MENTAL HEALTH TREATMENT PREFERENCES FOR PERSONS OF MEXICAN HERITAGE

by

Tanya R. Sorrell

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DEDICATION

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ABSTRACT
Culturally sensitive care is thought to take into account a person’s specific cultural values and preferences when providing mental health care services. Latinos currently comprise 17% of the total U.S. population at 50.5 million and persons of Mexican heritage constitute over 66% of all Latinos in the United States. Persons of Mexican heritage experience higher rates of mental health issues and illness with 30% lifetime incidence versus 20% incidence for Anglos. Few studies have focused on the mental health treatment preferences for persons of Mexican heritage. Treatment preferences could reflect personal characteristics, acculturation perspective about mental health issues and illness, and experience with treatment. Mass media may also influence treatment preferences and mental health information-seeking. The purpose of this study was to describe preferences for mental health treatment services for persons of Mexican heritage living in the Southwest along the United States-Mexico border. Twenty-one participants were interviewed individually and their responses analyzed using Atlas-ti qualitative analysis software. The participants reported twenty-five mental health treatment preferences. The top six preferences—medication, going to the doctor, social and family support, counseling and herbal medicines, were consistent throughout demographic categories of age, gender, income, generational status, insurance status, education, and acculturation. Self-management interventions and integrative medicine were also reported as treatment preferences. Participants reported media use of television, internet, books and magazines, in-person interaction, and radio as primary mental health information sources. Media influences on mental health included education/information, hope, normalization, and a catalyst for conversation. Ascribed meanings for anxiety, depression, substance abuse, schizophrenia, and bipolar disorder included cognitive, behavioral, and interactional reports. Mental health services for persons of Mexican heritage
should include varying holistic mental health treatment practices, recognizing the need for understanding of potential meanings for mental health issues and illness. Persons of Mexican heritage report the desire for the same types of allopathic care including medications and counseling as Anglos in the US. Additionally, self-management interventions and integrative medicine therapies were reported as integral to the holistic treatment process of obtaining help for mental health issues and illness.
CHAPTER I: MENTAL HEALTH TREATMENT PREFERENCES FOR PERSONS OF MEXICAN HERITAGE

A number of studies show the benefits of using culturally sensitive methods of care and treatment for minorities utilizing mental health services (Fox, Merwin, & Blank, 1995; Silva & Galvez, 2010; Wood & Newbold, 2011). Culturally sensitive care is thought to take into account a person’s specific cultural preferences, beliefs and norms when providing mental health care services. This study proposed to describe cultural preferences for mental health services for persons of Mexican heritage living in the Southwest along the US-Mexico border. Achieving patient-centered care in mental health services begins with understanding patient values and preferences and adapting services to meet those needs, values and preferences (Institute of Medicine [IOM], 2011).

Latinos currently comprise 17% of the total U.S. population at 50.5 million, with census projections that Latinos will remain the largest minority at 25% or 98 million in 2030 (Passel & Cohn, 2011). Persons of Mexican heritage include those of Mexican ancestry who were born in the United States or those who have immigrated to the US by legal or illegal methods and currently take up residence in the US, regardless of racial affiliation (Office of Management and Budget, 2012). Persons of Mexican heritage constitute over 66% of all Latinos in the US with their population expanding faster than that of other Latino groups (Passel & Cohn, 2011; U.S. Census Bureau, 2010, July 15).

As the population expands, concerns about the provision of health services to this population become a more salient issue. Mental health services are of particular concern because Mexican heritage persons are less likely to receive appropriate mental health care than are their
African-American or Anglo counterparts (Druss & Satcher, 2010). The reasons for this disparity are thought to be based on access to care, insurance and financial issues, stigma, language barriers and other cultural factors (2010). Persons of Mexican heritage are often reluctant to seek mental health services in traditional allopathic health care settings (Abe-Kim et al., 2007). A number of factors have been suggested as to the reason persons of Mexican heritage delay mental health care attention including stigma, dismissiveness of culture and discrimination (Nadeem et al., 2007; Vega, Kolody, & Aguilar-Gaxiola, 2001). As the Mexican-American population increases, efforts to address and ameliorate this vulnerability will need to be made. Determining culturally sensitive methods of care that align with patient values and preferences has remained a focal point in mental health services provision (Vega, Kolody, Aguilar-Gaxiola, & Catalano, 1999). Few studies have focused on the mental health treatment preferences of Mexican heritage. Persons of Mexican heritage may have differing expectations about treatment, setting, and various treatment preferences. Treatment preferences could influence overall perception of the health care experience, access, and use of mental health care, overall satisfaction, and treatment response to mental health issues. Identifying these culturally based methods of care will be crucial in providing culturally sensitive care to this group. This study focused on mental health treatment preferences for persons of Mexican heritage who experience higher percentages of mental illness than other groups (Druss & Satcher, 2010). Little information about mental health treatment preferences exists for of persons of Mexican heritage. A number of studies suggest persons of Mexican heritage may use cross border migration to Mexico for their health care needs (Wallace, Mende-Luck, & Casteñeda, 2009). As early as 2001, Macias and Morales showed that at the US-Mexico border, 24-28% of persons of Mexican heritage were utilizing medical services or medications in Mexico, with 90%
of those persons lacking health insurance in the US. However, to date, few studies have verified this practice or have provided data on mental health treatment preferences for Mexican heritage persons. This study describes values and preferences for mental health treatment for persons of Mexican heritage.

The use of Mexican Traditional Medicine (MTM), an indigenous healing system developed in Mexico, has been chronicled in persons of Mexican heritage since the arrival of Columbus (Kiev, 1968). Mexican traditional medicine is a whole medical system based on a dynamic balance between visible and non-visible elements (Zavaleta & Salinas, 2009). Whole medical systems are characterized by focus on the individual patient, consideration of relationships between the patient, patient’s family and the practitioner, individual approaches to treatment and their variety of outcomes in treatment including physical, social and spiritual (Ritenbaugh, Verhoef, Fleishman, Boon, & Leis, 2003). Culturally, persons of Mexican heritage may have experience with MTM as part of their health care. For persons of Mexican heritage, patient-centered care may mandate mental health services that include MTM. Persons of Mexican heritage whose cultural practices align most closely with Mexico are likely to be those living on the US-Mexico border. Persons who cross the border to Mexico, where traditional providers, traditional herbs, and other health products are easily accessible, may be the best cultural spokespersons for communicating the influence of both MTM and United States scientifically-based medicine.

**Background**

**Persons of Mexican Heritage**

Most persons of Mexican heritage immigrate to the US from rural or small urban areas in Mexico (Borjas & Katz, 2011). The majority of Mexican immigrants are from rural southern
Mexico, where traditional farming patterns have given way to industrialized farming methods after the North American Free Trade Agreement (NAFTA) treaty allowed U.S. agricultural businesses access to Mexico for farming (2011). Rural southern Mexicans have a more traditional pattern of health beliefs than those Mexicans living closer to the US-Mexico border (Heymann et al., 2009). Mexicans who also have a native or Indian background are also more likely to use traditional methods of healing; more in keeping with their Native American backgrounds (Lopez, 2005). The majority of Mexican immigrants continue to settle along the US-Mexico border area, as the characteristics of this area are more similar to the rural agrarian areas of their native Mexico (Borjas & Katz, 2011; Massey, 2004; Padilla, Gomez, Biggerstaff, & Mehler, 2001). Saenz and Torres (2003) first chronicled this border migration pattern in 2001, and their work shows the continued focus of migration towards the border southwest US (Saenz, Cready, & Morales, 2007; Slack et al., 2009).

**Acculturation of persons of Mexican heritage.** As a group, persons of Mexican heritage are more likely to continue traditional patterns and cultural identities once moving to the US, as there is a strong probability of finding enclaves of other Mexicans along the US-Mexico border in which to live a shared cultural heritage (Heymann et al., 2009; Lopez, 2005). Consequently, they are less likely to learn English, acculturate, or be required to interact extensively with those of non-Mexican heritage for goods or services (Heymann et al., 2009; Lara, Gamboa, Kahramanian, Morales, & Bautista, 2012). Continued exclusion does limit persons of Mexican heritage in assimilating and utilizing U.S.-based services (Carter-Pokras et al., 2008). Acculturation has been defined as “those phenomena which result when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original cultural patterns of either or both groups” (Page, 2006, p.271). From this
definition, acculturation would necessitate adaptation, modification, and incorporation of differing ideas, values, attitudes, and behaviors of the other culture, usually considered the dominant culture in the society (Cuellar, Arnold, & Gonzalez, 1995). Additionally, acculturation has been described as the process of interactivity between cultures, delineating two separate processes: maintenance of the original culture and the development of relationships with the new culture (Lopez-Class, Castro, & Ramirez, 2011; Thomson & Hoffman-Goetz, 2009). Most recently, acculturation studies have focused on those persons immigrating and living in the US and assessing those groups as they interface with the majority U.S. Anglo society. These factors are highlighted in interactions along the US-Mexico border, where a direct interface of differing cultures occurs.

**US-Mexico border.** The US-Mexico border is the 100-mile wide and 2000-mile long perimeter of states forming the lower southern United States from the states belonging to Mexico (Pan American Health Organization [PAHO], 2008). Approximately 14 million people reside in the 42 U.S. counties and 39 Mexican municipalities along the US-Mexico border, with 86% of those persons residing in 15 pairs of sister cities along the international border (Rodríguez-Saldaña, 2005; Stoney & Batalova, 2013). There are more than 1 million legal crossings along the border each day, making the US-Mexico border the busiest international border in the world. Primarily, health disparities between border communities result in lower health standards and conditions in Mexican border communities as compared with U.S. border communities (Rodríguez-Saldaña, 2005; Stoney & Batalova, 2013). Barriers in access to care and utilization of health care remain problematic along both sides of the border. Many areas along the US-Mexico border are considered health professions shortage areas defined by a dearth of doctors and nurses to patients, specifically 20% less than the national rate or 28 per 10,000 population
In addition, border health areas contain large areas of rural and frontier landscape within the 2000-mile long and 100-mile wide boundary between the US and Mexico, encompassing four U.S. states and six Mexican states (United States-México Border Health Commission, 2011). Thus, because of health professions shortage areas and access issues, border health areas are associated with health care disparities. Health disparities refer to differences between groups of people that affect how frequently a disease occurs, to what severity and to what outcomes (McGuire, Alegría, Cook, Wells, & Zaslavsky, 2006). Health disparities additionally impact those living along the border region due to increased rates of poverty and lack of health insurance (Bastida, Brown, & Pagán, 2008). Given this increased health risk, agencies within the U.S. health care system have been developed to address the potential vulnerabilities of health professions shortage areas along the US-Mexican border. These agencies utilize government funding for such tasks as increasing the number of providers for these areas, developing special programs to improve access and health care service utilization, and researching methods of health care services and delivery (United States-México, 2011).

**Rural status of persons of Mexican heritage.** The majority of persons of Mexican heritage living in the United States live in the fifteen ‘sister city’ pairs along the US-Mexico border (Rosenblum & Brick, 2010). Those not living in the sister cities live along rural areas of the US-Mexico border (Borjas & Katz, 2011; Salinas, Snih, Markides, Ray, & Angel, 2010). Rural refers to those areas with a population census of less than 50,000 people and/or less than one thousand persons per square mile (HRSA, 2012). Those persons living in rural areas may experience vulnerability with health and mental health care (PAHO, 2007). Lack of access, language barriers, financial barriers, and cultural limitations have been posited as reasons for
vulnerability related to ongoing health care (Bastida et al., 2008; Salinas et al., 2010; Vega, Rodriguez, & Ang, 2010). Persons of Mexican heritage are more than twice as likely to use the emergency room as their primary access to health and mental health care as non-Mexican populations, with rural status increasing the likelihood of substandard health care access and use (Salinas et al., 2010). Given this context, the health and mental health of persons of Mexican heritage is of particular interest.

Health in persons of Mexican heritage. Studies show that persons of Mexican heritage living in the US have poorer health outcomes than those Mexicans living in Mexico (Bastida et al., 2008). Acculturation, or the adaptation of U.S. cultural standards, also is a factor negatively affecting persons of Mexican heritage’s health care (Padilla et al., 2001). Aside from acculturation, there are other reasons that persons of Mexican heritage experience barriers. Financial issues, health insurance coverage, transportation, language barriers, and cultural differences have been suggested as potential factors negatively affecting health care access and utilization (Bastida et al., 2008; Saenz & Torres, 2003). These factors may lead to health care disparities in persons of Mexican heritage. Persons of Mexican heritage are more likely to have tuberculosis, untreated hypertension, and cardiac issues than their minority counterparts (Satcher & Higginbotham, 2010). In addition, persons of Mexican heritage appear to be more traditional in their health care utilization and seek traditional healing services in advance of organized allopathic medical care (Bastida et al., 2008). Persons of Mexican heritage are more likely to utilize holistic based methods of health care than Anglos and to use more culturally familiar methods of health care (Amerson, 2008; Lopez 2005; Vega et al., 2001). As of 2003, Saenz and Torres noted a paucity of evidence about treatments persons of Mexican heritage prefer for health and mental health care. Since 2003, few additions have been added to the literature.
The lifetime prevalence of mental health disorders of Mexican-Americans is 30% versus 20% for Anglos, with increased rates of mental illness diagnosed as acculturation and language proficiency becomes more evident (Alegría et al., 2007). Mexican immigrants who must adjust to a new language, culture, and systems (acculturation) as well as separate from family and country of origin, experience increased rates of mental health changes and illnesses (Cardemil et al., 2007). A current challenge is identifying and implementing culturally sensitive mental health treatment for this population. The US-Mexico rural border health areas are regions where diverse populations congregate under disabling social, political, and economic conditions. Securing mental health services is difficult, shrouded in secrecy related to stigma, and is often unavailable because of language differences and the lack of material resources (Nadeem, Lange, & Miranda, 2008; Vega et al., 1999).

Two of the most prevalent mental health issues affecting persons of Mexican heritage have specifically culturally derived meanings. *Ataque de nervios* is a culturally defined mental health illness characterized by the sudden onset of anxiety, feelings of sadness, anger, and/or guilt and verbal and physical aggression (Keough, Timpano, & Schmidt, 2009). This disorder appeared to be culturally distinct for those of Mexican heritage only and to differ significantly from panic attacks (2009). The treatments for this malady for persons of Mexican heritage were social support and interaction, and visits to a curandero or native healer (Grames, 2006). Allopathic care or presentation for mental health services was not considered part of the treatment for this malady by persons of Mexican heritage (Keough et al., 2009).

*Nervios* is a culturally defined illness attributed to a gradual change in emotional experience with feelings of stress and desperation, changes in blood pressure, chest and

There are several culturally bound mental health illnesses that apparently are experienced by only persons of Mexican heritage (Tyson & Flaskerud, 2009). Culture bound syndromes generally have symptoms, identifications, diagnoses, and treatments that differ from conventional or allopathic mental health care treatments (Glazer, Baer, Weller, Garcia de Alba, & Liebowitz, 2004). These syndromes can occur exclusively or in combination with other U.S.-recognized mental health illnesses (Tyson & Flaskerud, 2009). Typical treatments for mental health issues utilizing MTM include the use of medicinal herbs, hierba buena, tila de flora, as well as chants, prayers, and limpias, or cleansings with specific herbs (Amerson, 2008; Lopez, 2005). The MTM treatments for culturally bound and allopathic mental health illnesses are different from allopathic models of mental health care and treatment currently in use by allopathic providers. This decreases the likelihood that persons of Mexican heritage either seek out or utilize allopathic based forms of treatment for culturally bound and other mental health illnesses. Given these examples of differing treatments for mental health illnesses and the need for services for this population, understanding the treatment preferences for mental health services used by Mexican heritage persons at the US-Mexico border would be fundamental.

**Mexican Traditional Medicine**

Mexican Traditional Medicine is an indigenous healing system developed in Mexico to address health and mental health care needs. Developed from pre-Columbian Aztec, Mayan, and Incan traditional practices, coupled with African and Spanish-Catholic influences, MTM incorporates these influences into a whole medical system. A whole medical system is an approach to health care based on the principles of physical, emotional, psychic, and spiritual
balances for the entire being that are developed outside of traditional Western medicine (National Center for Complementary and Alternative Medicine [NCCAM], 2011b). Mexican Traditional Medicine treatments include platicas, or counseling, herbal medicine, chants, ritual acts, cleansings, and other methods designed to improve the overall balance of the individual (Zavaleta & Salinas, 2009). Many persons of Mexican heritage maintain traditional health and illness beliefs and patterns of healing (Lopez, 2005). Mexican Traditional Medicine is an important part of Mexican American health care with over 90% of Mexican American families aware of MTM services, and over 55% of Mexican American families utilizing these services in the United States (Amerson, 2008; Lopez, 2005).

**Definitions of Cultural Care**

When delineating care across the health care system, there has been some discussion about the terms used to describe care that is specifically designed to cater to the needs of particular cultural groups. The terms, when reviewed from the literature, appear to address health care from an organizational or systems level of care in a stepwise fashion to an interpersonal level of care.

Jeffreys (2006) defines cultural competence as “an ongoing, multidimensional learning process that integrates transcultural skills in all three dimensions (cognitive, affective, and practical), involves transcultural self-efficacy (confidence) as a major influencing factor, and aims to achieve culturally congruent care” (p. 32-33). Cultural competence focuses on the organizational view of a health care system and is thought to develop along a six-level continuum, an outline that was developed by the National Center for Cultural Competence (Srivastava, 2007). An organization with the highest level of cultural competence holds culture
as a valuable part of health care, shows cultural awareness and sensitivity, and operationally utilizes cultural care methods to guide quality health care provision (Spector, 2009).

Culturally appropriate methods of care are those utilized by organizations promoting the operationalization of cultural competence in health care service provision. Culturally appropriate, from Mala and Trudgen’s work (2000), defines “culturally is an adverb, from the word cultural and is of, or relating to a specific culture or civilization, and appropriate is an adjective, meaning suitable for the occasion or circumstance… Together therefore you would expect culturally appropriate to mean [something] suitable for that specific culture” (p.15). From this definition, the methods utilized to provide care to persons of culturally diverse backgrounds would be judged as to their cultural appropriateness. A culturally appropriate method of care would be one deemed suitable for the specific culture to which it was intended to serve.

Culturally congruent care refers to the explicit use of sensitive, creative, and meaningful care methods and practices to fit with the general values, beliefs, life-ways, and needs of clients for beneficial, satisfying, and meaningful health/care and well-being or to help them face illness, difficult life situations, disabilities, or death (Leininger & McFarland, 2006, p. 12).

Culturally sensitive care is a concept of the Spector (2009) model of cultural diversity in health and illness and implies that cultural awareness and sensitivity are needed in the attitude of the health care provider in order to provide culturally congruent care. For Spector, cultural awareness and sensitivity have to do with one’s personal understanding and attitude towards others of different cultures. Culturally congruent care is the actual provision of care by the culturally sensitive health care provider to the person of cultural difference.

In summary, in the world of cultural care, cultural competence is the organizational motivation towards providing culturally appropriate methods of care utilizing health care
providers with cultural awareness and sensitivity. The provision of this health care is culturally congruent to the person receiving the health care services rendered by the health care provider.

**Treatment Preferences**

Treatment preferences detail the methods of care, service, and assistance that an individual or group desire as part of their care. Persons with mental health issues may choose from among a number of methods to address their concerns. For purposes of this study, three systems of care from which treatment methods are derived will be used: allopathic, integrative, and MTM. Allopathic, or traditional Western medicine, includes areas of medication and psychotherapies to address mental health issues (Fiel, 2012). Integrative medicine (IM) is the term used when employing a combination of allopathic medicine with non-traditional medicine types (NCCAM, 2011a). Integrative medicine acknowledges diverse medical practices, therapies, and products not considered part of allopathic medicine (2011a). Over 38% of Americans utilize some form of IM as part of their everyday health care regimen (2011a). Integrative medicine, as the name describes, is used in conjunction with allopathic medicine, for example in providing herbs for treatment. Mexican traditional medicine offers a third method of addressing mental health issues. Mexican traditional medicine is a form of IM that utilizes holistic practices from the methods derived from pre-Columbian natives living in Mexico (Zavaleta & Salinas, 2009).

Persons of Mexican heritage constitute an important minority group in the US (Heymann et al., 2009). Living along the US-Mexico border in an area short of health professions places persons of Mexican heritage at particular risk for health and mental health disparities (Alegría et al., 2007). Persons of Mexican heritage have a higher percentage of mental health illness and a lower incidence of mental health services utilization than other minority groups or Anglos.
Identifying knowledge that is intended to support best practice will contribute to decreased health vulnerabilities and improved health outcomes for treating persons of Mexican heritage with mental health problems.

Use of culturally sensitive health care services has been shown to decrease health care vulnerabilities and disparities in minorities (Satcher & Higgenbotham, 2010). Satcher and Higgenbotham (2010) posited that culturally-sensitive health care services allow for increased service utilization, health outcomes, and satisfaction by minority groups. Barriers such as limited access, language, cultural exclusion, and insensitivity to treatment preferences can be addressed and ameliorated by the use of culturally appropriate systems of health care (Vega et al., 2010). Limited data about treatment preferences for mental health care are available for persons of Mexican heritage living in the US.

A rural border area such as Yuma County, AZ demonstrates the factors germane to this study. The growing numbers of persons with Mexican heritage, the incidence of mental health issues, and the need for culturally sensitive mental health care services and treatments for this group is a notable issue in the Yuma area. The proximity to the US-Mexico border for cross-border migration and access to MTM were other reasons to utilize this population to address these mental health concerns. Yuma County’s listing as a health professions shortage area served as a key reason to complete this type of study using persons from this area. Therefore, the purpose of this research study was to describe treatment preferences for mental health care services of persons of Mexican heritage living in a US-Mexico rural border town.
Aims and Research Questions

The specific aims and research questions for this study were:

AIM 1

Describe the treatment preferences for mental health issues and illness.

Research Question 1: What are the treatment preferences for mental health issues and illnesses?

Research Question 2: Are there personal characteristics that influence treatment preferences (age, gender, education, income, insurance, and generational status)?

Research Question 3: Are there characteristics related to acculturation that influence treatment preferences?

Research Question 4: Are there characteristics related to mental health issues and illnesses that influence treatment preferences?

Research Question 5: Does the mental health experience (self or immediate family) impact mental health treatment preferences?

AIM 2

Describe the media context that may influence treatment preferences.

Research Question 6: What is the use of media to obtain mental health information?

Research Question 7: How does acculturation and mental health experience influence media use for mental health information?

AIM 3

Describe the participant’s meaning associated with mental health illness and treatment preferences.

Research Question 8: How is understanding ascribed to anxiety/nervousness, depression, substance abuse, schizophrenia, and bipolar disorder?
Significance

*Healthy People 2020* addresses the goal of improving mental health and access to appropriate mental health services (Healthy People, 2012b). This includes improving access to culturally appropriate services for minority groups with the goal of eliminating health care disparities for vulnerable groups (Healthy People, 2012a). The bi-national mandate of Healthy Borders speaks to effective services for persons of Mexican heritage living in the border regions. Moreover, Healthy Borders 2020 specifically mandates the addition of mental health services to reduce mental health mortality (United States-México, 2010). Mental health disparities research shows Latinos less likely to have access to appropriate mental health care than any other minority (Druss & Satcher, 2010). A focus on culturally sensitive health care and access for those living along the US-Mexico border serves as a key feature in Healthy Borders 2020 (United States-México, 2010). This study invited the perspective of persons of Mexican heritage to provide feedback on their mental health treatment preferences as a step toward meeting the goals set forward in Healthy People 2020 and Healthy Borders 2020. Such data on treatment preferences for those of Mexican heritage will allow for the provision of services that will be more culturally appropriate to those needing care. Understanding treatment preferences for mental health issues provides contextual information to develop treatment strategies more suited to persons of Mexican heritage. Findings from this study contribute to cultural knowledge and scientific foundation for further work in developing clinical guidelines and best practices for the mental health treatment of persons of Mexican heritage.

Just as Healthy People and Healthy Borders develop health policy goals for patient care, the IOM develops clinical provider policy goals for patient care. The IOM’s Committee on Health Care in America developed initiatives focusing on the future of health care services in the
US (2011). The IOM included guidelines to improve the care of those suffering from mental and substance abuse conditions, with a goal of advancing the quality of health care for mental and substance-use conditions. The IOM described a chasm between health care currently delivered and optimum standards required for quality and safety (2011). Central to the report is that care should be patient-centered, which the IOM outlined as “respectful of and responsive to the individual patient’s preferences, needs and values and ensures that patient values guide all clinical decisions” (p. 78). By documenting the mental health treatment preferences of persons of Mexican heritage, this study contributed findings that show preferences that are more likely to provide patient-centered care.

As part of the goals for patient-centered care, the IOM identified consequences of delays for mental health care including loss of work, days off due to disability, and disruption of family systems due to delays in obtaining mental health care (IOM, 2011). The American economy loses over $105 billion per year due to untreated and mistreated mental illness (Armour, 2006). It has been shown that treating mental illness can reduce crime and save money in the overall economy (2006). Using patient-centered mental health treatment preferences for those persons of Mexican heritage could decrease the negative impact of mental illness on the economy and the population as a whole. The number of persons of Mexican heritage that could be successfully treated for mental health issues would decrease the losses seen economically as a result of mental illness and its resultant incapacity. The results of this study can be used to provide more effective mental health care and treatment for persons of Mexican heritage, which can serve as a cost effective measure in viewing today’s mental health care expenditures.
Summary

Persons of Mexican heritage form the largest minority group in the US and a growing segment of the total U.S. population (Dockterman, 2011). The persons of Mexican heritage who reside along the US-Mexico border in primarily rural settings (Heymann et al., 2009) continue to maintain their traditional health and cultural beliefs with only minimal adaptations to their new culture. The growing numbers of persons of Mexican heritage are a concern as health care services attempt to provide culturally sensitive treatment. Culturally sensitive health care methods have been shown to be important factors in minimizing health care disparities in minority groups (Satcher & Higginbotham, 2010). Persons of Mexican heritage demonstrate both general health and mental health care disparities that are more pronounced than other minority groups in the US (2010). Current mental health services have minimal evidence on treatment preferences for persons of Mexican heritage. This study has provided much-needed data on mental health preferences for persons of Mexican heritage living on the US-Mexico border. As national organizations and government health care systems outline the importance of culturally sensitive and patient-centered care, this study serves to improve the knowledge base of mental health treatment preferences for persons of Mexican heritage in an attempt to address those issues of patient-centered culturally sensitive mental health care.
CHAPTER II: LITERATURE REVIEW

This study describes the mental health treatment preferences of persons of Mexican heritage. The following literature review includes a review of the concept of treatment preferences and how it applies to mental health issues, the history between the US and Mexico regarding the border, Mexican migration to the US, Mexican acculturation in the US, definitions of mental health and illness, Mexican perceptions of health and illness in general, and mental health illness and treatment specifically. In addition, this section describes allopathic treatment of mental health, as well as IM, MTM, and differences between allopathic medicine, IM, and MTM.

