c. Secundaria
   d. Preparatoria
   e. Universidad

6. Estado civil?
   a. Soltero
   b. Casado
   c. Union Libre
   Divorciado o separado

7. Cuantos hijos tiene?
   a. 0
   b. 1-2
   c. 3 o mas

8. Ocupacion?
   a. Trabajo
   b. Desempleado, buscando
   c. Desempleado
   d. Ama de casa

9. Cual categoría describe sus ingresos anuales?
   a. menos de $24,999
   b. $25,000 a $49,999
   c. $50,000 a $99,999
   d. $100,000 o mas

10. Nacio en los Estados Unidos?
    a. Si
    b. No

11. Nacio en Mexico?
    a. Si
    b. No

PARTE III- Familiaridad con Enfermedades

12. Esta usted familiarizado con problemas de salud mental?
    a. Si
    b. No
    c. No lo se

13. Tiene cercania con alguien que sufre de problemas de salud mental?
    a. Si
    b. No
    c. No lo se
PARTE III- Actitudes Sobre la Salud Mental

Por favor use las siguientes medidas:
0= No estoy de acuerdo; 1= De acuerdo un poco; 2= Mas de acuerdo; 3= Completamente de acuerdo

Para las siguientes preguntas, por favor piense como ve su comunidad y familia a los problemas de salud mental.

14. Mi comunidad ve enfermedades mentales como algo para mantener en secreto
15. Mi comunidad ve enfermedades mentales como debilidad personal
16. Mi comunidad tiende a menospreciar a alguien con una enfermedad mental
17. Mi comunidad preferiría mantener su distancia de alguien con una enfermedad mental
18. Mi familia ve enfermedades mentales como algo para mantener en secreto
19. Mi familia ve enfermedades mentales como debilidad personal
20. Mi familia tiende a menospreciar a alguien con una enfermedad mental
21. Mi familia preferiría mantener su distancia de alguien con una enfermedad mental

Vergüenza Externa

Para las siguientes preguntas, por favor piense como se sentiría si usted sufriera de una enfermedad mental.

22. Creo que me comunidad me menospreciaría
23. Creo que mi comunidad me vería como inferior
24. Creo que mi comunidad me vería como inadecuado/a
25. Creo que mi comunidad me vería como débil
26. Creo que mi comunidad me vería por debajo de sus normas 0 1 2 3
27. Creo que mi familia me menospreciaría 0 1 2 3
28. Creo que mi familia me vería como inferior 0 1 2 3
29. Creo que mi familia me vería como inadecuado/a 0 1 2 3
30. Creo que mi familia me vería como débil 0 1 2 3
31. Creo que mi familia me vería por debajo de sus normas 0 1 2 3

**Vergüenza Interna**

Para las siguientes preguntas, por favor piense como se sentiría usted si sufriría de una enfermedad mental.

32. Me vería como inferior 0 1 2 3
33. Me vería como inadecuado/a 0 1 2 3
34. Me culparía a mi mismo/a por mi enfermedad 0 1 2 3
35. Me vería como una persona débil 0 1 2 3
36. Me vería como un fracaso 0 1 2 3

**Vergüenza Reflexionada 1**

Para las siguientes preguntas, por favor piense como se sentiría si usted sufriría de una enfermedad mental. Esta vez, considere que preocupado/a estaría por el impacto que tendría a su familia.

37. Mi familia me vería como inferior 0 1 2 3
38. Mi familia me vería como inadecuado/a 0 1 2 3
39. Mi familia sería culpada por mi enfermedad mental 0 1 2 3
40. Mi familia perdería estatus en la comunidad 0 1 2 3
41. Me preocuparía por los efectos que tendría mi enfermedad mental hacia mi familia 0 1 2 3
42. Me preocuparía que afectaría al honor de mi familia 0 1 2 3
43. Me preocuparía que mi enfermedad mental podría dañar la reputación de mi familia 0 1 2 3
Vergüenza Reflexionada 2

Para las siguientes preguntas, por favor piense como se sentiría si un familiar sufriera de una enfermedad mental. Esta vez, considere que preocupado/a estaría por el impacto que tendría hacia usted.

44. Me preocuparía que la gente me menospreciaría
45. Me preocuparía que la gente no se quiera asociar conmigo
46. Me preocuparía que se dañara mi reputación y honor
47. Me preocuparía que perdiera mi status en la comunidad si se supiera
48. Me preocuparía que piensen que yo también sufro de una enfermedad mental

Gilbert et al., 2007

PARTE V-Creencias Sobre la Causa de Enfermedades Mentales

Para las siguientes preguntas, por favor piense en lo que cree causar una enfermedad mental.