US-MEXICO BORDER HISTORY

Understanding US-Mexico border history provided a background for the setting of this study and the unique characteristics of the US-Mexico border area. As in the United States, prior to 1519, indigenous peoples occupied the US-Mexico border areas. In 1519, Hernando Cortez from Spain arrived and conquered the greater portion of Mexico, which included areas of present-day Texas, New Mexico, Arizona, and California (Espinosa, 1999). A Spanish colonial government was established in Mexico, with the indigenous population converted to Catholicism and the Spanish language, which lasted for a period of over 300 years (1999). After the Louisiana Purchase in 1804, increasing tensions between Spanish landowners and Americans moving westward led to the Adams-Onis treaty in 1819 (1999). This established the first official border between the United States and Mexico. In this treaty, Florida and parts of Texas were ceded to the United States, with the western border of Mexico reaching northward to current-day Oregon, Colorado, and parts of Oklahoma. It was also during this time that Mexico declared its
independence from Spain and became a self-governing republic in 1824 (Bureau of Western Hemisphere Affairs, 2011).

Immediately after Mexico’s independence, the Mexican government started to encourage the settlement of Texas as a Mexican colony, selling land cheaply and setting up forts to discourage settlement from the expanding United States (Byrd & Byrd, 1996). This influx of persons, however, led to increasing tensions between the Mexican and American settlers, leading to Texas’ declaration of independence from Mexico in 1836 (Figure 1). Texas, while calling itself an independent nation, became an increasing point of controversy between the United States and Mexico. The United States, continuing its expansion to the west, attempted to broker a deal with Mexico to purchase Texas, California, New Mexico, and Arizona. Mexico, still upset about the loss of Texas, refused to relinquish those areas to the US (Espinosa, 1999). These conflicts led to the Mexican-American War in 1846. The loss of the Mexican-American War and the subsequent Gadsden Purchase in 1853 led to the current border coordinates (Figure 2). This left a reported 300,000 Mexican nationals living in the new U.S. territories (Byrd & Byrd, 1996). At that time, border towns along the newly established lines began development, and those living on both sides of the border began to congregate along these established borders (Espinosa, 1999). Additionally, as gold and other minerals were discovered in these areas, Americans forced those of Mexican heritage off their land, resulting in increasing settlements along border cities in Arizona, Texas, and New Mexico (Bureau of Western, 2011).

In 1904, the U.S. Border Patrol was established, interestingly enough to stop Asian illegal workers that were coming into the United States from Mexico (Byrd & Byrd, 1996). Mexican workers continued to be enticed into the US to work on the developing railroad, mining, and agricultural interests in the southwest territories (Lorey, 1999). In 1910, the Mexican Revolution
began, which significantly increased the number of immigrants entering the United States. It is estimated that almost one million legal Mexican immigrants entered the US fleeing the fighting between 1910 and 1920 (Bureau of Western, 2011). President Wilson signed the Immigration Act of 1924, which restricted immigration from Europe and Asia but placed no quotas on Mexican immigrants (Lorey, 1999). Mexican immigration continued unabated, providing an ever-increasing percentage of the railroad and agricultural workers in the US (Espinosa, 1999). As this remained a fairly porous border for those of Mexican heritage, the distinctions of border were viewed differently, with ready movement across the borders without difficulty.
Mexican Migration to the US

Mexican migration to the US continued to develop and set the stage for the unique characteristics of the US-Mexico border. Mexicans have lived in increasing numbers along the Border States of the US and Mexico since the US-Mexican War (Zúñiga, Wallace, Berumen, & Castañeda, 2005). Those that lived inside of the US after the time of the Mexican War mostly occupied the states of Texas and California (2005). Considered the classic era of Mexican migration, the period from 1910 to 1940 saw approximately 85% of those of Mexican heritage immigrating to the Border States, with Texas being the preferred state for migration for various agricultural employment. The Bracero Program of 1942 allowed agricultural companies to hire and maintain undocumented persons of Mexican heritage and led to the growth of immigrants in
Texas. Starting in the 1950s, migrants were also sent to work the agriculturally developing areas of California (2005).

The Immigration and Nationality Act of 1965, a.k.a. the Hart-Cellar Act, abolished the national origins quota system that had been in place since the 1920s. Restrictions at that time limited immigration from non-Northern European countries to less than 150,000 persons from each country allowed to enter per year. Keely, in 1971, documented the increase in immigrants from southern European, Asian, Latin American, and Caribbean countries after 1965. Only Asian immigration noted an increase in the educational level of its incoming population; the majority of immigrants remained at low-level educational and socioeconomic standards.

From the 1970s, California became the area of migrant dominance, with unskilled agricultural work increasing during that time. It was also in the 1970s that the number of undocumented persons of Mexican heritage began to rise, initially related more to changes agriculturally in Mexico than by trade agreements between the US and Mexico (Zúñiga et al., 2005). The Immigration Reform and Control Act (IRCA) of 1986 provided for an amnesty program for those of Mexican heritage already living in the US without documentation, but started the trend of restrictions to further Mexican immigration now seen in today’s society. The IRCA provided the impetus and funding for the U.S. Border Patrol and the initiation of stricter border regulations. Shortly thereafter, the North American Free Trade Agreement (NAFTA) was started that allowed businesses to invest cheaply in Mexico, but had the unexpected result of decreasing agriculture and unskilled employment in Mexico (Borjas & Katz, 2011). These two policies further spurred undocumented migration into the US.

The economy of Mexico had a period of economic crisis in the 1990s that led to the largest influx of undocumented persons of Mexican heritage in U.S. history (Zúñiga et al., 2005).
The majority of these immigrants settled along the border, although there began to be growth in these immigrants in non-border states that needed unskilled workers, mostly in the carpet and meatpacking industries. Undocumented Mexican immigration continued to increase until recently enforced Border Patrol mobilization along the US-Mexico border and increasing political action to limit undocumented immigration. It is estimated that since 2008, migration of undocumented persons of Mexican heritage has been decreasing, with the number captured and deported back to Mexico thought to equal those crossing successfully (Borjas & Katz, 2011). The settling of persons of Mexican heritage along the US-Mexico border allowed the continued interaction with Mexico, its culture and traditions, and affected the acculturation of those living on this area.

**Mexican acculturation in the United States.** Acculturation remains a difficult concept to describe and study when it comes to minorities adjusting to life in foreign countries. The definition of acculturation is “the cultural modification of an individual, group, or people by adapting to or borrowing traits from another culture, a merging of cultures as a result of prolonged contact” (Berry, 2003, p. 6). In early studies, acculturation is considered a unidimensional process, as it was thought that persons abandoned their home culture while adopting a new culture (Schwartz, Unger, Zamboanga, & Szapocznik, 2010). More recent thought puts acculturation as a multidimensional process as various levels of new and pre-existing cultural predilections are maintained, simultaneously maintaining levels of cultural identity (Page, 2006). Acculturation occurs as immigrants have increasing interaction with the majority culture with integration of cultural beliefs occurring over time (Schwartz, Montgomery, & Briones, 2006; Schwartz et al., 2010). The person acculturating with time integrates existing cultural beliefs, norms, and activities with those of the newly encountered culture, with a
resulting mixture of old and new cultural beliefs. Cuellar, Arnold, and Gonzalez (1995) developed a scale called the Acculturation Rating Scale for Mexican Americans (ARSMA-II), which attempts to quantify the level of integration between the pre-existing Mexican and newly encountered American cultures (Appendix A). This scale takes into account the multidimensionality of acculturation and the processes that occur at a behavioral, emotional, and cognitive level as language, customs, foods, and expressions meld with the ongoing encounters of a new culture (Page, 2006). Health behaviors, especially mental health, may be a concept that is acculturated at a later stage, as mental health beliefs and traditions tend to be a more stable characteristic less amenable to change in minorities (Ramos-Sánchez & Atkinson, 2009).

Acculturation has been shown to have both positive and negative impacts on those of Mexican heritage. Acculturation for persons of Mexican heritage has been shown to increase socio-economic status and level of education for those living in the US (Roche, Ghazarian, & Fernandez-Esquer, 2012). Acculturation for children of fieldworker parents increased the likelihood of children’s completion of high school and entrance into higher-level occupations (Roosa et al., 2009). With increased acculturation, persons of Mexican heritage are able to gain a footing economically and educationally that allows for socio-economic gains in subsequent generations. Additionally, acculturation of persons living on the US-Mexico border has been shown to minimize negative effects of acculturation, as larger enclaves of Mexican persons provide emotional and social support, and serve as a protective factor while persons more slowly assimilate U.S. culture (Ruiz-Beltran & Kamau, 2001). However, a number of indices show that acculturation has resulted in negative health indicators for those of Mexican heritage, evidence that is significant for understanding treatment preferences for persons of Mexican heritage.
Multiple studies have shown that the health status of persons of Mexican heritage deteriorates concurrently with increasing acculturation (Carter-Pokras et al., 2008; Montoya, Salinas, Barroso, Mitchell-Bennet, & Reining, 2011; Peek et al., 2010). Exposure and acculturation to U.S. customs have a progressive rate of health status decline with prolonged exposure resulting in decreased health status. Factors related to this apparent health protective feature were posited to be related to social support, community resources, and proximity to health care services in Mexico (Page, 2006). For every year living in the US, persons of Mexican heritage showed decreasing health status and impacts in overall wellbeing (Ruiz-Beltran & Kamau, 2001). A number of questions that emerged from this evidence include “What health issues were experienced by those more acculturated? What treatment preferences and access to those preferences existed for this population? What mediating variables were noted that lessened the negative effects of acculturation?

Overall, mental health and wellbeing decreases proportionately based on level of acculturation (Alegría, Canino, et al., 2008). Breslau et al. (2011) showed an increase in depression and anxiety disorders expression as acculturation increased for Mexican heritage persons, with decreased acculturation and continued life in Mexico appearing as protective factors for mental health. Rates for depression were most commonly found to increase with increasing acculturation, with anxiety and incidence of PTSD secondarily elevated among those of Mexican heritage (Torres & Rollock, 2007).

When compared to their Mexican counterparts, persons of Mexican heritage living in the US had greater rates of depression and psychiatric disorders than those living in Mexico, with a 30% versus 20% incidence of depression across gender and age groups (Alegría, Canino, et al., 2008; Vega, Rodriguez, & Gruskin, 2009). Additionally, studies show persons of Mexican
heritage experienced twice the level of “nonspecific psychological distress” (without a diagnosis of mental illness) than non-Hispanic Anglos (Schwarz, McVeigh, Hoven, & Kerker, 2012, p. e554; see also Albrecht & McVeigh, 2012). This increased incidence of mental illness in those living in the US is labeled the ‘immigrant paradox’, as foreign nativity appears to serve as a protective factor against mental illness (Alegría, Canino, et al., 2008, p. 359). There also appears to be a protective factor in having been born in Mexico prior to immigration. Studies have shown that persons living in Mexico and those who move to the US during their lives have a lower incidence of mental illness than those persons of Mexican heritage born in the United States (Alegría, Canino, et al., 2008; Breslau et al., 2007). Overall, studies show a consensus that immigration to the US and subsequent acculturation results in negative mental and overall health outcomes.

Additionally, seeking help for mental health issues appeared to decrease with increasing acculturation in one study (Ramos-Sánchez & Atkinson, 2009). This contrasts to other studies that show increased help-seeking behaviors in those with increasing time in the US (Cox, 2008; Miville & Constantine, 2006). Most recent studies show acculturation as promoting help-seeking behaviors in persons of Mexican heritage (Cox, 2008). This increase in help-seeking behaviors appears to run concomitant with increased English language proficiency (2008). However, information was not given as to the types of treatments that were available to those of Mexican heritage, or the extent of use of allopathic, integrative, or MTM that was available and accessible to the population.

There has been some discussion about the differences between acculturation and assimilation of minorities in majority society. Assimilation is reported as the process of complete integration of ethnic minorities into the culture of the dominant society. According to Teske and
Nelson (1974), a leading report at that time, the minority culture, language, customs, and identity is subsumed by and into that of the larger majority culture (Brown, 2006). In theory, indicators of assimilation should regress to the mean in regard to health outcome as cultures were absorbed into the majority culture completely. For example, when Irish Americans immigrated to the US, though they were initially seen as a minority ethnic culture, their status became synonymous to that of the general Anglo population and their health outcomes became equivalent to that of the Anglo (Ignatiev, 1996; Roediger, 2006). Similar patterns of assimilation in the US were noted with the Italian and Jewish immigrant populations (Brodkin, 1998; Crispino, 1980). Their writings show that through rises in working class labor and labor unions, adoption of English language, Catholic church affiliation, and conflict issues pitting them against Blacks-Irish and Italian immigrants became accepted and assimilated as Anglo Americans (Ignatiev, 1996). Jews used academia, labor incorporations, and racial conflict against Blacks to gain entry and acceptance after World War II (Brodkin, 1998). Even today, Asians, Serbs, Croatians, and Bosnians have had similar entry points into Anglo American society, despite Bosnian Muslim status (Simić, 2007; Yancey, 2003; Zhou & Xiong, 2005). In addition, Arab-Americans were using similar patterns of assimilation as the Irish until post 9/11 events made them a more conspicuous group in American society (Nagel & Staheli, 2005). From the literature, most cultures have been able to utilize the assimilation track towards accordance with Anglo society in the US. Indeed, recent reviews consider these diverse groups as Anglo in regard to potential medical research studies (Aspinall, 1998; Bradby, 2003; McDermott & Samson, 2005). Conspicuously, African-Americans and Mexican-Americans appear to be unable to utilize similar methods of achieving equal status in U.S. society and thus, potential health equity (Alba & Nee, 2005; Telles & Ortiz, 2008). From these findings, it appears that ‘non-Anglo’ race serves
as the major determinant as to whether cultures will be able to assimilate into general Anglo society, or will be excluded from full assimilation and participation, with the resultant equitable health outcomes. With this exclusion from general culture, but the need to adapt to the generalities of Anglo society, non-Anglo cultures are relegated to the path of acculturation in attempts to integrate into broader U.S. society.

Acculturation refers to the exchange of cultural features which results when groups interact in continuous contact. The original cultural patterns of either or both groups may be altered or changed, but both groups continue to remain distinct. Research has focused more on the effects of the minority culture in contact with the majority culture, as if acculturation were a unidirectional process; the subsequent changes experienced by groups in response to interactions with the dominant majority have been noted by research measures (Page, 2006; Teske & Nelson, 1974). Assessments of acculturation are generally focused at the minority culture, with the attempt being made to gauge their rate and intensity of identification with the majority culture (Abraído-Lanza, Armbrister, Flórez, & Aguirre, 2006). Because acculturated groups do not actually assimilate into the majority society, their health outcomes and indicators also remain distinct.

Reasons for the lack of desire or inability of minority groups to assimilate into the majority culture take into account the notable difference that groups that are perceived as racially as Anglo are more readily able to assimilate into majority culture than minority groups of color (Huntington, 2004). Continued cultural and racial stereotypes, discrimination, and other factors appear to perpetuate this lack of full entry into general Anglo majority society, while permitting a parallel but lower level path of acculturation (Peek et al., 2010). Assimilation can be seen as a term of inclusion versus exclusion from majority society, with the majority society determining
entry into that culture, thus serving as the gatekeeper of assimilation. This forced exclusion from
the assimilation path and confinement to the acculturation path determines the allostatic load of a
culture or individual (2010).

    Allostatic load, the capacity of individuals’ physiological systems to adapt to challenges
or stressors placed on it in the confirmation towards the majority culture, serves as a significant
health indicator in the predictive ability of a minority culture to successfully acculturate and
maintain positive health indicators. A culture’s ability to adapt to pressured changes from the
majority culture serve as a reference point to that culture’s ultimate ability to maintain adequate
health during the acculturation process and maintain positive health outcomes (Peek et al.,
2010). This demonstrates how acculturation serves as a potential health risk or protective factor
(Abraído-Lanza et al., 2006).

    Recent researchers have considered adding an additional term to health care
acculturation, *pochismo*, which is considered the fusion and crystallization of American and
Mexican cultural elements that developed among Mexican-Americans along the southern border
of the US (Abraído-Lanza et al., 2006). Researchers report *pochismo* could be a potentially
distinct and free-standing culture with its own language (Spanglish), music, and identity evolved
from the dynamic and reciprocal interaction of Mexican and American cultures in the border
region and that would prove very difficult to assess with current acculturation measures. (p.
1345). Future studies assessing this cultural phenomenon may be better suited for border cultures
in determining actual levels of acculturation, although researchers note no current scales or
indicators have been developed to measure this distinct culture as a variable (Hauck, 2007).
Health Care Issues for Undocumented Immigrants at the US-Mexico Border

For those persons living along the US-Mexico border, immigration issues additionally impact health care and access to health care. Persons of Mexican heritage without documentation are limited in the social and health services they can receive based on the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Berk, Schur, Chavez, & Frankel, 2000). This act restricts the provision of publically funded health care services to undocumented immigrants, basically limiting available services for health care to those without legal documentation to emergency care services (Nandi et al., 2008). Along the US-Mexico border, ambulatory health care agencies have adopted policies allowing undocumented persons to receive health care if paid for as a fee-for-service or on a cash basis (http://www.capazmex.com). On a recent review of the health status of persons of Mexican heritage living in California, undocumented persons were the least likely to report their health status as poor, with most reporting their overall health status as fair or good (Ortega et al., 2007). However, this meant that overall, their rankings of their health status was the least among persons of Mexican heritage. Documented persons of Mexican heritage were more likely to report their health as good or excellent, with U.S.-born Anglos the most likely to report their health status as very good to excellent.

Despite their perceived status of health as less than that of documented persons, undocumented persons of Mexican heritage utilization rates of health care services were the lowest of all types of persons of Mexican heritage studied. Ortega et al. (2007) showed that in the California Health Interview Survey of health care utilization in over 6000 persons of Mexican heritage, 65% of undocumented persons of Mexican heritage reported they had an ongoing source of health care during the year 2006, whereas 79% of persons with a green card, 87% of naturalized persons, and 88% of U.S.-born persons of Mexican heritage reported they
had an ongoing source of health care. Those persons with an ongoing source of health care reported two health care visits per year average for undocumented persons, 3.4 visits per year for those with a green card, 4 visits per year for naturalized persons, and 4.5 visits per year for U.S.-born persons of Mexican heritage. During this survey, undocumented persons reported they experienced a higher percentage of difficulty understanding the health care provider during their visit (12% undocumented, 9% with green card, 7% naturalized persons, and 4% U.S.-born). Undocumented persons of Mexican heritage also reported the highest percentage of persons who felt they would have obtained better health care if their provider had been their same race/ethnicity (6% U.S.-born, 12% naturalized, 15% green-card holders, and 20% undocumented persons). Delays in seeking treatment were found to be related to subject’s immigration status and fears of deportation, with resulting hospitalizations stays longer and more acute than for Anglos reporting in the same study (2007). The most recent California Health Interview Survey in 2007 showed no changes in health care access and utilization for undocumented persons of Mexican heritage (Bustamante, 2012). When compared to documented persons from Mexico, undocumented subjects were more likely to be younger, single, poor, uninsured, with fewer years of schooling, lower English proficiency, and fewer years living in the US. Seventy-six percent of documented subjects reported having a primary care visit with an average of 3.24 visits in 2007, while only 56% of undocumented subjects reported having at least one primary care visit with an average of 2.26 in 2007. Undocumented subjects reported they were more likely to have access to primary care than undocumented subjects [68% vs. 47%] (2012).

A similar study assessed 505 undocumented persons of Mexican heritage regarding their health care experiences and utilization (Nandi et al., 2008). Interestingly, 60% of these subjects reported they experienced some form of discrimination in the past six months, with 25%
reporting language discrimination issues affecting their lives. Ten percent reported some type of physical or mental health limitation that prevented their working for more than one week in the six-month period reviewed. Ten percent of subjects reported they had some type of health care insurance, with 36% reporting access to a regular health care provider, and 13% reporting having utilized emergency department health services in the six months reviewed. Emergency department utilization and health insurance coverage was more common in women in men, with those reporting insurance coverage more likely to have more years of education and income (2008). Both studies found more common hospitalization rates for women of childbearing age, with hospitalizations more likely due to childbirth.

Rodríguez, Bustamante, and Ang (2009) completed a survey of 3847 persons of Mexican heritage in a Pew Hispanic Center national survey. Undocumented persons of Mexican heritage had lower rates of insurance coverage than permanent residents, naturalized subjects, or U.S.-born subjects (37%, 57%, 76% and 77% respectively). Fifty-eight percent of undocumented subjects had a reported source of health care, with 69% of permanent residents, 79% of naturalized subjects, and 80% of U.S.-born subjects reporting a regular source of health care. Sixty-seven and 56% percent of undocumented subjects reported they had received a blood pressure or cholesterol check in the past two years, with 76%/71% permanent residents, 81%/85% naturalized subjects, and 87% /83% of U.S.-born subjects reporting a blood pressure or cholesterol check in the past two years. Fifty-eight percent of undocumented subjects reported a usual source of health care, versus 69% for permanent residents, 76% naturalized citizens, and 77% U.S.-born subjects. Finally, undocumented subjects were the least likely to report receiving health care information during the health care visit with 40% reporting they received no information, versus 35% permanent residents, 28% naturalized citizens, and 20% U.S.-born
subjects (2009). This study shows that not only do undocumented persons of Mexican heritage have decreased access to and utilization of health care services, health insurance, and quality health care information; they have access and utilization of fewer preventive health care screening and services as well.

Only three studies have been conducted reporting mental health status of undocumented persons of Mexican heritage. Sullivan and Rehm (2005) attempted to delineate factors contributing to decreased mental health status of undocumented versus documented persons of Mexican heritage. Their review yielded themes including failure to succeed in their country of origin, blame/stigmatization, guilt, shame, vulnerability, exploitation, fear-based behaviors, stress, depression, and health related issues. These themes may decrease the mental health outcomes of undocumented persons and predispose them to higher levels of mental illness than documented persons. These themes were echoed in Pérez and Fortuna’s (2005) review of mental health access and challenges for undocumented persons of Mexican heritage. They reported that “the combined effects of minority status, specific ethnic group experiences (political, economic, trauma and immigration history), poverty, and illegal status pose a set of unique psychiatric risks for undocumented Latinos in the United States” (p. 107). One of their studies of 197 outpatient psychiatric subjects showed that undocumented persons were more likely to have a diagnosis of depression, anxiety, adjustment, and alcohol abuse disorders than documented or U.S.-born persons of Mexican heritage. Undocumented persons also reported a greater number of psychosocial stressors than their documented or U.S.-born counterparts. Undocumented persons had fewer mental health appointments than documented persons in the same mental health clinic. The undocumented persons had a lower rate of lifetime outpatient or inpatient mental health utilization than documented persons. Cabassa, Zayas, and Hansen (2006) similarly identified
structural, economic, psychiatric, and cultural factors that overall influence persons of Mexican heritage access and utilization of mental health care and more disproportionately affect undocumented persons. Although Cabassa, Molina, and Baron (2012) presented statistics of utilization of mental health care for documented persons of Mexican heritage, they were only able to extrapolate that undocumented persons were half as likely to have access and utilize mental health services as documented persons of Mexican heritage.

**Treatment Preferences in General Health Care**

In general, treatment preferences have referred to chosen methods of addressing and alleviating a condition by the patient and clinician. The importance of addressing patient treatment preferences as opposed to clinician treatment preferences has become more of a concern in recent years (Montgomery & Fahey, 2001). With the health care community’s acceptance of the “shared method of medical decision making” with providers and patients, the importance of allowing patients to choose their preferred method of treatment has been emphasized (p. 39). The need for patient-focused treatment preferences has also been the hallmark of recent IOM Quality of Care Standards (IOM, 2011). The IOM has cited in studies that utilizing patient focused treatment preferences improved patient outcomes, as well as acceptance and satisfaction with health care treatment (2011). The use of patient treatment preferences in health care has served as a significant advancement towards the overall improvement of the U.S. health care system.

Treatment preferences for health care have focused on specific disorders and how clinicians work with patients to arrive at treatment decisions. Montgomery and Fahey (2001) set the stage for the understanding of treatment preferences and the need for patients to have decision-making status for their medical treatments. By reviewing the literature on the health
outcomes and preferred treatment of patients for several different illnesses, Montgomery and Fahey (2001) showed, in a systematic literature review of the most recent studies at that time, patients with a decision-making hand in their treatment who were provided with their preferred treatment modality showed higher health related outcomes. Say and Thomson (2003) furthered this discussion in medical centers by a systematic literature review of the improvement of quality care, patient satisfaction and health outcomes when patient’s treatment preferences were utilized even above shared decision making practices. Treatment preferences were considered as important throughout the lifespan of patients from parental decisions about infant care to end-of-life care for elderly (Coppola, Ditto, Danks, & Smucker, 2001). Therefore, assessing treatment preferences in persons of Mexican heritage and offering those most desired by the population would serve to improve the quality of health care for this group.

**Treatment Preferences in Mental Health**

The first study identified that focused on treatment preferences for persons of Mexican heritage was Barrera’s (1978) systematic review of the literature in 1978. He reported that subjects preferred individual or group counseling rather than medications for mental health treatment. He also noted that a percentage of persons of Mexican heritage utilize MTM for treatment for mental illness, although this appeared to be declining with increasing acculturation. He also noted cultural, language, and socio-economic factors involved in those that preferred individual or group counseling over medication, suggesting higher socio-economic level subjects were more likely to identify need for mental health services and more likely to utilize available services including medication (1978). These factors continue to play an important role in treatment seeking and preferences for persons of Mexican heritage. Barrera’s study showed potential flaws in its results, as issues of discrimination, dismissiveness of cultural differences,
and societal trends at this time of its publication could have affected the reported results of the study. More recently, Nadeem, Lang, and Miranda (2008) surveyed 1893 immigrant and U.S.-born women regarding their treatment preference for mental health. Persons of Latino heritage preferred individual or group counseling to the use of medication for mental health issues. Immigrant persons of Latino heritage were more likely to use traditional or faith healing methods than U.S.-born persons of Latino heritage. This study was limited, as it did not separate persons of Mexican heritage from the general Latino population for its subjects.

Keyes et al. (2012) completed a national face-to-face survey on Latino mental health treatment preferences, which did separate country of origin. Results from this study showed of the 6359 Latinos surveyed, those of Mexican heritage were less likely to seek treatment than other Latino groups. Latino groups, including those of Mexican heritage, were more likely to prefer individual therapy rather than medications, with stigma, distrust of the medical health care system, and fear of discrimination posited as factors related to decreased desire for mental health treatment. Integrative services were not assessed in this study.

Vega, Kolody, and Aguilar-Gaxiola (2001) studied treatment preferences and help-seeking for 507 Mexican Americans in California. U.S.-born subjects of Mexican heritage were more likely to seek mental health treatment than subjects born in Mexico. For those born in Mexico, 13% sought treatment in general medical centers, 4% sought treatment in mental health centers, and 5% sought MTM services. The types of MTM services utilized included curanderos, sobradors (a type of physical therapist), folk healers, spiritualists, psychics, and herbalists. Of the subjects born in the US, 25% sought treatment from general medical centers, 13% from mental health centers, and only 3.5% from MTM (2001). It was noted that over 80% of subjects born in Mexico reported no notable treatment for their mental health problems through medical, mental
health, or MTM means. Both US- and Mexico-born subjects preferred treatment in primary care over psychiatric care (2001). These studies have not been replicated to address the changes in the Mexican immigrant community along the US-Mexico border over the past decade, or to address potential issues of bias or stigma that may have led to subjects minimizing their use of traditional methods despite acculturation. With a more culturally sensitive focus in one-to-one interviews, participants were expected to be more forthcoming in their use of traditional methods and their acknowledgement of issues related to mental health and illness.

**Treatment Preferences for Depression**

Treatment preference studies in mental health research generally focus on particular illnesses and the findings of patient preferences. For mental health illnesses, individual disorders have been the focus of treatment preference studies in the past ten years. Preferences for treatment of depression have the largest number of research studies documenting preferred methods of care.

As of 2000, Dwight-Johnson, Sherbourne, Liao, and Wells found that, of the 981 subjects studied, 83% of patients surveyed would seek professional help for their depression, with 67% of persons of Mexican descent preferring counseling rather than medication for treatment of their depression symptoms. Interestingly, rates of those actually obtaining treatment for depression was noted to be 47%, showing the continued disparity in those actual receiving treatment services. Those preferring treatment for depression were more likely to be of higher socio-economic status than those who preferred no treatment. Dwight-Johnson et al. (2000) did not address integrative types of treatment or MTM. In 2004, Dwight-Johnson, Lagomasino, Aisenberg, and Hay looked at Latino treatment preferences in subjects with depression. Ninety-three percent of subjects reported Mexican heritage. Forty-two subjects diagnosed with some
level of depression preferred the combination of counseling and medication to either treatment alone, and there were no differences noted in subjects preferences for receiving treatment at a mental health center or primary care clinic. Dwight-Johnson Lagomasino, Hay, et al. (2010) utilized a larger subject pool of three hundred thirty nine subjects for their 2010 study, which continued to show subjects preferred counseling or counseling with medication over medication alone. Treatment at a primary care center was also preferred over treatment at a mental health center. Again, Dwight-Johnson Lagomasino, Hay, et al. (2010) did not address complementary forms of treatment or compare findings between nationalities, although they reported 44% of subjects were of Mexican heritage.

Givens, Houston, Van Voorhees, Ford, and Cooper (2007) polled 3,203 Hispanics in their national Internet survey. Results showed Hispanics were more likely to prefer counseling (46%) to medications (31%), with 22% of subjects reporting no preference in treatment modalities for their depression symptoms. Hispanics (61%) were less likely than Anglos (75%) to believe in the effectiveness of medication, but more likely to believe medications for depression were addictive (45% vs. 25%). Hispanics were more likely than Anglos to believe that prayer can heal depression (51% vs. 40%), and more likely to prefer counseling services for depression (48% vs. 30%). This study did not mention other treatment options or delineate between nationalities of Hispanics. This study was limited in the likelihood of significant acculturation needed by those of Latino heritage to utilize the Internet for subject participation.

Fernandez, Garcia, Franks, Jerant, Bell, and Kravitz (2011) interviewed 139 Hispanic subjects by phone in regard to their treatment preferences for depression. Spanish-speaking Hispanics had a lower preference to medication and higher preference for counseling and family/social support than English-speaking Hispanics or non-Hispanic Anglos in the study.
Again, no distinctions between Mexican and other Hispanic ethnicities were made. Additionally, treatment preferences for those along the US-Mexico border were not addressed in these studies. These studies were completed by questionnaires or Internet surveys, which did not take into account the varying types of treatment services available or accessible through allopathic, integrative, or MTM care. One-to-one interview increases the potential for participants to feel trust and rapport with the interviewer in finding a confidant, and report more valid responses. Williams and Volberg (2009) found increased validity in reporting when interviews on sensitive subjects were done in face-to-face formats, rather than telephone or survey. Face-to-face interview may encourage more extended responses to treatment preference issues than questionnaires or surveys, which may more leading in nature and offer more limited responses (Schwartz, 2000). Furthermore, survey responses may have been affected by the educational status of the participants, with responses possibly skewed related to the participants’ knowledge of English. This language deficit may affect reporting on written questionnaires.

**Treatment Preferences in Post-Traumatic Stress Disorder (PTSD)**

One study by Eisenman et al. (2008) attempted to outline Latino patient’s treatment preferences for PSTD. Sixty Latino (only 5% identified as Mexican) adults in New York completed semi-structured interviews voicing their choices for services to address their diagnosed PTSD. Eighty percent of subjects reported they wanted some type of treatment. Over 90% of subjects also preferred to receive mental health services from their primary care center rather than a designated mental health center. Sixty-six percent of subjects reported they would be willing to accept counseling or some form of talk therapy from a professional. Two percent reported they wanted some type of help but would rely on their physician’s recommendation for what help they should receive. Only 1% of subjects accepted the possibility of medication for
help for their PTSD. What is noted in the above treatment preference studies is the notable effect of stigma in reporting or presenting for allopathic mental health treatment and how this affects those that ultimately seek help for mental health issues or illness. An unanswered question is whether integrative or MTM may be a more acceptable form of treatment for persons of Mexican heritage because of their holistic assumption that physical and mental health are not considered separate, therefore making it easier and less problematic for those considering mental health treatment.

**Integrative Medicine**

The National Center for Complementary and Alternative Medicine (2011a) defines integrative medicine (IM) as “a group of diverse medical healthcare systems, practices, and products that are not presently considered to be part of conventional medicine.” Integrative medicine practices are grouped into four categories: natural products [herbals, vitamins, supplements], mind-body medicine [meditation, yoga, acupuncture], body-based practices [massage, spinal manipulation], and other IM practices [reiki, traditional healers, whole medical systems] (2011a). The National Center for Complementary and Alternative Medicine has completed numerous studies outlining the extent of IM use in the United States. Barnes, Bloom, and Nahin (2008), in the 2007 National Health Interview Survey, reported 38% of U.S. adults use CAM practices, while others reported CAM use in adults as high as 60% (Neiberg et al., 2011; Nguyen, Davis, Kaptchuk, & Phillips, 2011; Tindle, Davis, Phillips, & Eisenberg, 2005). It was noted that 41% of adults utilized two IM practices in a 12-month period (Tindle et al., 2005). Approximately 5-10% of adults used IM therapies from three or more categories (Neiberg et al., 2011). In addition, 50% of U.S. parents used at least one IM practice for their children (Kemper, Vohra, & Walls, 2008).
U.S. citizens spent 34 billion dollars out-of-pocket on IM practices in 2007 (Nahin, Barnes, Stussman, & Bloom, 2009). Forty-three percent of those costs were spent on natural products; 35% of the costs were spent for IM practitioners, 12% for mind-body classes, 9% on homeopathic medicine, and 1% on relaxation techniques (2009). This shows the significant number of U.S. citizens utilizing the various IM techniques that are available today (Neiberg et al., 2011; Nguyen et al., 2011).

**Difference in Allopathic and Integrative Medicine**

Traditional or allopathic medicine has long held the view that illnesses and bodily symptoms are the focus of treatment and the primary method of treatment. Allopathy is “a system of medical practice that aims to combat disease by use of drugs or surgery producing effects different from those of the disease” (Hassed, 2004). Health in allopathic medicine is understood as the absence of disease or illness, and care is focused on restoring the person from a state of sickness to one of health (Fiel, 2012). Allopathic medicine, therefore, focuses on the biological dysfunction of an individual and its remediation (2012). The curative method of allopathic medicine also is a focus, where finding the reason for illness and treating it results in a cure and restoration of health. The U.S. medical system incorporated allopathic medical principles into its teachings and practice in the late 1800s after the development of the germ theory of disease (Micozzi, 1995). The understanding of disease as transmitted by organisms, furthered biological explanations of health and illness, and led to the understanding of biological process as the cause of disease. Cure and treatment in allopathic medicine follows the biomedical model, which focuses on physical and biochemical processes in the body to determine health or disease (Hassed, 2004). In the biomedical/allopathic model, care provided is based on pharmacological medications, surgery, radiation, or chemotherapies the developed modes of
treatment. This type of care is reactive in nature, such that when a person experiences symptoms, care is provided to alleviate them (Fiel, 2012). Treatment, which includes drugs, surgery, or radiation, is provided without specific concerns about the whole person, as the focus of treatment is on symptoms displayed by the person, not the root cause or the person (Piercey, 2009). Allopathic medicine only addresses the biomedical aspects of the person, the body, organs, and disease, and even treats issues of the mind or spirit utilizing the biomedical approach (MacIntosh, 2011).

Integrative medicine focuses on the systems approach to health and healing (Fiel, 2012). Integrative medicine is considered holistic in nature as it takes into account the whole person, body, mind, and spirit, in attempting to establish equilibrium within the body, rather than finding a curative state (2012). Health in IM is considered equilibrium between systems of the body, with complete physical, mental, and social wellbeing as the overarching goal of health (2012). The maintenance of health and prevention of illness is the focus of care for IM as the proactive maintenance of equilibrium (Piercey, 2009). Addressing the underlying cause of illness, rather than symptom management of a disease, is the focus of alternative medicine (Fiel, 2012). Allopathic medicine sees illness as solely of biomedical derivation, while underlying causes of illness in IM is based on body, mind, spirit, and the holistic balance of these areas in an individual (Piercey, 2009). In this way, individualization is a key feature in diagnosis using alternative medicine, with each individual considered whole, and the cause of illness disturbing the balance of holism for the individual. Treatments in IM focus on addressing causes of illness and how symptoms affect the mind, body, and spirit (2009). This focuses on maintaining health and the prevention of dysfunction.
Research studies consistently show a continued disparity in the access, utilization, and satisfaction of allopathic health care services by persons of Mexican heritage. Satcher’s 1998 Surgeon General Report led the national discussion of health care disparities for minorities including those of Mexican heritage (U.S. Department of Health and Human Services, 1999). Further studies showed the underutilization of health care services by Latinos, including those of Mexican heritage, with a national study by the Centers for Disease Control [CDC] (2004) that posited that Hispanics experience a disproportionate amount of disease, injury, death, and disability when compared to non-Hispanic Anglos. Hispanics experienced increased incidences of chronic disease, and trailed in the leading indicators of good health based on the national objectives of 2010 (2004). Bastida, Brown, and Pagán (2008) noted continued decreased utilization of health care services along the border when a study of 1048 Mexican subjects responded to written questionnaires reporting issues with health insurance coverage, access to care in the community, and preferences for use of medical care in Mexico as factors related to the decreased utilization of services in the US. Bustamante, Fang, Rizzo, and Ortega (2009) also noted substantial differences in the health care utilization rates of Mexican and non-Mexican Hispanic subjects. These disparities in health care utilization persisted despite controlling for the variable of age, poverty, and health insurance coverage.

Though disparities exist for persons of Mexican heritage versus Anglo subjects, the chasm of health care access, utilization, and satisfaction is even greater for those of Mexican heritage living along the US-Mexico border (Satcher & Higginbotham, 2010). Additional disparities, including lack of access to care, language barriers, and insurance issues, further limited care to those persons of Mexican heritage living along the US-Mexico border (Bastida et al., 2008). Hunter et al. (2003), in face to face interviews of 500 subjects living along the border,
found that those of Mexican heritage were the least likely Hispanic minority to have insurance, visit physicians regularly, or have preventive examinations. Later studies continue to highlight the health care disparities between other minorities, Anglos, and persons of Mexican heritage living along the US-Mexico border (Ramirez et al., 2011; Rodríguez-Saldaña, 2005).

Vega, Rodriguez, and Gruskin (2009) summarized the inequalities that remain salient issues for persons of Mexican heritage as access to patient-centered, culturally sensitive, and affordable health care in the preferred language of the patient. Given this context, the chasm in seeking treatment and treatment preferences becomes of even greater importance when addressing the health care disparities of persons of Mexican heritage.

With notable disparity in the use of allopathic medicine among persons of Mexican heritage, a review of the use of other forms of medical care proves helpful in developing an understanding of the use of medical services for this population. A number of U.S. surveys have been completed to estimate the prevalence of IM use by persons of Mexican heritage. One of the first studies using a national survey was completed by NIH in 2002 (Graham et al., 2005). They reported 27% of Hispanic utilized some form of IM practice during 2002. This is an equivalent finding to the later study from the National Center for Health Statistics, which reported Mexican born subjects (19%) were slightly less likely than U.S.-born persons of Mexican heritage (27%) to have utilized a CAM practice in 2007 (Barnes, Bloom, & Nahin, 2008). Ortiz, Shields, Clauson, and Clay (2007) completed a systematic literature review of 42 articles focusing on IM use in persons of Hispanic heritage. Rates of CAM use in the articles reviewed varied from 50-90% lifetime use, with the majority of subjects utilizing herbal medicines or remedies and IM providers (including herbalists, sobradores, and other MTM providers).
Kronenberg, Cushman, Wade, Kalmuss, and Chao (2006) surveyed 1057 persons of Mexican heritage and found over 37% reported having used at least one type of IM practice. The use of herbal medicines and spirituality/prayer were both used by 18% of subjects, and cultural based healers (e.g., MTM) were reportedly used by 4% of those surveyed. Similar findings were reported by Mackenzie, Taylor, Bloom, Hufford, and Johnson (2003), who reported use of IM by 43% of 581 subjects, with herbal medicine used by 23%, home remedies (herbals; botanicas in Spanish) by 32%, and MTM healers by 3% of subjects. Ransford, Carrillo, and Rivera (2010) interviewed 100 Mexican subjects by phone and found that over 50% used herbals and botanicas as a first treatment prior to seeking allopathic care, with 25% percent using herbals exclusively for medical care. Thirty percent of their subjects reported use of a healer or curandero for care services, with 50% reporting they would use a healer if they had no health insurance (2010).

Results of use of CAM along the US-Mexico border show increased usage of IM services. Stuart and Rodriguez (2008) surveyed 547 subjects of Mexican heritage living in El Paso, Texas, on the Texas/Mexico border. They found 77% had used some form of IM practice during their lifetime. Forty-eight percent of subjects reporting they had an IM provider, 59% reported using an herbal product or home remedy, and 76% reporting use of some nutritional or commercial IM product. Of IM providers utilized, 19% reported use of a massage therapist or sobrador, 12% reported use of an herbalist, 11% chiropractor, and 7% had used an acupuncturist (2008). Martinez (2009) corroborated the increased use of IM along the U.S. border in her study assessing the use of IM by persons of Mexican heritage living in Texas. Twenty-two percent of all subjects reported use of an IM practice in the past 12 months, with a 58% lifetime reported use of IM. Among IM modalities, herbal medicine, home remedies, and MTM healers were the top three IM practices utilized. Clearly, there is increased utilization of IM for the health care of
persons of Mexican heritage. There is not a significant understanding of the use of integrative treatments for mental health issues or illness in this population or of issues affecting the choice and preferences for integrative mental health treatments.

**Integrative Medicine Use for Mental Health**

An early review of IM therapies in the use of mental health disorders for a sample of U.S. citizens was completed in 2000. Unützer et al. (2000) reviewed data from a 9,600-subject telephone survey to assess the use of IM therapies for mental health issues and illness. Sixteen percent of the respondents reported the use of IM therapies. Of those persons reporting the use of IM therapies for treatment, 21% met criteria for a mental health disorder based on their responses to a structured diagnostic interview. Subjects with panic disorder and major depression were more likely to utilize IM services than those reporting mania, psychosis or generalized anxiety. The researchers did not elicit the specific IM therapies utilized by subjects in this study.

Subsequent studies assessed the types of IM practices utilized mostly by persons with depression or anxiety disorders. Kessler et al. (2001) reported that of the 2000 subjects with either depression or anxiety attacks surveyed nationally, 34% of anxious and 30% of depressed subjects utilized mind-body integrative techniques (relaxation, imagery, hypnosis or biofeedback) as part of their treatment. Nine percent of depressed and eight percent of anxious subjects reported use of oral integrative techniques (herbal medicine, homeopathy, naturopathy). Seven percent of anxious and five percent of depressed subjects used physical IM therapies (massage, chiropractics, acupuncture, yoga). Twenty-seven percent of depressed and 23% of anxious subjects reported use of other integrative therapies (spiritual healing, energy healing, aromatherapy). Ninety percent of these subjects also reported concurrent use of allopathic medicine through primary care or psychiatrist services, and reported satisfaction with the
utilization of IM therapies in their mental health care.

Grzywacz et al. (2006) noted similar patterns of use in subjects over 65 in a survey of 6000 subjects nationwide. Twenty percent of these subjects reported IM therapies use for their anxiety or depression symptoms, with use of spiritual practices, relaxation techniques, natural herbal supplements the predominant choices for anxiety and depression.

Inpatient psychiatric subjects have also utilized IM therapies with positive responses reported. Elkins, Rajab, and Marcus (2005) interviewed 82 psychiatric inpatients and reported their most commonly reported IM therapies included herbal medicines (44%), mind-body therapies (30%), spiritual healing methods (30%), and physical therapies (21%). These studies focused specifically on the use of IM therapies for anxiety and depression symptoms, but reported consistent use of these practices with notable positive results by those utilizing the therapies. Patients’ concurrent use of IM therapies alongside allopathic treatments is a consistent finding.

**Mexican Traditional Medicine**

Mexican Traditional Medicine, as many indigenous healing systems, has at its basis the principle of physical, emotional, and psychic balance that manifest in the body. The highest level of MTM practitioner is the curandero. The curandero’s overall goal is to assist in the recovery of the participant by restoring balance and recovering order, thereby preserving the participant, family, community, and culture. Curandero (male) means curer and healer, from the verb *curar*, to heal, and cura, priest or happy laugh (Torres & Sawyer, 2005). The curandera (female), with extensive knowledge of the treatment of mental and physical ailments, uses herbs and plants, prayers, chants, and rituals for the purpose of re-balancing the physical, emotional, and spiritual realms. The interaction with the curandera begins with the platicas, or participant-practitioner
consultation (2005). The MTM practitioner’s focus of treatment in the US is with Mexican-American participants.

Initial work on MTM curandero interactions in mental health was completed by Kiev in the 1960s as Mexican immigration began its climb towards present day numbers (1968). More recently, six MTM curanderos discussed their use of remedies for alcoholism and their role in the cleansing process as an integral part of the therapeutic interaction (Ortiz et al., 2007). Hence, MTM curandero focus has only been evident for alcoholism, and no studies have demonstrated MTM curandero treatment of non-substance abuse mental health ailments.

The practitioner’s use of MTM, including mental health remedies is intended to balance mind, body, and spirit, a focus that has shown positive responses for general health ailments. Zacharias (2006) followed participants after MTM treatment to document the health status, mechanisms of change and effectiveness of MTM services from the participant’s view, and noted improvements. Hoogasian and Lijtamaer (2010) most recently discussed incorporating certain curanderismo techniques into counseling sessions with Mexican-Americans. Del Castillo (1999) noted positive response in increased attendance and satisfaction with the incorporation of MTM health services for Mexican Americans in western Colorado. Similarly, Loera, Muñoz, Nott, and Sandefur (2009) discussed the potential implications of incorporating MTM practices in mental health centers, but without a thorough review of what practices would be utilized and/or their expected outcomes. The most recent study of the incorporation of MTM practitioners and health care was a study by Clark, Bunik, and Johnson (2010). This study used MTM practitioners in the community to provide information regarding weight control and healthy eating habits for children in the area. The study found that MTM practitioners were well versed in health care dialogues and were helpful in bringing up information regarding weight control, diet, and healthy
The continued collaboration of MTM practitioners with the medical community was suggested as a way to incorporate Western medical practice with traditional health modalities.

**Mexican Use of Mental Health Services**

Persons of Mexican heritage experience similarly reduced levels of access, service provision, and satisfaction in mental health services as they do in general health care services. Issues of access, language barriers, stigma, and health insurance coverage have been posited as reasons for the consistently lower utilization rates of persons of Mexican heritage (Alegria, Canino, et al., 2008; Sentell, Shumway, & Snowden, 2007; Vega et al., 2010). Vega, Kolody, Aguilar-Gaxiola, and Catalano (1999) and Vega, Kolody, and Aguilar-Gaxiola (2001) were among the first to outline the gap between those Mexicans experiencing mental health disorders and those utilizing either primary care or mental health services for treatment. The initial study by Vega et al. (1999) showed that, of the 3012 subjects of Mexican heritage interviewed by telephone, only 28% sought treatment of any type for their diagnosed mental health disorder. Nine percent of subjects sought mental health services while 18.4% sought treatment from primary care providers. Vega et al.’s (2001) second study sought to examine differences between U.S.-born and Mexican-born subjects. In their study, 507 subjects were interviewed by phone as to their utilization of mental health services for their diagnosed mental disorders. Only 25% of those persons diagnosed with a mental disorder obtained any type of treatment for their mental disorder, with 13% of those persons of Mexican heritage born in the US obtaining treatment, and 4% of Mexican-born subjects obtaining treatment from a mental health provider. Of those 25% seeking treatment, 13% of Mexican-born subjects, and 25% of U.S.-born subjects were seen by primary care providers. Despite the increased utilization of mental health services for those
persons of Mexican heritage that were born in the US, the concern that 75% of those diagnosed with a mental health disorder sought no treatment highlighted the disparity in mental health service utilization for those of Mexican heritage and the need for further research to address this vulnerability.

Alegría et al. (2002) showed that Mexicans were the least likely of all minorities to utilize mental health services in their study of 8000 subjects. Of those persons reporting mental health illness, 5.9% of persons of Mexican heritage received any type of treatment versus 7.2% of African Americans and 11.8% of Anglos. Subsequent studies by Alegría, Canino, et al. (2008) continued to show that Mexicans were the least likely of minorities to receive mental health treatment (Alegría, Chatterji, et al., 2008; Harris, Edlund, & Larson, 2005). In self-report surveys of over 15,000 subjects, Mexican-Americans were the least likely minority group to receive mental health services, with Puerto Ricans and Anglos the most likely to receive services (González et al., 2010). Issues of access to care, care in the preferred language of the patient, stigma regarding mental health, and potential treatment preferences serve as ongoing factors in the limited utilization of mental health services. Addressing this issue by research to identify potential treatment preferences becomes of paramount importance to address this ongoing disparity.

**Health Care at the US-Mexico Border**

Though a knowledge base exists of the health inequities at the US-Mexico border, it has been only in the last twenty years that researchers have attempted to quantify this inequity. Ruiz-Beltran and Kamau (2001) summarized the research to date on healthcare for residents living along the US-Mexico border. At that time, given the young age of the average population along the border (26.2 years old), primary care prevention needs were reported to be the most
concerning need for the population along the border. Gaps in services were reported along the border as early as the 1950s in primary care, with increasing gaps in hospital bed space and specialty medical services since the 1990s. Ruiz-Beltran and Kamau (2001) reported collateral effects on the documented Mexican population along the border after the 1998 passage of the Health Care Reform Act, preventing health care services for undocumented residents. A subsequent delay in health seeking behaviors was noted in the documented Mexican population during that time as stigma, worries about immigration status, and lack of access to care led to delays and poorer health outcomes in those seeking services. Parchman and Byrd (2001) also reported that health insurance was a significant factor in treatment-seeking at that time, with those without health insurance delaying needed healthcare services.

More recently, Bastida et al. (2008) reported continued difficulties and disparities in the access and use of health care along the US-Mexico border. In this research, aspects in care, including health insurance coverage, socioeconomic factors, the confluence of two health care systems, and contextual factors were reviewed to determine continued health care inequities along the Texas border. The high level of uninsured persons remained a pivotal influence in access and utilization of health care services, with delays in accessing care or traveling to Mexico only for acute or emergency care necessitated by financial reasons. Primary care in the US and Mexico continued to lag behind health care utilization in other areas of both countries. When surveying 931 residents along the US-Texas border, Bastida et al. (2008) found the most likely indicator of travel to Mexico for health care was lack of insurance, followed by preference for Mexican health care systems. Participants with incomes less that $7000 per year were more likely to utilize services in Mexico, while participants earning over $30,000 per year were more likely to obtain health care in the US, regardless of health insurance status. This continued to
serve as a barrier for the uninsured, as the need for cash payments for healthcare in Mexico was a barrier for the uninsured residents of the US. Proximity to the US-Mexico border was also seen to be a deterrent for U.S. health care providers to relocate there to set-up health care practices, thereby also limiting the pool of health care providers at the US-Mexico border.

**Mexican Use of Cross-Border Health Care Services**

Although not utilizing health or mental health care services in the US, many persons of Mexican heritage return to Mexico for health care services. Casner and Guerra, in 1992, reported the availability of prescription medications in Mexico without the need of a physician’s prescription. U.S. residents traveled to Mexico to purchase medication without physician’s prescriptions at a significantly reduced cost than in the US. Eighty persons of Mexican heritage from El Paso, TX completed written interviews and reported 81% had obtained medications from Mexico at some time in their lives. Macias and Morales (2001) surveyed 70 persons of Mexican heritage in regard to their cross-border health care. From this Los Angeles sample, 44% utilized health care services in Mexico during their lives. Eighty percent of those that used cross-border services had no health insurance, with 70% of subjects reporting the lower cost of health care as the primary reason for seeking cross-border services. This was similar to Landeck and Garza’s (2008) written survey of 1100 persons of Mexican heritage in Laredo, Texas; 42% of those subjects reported receiving cross-border medical services.

Wallace, Mende-Luck, and Casteñeda (2009) completed the first large scale analysis of California subjects who utilized cross-border health services. Using results from the California Health Interview Written Survey, Wallace et al. (2009) estimated 952,000 California adults utilized medical, dental, or prescription services from Mexico during the previous twelve months, with 488,000 of those being persons of Mexican heritage. Those with no insurance,
more recent immigration to the US, limited English, and no primary health care in the US were most likely to seek services in Mexico. Rivera, Ortiz, and Cardenas (2009) found similar levels of cross-border health migration in El Paso. After completing 1000 face-to-face interviews, over 34% of subjects reported crossing the border for medical services in Mexico, the majority of those resulting in medication purchases. Nine percent of subjects sought dental care in Mexico, with 5% seeking hospitalization and extended care services in Mexico.

Bergmark, Barr, and Garcia (2010) showed proximity to the border was not necessarily a factor in seeking cross-border services in their interviews with 35 persons of Mexican heritage living in northern California, outside the US-Mexico border area. Forty-six percent of those subjects had traveled to Mexico for health care services despite the distance from the border. These subjects reported difficulty accessing care in the US, poor perception of care in the US, and preference for care in Mexico as motivators for cross-border help-seeking.