49. Creo que enfermedades mentales resultan de eventos malos del pasado como abuso o eventos traumáticos
50. Creo que enfermedades mentales resultan de desbalances químicos en el cerebro
51. Creo que enfermedades mentales resultan de ciertos genes heredados de la familia
52. Creo que enfermedades mentales resultan de malos pensamientos y pecados
53. Creo que enfermedades mentales resultan por hechizos y brujería
54. Creo que enfermedades mentales resultan por fuerzas del mal incontrolables
55. Creo que enfermedades mentales resultan de ser débil y es un castigo
Appendix C

English Consent Form

Mental Health Perception and Attitude Differences in Mexican Immigrants and Mexican Americans

You are invited to participate in a research study which will involve measuring differences in mental illness causal beliefs, perceptions and attitudes among immigrants of Mexican descent born in Mexico and Mexican Americans born in the United States. My name is Joanna Gutierrez and I am a second year graduate student at California State University, Sacramento in the Division of Social Work, in the College of Health and Human Services. You were selected as a possible participant in this study because you meet the criteria: 18-65 years old and of Mexican descent born in the United States or Mexico.

The purpose of this research is to identify differences in mental illness causal beliefs, perceptions and attitudes between people of Mexican descent, both immigrants and U.S born. If you decide to participate, you will be asked to complete a self-administered questionnaire about your causal beliefs, perceptions and attitudes concerning mental illness. Your participation in this study will last approximately 30 minutes. There are no known risks involved for participants. Although you will not benefit directly from participating in this study, there are some benefits to this research, particularly that your responses will help make a major contribution and pave the way for further research aimed at explaining the mental health care treatment rates among Latinos of Mexican descent.

If you have any questions about the research at any time, please call me at (xxx) xxx-xxxx. If you have any questions about your rights as a participant in a research project please call my faculty advisor, Dr. Bankhead at (916) 278-7177, or email Bankhead@csus.edu.

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission. The data obtained will be maintained in a safe, locked location and will be destroyed after publication of the study is completed.

Your participation is entirely voluntary and your decision whether or not to participate will involve no penalty or loss of benefits to which you are otherwise entitled. If you decided to participate, you are free to discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled.

Your signature below indicates that you have read and understand the information provided above, that you willingly agree to participate, that you may withdraw your consent at any time and discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled, that you will receive a copy of this form, and
that you are not waiving any legal claims, rights or remedies.

You will be offered a copy of this signed form to keep.

Signature
____________________________

Date
____________________
Appendix D

Spanish Consent Form

Diferencias en Actitudes y Percepciones Sobre Enfermedades Mentales Entre Inmigrantes Mexicanos y Mexicanos Estadunidenses

Usted está invitado a participar en un estudio que involucrará medir las diferencias en actitudes y percepciones sobre enfermedades mentales entre inmigrantes Mexicanos nacidos en México y Mexicanos nacidos en los Estados Unidos. Mi nombre es Joanna Gutierrez, soy estudiante de maestría en mi segundo año en la Universidad de California, Sacramento en el Departamento de Servicio Social, en el Colegio de Salud y Servicios Humanos. Usted fue escogido/a como posible participante en este estudio porque cumple con los criterios de: tener entre 18-65 años, ser de descendencia Mexicana y ser nacido en México o en los Estados Unidos.

El propósito de este estudio es identificar diferencias en las creencias, actitudes y percepciones sobre las enfermedades mentales entre inmigrantes Mexicanos nacidos en México y Mexicanos nacidos en los Estados Unidos. Si usted decide participar, se le pedirá que complete un cuestionario escrito sobre sus creencias, percepciones y actitudes sobre la salud mental y enfermedades mentales. Su participación en este estudio tardará aproximadamente 30 minutos.

No hay ningún riesgo en participar. Aunque usted no se beneficiara directamente de este estudio, este proyecto tiene algunos beneficios, en particular que sus respuestas ayudaran a contribuir y allanar el camino para investigaciones en el futuro que servirán a explicar las tasas bajas de tratamiento de salud mental entre Latinos de descendencia Mexicana. Si usted tiene alguna pregunta sobre este estudio, por favor llamarme al (xxx) xxx-xxxx. Si usted tiene alguna pregunta sobre sus derechos como participante en un estudio por favor llame a mi consejera, la Dra. Bankhead al (916) 278-7177 o mande un correo electrónico a Bankhead@csus.edu.

Cualquier información que es obtenida en conexión con este estudio y que lo/a pueda identificar se mantendrá confidencial y solo será revelada con su permiso. Los datos que serán obtenidos se mantendrán en un lugar seguro y cerrado con llave y será destruida después de la publicación del estudio.

Su participación es totalmente voluntaria y su decisión en participar o no no involucrara ninguna penalidad ni perdida de beneficios a los cual usted recibe. Si usted decide participar, tiene la libertad de descontinuar su participación en cualquier momento sin penalidad.

Su firma a continuación indica que usted ha leído y entiende la información dada anteriormente, que usted está de acuerdo con participar voluntariamente, que usted puede
decidir retirarse del estudio y descontinuar su participación en cualquier momento y que usted no está renunciando a reclamos legales, derechos o recursos.

Una copia de este consentimiento informado firmado por usted se le hará disponible.

___________  ____________
Firma       Fecha
References