In the most recent study identified, Su, Richardson, Wen, and Pagán (2011) completed population-based telephone interviews with 1405 persons of Mexican heritage living along the Texas border. Forty-nine percent of those surveyed had purchased medications in Mexico, 41% sought dental care services, 37.3% received physician care, and 7% received inpatient care. Predictors of cross-border health care utilization were lack of health insurance, dissatisfaction with U.S. health care, and poor self-perceived health status. Su and Wang (2012) further reported that acculturation likely played a factor in cross-border health migration, as second-generation persons of Mexican heritage were less likely to seek Mexican health care services than first-generation persons, but no more likely to seek treatment in the US for health care issues. It is clear from the few studies completed that a significant number of persons of Mexican heritage prefer care in their native country. Factors motivating cross-border migration for health care and
preference for these services have not been fully delineated and further study to identify these factors is needed.

**Mexicans’ Perceptions of Health and Illness**

Cultural values about health and illness regulate behaviors and interactions of persons of Mexican heritage and can provide insight into issues that may affect treatment preferences (Ortiz et al., 2007). These values are particularly important when addressing issues of health and illness. Health can be seen as the person’s state of being resulting from luck, good behavior, or a gift from God (Garcia & Saewyc, 2007). In general, health is seen holistically, with the combination of biological, spiritual, mental, social, and interpersonally derived (Ortiz et al., 2007; Spector, 2004). In this way, the definition of health for those of Mexican heritage is quite similar to the WHO (2003) definition of health listed earlier, encompassing the physical, emotional, and spiritual in balance.

In the theory of health and illness for persons of Mexican heritage, illness results from an imbalance of two humors - hot and cold (Ortiz et al., 2007). The imbalance can be the result of physical or emotional changes, interactions with others, changes in body temperature, or negative interactions with spirits (Tafur, Crowe, & Torres, 2009). Specific illnesses are considered as having hot or cold derivations, with remedies serving to balance the system. For example, cold diseases such as arthritis are treated with remedies, foods, and herbs that are considered hot (2009). The seeking of equilibrium or balance in the system is brought about by the use of herbs, remedies, chants, prayers, and other healing treatments (Ortiz et al., 2007). This balance serves as part of the cultural value system of persons of Mexican heritage, and the motivation to maintain this balance is part of the goal of life and life achievement (Amerson, 2008).
A number of cultural values are characteristic of persons of Mexican heritage in regard to health and health concerns. Familiarismo, or family, concerns the importance of the entire family as central to the health and support of individual persons of Mexican heritage (Robles, 2010). The family is considered the primary social unit; with the individual second (Gallo, Penedo, Espinosa de los Monteros, & Arguelles, 2009). Nuclear and extended family are initially sought for information, support, and advice regarding a health topic or concern, and this advice is utilized prior to seeking other provider care (Estrada, 2008). This loyalty to the extended family has a supportive role in the encouragement, support, and assistance provided when someone is ill or making health care decisions (Caballero, 2011). Medical issues and illness are considered a family matter and all family members are involved with health-based decisions (Kouame, 2010). This may render individual decision-making challenging in health care, as treatment options, medication, and other therapeutic techniques require approval of most family members (Caballero, 2011). Additionally, factors may encourage family members to keep issues of health within the family and may negatively impact help-seeking behavior outside the family (Barrera, 2008).

Gender in the families of those of Mexican heritage also plays a role in health care. Machismo/marianismo are still roles portrayed in many families of Mexican heritage. Machismo refers to the male role of dominance, strength, rule, and decision-making for issues that occur within the family (Gallo et al., 2009). The value of machismo may have a positive influence on men’s health, as good health is necessary to be a good father and husband, so overall good health is encouraged (Sobralske, 2006). However, Robles (2010) notes that reliance on the macho role may delay help-seeking for illness in males of Mexican heritage. Men may take health risks or endure pain as a sign of machismo rather than seek medical assistance (Caballero, 2011).
Acculturation and the changing role of finances in families has reportedly lessened but not eliminated male dominance roles in Mexican families (Robles, 2010). Marianismo refers to the ‘virgin mother’ or maternal role that women of families of Mexican heritage may portray (2010). The female is noted to embody submissiveness, and is considered the central role in the family. Mothers or grandmothers are thought to be in charge of the overall health of the family, and are among those initially consulted in the event of health change or illness (Kouame, 2010). In addition, empowering women in regard to their health and health-promoting behaviors positively impacts the family’s health for those of Mexican heritage (Caballero, 2011).

Fatalismo is the belief that persons cannot alter their destinies, lives, or health, as these are predetermined and foregone conclusions of God’s Will or Fate (Robles, 2010). In this belief, illness is caused by God, evil, or fate, such that the individual has little control of the course or outcome. This is considered an external locus of control, with the individual having little to do with the trajectory of illness or its outcome (Caballero, 2011). This fatalistic view offers the person minimal responsibility in the course of illness and decreases the ability of the person to assist in self-management of illness (Gallo et al., 2009). This thinking may result in a person delaying treatment seeking or not adhering to treatment and may hinder preventive health behaviors (Robles, 2010).

Familiarismo is reported as the “tendency to place the extended family at the center of one’s experience” (Rodriguez, 2002, p. 22). The term means that the family, not the individual, is the focus of one’s life, and sacrifices are made on the part of the individual to further the needs and ideals of the family. Dedication and loyalty to the family unit and its preservation are the main determinants in decision-making for financial, occupational, and health care decisions (Ginorio, Gutierrez, Cauce, & Acosta, 1995).
Present orientation is noted as the tendency to give priority to current activities without thought to planning ahead (Robles, 2010). Persons of Mexican heritage may focus on activities and planning solely for the present and may minimize the importance of past or future activities, or the impact of these activities on potential health outcomes. In this way, a person may be late for appointments or neglect preventive care activities due to a focus on present activities and interactions, rather than rudeness or lack of concern (Caballero, 2011). These cultural values in regards to health for persons of Mexican heritage may affect their overall health care experience, play a factor in their perception of health in allopathic medicine settings, and may influence their treatment preferences for health and mental health care.

**Perceptions of Mental Health and Illness**

An examination of the literature reveals there is limited information on the perceptions of mental health in the Mexican heritage community. An initial study was found by Karno and Edgerton in 1969. They found that, of the 444 persons interviewed, the majority reported that mental illness was better identified as a “nervous or emotional condition”, and were reluctant to use the terminology ‘mentally ill’ (p. 237). Those subjects of Mexican heritage were more likely to recommend that someone with an emotional condition see a physician, rather than a mental health professional (1969). They posited a number of factors accounting for the underrepresentation of Mexican-Americans in psychiatric services including language issues, stigma, and preference for family practice provider, and access to mental health facilities (1969). The focus of literature in this area during the following twenty years appears to be in the areas of mental health services, utilization, and barriers to access.

Since 2000, several authors have again sought to assess mental health perceptions in persons of Mexican heritage. Garcia and Saewyc (2007) completed ethnographic interviews of
recently immigrated adolescents who reported they were able to identify issues in mental health and illness. Their findings suggested adolescents found social support and activity as a promotion strategy for mental health, and interactions with parents, family, and school officials were supportive when they felt mentally ill. Their perceptions of illness were based on changes in eating habits, energy levels, and physical issues, more so than cognitive changes that signified mental illness. Researchers suggested that for adolescents, noticing changing in physical functioning may be clues to mental health issues.

Garcia and Lindgren (2009) attempted to identify mental health issues in 53 Mexican adolescents. They reported adolescents felt mental illness was precipitated by social issues—discrimination, immigration, and family disconnection, with social support and community attachments as supportive of mental health. Interventions collaborating with parents, school, and adolescents were suggested as supportive of healthy emotional development for adolescents.

Jang, Chiriboga, Herrera, Martinez Tyson, and Schonfeld (2011) interviewed 297 Hispanic elders regarding their beliefs and perceptions of depression and mental health. These subjects identified more negative perceptions of mental illness with advancing age and reported that depression was thought to be a normal part of aging. Depression was also seen as a sign of personal weakness as well as and the need for family support and communication rather than medication for treatment. Older Hispanics felt more vulnerable to mental health illness as they aged and when they had less family support nearby.

Torres (2007) surveyed 40 Latinos in Texas and found that most understood the need for mental health, were aware of mental health services in their area, and felt counseling and family community support was helpful in mental health treatment. Concerns about mental health service access, language availability, and cultural stigma were barriers to seeking treatment for those
respondents. Torres (2007) suggested that based on his findings, subjects were aware of available services, but had concerns about the access and cultural adaptability of these services in their area. Overall, there remains a concern about the types of mental health treatments available for persons of Mexican heritage and whether those services were specifically culturally sensitive to their needs.

**Mass Media and Health Information**

Mass media is considered the collection of methods utilized to reach large audiences through communication (Smith, 2012). Broadcast media includes television and radio; other media include print media—newspapers and magazines, and Internet media. Ninety-nine percent of Americans are estimated to own at least one television, while 88% of Americans watch television daily, with an average of 6 ½ hours of television viewing each day (Nielsen, 2009). Of note is that Hispanics in the US (including those of Mexican heritage) spend 37% less time watching television than the general U.S. population (Razzetti, 2012). Seventy-four percent of Americans listen to radio stations daily, with 93% listening to radio at least one time per week (Resnikoff, 2011). For Hispanics, 95% report listening to radio broadcasts at least one time per week (Razzetti, 2012). Print media is less utilized than broadcast media. Approximately 30% of Americans read a newspaper or magazine daily with 21% of Hispanics reading print media daily (2012). Internet media has higher use than print media. Seventy-eight percent of Americans utilized the Internet in 2011, equivalent to the percentage of Hispanics that utilized the Internet for that same year (Livingston, Minushkin, & Cohn, 2008). These percentages show the ubiquity of mass media in the US and the fairly equivalent usage patterns of Hispanics and the general U.S. population.
The research term health information seeking behavior (HISB) has been developed to encompass the ways persons obtain information related to health, illness, health promotion, and risks to health (Cutilli, 2010). Initial studies showed that, in 2007, 56% of American adults sought health information on mass media sources, an increase from 38% in 2001 (Tu & Cohen, 2008). Thirty-two percent of Americans used the Internet or print media for health information, while 15% found health information through television or radio. Education played the most significant role in health information seeking behavior, with 42% of persons without a high school diploma seeking media health information, 48% with a high school diploma, 60% with some college, 65% with college degree, and 72% with graduate education seeking health information through media sources (2008). Tu repeated the study of Tu and Cohen (2008) in 2011 and noted a surprising decline in consumers seeking health care information through print media sources. Approximately 50% of Americans obtained health care information through all media sources, a decrease from the 56% reported in 2007. Interestingly, the percentage of persons using Internet media for health care remained equivalent, although the percentages for those using print media dropped by 18%. Thirty-three percent of Americans used the Internet for health information sources, while only 18% used print media (a decline from 33% in 2007), and only 10% used television or radio sources (a decline from 15% in 2007). This surge in Internet use for health information was also noted in a study by Manhattan Research Centers (Data Points, 2011).

**Latino Media Use for Health Information**

For Latinos living in the US, mass media also plays an important role as a source of health care information. This article reported the media use of Latinos, an ethnicity term that is frequently used synonymously with Hispanic. According to recent Pew Hispanic research, an
average of 83% of Latinos obtained some information from mass media sources during the year 2008 (Livingston et al., 2008). Over 68% of Latinos received health care information from television, 51% received health care information from print media, 40% obtained health information from radio, and 35% obtained health care information from the Internet. Latino women were more likely than men were to report obtaining health from mass media sources, with 77% of women versus 66% of men reporting obtaining health care information from mass media sources. This study also differentiated for Latinos of differing countries, with 69% of persons of Mexican heritage reporting obtaining health care information from mass media sources. An interesting finding was that foreign-born and less-assimilated individuals demonstrated higher percentages of television and radio use for health information. Twenty-six percent of foreign-born versus 19% of U.S.-born obtained most of the health information from television. Similarly, percentages of use of television and radio were higher for Spanish-dominant Latinos (27% and 42% respectively) than English-dominant Latinos (18% and 35% respectively). For print media, higher education and U.S. nativity were associated with increased use of print media for health information. In print media, 43% obtained health information only in English, 29% obtained both English and Spanish print media health information, and 27% obtained health information in Spanish-only publications. Age, education, and nativity were also strongly associated with increased Internet use for health information.

For Latinos seeking health information from television, 40% obtained that information from Spanish-language television, 32% from a mix of Spanish and English language television, and 28% from only English-language television (Livingston et al., 2008). This mirrored radio use with 47% using only Spanish-language radio, 26% using a mix of Spanish and English, and 27% using English-only radio stations. Women were more likely than men were to obtain their health
information in Spanish (44%-36% for television, 53%-43% for radio). Increasing age was also
correlated with increased Spanish-only media use. For those using the Internet, 58% of health
information was in English, 29% obtaining information in both English and Spanish on the
Internet, and 13% reporting obtaining Spanish language Internet health information. These
findings were much higher than those by Wilkin and Ball-Rokeach (2011) who found in a
telephone survey of 739 persons living in the Los Angeles, CA area that 32% obtained health
care information from Spanish television, 12% from print media, 8% from Spanish radio, and
7% from the Internet. The lower socioeconomic and undocumented status of the sample was
given as potential reasons for lowered media usage (Livingston et al., 2008) [Figure 3].
FIGURE 3. Sources of Health Information.
Impact of Media on Latino Health Behaviors

As a significant number of Latinos seek health information from mass media sources, the impact of this media interaction would prove important to quantify. To date only a few studies have assessed the impact of media on particular health behaviors. In general, 41% of Latinos made decisions regarding treatment for health and illness based on information obtained through mass media (Livingston et al., 2008). This is similar to the findings of Britigan, Murnan, and Rojas-Guyler (2009) who reported 46% of the 51 Latinos surveyed (37% were of Mexican heritage) in Ohio made health care decisions based on information from media sources. Most notably, 66% of Latinos report they have changed their diet and/or exercise patterns based on information obtained from mass media (Livingston et al., 2008). Abejuela, Bazargan-Hejazi, Wolf, Manousogiannakis, and Kuo (2011) surveyed 301 Latinos in Los Angeles, CA with 61% reporting they sought dietary information through mass media sources. Age and gender appear a factor in mediating behavior change; women and younger Latinos were most likely to change their diet and/or exercise patterns after learning of information through mass media sources. Nativity also played a role in health behaviors; 69% of Latino immigrants versus 56% of U.S.-born Latinos made behavioral changes based on information obtained through mass media sources.

Given the prevalence of diabetes in the Latino/Mexican population, current research has mostly focused on the mass media impact on diabetes care and treatment for Latinos. From the Pew Hispanic reports, 76% of Latinos obtained information regarding diabetes treatment from mass media sources (Livingston et al., 2008). Abejuela et al. (2011) reported that 58% of subjects found chronic diabetes management information through mass media. Information included discussions of diabetes care, diagnosis, and treatment on television, radio, and print
media sources, as well as information available by Internet review (Livingston et al., 2008). Unger, Molina, and Baron (2009) used telenovelas for the dissemination of information on diabetes education with notable results.

**Mexican Media Use for Mental Health Information**

There is only minimal information on the media impact of mental health information for Latinos or persons of Mexican heritage. Abejuela et al. (2011) reported that, of the 301 Latino subjects surveyed (37% were of Mexican heritage), 48% sought information to deal with stress, 37% sought information to deal with depression, and 17% sought substance use information through media sources at some point during the years 2006-2007. Interestingly, the term ‘mental health’ was not used in the key items from this study. No further information regarding specific Latino or Mexican heritage use of mass media mental health information was located in the literature, underscoring the need for more information in this area.

Elder, Ayala, Parra-Medina, and Talavera (2009) reported the potential positive use of print, radio, and television media to communicate health care information for Latino populations including those of Mexican heritage. The use of telenovelas and radio story-telling was thought to have the most likely positive impact on health care decision-making for Latinos living along the US-Mexico border (2009). In addition, lay community workers were also thought to be a potential area of impact for health care decision-making for Latinos. Only television and radio media communication had been considered in this publication.

Aguilar-Gaxiola (2012), in printed directives set to outline the Latino mental health goals for California in the coming years, set forth recommendations for areas in which media can be utilized to impact mental health care for persons of Mexican heritage. The directives provided for several differing media opportunities to provide mental health information for Latinos,
including persons of Mexican heritage, with the goals of education regarding mental health, decreasing barriers to care, and decreasing stigma related to mental illness. Television is suggested in the article to play a key role in disseminating mental health information to Latino populations. Novelas and commercials featuring mental health programming are recommended to address issues such as stigma, education on mental illness, and improving access to community services for mental health. Cabassa et al. (2012) developed telenovelas and fotonovelas for Latinos with limited English proficiency. In print media, fotonovelas, media booklets that educate Latinos about mental health issues, illness, and community resources, were suggested as useful for placement in health care centers, grocery stores, and other commercial areas where large percentages of Latinos populate. Radio novelas and interviews were posted for information about personal stories of those with mental illness, to decrease stigma, and to provide question/answer sessions for the general public. The Internet is being used by Latinos for health information, and additional sites in English and Spanish were recommended to provide mental health information. The article noted that research in mass media for Latinos was a critical area to explore as an approach to accessing and reducing mental health disparities.

**Summary**

A number of researchers have made initial attempts since the 1970s to document the relevant health care issues, treatment preferences, and mental health needs of persons of Mexican heritage. The proximity of the US-Mexico border, the history of immigration, and settlement along the border set the background for an understanding of the complexities. Acculturation by persons of Mexican heritage living along the US-Mexican border remains irregular, with continued health disparities, but varying reports of the extent of these health care disparities based on acculturation. Studies of treatment preferences in health and mental health care have
only recently been completed with contradictory results overall. Survey and phone studies have shown increasing reliance on allopathic care, but without accounting for US-Mexico border preferences of subjects or the potential stigma of reporting more traditional health care methods. Culturally sensitive studies have yet to be completed encouraging the full disclosure of health care treatment preferences.

The initial research shows that persons of Mexican heritage may have differing mental health care needs and desires for treatment than the general population. Persons of Mexican heritage utilize both allopathic and IM techniques as part of their general health care, but may be underreporting their use of traditional medicine due to perceived stigma. An understudied but notable method of treatment for persons of Mexican heritage is cross-border health care services. Additionally, the use of MTM is an approach to medical care that may play a notable part in health and mental health care for persons of Mexican heritage, but most current studies have not addressed this area of treatment. Recent studies appear lacking, with notable gaps in the current status of services for mental health care for persons of Mexican heritage. Attempts to address those particular needs have started, but significant information remains to be obtained to address the specific mental health care needs of persons of Mexican heritage. Identifying methods and services particularly amenable to this group will serve to specifically address their needs and to potentially lower the mental health care disparity and vulnerability of persons of Mexican heritage.
CHAPTER III: METHODOLOGY

Chapter III discusses the research design selected for this study, based on the research purpose and aims. Qualitative research is presented, specifically, qualitative description methods. This study used a qualitative description approach to develop a rich description of preferences for mental health treatment in persons of Mexican heritage. Study methods, sample, data collection, and analysis have also been reviewed here. Finally, a thorough discussion of rigor and trustworthiness in qualitative studies as well as the human subject process are presented.

Research Design

The research purpose was to describe the treatment preferences for mental health treatment in persons of Mexican heritage living in a US-Mexico rural border town. Treatment preferences could influence overall perception of the health care experience, access, and use of mental health care, and overall satisfaction and treatment response to mental health issues. Identifying culturally sensitive treatment services will be crucial in providing care to this group.

The specific aims and research questions that were answered include:

AIM 1. Describe the treatment preferences for mental health issues and illness.

Research Question 1: What are the treatment preferences for mental health issues and illnesses?

Research Question 2: Are there personal characteristics that influence treatment preferences (age, gender, education, income, acculturation, and generational status)?

Research Question 3: Are there characteristics related to acculturation that influence treatment preferences?
Research Question 4: Are there characteristics related to mental health issues and illnesses that influence treatment preferences?

Research Question 5: Does the mental health experience (self or immediate family) impact mental health treatment preferences?

AIM 2. Describe the media context that may influence treatment preferences.

Research Question 6: What is the use of media to obtain mental health information?

Research Question 7: How do acculturation and mental health experience influence media use for mental health information?

AIM 3. Describe the participant’s understanding associated with mental health illness and treatment preferences.

Research Question 8: How is understanding ascribed to nervousness/ anxiety, depression, schizophrenia, and substance abuse?

**Qualitative Research**

Qualitative research is considered a process of inquiry that allows assessment of observations and compilation of data that leads to a further understanding a phenomenon to an individual, group, or culture, with a language orientation (Crotty, 1998). Crotty stated “truth and reality are concepts constructed based on the meanings and experiences of a person’s interactions with their environment” (p. 6). Qualitative research allows for the derivation of these meanings and constructions of knowledge for use in understanding human behavior. Myers (2002) further described the results of qualitative research as “the communication of data interpretation through the use of rich, thick descriptions” (p. 3). Qualitative study generally is utilized to answer questions of cultural meaning [ethnography], interpretation [narrative themes], and to generate a language for further discussion and research on a phenomenon [phenomenology] (Creswell,
2008). Frequently qualitative research results yield hypotheses and relational themes for potential theories that can be quantified and studied further with quantitative research (Schweitzer, 2009). Indeed some quantitative researchers note “all research ultimately has a qualitative grounding” (Miles & Huberman, 1994, p. 40). Qualitative research in general provides the language, meaning, and theory for description and explanation of human experience.

The chosen methodology forms the basis for the type of methods, such as case study, interview, and participant observation in a ‘researcher as participant’ or emic point of view (Munhall, 2007).

**Qualitative Descriptive Design**

This study utilized a qualitative descriptive design to address the research questions. Qualitative description studies “offer a comprehensive summary description of an event in the everyday terms of those events” (Sandelowski, 2000, p. 336). This qualitative descriptive study focuses on describing treatment preferences of persons of Mexican heritage. Qualitative description “facilitates a comprehensive summary of an event in the everyday terms of those events” (Sandelowski, 2000, p. 336). A qualitative descriptive approach is used when there is minimal research in existence to explain in the most naturalistic way, the main issues concerning an experience of interest. Sandelowski (2000) noted that, in qualitative description, the major goal in research is the thick description of phenomena in the language of the participant.

Although inference and interpretation is made and is part of all qualitative research, Sandelowski (2000) posited qualitative description as maintaining only low-level inferences and interpretation and staying closer to the original data and wording in the description and analysis of participants’ reports. The current study reviewed the context of treatment preferences for mental health in persons of Mexican heritage, described the intentions and meanings that organized mental health
treatment preferences, and presented the results

Methods

Setting

Over 70% of Mexican-Americans in the US live in US-Mexico Border States (Vogel, 2004). Yuma County, Arizona is a US-Mexico border county in the southwestern corner of Arizona (Figure 4). The population of the county is approximately 195,751 with over 59% persons of Mexican heritage [Figure 5] (U.S. Census Bureau, 2010). Rural areas are those with have a population census of less than 50,000 people and/or less than 1000 persons per square mile. This person-per-square-mile designation allows Yuma to be considered a rural county (Rural Assistance Center, 2011). Rural areas traditionally experience deficits in the area of health service provision as a result of decreased health service providers and facilities in the area. Persons living in Yuma County experience health care vulnerabilities due to their rural status and placement in what is considered a health profession shortage area (PAHO, 2007). Health profession shortage areas such as Yuma County, Arizona have a ratio of doctors and nurses to patients 20% below the national rate of 28 per 10,000 in population (Rural Assistance Center, 2011). The US attempts to focus additional health care funding and services to these HPSA areas to increase access to health care and services for those living in these areas.

FIGURE 5. Racial Demographics of Yuma County, Arizona, 2011.
(Hispanic 54.8%; Anglo alone 37.9%; Black alone 2.7%; Asian alone 1.7%; Two or more race 1.5%; American Indian alone 1.1%; Native Hawaiian and Other Pacific Islander alone 0.2%; Other race alone 0.1%. From “Races in Yuma, AZ,” at City-Data.com, circa 2012. Public use information retrieved from http://www.city-data.com/city/Yuma-Arizona.html)
Sample

Purposive sampling was used in the selection of a specific group of participants in order to provide the richest data regarding the aims of a research study (Neergaard, Olesen, Andersen, & Sondergaard, 2009). Purposive sampling is a type of non-probability sampling that is used so that the researcher can use specific elements for inclusion in the study to add relevance to the study (Collingridge & Gantt, 2008). This type of sampling was utilized in this study to obtain the maximum variation in the sample, which increased transferability and credibility of results (Neergard et al., 2009). The plan in purposive sampling was to obtain a heterogeneous group of persons of Mexican heritage living along the Southwest US-Mexico border in Yuma County, Arizona.

Inclusion criteria for participant eligibility were:

- Adults over 18 years of age.
- Persons who self-identified as being of Mexican heritage.
- Persons living in the southwest US-Mexico border area of Yuma County, Arizona.
- Persons who read and speak English. Novice interviewers may have been overwhelmed when conducting interviews in a language different from their own, so only English-speaking participants were used (Spradley, 1979).

Recruitment of Participants

English speaking participants were recruited, although recruitment materials were available in both English and Spanish. Given the bilingual characteristics of the population in this region, recruitment flyers (Appendix B), commercials, and other information were available in both languages to reach the optimum distribution of potential participants. It was anticipated
that twenty persons of Mexican heritage would be interviewed as part of the sample for this study, although data saturation could have been achieved at a lesser number.

Recruitment was conducted primarily through radio announcements on both English and Spanish radio stations and print media flyers. During the 30-second public service announcements, the stations announced the opportunity to participate in this study, provided a brief description of the study, brief eligibility requirements, and contact information (name, phone number, and e-mail address of the researcher). The announcements stated that compensation would be provided upon completion of participation. The recruitment announcements ran for six weeks, three times daily during morning, afternoon, and evening radio listening times.

Printed flyers worded in English and Spanish were posted in a number of locations catering to adults of Mexican heritage in Yuma County, AZ. These included grocery stores, beauty and barbershops, local Catholic churches, flea markets, laundromats, restaurants, and an herbolaria. The flyers included information on the study and its significance, eligibility requirements for Mexican heritage participants, and phone and e-mail contact information for this researcher. Those persons responding to the flyers and announcements indicating their interest in participating in the study were contacted by the researcher to review for potential participant selection. A recruitment script (Appendix C) was read to those potential participants calling in by phone and e-mailed to those responding by e-mail. From those persons that agreed to participate after being read the recruitment scripts and meeting eligibility for study inclusion, participants were selected.

For potential participants who responded to the flyers, information was obtained by phone call to screen for eligibility. Basic demographic information was collected when the
potential subject called or e-mailed indicating an interest. Based upon age, place of birth (US or Mexico), years living in the US, and availability, participants were selected to provide the most heterogeneous group of participants and to allow for maximum variation in the sample selection. Once selected, the time and place for the interview was chosen by the participant and an appointment time set. As the study proceeded, there were specific subject qualities that motivated the types of participants recruited, so that maximum variation in participants’ selection was met. Participant characteristics of interest were years living in the US, varying educational levels, and nativity. Participants completed informed consent (Appendix D) to enroll in the study and demographic information (Appendix E) prior to the start of the interview. No participants were dropped during the study. Participants who completed the study were provided with a $20 gift card. Compensation for subject participation as outlined in Mann, Hoke, and Williams (2005) served to improve subject interest in participation and to assist in recognition of the importance placed on their role in research.

**Data Sources**

Three data sources were utilized to gather data on mental health treatment preferences of persons of Mexican heritage: (a) interview data, (b) demographic data, and (c) acculturation scale data. Multiple data sources are characteristic of qualitative descriptive approach. The use of multiple data sources is in keeping with Sandelowski’s (2008) intent for deriving strong, rich descriptions of treatment preferences for persons of Mexican heritage. Additionally, the use of multiple data sources minimized the likelihood of drawing erroneous conclusions that could occur from using only one data source exclusively. With the simultaneous use of multiple data sources, a more detailed and comprehensive understanding of the treatment preferences can be obtained (Sandelowski, 2000). The data sources used will be expounded here.
Interview

The intent of the individual interviews was to elicit data that would elucidate the mental health treatment preferences of persons of Mexican heritage. Mason (2010) showed that data saturation may be obtained using single interviews with participants yielding suitable results in qualitative interviews. Robson and Robson (2002) also noted that the most common type of interview in qualitative studies is the one-time face-to-face semi-structured interview. The interview had two specific purposes in the research process: to develop rapport and elicit information (Spradley, 1979). The goal of the interview was to allow the subject to express himself freely and respond in conversation to the areas s/he felt were of most importance, with questioning to explore areas in-depth and to address areas of particular interest. The interview consisted of open-ended questions posed to elicit maximum discussion and response from the participants.

Demographic Questionnaire

Participants completed a demographic questionnaire after agreeing to participate in the study and signing informed consent (Appendixes E, D). Obtaining these demographic data provided a further understanding of the subject’s socio-economic status and potential health status. More specifically, a demographic questionnaire asking information about the participants was obtained to develop an understanding of the sample characteristics (Appendix E). This demographic information included age, gender, number of years residing in the US, household income, insurance status, travel to Mexico for shopping/visiting or medical care and treatment, and health care provider interaction.
Acculturation Scale

Participants completed the 48-question Acculturation Rating Scale of Mexican-Americans II [ARSMA-II] (Cuellar et al., 1995). The multidimensional assessment of acculturation has versions in English and Spanish (Appendix A). The ARSMA-II asked 48 questions utilizing a Likert-type rating scale that assesses acculturation based on cultural heritage, ethnic behaviors, ethnic identity, ethnic interaction, language use and preference, and values and belief in ethnic customs and practices. The ARSMA-II also asked demographic questions that assess religious preference, education level, and generational status. Results from the ARSMA-II scale were coded to yield several categories based on level of acculturation (very Mexican-oriented, Mexican-oriented to approximately balanced bicultural, slightly Anglo-oriented bicultural, strongly Anglo-oriented, and very assimilated, Anglicized. The differing categories, as determined by total scores from the ARSMA-II scales, demarcate levels of acculturation from very Mexican to very Anglo-oriented. For example, language use has been highlighted as a major acculturation factor predicting poorer health outcomes (Hamner, Cogswell, & Johnson, 2011). Scale I consists of two subscales with 30 items that measure Anglo and Mexican orientation (Cuellar et al., 1995). Acculturation was measured based on the scores of the two subscales as very Mexican-oriented, Mexican-oriented to approximately balanced bicultural, slightly Anglo-oriented bicultural, strongly Anglo-oriented, and very assimilated-Anglicized. The ARSMA-II has good reliability with a Cronbach’s Alpha of 0.87 for the total scale, 0.86 for the Mexican-oriented subscale, and 0.88 for the Anglo-oriented subscale. Concurrent validity was established using the original ARSMA scale with a Pearson product moment correlation coefficient of 0.89 (1995).
Scale II consists of three subscales with 18 items that measure cultural marginality—the ability to accept ideas, beliefs, and values of one’s own culture and other cultures. This score reflected the total difficulty of participant’s acceptance of Anglo, Mexican, and Mexican-American ideas, beliefs, customs, and values (Cuellar et al., 1995). The three subscales, Anglo Marginality, Mexican Marginality, and Mexican-American Marginality, assessed the difficulty accepting the three cultures and representations of that culture. Combined use of the marginality scale and the Mexican and Anglo orientation scales categorized participants into four acculturative levels for multidimensional cultural comparisons (integration, assimilation, separation, and marginalization). The reliability for the total Marginality scale was good at 0.87 (Thomson & Hoffman-Goetz, 2009).

**Data Collection**

**The Interview**

Interviews were used to gather data about mental health treatment preferences from persons of Mexican heritage. The intent of the individual interviews was to elicit data that would describe the mental health treatment preferences of persons of Mexican heritage. The following section discusses in detail the process of the interview. Interview data were collected through a digitally audiotaped session with the participants. The interviews lasted approximately two hours. Interviews occurred initially at the participant’s homes for the first three interviews; subsequent interviews took place in the Yuma, Somerton, or San Luis libraries. The format was intentionally loosely structured to prevent possible bias from the researcher and to gather a full perspective from the position of the subject.

The interview was conducted in English with Spanish translations provided of the main mental health terms used in the study. This allowed the participant to understand the full
meanings of the mental health terms utilized for discussion. For the mental health terms nervous, anxious, and depressed, the corresponding Spanish translations of nervios, ansiedad, and deprimido were also provided for the participants. Frequently, translations of words into differing languages may lose some of the nuances of meaning of the translated terms, so providing both English and Spanish terminology added meaning and additional definition for the participants that improved the quality of their discussion and understanding of the mental health terminology used (Noguera et al., 2009; Temple & Edwards, 2002). Felis required translations of some terminology, and at times, her responses were initially in Spanish, and then self-translated into English. Ricky required some initial discussion in Spanish to explain that the transcriber only understood English, therefore his participant responses needed to be in English.

The initial portion of the interview was used to complete informed consent. Once informed consent was obtained, participants completed a demographic questionnaire (Appendix E). The demographic questionnaire included information about participant’s age, marital status, employment status, birthplace (US or Mexico), years living in the US, and education level. Time was allotted for questions before proceeding to the participant interviews. The participants were asked to select a pseudonym to utilize throughout the interview for participant confidentiality.

The interviews were digitally recorded. The interviewer initially asked participants to discuss general health related topics then proceeded to encourage participants to tell his/her story related to mental health issues and illness. Given the potential stigma regarding mental health questioning, initial questions focused on general health to allow the participant to develop rapport and gain a level of trust with the researcher, for example, “Tell me about a recent situation in which you were concerned about your health.” Then questions focused on mental health issues using a case approach again to avoid any stigma, for example, “Tell me about
someone you know who is nervous, anxious, or depressed.” At this point, probing questions, such as, “Tell me more about that” were used to expand on comments initiated by the participant. Probing questions were utilized to obtain a more expanded response, additional detail and a fuller description to the initial questions. Probing questions place the responses in context and allow the researcher to understand more of the participants’ knowledge and how they organize that knowledge (Spradley, 1979). Further specific questions, such as “What kind of help would you want for anxiety, nervousness or depression?” and “Why would you want that kind of help?” focused on what the participants themselves would want for their own mental health treatment preferences. In general, questions sought to elicit the participants’ thoughts, feelings, and experience regarding treatment preferences for mental health issues and illness using probing questions to enrich detail.

The interview continued, allowing the participant to express his/her thoughts on mental health issues and illness treatment preferences and responses to questions and prompts for clarification. The interview concluded when the interviewer no longer obtained new data. After the interview was completed, the participant was provided with a $20 Visa gift card as compensation.

Data Management

Recording and Data Security

Interviews were digitally recorded using a Droid X smart phone and omni-directional external microphone to record all statements, pauses, utterances made during the interview. Digital recordings were transferred to the researcher’s computer, which utilized facial recognition security software for the researcher to access the data in a secure way.
Transcription

Digitally recorded encrypted and password protected interviews were sent through secure e-mail to the transcriptionist. The transcriptionist transcribed the digital recordings as Microsoft Word documents and then returned the transcription as a Microsoft Word document to the researcher through secure e-mail. The researcher then reviewed the written transcript for comparison to the recorded interview with needed corrections made at the time of review. The dissertation chair reviewed the recordings and transcriptions of the first three interviews, and randomly reviewed two additional recordings and transcripts of other participant interviews for veracity of transcriptions and as an audit trail. The interviews were coded using Atlas-ti 7.0 qualitative data analysis software.

Coding

Once transcripts were reviewed, the documents were uploaded into the Atlas-ti 7.0 qualitative data analysis program and prepared for coding. In coding, meaning units are obtained by reviewing the interview narrative data and then dividing that text data into meaningful segments or chunks that can be analyzed, termed “fracturing the data” (Revicki et al, 2009). The label for this data unit is termed the code, this refers to the label applied to discrete information so that it may be understood in context to the research questions (Graneheim & Lundman, 2003). In this study, meaningful units were phrases that could be theoretically coded as mental health treatment preferences, media mode, and media influences.

**Theoretical coding.** Theoretical codes were derived from the research questions. Research Question 1 focused on mental health treatment preferences; a total of 12 theoretical codes were initially developed. Mental health treatment preferences were theoretically derived from the provision of care to remediate mental illness symptoms related to physical, emotional,
and psychical changes to a person’s experience (Mental Health Treatment, 2012). Mental health treatment preferences initially included 12 theoretically derived codes such as medications, individual, family, or group counseling by a licensed provider (Federal Corrections and Supervision Division, 2000).

For Research Question 6, a total of eight codes were developed about media mode and media influence. Five codes were developed about media mode use, and three regarding media influence. These codes were developed theoretically using the Pew Research Latino Media Study (Livingston et al., 2008). Theoretical coding for media influence related to education (providing information about mental health), hope (providing motivation in improvement for mental health), and normalization (decreasing stigma and understanding of mental health as a normal part of life) were derived from logic based on researcher and dissertation chair discussion. Media use definitions, for example Media-television, was defined as any activity seen or heard as taking place through the medium of television.

**Open coding.** Open coding was used in conjunction with the theoretical coding based on the research questions. More specifically, open coding was used for nuances and findings within the theoretical codes—mental health description, treatment preferences, media use, and experience.

**Mental Health Treatment.** As reports of mental health treatment preferences were observed that had not been theoretically coded, these preferences were emically labeled and defined, based on the description provided by the participant. These open-coded mental health treatment preferences were then reviewed to assess consistency across all participants. This process allowed additional codes to emerge as mental health treatment treatments. A total of 25 codes were obtained through theoretical and open coding for the reporting of mental health
treatment preferences (Appendix F).

**Media Mode and Influence.** As other reports of media modes were observed that had not been theoretically coded, these media modes were emically described then etically defined based on the description provided by participants. Those open-coded media modes were then reviewed to assess consistency across all participants. A total of 13 media modes were described by participants (Appendix F). Participants also described other media influences. These were open-coded, emically described and etically defined, based on the description provided by the participants. A total of five media influences were described by participants (Appendix F).

**Ascribed Meaning of Mental Health Issues and Illness.** Reports of one’s own or one’s family member’s mental health issues and illness were open-coded to answer Research Question 8. To develop the ascribed meanings of mental health issues and illness, theoretical codes for anxiety/nervousness and depression were derived from DSM IV-TR. During the interviews, participants reported experience with substance abuse, bipolar disorder, and schizophrenia; these three mental health issues and illness were open-coded to analyze for ascribed meaning. The definitions for these codes were then derived from DSM IV-TR.

**Data Analysis**

Three methods of data analysis were utilized to answer the research questions in the current study. Coded data were analyzed using content analysis, matrix analysis, or thematic analysis.

**Content Analysis**

Content analysis is defined as “the analysis of the manifest and latent content of a body of communicated material through classification, tabulation, and evaluation of its key symbols and themes in order to ascertain its meaning and probable effect (Krippendorff, 2012, p. 1). For this
study, content analysis was used to address research questions 1 and 6. Analysis tables were created reporting mental health treatment preferences and media modes and influences. Analysis was completed using Atlas-ti 7.0, setting the global filter for Atlas-ti 7.0.

**Thematic Analysis**

Thematic analysis was used to answer Research Question 8. A report of all statements coded as anxiety/nervousness, depression, substance abuse, schizophrenia, and bipolar disorder was run. This report grouped all statements described by the participants for each of the five mental health issues and illnesses. These code reports were then reviewed, and open-codes with similar meanings were grouped. From these similar meanings, emically-expressed themes were identified to capture the ascribed meanings of mental health issues and illness as stated in Research Question 8. According to Braun and Clarke (2006), “a theme captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set” (p. 82).

**Matrix Analysis**

In the process of qualitative analysis, developing a matrix utilized “the crossing of two or more dimensions to see how they interact” (Miles & Huberman, 1994, p. 239). The use of matrix analysis for research questions 2-5 and 7 in this study permitted understanding of individual and group similarities and differences while addressing the research question. The first comparison was the first-order matrix, the review of the participant’s transcribed interview, and described mental health treatment preferences, media modes, and media influences. Second-order matrices were completed for Research Question 2 using mental health treatment preferences and demographic variables (e.g., age, gender, etc.) to determine if there were differences in demographic reporting between the categories. Third-order matrices were attempted for research
question 2, but without notable findings. Research Question 7 required a third-order matrix analysis regarding acculturation, mental health experience (self or immediate family), and media mode use. With the third order, analysis was completed merging the grouping results of those categories based on the media mode used. A primary documents table for Research Question 7 was then created displaying the number and percentages of participants reporting each statement.

**Trustworthiness**

Methods to increase trustworthiness in research improve the likelihood that the results and conclusions of research truly reflect the reality of the phenomena studied (Trochim, 2006). This section reviews methods used to increase trustworthiness in qualitative studies. While utilizing a constructivist framework of uniqueness and individual meaning, qualitative researchers similarly want to show trustworthiness in their studies. Lincoln and Guba (1985) identify issues of trustworthiness as “the ability of the inquirer to persuade audiences that the findings of an inquiry are worth paying attention to, taking account of” (p. 290). In this persuasion, Guba developed criteria for guidance and evaluation in trustworthiness in qualitative research studies. The criteria of credibility, dependability, confirmability, and transferability in research are discussed with examples of qualitative approaches and methods to address those concerns when using qualitative descriptive approach (Key, 1997).

**Reflexivity**

An extensive journal was maintained by the researcher as part of this study in keeping with the reflexivity central to qualitative research. According to Robson and Robson (2002), reflexivity is “an awareness of the ways in which the research as an individual with a particular social identity and background has an impact on the research process” (p. 22). Thus, a reflexivity journal documents the researcher’s thoughts, preconceptions, questions about research, and
potential areas of bias to be addressed as part of the study. By documenting potential bias and other ideas regarding treatment preferences, a more objective role of the researcher was maintained in the study. Throughout the study process, continued journaling was maintained to document what happened subjectively and objectively during the formation of concepts and themes from research.

Methodological decisions, ongoing clinical and analytical notes, issues arising in the study, debriefing from interviews, and research field notes were maintained and reviewed with the dissertation committee chairperson, Dr. Cathy Michaels. The reflexive commentary, self-reflective journaling, and codebook were reviewed by a research consultant, Dr. Peter Guarnero. Dr. Guarnero, an individual of Mexican heritage whose family includes curanderos and traditional healers, is a Psychiatric Nurse Practitioner living in San Antonio, Texas. Dr. Guarnero has a long history of working within the Mexican community to provide for their health care needs. This has afforded him a depth of knowledge of persons of Mexican heritage treatment needs and preferences in the area of medical and mental health care. His review of the self-reflective journal was included in the discussion section of the research.

The use of reflexivity ensures ongoing maintenance of an objective attitude towards the data with freedom from Western biases. The researcher, while gathering data, is not ‘in the know’, and yields control to the participants, thus allowing the participants to determine the pace and dynamics of the interview (Thorne, 2008, p. 110). Reflexivity allowed the writer to understand her frame of reference such that she could present herself in the best way to potential participants, again addressing those in the know when the writer was not ‘in the know’ (p. 110). This increased the self-awareness of the researcher in the context of a qualitative study design and was useful as part of the content analysis of data collected (Lincoln & Guba, 1985).
Reflexivity journaling was reviewed on a periodic basis with Dr. Michaels. Journaling continued throughout the data collection phase of the study through the completion of data analysis. Once data analysis was completed, the journaling process received a final review from Dr. Michaels with information obtained from this last review incorporated into the final data analysis of themes.

**Credibility**

Credibility is the confidence in the reported findings of qualitative research (Lincoln & Guba, 1985). Credibility is enhanced when the research findings provide a faithful, rich description and interpretation of the reported information of the participants such that it is easily recognized by other similar participants as accurate. Digitally recording audio transcripts, verbatim translations, transcriptions, and review of transcripts/translations, and member checking among participants increased the accuracy of reporting recorded data and credibility (Pulkkinen, 2003). Debriefing issues during and after interviews with the dissertation chair and having selected colleagues review and discuss information about the research process, data collection, and analysis (peer debriefing) added credibility to data analysis and research findings (Cohen & Crabtree, 2006). Informed consent assured the participant of his/her privacy and anonymity in discussing information about the research study (Lincoln & Guba, 1985). Using iterative questions and reflection in research interview techniques, along with open-ended questions with rephrasing used to obtain thick descriptions of the phenomena improves the credibility of the participant’s responses in studies (1985). These steps minimized bias and allowed the researcher to have clear information about the usual occurrences regarding a given phenomenon (Siegle, 2010).
Dependability

Dependability addresses the ability of findings to remain constant on replication (Tobin & Begley, 2004). Dependability is noted when findings are consistent and replicable (Lincoln & Guba, 1985). Dependability was maintained by completing an audit trail with the dissertation chair to verify methods (Shenton, 2004). A clear audit trail, with thorough explication of the design and data collection, diary, field notes for comparison, and a discussion with the dissertation chair of ongoing results, limitations, and potential areas/questions for future study were used to increase the dependability of results (Tobin & Begley, 2004).

Confirmability

Confirmability considers the extent that study findings truly represent the meanings intended by participants, without potential interference from the researcher. Confirmability is noted as the level of assurance that research findings are truly those of the participants, not the researcher (Lincoln & Guba, 1985). Confirmability was upheld during the interviews with the researcher asking for clarification from the subject as well as in discussion to decrease potential bias of the researcher. During collection of data, the researcher analyzed the information to obtain initial thoughts and concepts, and then asked more direct questions for probing, clarification and corroboration or rebuttal, in an ongoing iterative process that increased the depth of information and confirmed findings without potential bias from the researcher (Cohen & Crabtree, 2006). Additionally, a reflexivity process was used to serve as an active engagement of the researcher to understand his/her own views, journal, and remove bias and predispositions that may have influenced the data gathering process (Beck, 2009).

After the first six interviews, the researcher met with the dissertation chair, and all interviews were reviewed line-by-line to confirm appropriate coding and themes by third-party
objective review (Creswell, 2008). This was completed in order to adequately gauge the effectiveness of researcher coding strategies, to provide feedback regarding reported coding and themes obtained emically through the first six participants, to alleviate researcher bias, and to address concerns in the open coding process. Participants 9 and 12 were reviewed together with the dissertation chair for accuracy in coding of each mental health treatment preference.

**Transferability**

Transferability deals with the potential for study results to be useful in other settings or similar participants by utilizing approaches that increase the transferability of the study (Lincoln & Guba, 1985). Transferability shows whether research results are useful in other settings (Cohen & Crabtree, 2006). Given the relativity of the qualitative descriptive approach, difficulties in the ability to replicate qualitative studies remain an issue (Siegle, 2010; Tobin & Begley, 2004). Purposive sampling increased the transferability of results by increasing the comprehensiveness of information that was obtained for a phenomenon by choosing participants from differing backgrounds, ages, levels of education, insurance coverage, and so forth (Siegle, 2010). Providing a thick description of mental health treatment preferences for persons of Mexican heritage improved potential transferability of findings for subsequent research studies (Shenton, 2004).

**Human Subjects**

**Ethical Considerations**

An application for Approval of Human Subjects was sent to the University of Arizona Institutional Review Board. This board reviewed the purpose and methods of the proposed research to assure that needed appropriate steps were taken to protect the rights and welfare of humans participating as research participants before granting approval of data collection. Once
gran, the research was required to comply specifically with all requirements of the approved research study.

All research study participants were made aware of the study’s purpose, the need for their involvement in the study, a timeline for their participation, and the requirement of audiotape for accuracy. All research participants received informed consent to familiarize them about the study purpose, methodology, including the interview process, any potential risks, and measures used to protect privacy and confidentiality.

All study participants were informed that their participation in this study was voluntary, with the ability to ask questions at any time in their participation, to decline to respond to certain questions, and to withdraw from the study at any time without repercussion. As stated earlier, a $20 Visa gift card was provided to each participant that completed the interview as part of his or her remuneration for the two-hour time allotment.

Participants’ identities were de-identified with pseudonyms, and numbers were substituted for identifying names of persons. Pseudonyms, selected by the participant, were used to identify participants in tapings, transcriptions, and analysis. In this way, confidentiality of interview participants was maintained. Data were maintained electronically through encryption and required passwords and facial recognition of the researcher to obtain access to the data pages. Data were deleted from all sources once analysis was completed, according to University of Arizona IRB guidelines.

**Summary**

The qualitative descriptive approach for this study was examined along with the specific components of each aspect of this qualitative design. The overall purpose, aims, goals, and research questions were presented. Information regarding the setting, sample, and sources of data
were reviewed, as well as data collection, analysis, and qualitative comparative analysis techniques.

A review of procedures to assess and enhance trustworthiness in qualitative descriptive approach was presented. Lastly, a discussion of procedures that protect human subjects’ rights related to research was delineated in detail.
CHAPTER IV: STUDY PARTICIPANTS AND CONTEXT

Chapter IV presents the individuals who participated in this qualitative descriptive study to describe the treatment preferences of persons of Mexican heritage living in the Southwest along the US-Mexico border. This study proposed to describe cultural preferences for mental health treatment services for persons of Mexican heritage living in the Southwest along the US-Mexico border. Completing this study will enable researchers to understand the specific treatment needs and media influences of persons of Mexican heritage. Chapter 4 describes a summary of the sample as well as an individual report of each participant’s interview regarding mental health treatment preferences. These stories represent the participants’ views as they intended to report them.

Purposive Sampling Pattern

In the development of a system to monitor purposive sampling, a review of prior demographic models was initially completed. When suitable methods to arrive at a representative sample were not forthcoming, the researcher developed a system of categorizing the participants obtained in the study. To obtain a representative sample using purposive methods for this study, an outline of the first participants by the major demographic factors was completed as a table. This allowed the tracking of the progression of the participant pool, to assess for representative numbers from each demographic indicator (age, gender, income, etc.) in the participant pool, in order to address issues of dependability in research rigor.

Sample Description

Twenty-one participants were interviewed between July, 2012 and September, 2012. Twelve men and nine women were recruited for participation. Twenty participants responded to
flyers (Appendix B) posted in the community; one participant was recruited by newspaper advertisements.

Sample demographics are identified in Table 1. The study was equally represented by gender, educational level, insurance types, and mental health experiences. The participant’s ages ranged from 18 to 68, with a mean of 33.8, very similar to the median age of persons living in Yuma County (Greater Yuma Economic Development Corporation, 2012). Three participants reported they were full-time students, one participant was retired, and the remaining participants were in various stages of employment, unemployment benefits recipients, or unemployed.

Participants completed the 48-question Acculturation Rating Scale of Mexican-Americans II [ARSMA-II] (Cuellar et al., 1995). The multidimensional assessment of acculturation has versions in English and Spanish (Appendix A). Only one participant, Felis, completed the Spanish portions of the ARSMA-II. The ARSMA-II asked 48 questions utilizing a Likert-type rating scale that assesses acculturation based on cultural heritage and ethnic behaviors, ethnic identity, ethnic interaction, language use and preference, and values and belief in ethnic customs and practices. The ARSMA-II also asked demographic questions that assess religious preference, education level, and generational status. Results from the ARMSA-II scale were coded to yield several categories based on level of acculturation (very Mexican-oriented, Mexican-oriented to approximately balanced bicultural, slightly Anglo-oriented bicultural, strongly Anglo-oriented, and very assimilated, Anglicized). The differing categories, as determined by total scores from the ARSMA-II scales, demarcate levels of acculturation from very Mexican to very Anglo-oriented. The acculturation rating serves as a delineation of the participants’ acceptance and inculcation into Western majority society.
Participants were grouped according to generational status. Generational status was defined by Cuellar et al. (1995) as part of the ARSMA-II scale that was completed by each participant. First-generation status related to participants that were born in Mexico. Second-generation status referred to participants that were born in the US, with either parent having been born in Mexico. Third-generation status consisted of the participant and both parents having been born in the US, with all grandparents having been born in Mexico.

Participants reported various mental health issues and illnesses during the course of questioning. Mental Illness in Self referred to the actual participant reporting having experienced mental health issues and/or illness. Mental Illness in Family represented the participant’s report that an immediate family member experienced mental health issues and/or illness. Mental Illness in Others referred to general statements participants made regarding mental health issues and illnesses without reference to whom experienced them.

Coding for mental health definitions was completed according to DSM-IV-TR terminology (APA, 2000). Depression symptoms listed included sad mood, tearfulness, isolation, decreased/increased sleep or appetite, and poor self-esteem. Anxiety/nervousness was coded based on DSM-IV-TR symptoms reportedly expressed in anxiety disorders: worry, nervousness, anxiety, and stress. Substance abuse was defined as a maladaptive pattern of use of any known reported substance. Based on the symptoms reported during participants’ responses, their reported mental health issues and illness was coded based on current DSM-IV-TR symptoms categories.
## TABLE 1. Sample Demographics

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Participant n (%)</th>
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<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
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<tr>
<td>Male</td>
<td>12 (57)</td>
</tr>
<tr>
<td>Female</td>
<td>9 (43)</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>≤ 25</td>
<td>6 (29)</td>
</tr>
<tr>
<td>26–40</td>
<td>9 (43)</td>
</tr>
<tr>
<td>41–55</td>
<td>5 (24)</td>
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<tr>
<td>≥ 56</td>
<td>1 (5)</td>
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<tr>
<td><strong>Insurance</strong></td>
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</tr>
<tr>
<td>AHCCCS</td>
<td>7 (33)</td>
</tr>
<tr>
<td>Private</td>
<td>7 (33)</td>
</tr>
<tr>
<td>None</td>
<td>7 (33)</td>
</tr>
<tr>
<td><strong>Income</strong></td>
<td></td>
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<tr>
<td>&lt; 10K</td>
<td>12 (57)</td>
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<tr>
<td>10–19K</td>
<td>1 (5)</td>
</tr>
<tr>
<td>20–34K</td>
<td>6 (29)</td>
</tr>
<tr>
<td>35–49K</td>
<td>1 (5)</td>
</tr>
<tr>
<td>50–74K</td>
<td>1 (5)</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
</tr>
<tr>
<td>≤ 6th</td>
<td>1 (5)</td>
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<tr>
<td>7th–8th</td>
<td>1 (5)</td>
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<tr>
<td>9th–12th</td>
<td>7 (33)</td>
</tr>
<tr>
<td>1–4 College</td>
<td>8 (38)</td>
</tr>
<tr>
<td>Post Grad</td>
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<tr>
<td><strong>ARSMA-II Scale</strong></td>
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<tr>
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<tr>
<td>Strongly Anglo</td>
<td>5 (24)</td>
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<tr>
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<tr>
<td>Yes</td>
<td>8 (38)</td>
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<tr>
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<td>13 (62)</td>
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<td>Student</td>
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<td><strong>Generation</strong></td>
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<td>14 (66)</td>
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<tr>
<td>3rd</td>
<td>4 (19)</td>
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<tr>
<td><strong>Mental Illness</strong></td>
<td></td>
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<tr>
<td>Self</td>
<td>11 (52)</td>
</tr>
<tr>
<td>Family</td>
<td>10 (48)</td>
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(Note. Participant n=21. Median age: Study participants: 34.5 yrs. Yearly Income: <10K=Less than $10,000; 10-19K=$10,000–$19,000; 20-34K=$20,000–$34,000; 35-49K=$35,000–$49,000; 50-74K=$50,000–$74,000. Last Grade Completed: ≤6th=Completed grade 6 or less; 7th-8th=Completed 7th or 8th grade; 9th-12th=Completed between grades 9 and 12; 1-4 College=Completed from 1-4 years of college; Post Grad=post graduate studies. Generation=Number of generations the individual’s family has resided in the US. Health Insurance: None=No insurance coverage; Private=Private insurance coverage; AHCCCS=Arizona Health Care Cost Containment System, a public health care assistance program; Mexican=Mexican insurance coverage; Other=Other insurance coverage. ARSMA-II Scale (Acculturation Rating Scale for Mexican Americans): Mexican-Anglo=Mexican-Anglo Balanced.)
The Participants

Andrea

Andrea was interviewed at the library. She initially reported some difficulty seeing mental health as a health issue, as she denied having any health problems; immediately thereafter, she stated she was currently on Lexapro for depression. She discussed her conflicts with parents who dismissed mental illness issues, “You don’t need a therapist; you just need to snap out of your mood,” versus her own thoughts of depression being a viable mental health illness. “So then I had kind of some sound medical information telling me why it is you’re probably feeling this way, that the medication’s gonna help regulate.” She reported individual counseling, medications, family, and social support as her treatment preferences. Andrea felt strongly that media influences normalized the experience of mental illness, making mental illness a more acceptable topic for discussion. She noted this has been a problem for her, “For me it was my family, my mom, because we don’t [talk about it].” Media sources provided education and validation that someone was experiencing mental illness, and the hope to return to normal functioning, “[I felt] definitely optimism. Yes. I felt more normal, yeah.” Financial issues were the main reason for potential travel to Mexico according to Andrea, and she admitted some strong prejudices about Mexican healthcare, “Honestly, I would expect to walk, and there’s chickens running around, and I know that’s not the truth…I just feel so Americanized.”

Reuben

Reuben was interviewed at his home. He was anxious to talk about health matters, and while watching me put up the flyer recruiting participants, came up to me asking about the research, gladly volunteering to talk about his circumstances. His main issues regarding health care were financial, as he had insurance from his work, but his wife was uninsured. She had
multiple medical and mental health problems, and he struggled to provide for her healthcare needs and services. He reported she experienced bipolar disorder. During times when she was sick, he defined her symptoms as being “more stressed, irritable, and [she] stayed in bed more.” When doing well, he reported, his wife “had more energy, was happy, more energetic, and didn’t get a short temper.” His wife also had lost her immigration cards, so could not travel to Mexico for health care. Reuben reported his wife sought counseling and medication for her mental illness, which he felt had been helpful, but now that she had no insurance, she was rationing her medications, taking pills every other day or half of a tablet, with a notable decline in her mental status. He was even planning to move out of the family home, severing all financial ties to his wife, so that his wife would be able to qualify for AHCCCS health care. He reported his efforts at family support, trying to minimize her stress and workload, avoiding arguments, helping around the house. He also reported concern that his wife might feel abandoned when he moved out of the house for her health care, so that he had made extra attempts to comfort her regarding this. He reported spirituality was a source of strength for his wife, and her attendance at church improved her mood and attitude about her health and wellness. He lamented the lack of availability of herbal medicines, reporting this had helped him with his kidney stones. He strongly believed his wife’s lupus could be cured by herbal and integrative services that were available in Mexico, and had made attempts to get family to bring her those remedies.

**Linda**

Linda was interviewed in her home. She was the eldest of the participants, and immediately relayed she had recently experienced health care issues and had relied on herbal medications from Mexico to treat them when she felt dissatisfied with the response of her U.S. primary care provider. She described her understanding of the mental health issues of her
children and their interaction with the metal health system. She reported her daughter has anxiety symptoms, had tried vitamins and acupuncture, but still relied on her husband for support to address her isolation, panic attacks, and inability to find gainful employment, or even shop due to claustrophobic symptoms. Linda reported her daughter’s anxiety affected not only her daughter, but also her daughter’s relationship with her children, “Well, I think she suffers because she worries when she can’t do anything about it. Or she tries to tell the girls, her daughters, and they don’t try to help her, because they don’t know what’s going on. You know, and they ignore her, because even when she goes to the dentist or the doctors, she gets scared and she tries to run out. But I always call her and try to see how she’s doing or what’s going on. Sometimes she’s mad and she cries and that’s about it.” Linda’s son had developmental difficulties and was on disability. She reported having had trouble keeping up with the health care and social services appointments needed to maintain his disability status. He had also been unable to look for any part-time employment for fear of losing his disability services. She gave examples of potential services she would like for her children as well as herself. At the end of the interview, she happily proclaimed, “And you know, this is the first time I’ve talked like that to you. I never have, not even when I was a kid! I was embarrassed when I would try to speak up.”

Mr. C.

Mr. C. was interviewed at the library. His initial discussion was a recent health concern about his fiancé that left him disenchanted with the local health care system and barriers to health care. He expressed distrust in the U.S. health care system and attributed some of this to racial discrimination, “They treat you like you were a drug addict, speak all rude, judgmental,” and reported this was especially the case in his community. He reported his fiancé experienced depression, anxiety, and bipolar disorder, and was on medications and counseling to manage her
symptoms. He reported encouraging her to seek help, stating, “You know, I was tryin’ to give her little helpful hints to try and go, like, seek counseling, or take some kind of behavioral health specialist, or something like that. So, it took her a while, because she had a lot of pride and was like, ‘Oh no, no, no.’ But then finally, I just told her, ‘Go get some kind of counseling.’ So we called around and called around.” He reported finding calming outlets, such as video games, music, and social support were also helpful to coping. Mr. C.’s concerns led him to question the genuineness of the U.S. system and their desire to ‘help people stay well’. He therefore sought herbal medications and services for care for himself and his fiancé. “You can go and drink some relaxing teas, or stuff like that are actual; there’s like mood enhancement that can come from plants, herbs that you can get. Uh-huh, there’s actual pills that are all herbal, so…And they’re all different kinds of plants, and that can boost your immune system to help you mentally and physically to get you goin’ in the morning. Okay, it’s, there’s no really harmful side-effects. So, that’s a plus, and if it helps the same way a pill [medication] would help you, why not try to get away from that, instead of staying stuck on pills that can hurt you in the long run?” Mr. C. felt distrust and perceived prejudices were prevalent in his community, with the need for one-to-one information to address these issues, provide educational materials, such as pamphlets and one-to-one interaction to decrease the likelihood of negative interactions with the health system in the area.

**Gerardo**

Gerardo was interviewed at the library. He relayed his concerns about his father’s heart issues and lifestyle concerns, in what he perceived as the stubbornness in elders to listen to their children about health care issues, smoking, and exercise. Gerardo reported his mother suffered from depression and he described the changes he has seen in her behavior and mood over the
years. He reported the changes he has noticed in her activity level and interactions with family, and reported feeling unable to offer her suggestions to improve her mood. He lamented her attitude about her status stating, “Pessimism is a product of inactivity,” and reported he encourages her to do more outside with friends and church. Gerardo then relayed his experience of losing over 125 pounds by changing his attitude, eating habits, and activity level. He attributed his obesity, in part, to emotional issues and bullying as a child due to his weight. He reported, “So not that I’m mad or anything like that. But the thing is, it’s just I didn’t know how to deal with my stress; I didn’t know what stress was, really. I mean I just thought everybody felt the way I did at certain times, things like that. But now, even now, I can see certain situations whether it’s tougher situations, whether it’s social, whatever, and I can see little, what’s coming next, almost. I’ve been there. I’ve done that. I’ve felt that way. I’ve dealt with it. I got over it, and I have memories.” Gerardo attributed this ‘stubbornness’ in treatment-seeking, as he saw in his mother, to a lack of understanding of the U.S. healthcare system, and a slow move towards health promotion and disease prevention for older generation persons of Mexican heritage. He also highlighted the negative impacts of this lack of preventative care, and the lack of utilization of mental health care, especially for elderly persons. He focused on the need for sound mind, body, and spirit in achieving mental health and overcoming stigma to access both physical and mental health services, which he acknowledged was a barrier to treatment seeking for persons of Mexican heritage.

Cepeda

Cepeda was interviewed in the library. He voiced concerns about his sister’s depression issues and treatment. His sister experienced anxiety symptoms and depression, rarely leaving her home due to panic attacks. He reported that she had gone to numerous doctors and treatments
without much success. He described her anxiety as, “Try to figure out what your feelings at the time say, and give those attacks, and I can just imagine how that feels. If you’re like tryin’ to get yourself out of a box, and you’re trying your hardest to get out, and that’s about all of it. No matter how hard you try to escape, try to kick, punch, and it won’t open. It’s pointless. Cut it, and it won’t open. Without it you suffocate, and I can just imagine what it feels like, mental, mental suffocation.” He reported that because of his sister’s issues, he had become well versed in the television and radio programs that discussed mental health topics, having obtained mental health information from these media, and concluding media had been helpful to him and his family. He reported, “Well, like, self-help books, websites, radio shows like John and Katy; sometimes there’s radio shows, just do that, Doctor Oz, various information. Of course there’s information you can get from like asking doctors, other people that have had the same kind of treatment, the same kind of diseases or complications from those things with their own children that have problems.” Cepeda reported understanding that some people struggled to accept mental illness. He, himself, noted using medications and therapy along with IM approaches, such as acupuncture and hypnosis. He recommended acupuncture and hypnosis as methods that could be helpful for his sister. He specifically pointed to information he had read on acupuncture and hypnosis in helping anxiety symptoms. He stated “They can talk to people that are in that field: acupuncture, hypnosis. There is teas; there is medications, self-help books. Do the research into it. It comes back, the energy, the happiness.” He felt ‘the Internet- the most powerful information place’ helped him to understand anxiety symptoms and how integrative treatments and herbal medicines could be of benefit.

Felis

Felis was interviewed in the library. Felis required some translations of information into
Spanish during the interview. At times, she also answered initially in Spanish, and then self-translated her responses, reporting she felt uncertain about her English proficiency. Her initial concerns were about her own lack of insurance and need for a health checkup. She soon discussed the focal point of her life and concerns: her son’s battle with schizophrenia. She reported difficulties she had obtaining proper treatment and supportive services through his public insurance. She also reported difficulty assisting her son with co-payments for medications. She needed support from family and friends to assist with care for her son. Because Felis experienced stigma from some family members, she carefully chose with whom to discuss mental health issues. She reported no family support from her immediate family living five hours away, and became tearful about relying on friends and respite mental health services for support. Felis described the difficulties she had accessing mental health services for her son, and how the lack of these services limited his ability to achieve an independent life. She reported medications and therapy had been helpful for her son. She had, however, recognized, in caring for her son, that she had her own self-care needs. She felt massages, pedicures, and other self-care activities were important in building her own self-esteem and positive mood. She started attending women’s domestic violence groups, reportedly finding them empowering, encouraging, and comforting. In interacting with other women, she reported she felt “okay, my problems aren’t so bad”. Felis found solace by obtaining mental health information, specifically educational information on schizophrenia, from the Internet. She reported she found less information in Spanish online, and that this decreased her ability to find what she felt was sufficient information. Information in Spanish would have been easier to understand, she felt, and would have provided for a more “complete understanding of the issues.” She also reported television programs, shows, and crisis numbers were supportive in informing her of mental health issues.
Felis reported she felt a freedom of movement and interaction obtaining services in Mexico, “It’s like home, more comfortable, a freedom over there to get help.” She felt the lower cost of health care in Mexico was a motivation for cross-border health migration, even though she had one bad experience of mental health care treatment for her son. She felt the support and educational groups in the US were less accessible in Mexico, but liked that most Mexican health care providers were a ‘one-stop-shop’, able to do lab work, tests, diagnose, and dispense medications from one office, minimizing the need for multiple health care visits for one issue.

Mary

Mary was interviewed at the library. She initially discussed her recent Internet interactions in the pursuit of health care and nutritional information. She reported that, as a person of Mexican heritage, she was keenly aware of the health challenges facing this minority. Mary also noted the influence of alcohol abuse and its potential complication for her uncle’s mental health, as well as for general health. She then divulged that her keen interest in health and nutrition stemmed from her own issues related to anxiety, and how this anxiety was affecting her everyday life. She recognized her experience of ‘lack of control’ as anxiety symptoms, which she believed, was a potential health threat. She attempted using self-help methods that she learned in her social work classes at college. In particular, Mary felt that reading for pleasure was a self-help strategy that provided distraction and relieved her anxiety symptoms. She admitted that her sister also had anxiety issues and had sought treatment in an urban center. Both shared the lessons and information, including medications, counseling, and lifestyle changes in nutrition and exercise. Mary reported a lack of these available mental health services in her community likely affected community residents negatively. Mary felt that, as a group, persons of Mexican heritage may negate the reality of mental health issues, “It doesn’t exist; they’re too busy
working to [notice mental health],” which serves as a barrier for disseminating information to her community. Mary felt that providing educational classes at the local library could increase knowledge and understanding of mental illness. This could decrease the notable stigma she felt was prevalent in her community, “Someone needs to tell you, ‘You’re not crazy; this is what’s happening.’” She believed that most persons suffering from mental illness aren’t aware of their illness themselves, or if they noticed a problem, might be afraid to seek help to confirm a mental illness or to obtain treatment. She felt these persons need family or friends to encourage them to seek help for their symptoms. To encourage persons in her community to seek treatment, Mary encouraged the use of herbal medicines for physical and mental health, “My parents were in Mexico most of their lives. They like the all-natural ways to help; no need for drugs. They trust the naturals more.” She reported her parents had even visited curanderos, traditional healers, although she felt persons her age, born in the US and more accustomed to Western medicine, might not seek these types of services, but might find other integrative services, massages, or acupuncture assistive. She reported community members might respond more positively to information conveyed through TV, flyers, and one-to-one interaction. She reported her concern that information about mental health should be provided in Spanish. She perceived that English information or word-for-word translations of information had less relevance and meaning for her community members and therefore represented a barrier to seeking effective treatment. Mary closed her interview restating her focus on one-to-one interaction as necessary to increase knowledge of mental health issues, minimizing stigma of treatment seeking, and encouraging the potential of benefit from treatment services.

**Princess**

Princess was interviewed at the library. Princess started out the conversation talking
about a close friend with drug addiction issues. Later in her talk, she accidentally admitted that this close friend was her brother. “I wasn’t exposed to none of that [mental illness]. And now that I see it, before it was more like my brother, my family member, is taking these things and we didn’t, we don’t believe in none of that stuff [medications]. Because, like I said, before none of that existed, I was like, do this, do this, and then when things got really bad, but as I see it, in my workplace, that I’ve seen it, now I understand better the consequences of doing it [taking medication] and not doing it, supporting and not supporting.” When asked why she initially called him only “a close friend”, she admitted that stigma still existed for mental health, but more so for substance use issues, regarded as weakness and moral failing. By the end of her interview, Princess admitted that multiple family members had substance use issues. She felt her source for strength in all things was God and Christ, not medications, and she minimized the effectiveness of medications or counseling that wasn’t church-based. She reported medications had helped her brother for a time, but in the end, his decision of faith was the turning point in his recovery. Her family support and relationships were an important part of her stability, but more important was her relationship with God, through Christ, in making her life worthwhile, and in rescuing her family members from substance abuse.

Pedro

Pedro immediately began his interview at the library by discussing the media information he had recently gained from television, and how that information influenced his health and treatment decisions. He described how his son being killed in a freak accident was a catalyst for his mental health issues. He described depression as “not wanting to be with people, coming out of your room, just lost in your own world.” He reported finding solace and understanding for himself and his family when he met a woman from his church that had lost all three of her
children to the drug wars in Mexico, “She had been through it too, so we could talk about things.” He admitted the difficulty he felt himself over the loss of his son, and how family and friends provided support for his healing and adjustment to this loss. Pedro appreciated the benefit of medications and therapy for treatment, but also gave great credit to herbal medicines, listing yerba buena and cinnamon as noted Mexican herbal remedies used by himself and his parents. He also reported that, learning from childhood the importance of spirituality, he felt prayer was also an effective support in mental health treatment and life in general. Pedro relied on newspapers, Internet, and search engines for mental health information, preferring information in Spanish as being more readily understandable by himself and others of Mexican heritage. He also thought contextual information in Spanish would more likely be followed by native Spanish speakers, stating he “felt more meat reading the Bible in Spanish, so more information in Spanish will mean more.” He also felt more one-to-one communication was needed to inform others of mental health issues. He stated people sought health care in Mexico when they didn’t have healthcare in the US, and attributed financial needs as a primary motivator for cross-border health migration. He reported people felt more comfortable going to Mexico for health care, as he believed their treatments to be ‘stronger’ than in the US, although he personally favored the U.S. health care system.

**Tiger**

Tiger started his story, raising his voice even in the library, to describe his fiercest opponent throughout his life: substance abuse and addiction. He revealed how substance addiction led to feelings of anxiety and depression. He reported working hard to overcome his addictions with the help of medication and treatment, “You know, you gotta take the medication, take care of yourself, ‘cause when you’re high --you’re like the worst.” He described his
depression as a withdrawing from the world, isolating, and getting upset easily. He reported the ravaging cycle of substance abuse he saw in himself and others as he relayed the loss of weight, anxiety, and desperation, and the lowering of self-esteem as “people hustled family for money to buy dope.” He sought help at a mental health clinic, and felt that those services, along with positive peer support, played an important role in his recovery from depression and substance abuse. He emphasized the need for spirituality and family support in healing. He reported positive effects in his life with treatment; he returned to a healthy weight, started interacting with family again, and participated in health activities with family and sober friends. Tiger also reported using herbal teas for relaxation, and noted this form of treatment, along with medications and therapy “help you be human. They put you where you’re supposed to be at.” Tiger preferred to receive mental health information firsthand from others, reporting a friend led him to a treatment center on his road to sobriety. Hence, he relied on TV and commercials only to provide numbers and contact information for mental health treatment, but did see those media as providing incentives for people to “cut loose their addictions.” He reported his belief that health care services were better in Mexico, “The pills are different. The treatments are better to kick the habit.” He believed that some health systems were more motivated by profit than providing help, and that insurance in the US helped to offset this potential barrier to mental health access. Ultimately, he felt the person with mental illness must want the help in order to benefit. Having financial assistance and insurance allowed that help to be provided for him in saving his life from substance addiction and its consequences.
Ricky

Ricky required some initial discussion in Spanish to explain that the transcriber only understood English, therefore, his participant responses needed to be in English. Ricky reported he had multiple surgeries for leg problems, Hepatitis C, and hypertension, and disclosed in the library, that he came from a drug- and sexually-abusive home, was in foster care and prisons most of his life, and now, sober, he has been unable to find work and health insurance. Ricky discussed his paranoia, psychosis, and mood swings, and how these, along with his multiple medical problems, affected his thinking. He reported wanting medications and therapy to assist with his coping, “Self-help classes helped, because we had to dig down deep to the core of our problems to work on those resentments, to speak rather than act out.” He learned in prison that exercise and non-pharmacological methods were also helpful in coping, along with integrative treatments, such as acupuncture and herbal teas. Even he could find humor in his life though, when, with his tattoo-covered arms and legs, he related he was worried about acupuncture because he was afraid of needles. He reported that, while he’s waiting for insurance to receive medication, counseling, and integrative care, he’s found relaxation in painting. Ricky then displayed some of his portraits and landscapes, stating painting in prison provided him with a positive coping skill. He reported preferring mental health information in one-to-one interaction and did not rely on TV, radio, or newspapers for information, as he admitted that hearing about potential side effects of medications worried him. Ricky felt the Internet was helpful in providing mental health information, but reiterated his preference for face-to-face communication, hoping that, in the future, he would be in a position to provide this type of support to others who had lived through similar situations. He felt finances were a primary motivator in seeking health care in Mexico, “They’re cheaper. You can get medications there cheaper. The doctors are cheaper; I
just don’t have my passport.” He felt the US had better training in health, but that Mexican has a better system of service provision, the “one-stop-shop”. He stated doctors, laboratories, and pharmacies were all part of the same company, in the same building, so service provision was smoother than in the US. Lastly, he highlighted the need for mental health services in education and child development, and services for the identification of children at risk. He believed himself to be one of those children Ricky believes his subsequent substance abuse and incarceration resulted from the failure to properly identify mental health issues and provide treatment. Ricky, because of his report, was provided with social services resources at the end of this interview.

**Tino**

Tino, during his interview at the library, expressed his concern about the Mexican community that he felt experienced health inequities and were less likely to seek physical and mental health treatment. Tino reported he had a cousin with depression who was on medication. He spoke in great detail describing the difficulties his cousin faced with depression. Tino admitted that his own situation was different, as he uses physical activity for stress reduction and relaxation, “…uses exercise to channel your energy, getting everything you have within you out there, to walk through what you’re feeling.” Tino also reported psychiatrists, counselors, medications, family, and church can be helpful in coping, as well as IM activities such as acupuncture and herbal medicines. He then described a time when he misused alcohol and was sent to DUI classes by the judge. He reported these classes were helpful in learning about substance use and coping skills to prevent misuse. He found little information available in the public forum on mental health, reporting he did not even think there was an Alcoholics Anonymous, as it was not advertised. He believed medical providers should dispense mental health information and education, and thought this mode would minimize the stigma associated
with mental illness. He also liked the ‘Anonymous’ model of phone hotlines or groups as a method to reduce stigma. He acknowledged TV shows, like Dr. Phil, as helpful in educating the public, but felt a hotline number should be part of the closing credits of shows such as these. He reported seeing information in Spanish, but considered this information as more confrontational, like Maury Povich- or Jerry Springer-type entertainment. Tino felt having the information in Spanish would allow it to be more acceptable for persons of Mexican heritage, and more easily understood through their native language. He reported persons travel to Mexico for health care due to financial reasons, but felt negatively about the Mexican health care system. He believed some providers in Mexico weren’t legitimate or lacked credentials, while in the US, accreditation was enforced. He did not know anyone that had sought health care in Mexico and did not feel he would ever have a desire to seek healthcare there, despite his lack of insurance.

Bobby

At the library, Bobby started her report from age fifteen; when diagnosed with multiple sclerosis (MS), she began to experience depression. She reported progressively losing feeling in her limbs, and one day woke up and could not move. She chronicled the struggles her parents had finding treatment, taking her to doctors on both sides of the border, and even taking her to herbalists and healers in Mexico. One healer even used bee stings as part of his traditional treatments. She admitted that, during this time, she experienced depression, and described her depression as feelings of hopelessness and loneliness. Bobby was placed on medication for depression and had behavioral therapy for depression while in the hospital recovering from the exacerbation of MS. She spoke of her therapist, “She was nice, interested in talking to me, listening to me. I had more trust in her than my family; she knew what I was going through.” Bobby reported the connection with her behavioral therapist empowered her and motivated her
to get better, “Instead of worrying about getting better [with MS], she [the therapist] changed the way I thought about things.” She also felt integrative methods of care, especially herbal remedies, were helpful. She relayed how families carry on herbal traditions in healing. For her family, herbal traditions were considered the first line of treatment for any ailment. She believed mental health education and information should be started with children in school, with counselors, teachers, and nurses providing mental health information and helping to identify students at risk. Bobby also felt family and friends were helpful in providing mental health information, and preferred the one-to-one interaction that this offered. She reported reading newspapers and articles on the Internet for educational information and referral resources. She felt that mental health information was not prominent in Spanish language media. Bobby believed that, by providing stories of persons overcoming mental illness, like her, this would inform others, while minimizing stigma and encouraging the search for mental illness treatment. She also reported perceiving a lack of mental health care in Mexicans due to a focus on work to the exclusion of self-care needs. Bobby reported “speaking out to them [Mexicans]” would encourage people to not minimize their mental sufferings, but to seek help. She reported people mostly go to Mexico for healthcare related to the lower costs and lack of insurance. She also reported the preference for one-stop healthcare in Mexico, contrasted with the US, “Getting healthcare in the US is strenuous. It takes a lot of work to get medical health, and over there it’s very easy.”

J

As he told from the library, J. has diabetes, and his sister has depression. J. described how depression leads his sister to argue with her daughter. He also described depression “Like a painting; to be depressed...you’re in another state of mind, just out of the sunshine, like in a deep
corner or something.” He spoke of depression as being a self-imposed dark corner of punishment. He described anxiety and nervousness as “You’re in danger. Somebody’s out to rob a store and you’re there, and you’re scared.” He reported he would access mental health services by calling the police, a doctor, or a helpline. He also named community services agencies as being assistive for overall health and support. J. felt those seeking mental health care would benefit from medications and therapies, helping people to feel happier, have nicer relationships, and better lives. He was aware of mental health information available on television, naming Abilify® as a commercial he saw for anxiety and depression. He also felt books and the Internet were important sources of mental health information. Stating of the Internet “It’s like a cloud and you; it’s like a lot of little clouds, and you choose the best ones, the best ones for your, for your, for your, to solve your problems.” J reported Spanish language information might encourage someone of Mexican heritage to get help, which may not occur with information heard in English. Finances were a primary motivation for J. to seek treatment help in Mexico, but he was not someone that had utilized this resource.

**Christian**

At the library, Christian reported his knowledge and experience with mental health stemmed from his mother’s claustrophobia. He has felt fear and frustration, in the past, in his inability to help her when she has panic attacks in crowds and, at times, even in their home. He also reported that is father was drug addicted, and he observed significant spousal abuse in the home. He reported his mother and father exposed him to the effects of mental illness through their use of drugs and pills to cope with depression. He saw his father “lose his moral status, his values. Things they wouldn’t do before, they do it…They lose track of who they are; forget who they were.” He felt spirituality and the Bible could be supportive during these times. He reported
a rehabilitation program helped his father, and that hearing about the rehabilitation program on a radio station, hearing “other people can get well, I can too,” was instrumental in providing support for his father’s sobriety. Christian believed when someone recovers from mental illness, s/he is more positive, “Doesn’t focus on themselves, looks outwards to other people, and start to associate with people, good people again. They have a purpose.” He found mental health assistance through help lines, billboard advertisements, as well as through television commercials. He also reported finding mental health information available to him at his workplace, which was convenient and encouraging. He believed information in Spanish was exceedingly helpful for those who speak Spanish exclusively, but also because he felt culturally persons may “get more out of hearing someone from the culture; like from a family member, they’d open up to seeing Mexican people.” He also found flyers helpful in informing him on mental health matters. He reported financial issues were the primary reasons for Mexico travel for health care, but that he preferred health care facilities in the US.

Yali

Yali was interviewed at the library after having just returned from the dentist in Mexico, so had a slightly garbled speech for a time, as the Novocain was wearing off. She reported, since she doesn’t have health insurance, she routinely goes to Mexico for healthcare treatments. She reported her aunt had significant depression after the birth of her son, and she watched as this depression affected not only her aunt, but her cousin as he grew up. She described her aunt’s continued difficulties, “Not wanting to leave her room even, just stares at the walls. The family goes to encourage her and help her, but she’s nervous; she heard voices, and was scared of us.” Yali related her heartbreak in the story of failed treatments, hospitalizations; next, the family is taking this aunt to Mexico for treatment, unable to find something that would “bring her back.
We used to have fun. We all used to dance and have fun. Now when we come over, she’s still in her robe.” Yali felt medications, family, and group therapy support had been most helpful in treatment for mental health issues. She also saw what she termed the ‘old Mexico botanico’ benefits of herbal remedies like yerba buena. She reported she and her sister, a nurse, have debated the effects of herbal remedies and their place in current health care. She also noted the benefits of integrative care, such as acupuncture and massage. She described reading books and the Internet for mental health information, reporting she had read many articles in search of information for her aunt and cousin. Of her cousin, whose life was significantly affected by his mother’s mental illness, she said, “I try to take him to things, be there for him. He’s smart, but he has no one to talk to about life.” She reported television programs “make people more comfortable to get help that someone was having a similar experience.” Yali reported flyers and pamphlets on mental health topics allowed for community knowledge of these issues. She favored providing information in Spanish, “They can open up better, express themselves better, and have less stress to get help.” She reported people traveled to Mexico for familiar comfort as well as financial matters. Besides financial efficiency, she reported that services in Mexico were easier to obtain; there was one-stop-shopping, “where all services from doctor, lab to pharmacy were in one building.” Overall, she believed the dissemination of mental health information in Spanish and English in schools, work, and the community is an important step in assisting people who continue to suffer as her aunt does.

Debbie

Debbie voiced her main concern, during the interview at the library, as indifference to the health insurance system. She reported having hypercholesterolemia and, “When I had insurance, I still had a deductible, so there wasn’t a lot I could do for treatment. Now I don’t even have
insurance,” and her cholesterol issues still weren’t being addressed. She voiced similar concerns regarding her sister with bipolar disease, as she has observed her efforts at obtaining adequate mental health care. When her sister was having mood issues, “She was upset, gaining weight, wasn’t paying attention to her kids, wasn’t herself.” She reported her sister sought medication management and counseling to address her concerns. She admits her sister also has anxiety issues, and felt guilty, embarrassed, and worried about getting help based on the potential reactions of others. When improved, she reported her sister “was smiling, wanting to be with her family, changed things for the better.” Debbie reported she received assistance and information on mental health issues from television, with commercials and programs providing education and understanding of mental illness and “how it’s so common, but people can get better. It’s not hush-hush.” She reported family, faith, and community supports were also helpful in providing assistance for mental health issues. She believed flyers, billboards, and information in health care offices could be assistive in informing persons about mental health and minimizing anxiety about treatment seeking. She felt reaching out individually in the Mexican community was an important part of improving access for this group, “Go to them personally to let them know there’s some kind of help out there.” In Spanish, mental health information would be helpful in reducing stigma, and informing people that “it was possible to get better, not to be nervous about reaching out.” Debbie reported travel to Mexico for general health care was motivated by cost, but also by the ease of obtaining a full-service consultation. She admitted, however, that some in her family shunned services or anything to do with Mexico, “The Americanized Mexicans, Chicanos, they act like it [herbal medicines] is poison, when that’s where we grew up, and taking it then was fine. We lived more and better over there than we have lived over here; my grandma lived to be 103, and nothing happened to her that was bad. We came for a better life for our kids,
but I don’t know if I’m going to make it to 103. My grandfather was 93; they were doing something right in Mexico versus the US.”

Carlos

Carlos, interviewed at the library, had a car accident and head injury two weeks prior to his interview and, since he had no insurance, he sought no treatment. He did report he used somewhat more marijuana that week for headaches, but didn’t report any other problems from his recent car accident. Besides his own mental health issue of substance abuse, Carlos reported a friend with anxiety and tremors. His friend was almost arrested as he was stopped by police who became suspicious of his friend’s level of anxiety to the point that others in the car had to convince the police there was no cause for alarm. Carlos reported that for any symptoms of anxiety or depression, “I would try weed; smokin’ pot, cannabis, sativa, herb, cannabis, medicinal marijuana.” He felt mental illness and substance abuse were problems of the mind, the things we consume today, the stress of chasing after money, and how people live today. Given this, he felt cannabis helped him overcome these pressures, and he minimized the ability of commercial medications to treat mood issues. He believed depression and anxiety were caused by chemical imbalances, which cannabis could correct. He also believed that, because of the push for pharmaceuticals and the associated gain, medical marijuana use was being suppressed from the general public. For Carlos, family support played a significant role, “The family is like the closest thing; you’re connected with them somehow or ways. What’s love, parents, the family?” Carlos also reported herbal medicines, traditional healers, and integrative care (acupuncture, natural foods) were important treatments, and felt integrating these services into everyday life led to more optimistic persons overall. He used the Internet extensively for healthcare information, specifically to join fights for changes in medical marijuana legislation.
Carlos believed that television and crisis hotlines were helpful in providing information and support for mental issues, although he questioned the motives of the advertising business. He reported financial reasons as primary in seeking healthcare in Mexico, but that older persons might be likely to seek healthcare in Mexico because of their familiarity with Mexican health services, “The first-generation people are more stuck in their ways.” He reported he did not travel to Mexico as “It’s a hassle, a drag” to deal with border patrol when crossing. He reported mental health information should be provided in school throughout education, “If we don’t know what is healthy, how can we be healthy, or know when we’re not mentally healthy?” He reported information in Spanish could be helpful, “They would see a person like them communicating. They’d understand it better. They’d start to care about their health.”

**Santiago**

Santiago reported from the library that his cousin experienced significant depression after the breakup of his relationship. He stated he had used his own story of depression to give his cousin hope and assistance in coping. Santiago saw depressive symptoms as withdrawal, negative attitudes, and thoughts of self-cutting and death as symptoms of depression. Santiago almost cried as he shared the story of his cousin. His cousin’s former girlfriend aborted their baby without his knowledge, and Santiago reported how he helped his cousin deal with this. He believed spirituality helped in coping with mental health issues, along with medication, counseling, and, when needed, police intervention. He admits he had anger issues and learned coping skills through domestic violence classes, and he relayed this knowledge to his cousin in his time of need. Santiago spoke of how removal from the current life worries to the seclusion of a boot camp may help a person focus on his/her current state to work towards addressing his/her issues individually. He also reported the need for family support, later, as part of this process.
With treatment, Santiago felt people could “be themselves again, be there for their families, stay out of jail, and be a light.” He notably saw the intervention of law enforcement and crisis teams as helpful for some people, “They come and talk to you, decide if you’re safe, then help figure out what to do with you.” He reported benefits from herbal teas, acupuncture, and other integrative methods. He reported he obtained more information from the Internet than TV or radio, but acknowledged the ability of media to communicate information, “Maybe you’ve never heard about it [mental illness]. What you see, you can see it on TV or a movie, and that’s gonna tell you what’s going on, what can happen.” He believed information in Spanish would tell the same story, but with a Spanish voice, “They might not think it will happen to them; they’re not Anglos. When you see a Mexican, you think, ‘Maybe we can have those problems too.’ ” He felt there were advantages in going to Mexico for healthcare services, notably reporting providers had more training in Mexico and believed the Mexican health system was, in some ways, more competent in technology equipment, and medications and services than in the US. Santiago reported that persons of Mexican heritage would appreciate these extra services specifically tailored for them.

**Julia**

Julia interviewed at the library, reported she had interstitial cystitis, one of the more recently developing autoimmune medical disorders that has both physical and mental health symptoms. In the years since her diagnosis, she reported multiple medical and mental health treatments, finding only modest relief, “I was put on every type of pain pill, finally something that just numbs your bladder. Oh my gosh, they put me on antidepressants; I was catatonic, then Prozac®, then Adderall® saying I was ADHD. I just stopped it because I heard all the bad side effects it has on your body, so I just stopped taking it.” Julia reported that her issues were
eclipsed by the anxiety and mood changes in her daughter, describing her “meltdowns, crying, making a big scene, saying mean things to me, just nasty things.” She and her daughter had counseling, when her daughter was a child, for support and parenting tips, but subsequently, Julia felt her daughter still experienced significant difficulties with her mental health. Julia found that her daughter’s mood and behavior improved with medical marijuana, and that, with counseling, some relief was provided, although she admitted she still had misgivings about her daughter’s marijuana use. Julia also felt medications and therapy were important methods in coping, and found group therapy particularly helpful for her own cystitis-related mood changes. She reported strong family and spiritual connections and their impact on her mental health. She named acupuncture, herbal medications, and exercise as helpful treatment. Julia found television shows on mental health topics were also helpful for obtaining mental health education and information, but questioned the availability of these programs locally, “There are job fairs, why aren’t they health fairs with people providing mental health information?” She also reported word-of-mouth methods more helpful for garnering the attention of persons of Mexican heritage for mental health information, relaying a story of how she helped someone who opened up to her while she was at work, and provided information and resources for mental health services. She reported information in Spanish would be especially helpful for those who have little English and, as such, obtain less information through media sources about general health and mental health topics. She reported these issues caused problems for her when growing up, and, having that knowledge and resource information in Spanish TV may have prevented some of her and her family’s sufferings as a child. Julia reported people went to Mexico for healthcare because of the increased level of comfort they feel in Spanish-language services and a familiar system, “Seeing someone Hispanic and they’re speaking Spanish too, that’s probably why they’d go. They’re on
the same level as the person they’re talking to. No one’s talking down to them, like seeing a
girl provider if you’re a woman.” She reported Mexican families have esteem for the elders
and learn many health practices from them that improved overall health outcomes, a custom that
was decreasing as many younger families moved away from elders to migrate to the US.
CHAPTER V: RESULTS

Chapter V presents the findings about treatment preferences for mental health from interviews with participants of Mexican heritage living on the US-Mexico border. This chapter will address the research questions that guided this study.

1) What are the treatment preferences for mental health issues and illnesses?
2) Are there personal characteristics that influence treatment preferences (age, gender, education, income, insurance, employment, and generational status)?
3) Are there characteristics related to acculturation that influence treatment preferences?
4) Are there characteristics related to mental health issues and illnesses that influence treatment preferences?
5) Does the mental health experience (self or immediate family) impact mental health treatment preferences?
6) What is the use of media to obtain mental health information?
7) How does acculturation and treatment experience influence media use for mental health information?
8) How is understanding ascribed to anxiety/nervousness, depression, substance abuse, schizophrenia, and bipolar disorder?

Overall, results demonstrated that preferred mental health treatment aligned with allopathic practices, such as taking medication and going to the doctor. Matrix order analysis, however, revealed several patterns that are presented in this chapter.
Description of Treatment Preferences

Research Question 1: What are the Treatment Preferences for Mental Health Issues and Illnesses?

To answer Research Question 1, participant responses to mental health treatment preferences were grouped by category of mental health treatment preference. For this study, mental health treatments were broadly defined as seeking or participating in adaptive methods of coping with mental health issues and illness. Additionally, mental health treatment preferences were coded based on the participant’s perception of mental health treatment preference to improve mental health outcomes, not on professional standards of what has been traditionally considered mental health treatment. A total of twenty-five mental health treatment preferences, ranging from provider-prescribed treatments, to traditional remedies, to self-management approaches, were reported by participants. The number and percentage of participants reporting each mental health treatment preference is presented in Figure 6, as well as the use, definition for each mental health treatment and a participant example presented in Table 2. Each mental health treatment preference is defined and accompanied by a quote from participants.
FIGURE 6. Mental Health Treatment Preferences by Percentage.
<table>
<thead>
<tr>
<th>Treatment</th>
<th>n (%)</th>
<th>Definition</th>
<th>Quote</th>
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<tr>
<td>Medications</td>
<td>21 (100)</td>
<td>Use of pharmacological agents prescribed by a health care provider</td>
<td>Linda: <em>When you’re on medication, I think you get better. It’s just giving you an idea of what you’re doing. Like, what medication they gave ‘em and they go over there, they give ‘em the right [med]. They know what they’re dealing with.</em></td>
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<tr>
<td>Going to the Doctor</td>
<td>20 (95)</td>
<td>Seeking help through a doctor’s office or other health care provider in a clinic or other medical outpatient facility.</td>
<td>Mary: <em>I think going to a doctor, maybe they’re primary care, and just talkin’ about what’s going on, “I don’t know what to do.” And I think your primary care physician can always, you know, lead you towards the right direction, “Do you need to go talk to this person? Or this other doctor?”</em></td>
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<tr>
<td>Family Support</td>
<td>20 (95)</td>
<td>Interaction and support from immediate and extended family members.</td>
<td>Cepeda: <em>If it’s too much for you to be even and ask one of your family members can check for you. You can get that for; you can get that real support network. Reach out for help? It’s just a relief; you can go and have that option. Then you can go to get help.</em></td>
</tr>
<tr>
<td>Social Support</td>
<td>19 (90)</td>
<td>Interaction with friends and non-professional verbal discussion and validation.</td>
<td>Debbie: <em>Well, just by their experiences, I’m sure that there’s people out there who have gone through the same thing, and when you share with someone, I think that opens the door for communication, and then, “Well you know what I have? – So-and-so.”</em></td>
</tr>
<tr>
<td>Counseling</td>
<td>19 (90)</td>
<td>Use of individual or group therapy and interaction with a trained mental health professional.</td>
<td>Mr. C.: <em>So, it took a while because she had a lot of pride was like, “Oh no, no, no.” But then finally, I just told her, “Go get some kind of counseling.” So we called around and called around until finally we got hold of some people, and instead of making us wait so long, they got us in within about a week, maybe. So, they got us in, she did her first session, and she got diagnosed bi-polar, anxiety, and depression.</em></td>
</tr>
<tr>
<td>Herbal Medicine</td>
<td>17 (81)</td>
<td>Use of herbs as medicines in the form of teas, potions, or compounds obtained over-the-counter or by trained providers.</td>
<td>Princess: <em>The herbs and all those natural resources. For you to bring it in, boil it, and the pill is like, “Just take it. It will take away your anxiety and whatever.” You know what I mean? So it’s a big change. Herbs is medicine; it’s just that it’s a plant, and it needs to be boiled and cooked and whatever. It helps them because it’s a medicine. It helps them because it’s a medicine. And I know a person that studies plants, but I know that it’s a medicine that will medicate.</em></td>
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<tr>
<td>Category</td>
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<td>Description</td>
<td>Example</td>
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<tr>
<td><strong>Spirituality</strong></td>
<td>14</td>
<td>Any use of religion, prayer, meditation, or mind/spirit/sacred-based methods of treatment.</td>
<td>Tiger: I’ve been meditating like, praying and meditating, too, but I don’t take no medicine right now, ’cause I don’t know, I have a meeting today at three for treatment, medical and mental.</td>
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<tr>
<td><strong>Physical Activity</strong></td>
<td>14</td>
<td>Any form of exercise or physical activity.</td>
<td>Tino: Most definitely, actually, and now that I’ve been getting more into fitness, I’ve seen how being able to have an excerpt, like any type of fitness or any type of physical activity, actually helps you channel any kind of left out energy you may have or anger.</td>
</tr>
<tr>
<td><strong>Integrative Medicine</strong></td>
<td>13</td>
<td>Methods of treatment for mental illness as integrative or alternative therapies, classified by NCCAM*.</td>
<td>Carlos: It’s pretty interesting, but then there’s people that believe you can purify all this stuff with your mind, and like there’s a doctor who does that Chinese water study, like, to be like, ah, channel our energies or diseases, too, food to like, anything.</td>
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<tr>
<td><strong>Coping Skills</strong></td>
<td>12</td>
<td>Methods of treatment for mental illness as positive ways of solving personal problems by reducing stress and anxiety and managing negative emotion.</td>
<td>Andrea: In fact, when I was working with her, she taught some really good coping skills, and I was even able to get off my medication for a while. So I just kind of learned how to work on things little by little. So it really worked well for me.</td>
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<tr>
<td><strong>Activity Management</strong></td>
<td>11</td>
<td>Participation in indoor/outdoor, solitary, or group activities that may be useful in addressing emotional, social, and interactional needs.</td>
<td>Yali: Well, even to play board games, or to watch TV with them, and like, I don’t know, just make them feel more comfortable around you. Even to get their minds off of things, whatever they was on.</td>
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<tr>
<td><strong>Inpatient Facility</strong></td>
<td>9</td>
<td>Facility other than on an outpatient basis, Group homes, halfway houses, or other facilities that provide milieu.</td>
<td>Christian: ‘Cause they’ll take ’em from that environment that they’ve been in, so there will be something different about the environment [inpatient], and they’ll be more people that want to help them there, if they want help to change it, change the way we think.</td>
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<tr>
<td><strong>Small Group Interaction</strong></td>
<td>9</td>
<td>Therapeutic interactions with a group leader and a number of non-related participants experiencing similar mental health issues.</td>
<td>Gerardo: A lot of people tend to lock up and not say stuff. But just find a way to get ’em to open up, and there’s probably going to be tears shed and whatnot, things like that, but I think it’s better that way. Because it [group] could prevent a lot of domestic violence, and a lot of unnecessary arguments, a lot of drug use, and alcohol, and things like that.</td>
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### Healthful Eating and Appetite

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<th>Num</th>
<th>Description</th>
<th>Julia:</th>
<th>Notes</th>
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<tr>
<td>9 (43)</td>
<td>Healthy eating in relation to types of food, portions; better food choices that maximize health and wellness through nutrition.</td>
<td>She went through natural foods, trying to use natural food. I know certain foods, so she went to raw foods that would help her. . . I know certain foods, natural foods can help.</td>
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### Contacting Police

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<th>Felis:</th>
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<tr>
<td>8 (38)</td>
<td>Interaction with the police or jail in order to obtain mental health services.</td>
<td>I think I needed something to help him if he overheats or something for help me with him, because I have to go to the police for (them to) calm down my son sometimes.</td>
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### Mental Health Assessment

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<th>Num</th>
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<th>Santiago:</th>
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<tr>
<td>7 (33)</td>
<td>Interaction with a crisis or mental health team that evaluates a person’s risk for self-harm and determines need for inpatient placement or other mental health dispositions.</td>
<td>Well, they come and talk to you, and say, “Hey, you want to kill yourself? Do you, like; see stuff when you’re sleeping? Or when you’re awake?” Or take it to where they’ll put you in there, they just come and talk to you, they come to your house, and they take you out to eat and chill.</td>
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### Avoiding Negative Influences

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<th>Description</th>
<th>Reuben:</th>
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<tr>
<td>5 (24)</td>
<td>Use of active, adaptive avoidance of negative interactions, people, and places in order to maintain mental health and prevent substance abuse.</td>
<td>“Well, she’s different, more happy, more energetic; she doesn’t get short tempered. “MmHmm,” her doctor would tell us. “You know, don’t make her angry, you know, do everything. Stress-free as much as possible.” And we try to do that.</td>
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### Traditional Healers

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<th>Num</th>
<th>Description</th>
<th>Mary:</th>
<th>Notes</th>
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<tr>
<td>4 (19)</td>
<td>Use of faith- or other- based cultural healers.</td>
<td>Curanderos, I think it’s kind of like the same thing with herbals and all that. I’ve seen my parents go to a Curandero, and if they’re not feeling good, and if there’s someone who’s not feeling good, and they go and all the sudden it’s like “Hey, I’m feeling better.”</td>
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### Positive Energy

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<th>Num</th>
<th>Description</th>
<th>Carlos:</th>
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<tr>
<td>4 (19)</td>
<td>Feelings of emotional or mental energy or personal strength that affect and improve overall well-being.</td>
<td>It’s pretty interesting, but then there’s people that believe you can purify all this stuff with your mind, and like there’s a doctor who does that Chinese water study, like, to be like, ah, channel our energies or diseases, too, food to like, anything.</td>
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### Body-Based IM Practices

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<th>Description</th>
<th>Felis:</th>
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<tr>
<td>3 (14)</td>
<td>Activities promoting self-care, esteem, and awareness, such as manicures, pedicures, facials, and non-therapeutic health care procedures.</td>
<td>It’s very comfortable, yeah, I got it [to relax]. I love massages. They help a lot, yeah. And that helps me sometimes, and a pedicure.</td>
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### Social Service Agency

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<th>Description</th>
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<tr>
<td>3 (14)</td>
<td>Seeking services and treatment through a non-mental health social assistance service agency.</td>
<td>The food bank in Yuma, I mean they give you food there, and you get like a monthly membership if you feel certain, for certain criteria. And there’s a mission in Yuma.</td>
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Mental Illness Prevention

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<tr>
<td>3 (14)</td>
<td>Any activity performed proactively for the purpose of promoting mental health/wellness and preventing mental health issues and illness.</td>
<td>Tino: <em>I believe that now that I’ve been through that, I believe a lot of youth should be exposed to help like that at the first symptoms, instead of being helped when the problem’s already huge and has already engulfed their whole life.</em></td>
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Journaling

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<tr>
<td>2 (9)</td>
<td>Writing, journaling, or recording by hand life or emotional experiences that are designed to improve mental health outcomes.</td>
<td>Mary: <em>And I’m like, writing, so I start writing. Maybe not even related to what if, just about anything else. If at some point I’m distracted, or very anxious, or whatever, I have to leave, I know I have my notes.</em></td>
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Social Skills Training

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<tr>
<td>2 (9)</td>
<td>Training in social inclusion and interacting positively with others from a licensed provider.</td>
<td>Mary: <em>[I learned how to cope with things] like different, like maybe, not social skills conference, but some other conflicts that I know, different communities have different stuff, like social fields.</em></td>
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Reading

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<td>1 (5)</td>
<td>Use of book, magazine, or print material as a positive coping skill to minimize stress or negative emotion or affect.</td>
<td>Mary: <em>Reading helps for me, at the moment, when I’m like, very stressed. I’m like, “Okay, I’m just gonna read a magazine.” Whatever I reading for 30 minutes, it helps for 30 minutes.</em></td>
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Note: NCCAM methods of treatment for mental illness include natural products, mind and body medicine, and other CAM practices.

All participants reported taking medications as the preferred mental health treatment preference. Over 90% of participants reported going to the doctor, family support, social support and counseling as preferred mental health treatments. Herbal medicine was a preferred mental health treatment method for over 80% of participants. In addition, over 50% of participants reported mental health treatment preferences for spirituality, physical activity, IM, coping skills and activity management as mental health treatment preferences. Over 30% of participants reported mental health treatment preferences for inpatient hospitalization, small group activity, healthy eating and appetite, contacting police and mental health assessment. Fewer than 30% of participants reported the following mental health treatment preferences- avoiding negative
influences, traditional healers, positive energy, body-based IM practices, mental illness prevention, journaling, social skills training, and reading.

Although 90-100% of participants reported fairly traditional allopathically oriented mental health treatment preferences, other preferences were described. For example, Rueben and Yali highlighted the importance of herbal medicine. Reuben reported belief in positive effects from herbal medicines:

I told her that if she takes herbal medicines, like the ones they sell in Mexico, you know, I think you would be cured.

Gerardo highly regarded physical activity and positive coping skills as effective mental health treatment preferences:

Yes, sometimes I’ll be running down the street at midnight, and, because that’s what it took, I couldn’t sleep, so I’ll go and exercise. So I think exercise, bein’ active, is also a very, very good way of treating your stresses.

Felis preferred social support, counseling and small group interactions:

I go to support her, and I think it’s nice, because these ladies or people stopping to teach you different things, talk about what happened to them, and all these different things that happened, that you cannot do something bad or something, it’s good.

A few others, like Pedro reported use of spirituality and social support as a mental health treatment preference:

Praying to God. He’s our Way. --That’s the only thing that could help me. You could really go into darkness or, what’s the one word, sorrow, where you don’t really want to do anything.

Christian notably reported avoiding negative influences as a mental health treatment preference:

Because they’re [bad friends] not always focused on their problems; they’re focused on whatever’s goin’ on around them. It depends on your friends too, if they are good, [not bad] friends, they’re focused on other things.
Each participant’s statements and sentiments about the seven most commonly reported mental health treatment preferences is presented in Appendix G. Selection was based on highlighting the major statements and sentiments reported by each participant during his/her interview for his/her most preferred mental health treatments.

The mental health treatment preferences reported by the study participants represent a variety of types of services, provider-prescribed, self-management approaches, and assessment related and initiation of services. The mental health treatment preferences were recorded from the vantage point of the participants, and not limited to traditional professional treatment services, to allow for the full description of the reported treatment preferences of the participants and their concepts of the access, utilization, and, satisfaction in mental health treatment services.

**Research Question 2: Are There Personal Characteristics that Influence Mental Health Treatment Preferences (Age, Gender, Education, Income, Insurance, Employment, and Generational Status)?**

A second-order matrix analysis of each demographic variable and mental health treatment preference was conducted to answer Research Question 2. Statements reported by the participants were noted and compared to responses from participants in other groups.

**Gender.** Figure 7 presents the second-order matrix analysis of gender and mental health treatment preferences. The table lists the number of participants and percentages reporting each mental health treatment preference.
There were consistent reports of the mental health treatment preferences between both groups for the top four reported preferences, with some differences between groups from that
Across all 25 mental health treatment preferences, the top four preferences for both genders were medications (100%), going to the doctor (100% females, 92% males), family support (100% females, 92% males), and social support (89% females, 92% males). For males, the next three mental health treatment preferences were counseling (75%), spirituality (75%), and physical activity (75%). Ricky (male), for example, talked about how family support helped, not only his family member, but also himself:

Yeah, she cries; she’s depressed, you know. I try to bring her out of it, you know, but at the same time, know that by that, that’s kind of like, I just self-medicate myself. Because I’m helpin’ her, but it also helps me. It actually gives me time to think about myself and my mistakes that I make and, like, what to say and what not to say, and when to speak and when not to speak, and it actually helps me to humble myself. Like I say, I grew up being a really angry person.

For females, the next three mental health treatment preferences reported were counseling (89%), herbal medicine (78%), and IM (78%). Linda (female) stated an herbal tea from Mexico helped her when she felt her primary care provider had not given her the medication she needed:

No, because he [PCP] told me to go back in three months. He told me to drink water, and that was it. Well, she [friend] told me that her ex-husband had kidney problems too. And she recommended that tea to him, and so it helped him. She went to Mexico and got it for me. [Interviewer: And when you took that tea, it helped how you were doing, how you felt?] Yes. Well, I don’t have pain anymore.

Physical activity (75%) was reported more frequently as a mental health treatment preference for men, while IM (78%) was reported more frequently for women than for men. Christian (male) reported his friend’s preference, mental health treatment, was a local rehabilitation center:

Experience, well, one of my friends, he got help. And I’m gonna say he, I think he went to the rehab center. And he was coming down from crystal meth; he’d been doing crystal for a long time, like 12, 15 years. And then he was having anxiety attacks, so he needed help. They gave him some, and it helped him out, ‘cause he was getting paranoid; it was messing with him.
Avoiding negative influences (33%) and contacting police (43%) were reported more frequently in male than in female participants. Christian (male) reported benefit from avoiding negative influences as part of mental health treatment preferences:

It helps because they’re, they’re around people who are positive. They’re around people that are gonna help them overcome those, whatever depression they’re going through. Because it helps them focus on things that are good, not focused on things that are bad.

Female participants reported activity management (56%) and body-based IM practices (33%) at a higher percentage than their male counterparts. Felis (female) espoused the benefits of massage as a mental health treatment preference:

I don’t know about such a thing. I don’t know about that, but I get a massage, like every month, I think. I recommend it. It’s very comfortable, yeah, I got it. I love massages. They help a lot, yeah.

Though both genders reported the same six primary mental health treatment preferences, men reported higher use of physical activity and avoiding negative influences, while women reported more statements regarding activity management and body-based IM practices to aid with mental health issues and illness.

Age. Figure 8 presents the second-order matrix analysis of age and mental health treatment preferences. The participants were grouped based on age ranges used by the U.S. Census Bureau.
When separating the participant mental health treatment responses by age, a number of interesting findings were observed. Across all age groups, 100% of the sample reported
medication as the top preference for mental health treatment. Tiger (age 26-40) reported medication was helpful as part of his recovery from substance abuse:

The methadone [medication]. ‘Cause I stopped doing drugs. I went to Aaron [pseudonym of NP at methadone clinic]. He got me, like, so I would feel alright, and that helped me kick heroin, little by little.

Participants between 41-55 years of age reported social support, counseling, and spirituality at a higher percentage than the other age groups. Ricky (41-55) reported talking to his best friend as a mental health treatment preference:

I can call and talk with, I have my best friend. But, you know, he’s known me for 30-some; put my problems on him, because he has his own problems, you know? If he really, yeah, if I need someone to really talk to, to me it’s just a roundabout, just the same old thing. So, I’m actually, mentally, I’m becoming a better person. But mentally, I still think I need to talk to somebody, too.

Participants under 25 reported coping skills and small group interaction at 80%, higher than any other age group. Mr. C. (Under 25) provided several insights into how traditional healers were helpful for mental health issues and illness:

It’s like that, and it’s their faith that heals them; and some Mexicans, Latinos and stuff like that, use espíritu, if they feel that anxiety can be attributed to someone, someone having something bad on you. ‘Cause it makes people out here in the States would think that it’s taboo, Mexican voodoo and devil and this-and-that. You can go, and it’s the same thing as talkin’ to someone. And then they can do what’s called a limpia, and they can do a little ceremony and cling to you and just help you write ‘em off to where you don’t have like a pure god, not like impure gods, but you feel a little but lifted. You feel better, as opposed to having a priest go around the rosary. Yeah, some people believe that doing stuff like that can help mentally, physically, the strength that you need; it’s just like Christ and all that.

Ricky (41-55) reported several patterns of healthy eating and appetite that helped with his coping for mental health issues and illness:

I don’t stay up all night watchin’ TV. I don’t wake up at four o’clock every morning, for some reason I wake up at four o’clock in the morning, and I don’t know what that is. I may even eat better; I watch my eating habits as opposed to eatin’ a lot, to not eat at all. You know, I don’t drink as much coffee. I don’t get
too upset at too many things, you know, that’s when I know I’m well, I don’t just, yeah.

Participants reported avoiding negative influences and body-based IM practices more often among participants aged 26-40 than for other age groups. Tiger (26-40) reported how avoiding negative influences was a part of his mental health treatment preferences:

Mostly I needed to stay away from those people, because they are a trigger, you know? Just by looking, you can tell who’s high; and that’s my thing right now, because, you know? The new friends are doing exercises, active, church, eating, getting together, and seeing and doing something where you drink with somebody else, things like that, you know? Drink real milk. My old friends, they just want your money and just want dope and you know?

Persons 41-55 years of age reported social support, family support, and counseling at a higher percentage than other age groups. Julia (41-55) reported the benefits that counseling could provide for mental health issues and illness:

Yes, I think personally, they can also help build a person’s self-esteem. Because maybe they’re not all to par. They may not think they’re not all to what they can be, and they’re down. There’s a lot of things down right now with the economy, et cetera, so I think counseling’s a really good thing.

As participants age, the report of more social-based interactive mental health treatment preference supports appears to increase, while more individualized mental health treatment preferences were reported by younger group participants.

**Income.** Figure 9 presents the second-order matrix analysis of income and mental health treatment preferences. Participants were grouped based on the income ratings listed as part of the income demographics questions of the ARSMA-II acculturation questionnaire (Cuellar et al., 1995).
Assessing group differences among income and mental health treatment preferences was somewhat difficult as groups were basically limited to those making under $10,000 per year and those making $20,000-$34,000 per year; other income categories were represented by only one
participant. Social and family support, and herbal medicine remain the more commonly reported mental health treatment preferences for all groups, while counseling was reported as the major mental health treatment preference expected by participants making $10,000-$19,000 per year. Participants earning $20,000-$34,000 per year were more likely to report social support (100% vs. 92%), counseling (100% vs. 75%), herbal medicine (83% vs. 75%), and spirituality (83% vs. 67%) than those the under $10,000 per year income group. Yali ($20,000-$34,000 per year) reported her doctor would be the person she would talk to about mental health issues and illness:

Well, I guess just consulting your primary doctor, and then going, kind of referring you, to wherever they think you should be. Like, different activities, like you said, or from a psychologist or psychiatrist, I don’t know. Well, they’d be more, like, equipped to deal with the situation, probably be a little bit more difficult for them. Well, they’re more trained and more equipped to ask the proper questions, proper techniques to use, so I guess that work.

Participants reporting less than $10,000 per year in income reported physical activity (75%) and IM (67%) as mental health treatment preferences.

Cepeda (under $10,000 per year) noted the benefit of IM as a mental health treatment preference:

They can talk to people that are in that field. Acupuncture, hypnosis. I would go and try to get phone numbers down, check newspapers for ads, or contacts, or promotions of the acupuncturist.

Gerardo (under 10,000 per year) also noted the benefits of healthy eating and appetite for addressing mental health issues and illness:

If you ate something healthy, some light meat maybe with some veggies and stuff, there’s some ways to get rid of it, digesting it properly, and you’re extracting all of the nutrition out of it. And it’s gonna give you energy. You’re gonna get up and go and move. You’re gonna feel a lot of energy, and in turn, you’re gonna feel better to where it’s just so simple. I mean, just the feel of this is a very, very big deal.
Participants making under $10,000 per year reported the use of more self-management approaches as mental health treatment preferences while those earning more were able to utilize other types of mental health treatment preferences.

**Generational status.** Participants were reviewed based on generational status in the US as reported on their ARSMA-II Acculturation Scales. Participants were grouped based on whether they declared their status as first-generation (born in Mexico), second-generation (born in the US, with either parent born in Mexico), or third-generation (self and both parents born in US, grandparent born in Mexico) [Figure 10].
FIGURE 10. Mental Health Treatment Preference Based on Generational Status.
(Generational Status=Number of generations the individual’s family has resided in the US. 1st generation n=3; 2nd generation n=14; 3rd generation n=4.)

Results are displayed for participant mental health treatment preferences, grouped by their generational status in the US. The majority of participants in the study were second-
generation immigrants. Second-generation participants were more likely to report IM as a mental health treatment preference than other generational groups.

Tino (second-generation) reported the benefits of IM as a mental health treatment preference:

I guess that’s where I’ve heard about it, and talking about how it’s a replacement for medications, for medicine in the West. Yeah, I’m pretty sure I’ve seen articles about that, but I’ve never really been interested in it. You know how it’s, I’m not gonna infer, but, it’s referred how medication here in the Western Hemisphere is taken a little bit more lightly than any other country. It’s more preventive instead of trying to cure whatever their problem is you already have. And I guess every, they try, in some places, they try to use a little bit more of an herbal-type of approach to most things.

First-generation participants reported increased use of herbal medicine (100%), contacting police (67%), and inpatient facility (67%) as mental health preferences at a higher rate than other generational groups.

Reuben (first-generation) reported he has looked for herbal medicine as a mental health treatment to help his wife with her concerns:

Herbal medicine? I told her that if she takes herbal medicines --like the ones they sell in Mexico-- I told her, you know, “I think you would be cured.” But one of the things is that they stole her Green Card. They won’t let her back [into the US]. I think herbal medicine would cure her.

Third-generation participants reported physical activity (100%), coping skills (100%), healthy eating and appetite (75%) and mental health assessment (75%) as mental health treatment preferences at a higher percentage than other generational group participants.

Christian (third-generation) reported how physical activity was helpful for him as a mental health treatment preference:

Yeah. It [physical activity] helps reduce a lot of stress. Well, yeah, it helps you think straight, too. It gives you, like, I can do it myself. I jiu-jitsu. So, it helps me mentally, because we wrestle around, and it does a lot of choking. Choking so you
cannot breathe, so you learn not to panic, so it helps you. So it helps you, if you’re going through something, to just calm down and focus.”

Although the top six reported mental health treatment preferences remained consistent between groups, participants reported some notable differences in secondary mental health treatment preferences when reviewed based on generational status.

**Insurance.** Participants were grouped according to their insurance status, no insurance, private insurance, or public insurance (AHCCS). Mental health treatment preference was analyzed (Figure 11).
All three groups reported the same preferences for their top six mental health treatments: medications, going to the doctor, social and family support, counseling, and herbal medicine.
Andrea (private insurance) reported that she and her friend discussed medication use as a treatment preference for mental health issues and illness.

Recently, I was talking to one of my friends and I told her I was on medication. So that surprised her that I was, that I needed something to help me. And so, like I made her consider, like, no, I’m not crazy. I can, you know, like normal people, we’re on medication.

However, other than these six preferences, participants with AHCCCS (Medicaid) insurance reported fewer statements regarding the use of other mental health treatment preferences, while those with private or no insurance reported use of other non-pharmacological mental health treatment preferences. Both Mary, a participant with private insurance, and Bobby, who has AHCCCS, reported how journaling helps them with their coping with mental health issues and illness:

Mary: For me journaling helps a lot, yeah, just what’s ever on my mind, I just start writing. And then I just leave it there and in a few days I come back and I read it again, I just kind of like throw it away, ‘cause I’m like, I don’t need this anymore.

Bobby: It helps you a lot. I’ve actually written articles for newspapers about that, about depression and multiple sclerosis.

Participants with no insurance reported preferences for small group interaction (71%), activity management (71%), and body-based IM practices (29%) more frequently than other groups. Yali (no insurance) reported body-based IM practices as a mental health treatment preference that would help her deal with stress:

I think it would be pretty neat, though massage would still feel good. I guess it would lower stress levels, I don’t know.

Participants with AHCCCS insurance reported fewer mental health treatment preferences than those in the private and no insurance groups. Differences between groups in their reporting of mental health treatment preferences were reviewed.
Education. Participants were grouped based on educational levels and ranges delineated on the demographics questions on the ARSMA-II Acculturation Scale. Mental health treatment preferences were reviewed based on the percentages of reports by each educational category (Figure 12).
FIGURE 12. Mental Health Treatment Preferences Based on Education.

(Education: ≤6th=Completed grade 6 or less; 7th-8th=Completed 7th or 8th grade; 9th-12th=Completed between grades 9 and 12; 1-4 College=Completed from 1-4 years of college; Post Grad=post graduate studies. ≤6th n =1; 7th-8th n =1; 9th-12th n =7; 1-4 College n=8; Post-Grad n =4.)

Most participants had at least a 9th grade education, with only one participant having an elementary education, and one participant having a middle-school education. Participant groups throughout the educational spectrum reported preferences for medications, social and family
support, and going to the doctor. For participants with only elementary education, mental health treatment preferences were related to medications, going to the doctor, family and social support, and herbal medicine. Participants with higher educational levels reported additional mental health treatment preferences. Participants with 9-12th grade education reported more responses regarding physical activity (100%), inpatient facility (71%), mental health assessment (57%), and social service agencies (29%) than those of other educational levels. Mr. C. reported a variety of activities that were helpful for mental health care:

> Just basic outlets, exercising, running, like I said, music, playing videogames, whatever you find, scrapbooking, whatever calms you. If you, if going and sitting outside for an hour, just sitting there, no nothing, if that’s what calms you and helps you, then that’s a good way. Exercising for an hour helps you, calms you. Little things like that, and you’ll notice a change within yourself. Stuff like that.

Post-graduate participants reported counseling (100%) and small group interaction (75%) more often than other insurance groups. Andrea (post-graduate) reported how counseling could be a helpful mental health treatment preference:

> To get help means to see a professional, such as a therapist or psychiatrist; somebody to help them with whatever the issue is that they have, so they can get better coping skills, and understand why it is they’re anxious or depressed. So that’s what it sounds like to me.

Participants with 1 to 4 years of college reported social support (100%), spirituality (88%), contacting police (50%), avoiding negative influences (38%), and positive energy (23%) responses more often than other insurance groups. Tino (1 to 4 years college) reported how maintaining positive energy was an important mental health treatment preference:

> I believe everything can be solved by just, you know, talking it out, or doing some type of activity, trying to get rid of whatever bad energy you may have, and do something, breaking, break, whatever. And I’ve seen a lot of people just get through stuff like that.
Participants, based on education, reported some differences in mental health treatment preferences with increasing education, although the top six mental health treatment preferences remain consistent between groups.

**Employment.** Study participants were grouped based on their employment status, using the ARSMA-II Acculturation Scale approach as employed or not employed. ARSMA-II Acculturation Scale response to the employment question was used to group participants into employed or unemployed groups. Reported mental health treatment preferences appear similar across employment groups (Figure 13).
There was one notable difference between the two groups: those reporting that they were unemployed also preferred herbal medicine (85%), as compared to 64% of those participants.
who were employed. Carlos (unemployed) named a number of herbal medicines that were helpful for mental health issues and illness:

> Oh yeah, definitely, well, chamomile is, like the basic. Chamomile may help you to sleep or calm you down. There are all kinds of plants that we don’t know about, that are still used in rituals, spiritually, like to treat depression. One way is, it’s another drug that they keep legal, the mushroom; they call ‘em magic mushrooms, ‘cause psilocybin is the chemical that, well, it gets into the brain. It’s a lot, like people of different cultures use it. And there is ways to self-medicate oneself. And there’s like, ‘cause it comes from, we are from the earth.

Employed participants made more statements regarding counseling (100%), physical activity (88%), inpatient facility (75%), coping skills (75%), and contacting police (63%) than those participants who were unemployed. Gerardo (employed) explained how developing coping skills has helped him address his anger issues:

> I think I found a way to channel the anger. I’m workin’ on it, even now, I’m workin’ on it. So, now I’m at the point where it’s not hardly anything bothers me. I mean, people are gonna say whatever they want to say, and at the same time, inside myself, I’m saying, “Well, I kind of know why you do it.” In other words, I kind of know why you took your anger out on other people, because you have issues, because you have things you need to deal with, and this is your way of dealing with it. And I just don’t let it bother me. And if it does, see, I’m not the kind of person that, somebody says something, I’ll say something back. So I kind of developed that character, that attitude now, to where when somebody says something, I’ll say it back. But it’ll put ‘em on to think more, like, “Whoa -- you’ve got me. Like a wolf, you got me good.” You know what I’m sayin’?

J. (employed) reported that for many people with substance abuse, they were able to get help from contacting police as a mental health treatment preference.

> Um, they probably go to jail. Yeah. Um, how would they go to jail? I don’t know, just facing the consequences of their actions. Because they’re getting into a lot of trouble, and they would get locked up. They could get treatment there to make a person more happy.
Unemployed participants reported social support (100%) and herbal medicines (85%) more often than employed participants. Pedro reported how social support was a needed mental health treatment preference for his family after the death of his son:

> Like when this happened to us, there was this lady that, she lost three of her kids, she had three boys, and she lost them all. And she was a person that we related to, like, me and my wife went and she made breakfast for us one day, and just that bond clicked. Because she’d been through it, so she said, “Something has happened and I can offer some kind of help, because I know how to deal with it.”

Employed participants reported more statements regarding counseling, physical activity, and coping skills. Unemployed participants reported higher proportions of social support and herbal medicines than employed participants.

**Research Question 3: Are There Characteristics Related to Acculturation that Influence Mental Health Treatment Preferences?**

Participants completed the ARSMA-II Acculturation Scale (Appendix A) and were grouped according to their scores. ARSMA-II categorizes responses into one of four categories based on total scores, demarcating levels of acculturation from very Mexican to very Anglo-oriented. Results from the ARSMA-II scale were coded to yield four categories based on level of acculturation (*very Mexican-oriented, Mexican-oriented to approximately balanced bicultural, slightly Anglo-oriented-bicultural, and strongly Anglo-oriented*). None of the participants in this study reported responses corresponding to fully Anglo-oriented. From this, participants were placed into groups based on their ARSMA-II score and their mental health treatment preference responses reviewed in Figure 14.
When reviewing reports of mental health treatment preferences for the differing acculturation score responses to the ARSMA-II, The five mental health treatments, medications, going to the doctor, family and social support, and counseling, were preferred by all participants.
who scored from very Mexican to slightly Anglo-oriented bicultural. Tino (slightly Anglo) reported the benefits of family support in coping with mental health issues and illness:

I guess if you have a pretty strong family background, they can be there for you. They can be there to hear you out. To me it's the same kind of system; they can either back you up with helping out and trying to walk you through whatever you're going through. 'Cause most of them are older than you and might have gone through the same thing.

Inpatient facility (70%), small group interaction (70%), coping skills (70%), and contacting police (60%) were mental health treatment preferences described more often by slightly Anglo group participants. Felis (slightly Anglo) reported using an inpatient facility as part of the mental health treatment for her son:

I called his case manager, and I ask her one time for making Title 36. I don’t want him to go to the hospital, ‘cause they can do nothing. It’s hard for me, because I push the case manager to make it for my son the SMI. They don’t have it a little more case managers. They don’t have nothing, only the psychiatric and hospitals, I think.

Andrea (strongly Anglo) stated how coping skills were helpful as treatment for mental health illness:

‘To get help’ means to see a professional, such as a therapist or psychiatrist. Somebody to help them with whatever the issue is that they have, so they can get better coping skills and understand why it is they’re anxious or depressed. So that's what it sounds like to me.

Strongly Anglo participants made more statements regarding physical activity (80%) and healthy eating and appetite (60%) than other acculturation groups. Ricky (strongly Anglo) reported how physical activity helped as a mental health treatment:

Exercise takes your mind off of things, and it actually makes you really tired. Like you work out the stress.

Mexican-oriented to approximately balanced bicultural participants reported spirituality (80%) and activity management (60%) more than other groups.
Princess (Mexican-balanced) reported several activities that were preferences for mental health illness:

It would help our community, people, and help them to work. I think they should put more into positive things: exercise, keep yourself occupied, work on your garden, be outside, go for a walk, stuff like that.

When reviewing mental health treatment preferences based on acculturation, differences in reports of mental health treatment preferences were noted between acculturation groups as discussed above.

**Research Question 4: Are There Characteristics Related to Mental Health Issues and Illnesses that Influence Mental Health Treatment Preferences?**

For this question, interview data were analyzed in regard to the participant report of their understanding of mental illness. Participants were divided into groups based on the number of responses related to types of mental illness: depression, anxiety/nervousness, or substance abuse. Participants were grouped according to their most commonly reported mental illness experience: anxiety, depression, or substance abuse. Substance abuse was not theoretically coded in the study, but was added, given the number of participants reporting mental health treatment preferences relative to this mental illness experience. Mental health treatment preferences were assessed and are presented in Figure 15.
FIGURE 15. Mental Health Treatment Preferences Based on Mental Health Issues.

(Anxiety n = 5; Depression n = 9; Schizophrenia n = 7.)

As stated previously, participants preferred medications, going to the doctor, family and social support, counseling, and herbal medicine as preferences for mental health treatment.

Participants who spoke about depression described counseling (100%), activity management (67%), inpatient facility (57%), and contacting police (67%) as mental health treatment.
preferences at higher proportions than other groups. Felis (depression) described how she contacted police for help with her son’s depression:

Because I think I needed something to help him if he overheats or something for help me with him. Because I have to go to the police for calm down my son. Because sometimes, it’s not a good idea, because I don’t know exactly where the problem is.

Participants who spoke about substance abuse group described spirituality (86%), physical activity (86%), healthy eating and appetite (86%), IM (71%), and small group interaction (71%) as mental health treatment preferences more than the other two mental illness experience groups. Interestingly, participants in the substance abuse group reported going to the doctor at only 86%, the lowest of any group. Princess (substance abuse) described how attending to healthy eating and to her appetite aided her health:

Yeah, and also I try to eat more healthy; like I haven’t eaten any carbs. Like bread and tortillas, we used to eat a lot of, but we eliminated all of the, like, we’ll eat it once or twice a week, but not- not every day. Yes, yes, because exercising helps your heart, and it helps your health, helps yourself to maintain a better healthy life and eating.

Mary (anxiety group) offered a number of group activities that would be helpful for substance abuse:

I think, not only individual, I think group therapy, or like different, like maybe, not social skills conference, but some other conflicts that I know. Different communities have different stuff, like social fields, or maybe like even baking, or reading, I don’t know, other classes that you, like, that help you get distracted. And, you know, things you like. Besides, maybe if you’re depressed, then you’re just sitting there at home. And maybe you can go out there and sign up for, maybe, a baking class if you like baking. It helps you get distracted. It helps you interact, and it helps you get out of your home.

Participants who talked about anxiety valued herbal medicine (80%), traditional healers (40%), and coping skills (60%) compared to those who spoke about depression and substance
abuse. Mr. C. (anxiety) described how traditional healers could assist with mental health issues and illness:

Yeah, you can go to healers. And Mexicans have a strong belief in all that. They can kind of try to, it’s - how can I say this? -- it’s like how this, the Western Civilization, how they have Jesus and Christianity and Catholic-- it’s like that, and it’s their faith that heals them. And some Mexicans, Latinos and stuff like that, use brujeria, like voodoo, and stuff like that, to heal them, which is just, and the essence is the same as having faith, because it’s their faith that heals them, and helps them.

Participants, based on mental health issues and illness, expressed some differences in mental health treatment preferences based on their report of anxiety, depression, or substance abuse. Trends in their reports were reviewed.

**Research Question 5: Does the Mental Health Experience (Self or Immediate Family Member) Impact Mental Health Treatment Preferences?**

For this question, participants who described a mental issue or illness in themselves or those who reported a mental health issue or illness in their immediate family were grouped accordingly, and their mental health treatment preferences analyzed and presented in Figure 16.
Although both groups selected the same mental health treatment preferences, medications, going to the doctor, family and social support, counseling, herbal medicine, and spirituality, participants who experienced mental illness as family members reported higher proportions of the mental health treatment preferences spirituality (70%), IM (70%), and healthy
eating and appetite (50%), than persons with mental health illness. Princess (family member) reported how spirituality helped her brother with his addictions:

He was a drug addict: heroin, for many years. And he got saved at church, and started being healed by the blood of Jesus who died for him. Believing, and reading the word of God, and applying the principles to his life. So he’s been sober for a long time. He was receiving services, at a mental health specialist with counselors, and then he was doing methadone as well. And we asked the leaders, the church leaders, to help him, because he didn’t know, nothing in his system, he would try to force his mindset, and believe what the word of God saved him, remove his mind, because he was in the same pattern of life, you know.

Felis (self) spoke about the benefit of body-based integrated medicine practices as part of her mental health treatment preferences:

It’s very comfortable, yeah. I love massages. They help a lot, yeah. [Interviewer: They helped you to relax?] Yeah, I go over here, where there’s one that has it here. And that helps me sometimes. Pedicure. Facials. [Interviewer: So taking care of yourself?] Yeah.

Participants who experienced mental illness themselves described more statements regarding counseling (100%), herbal medicine (82%), physical activity (91%), coping skills (73%), and small group interactions (55%) than those who described family mental health issues and illness. Tiger (self) reported a number of physical activities that he felt were helpful in coping with mental illness:

The new friends are doing exercises, active, church, eating, getting together and seeing and doing something where you drink with somebody else, things like that, you know?

Ricky (self) described how small group interaction was helpful for him in addressing his mental health issues and illness:

So I really didn’t know how to handle things; so by me talkin’ to somebody, like therapeutical [sic], because I’ve been in therapy classes, like in prison and stuff. The self-help groups and stuff, it actually works for me. And I remember where I take time to think about things like that, but at the same time, I have my health issues; I needed help.
Participants who reported self-experience of mental health issues and illness and those reporting immediate family experience of mental health issues and illness were grouped and their mental health treatment preferences explored. Differences between groups were highlighted and discussed.

**Media Preferences and Health Care Information**

**Research Question 6: What is the Use of Media to Obtain Mental Health Information?**

Five media modes were identified, and additional media modes were added as they were reported by participants during interviews for a total of 12 media modes. All reported media modes are presented in Table 3 along with the number of participants reporting these media modes, percentages, followed by media mode definitions and representative quotes for each media mode.
TABLE 3. Frequency of Media Use for Mental Health Information

<table>
<thead>
<tr>
<th>Media</th>
<th>n (%)</th>
<th>Total*</th>
</tr>
</thead>
<tbody>
<tr>
<td>TV</td>
<td>21 (100)</td>
<td>86</td>
</tr>
<tr>
<td>Andrea: Just from ads you see for medication. if you’re feeling like this, then I would just having that: I don’t want to get out of bed, I don’t want to get dressed. But I would do it, but I just didn’t want to. There were a lot of other factors that I thought were playing into everything. So, when I started seeing some of the TV ads, then I thought, “Oh, maybe there is something going on with me.”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internet</td>
<td>16 (76)</td>
<td>53</td>
</tr>
<tr>
<td>Gerardo: There’s a lot of sources out there; it’s up to you, whatever you want to do. But I mean today we have that simpleness of hitting, tapping something into the computer, and it comes right out, giving you a whole world of things to do. You know what I’m sayin’?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Books and Magazines</td>
<td>15 (71)</td>
<td>47</td>
</tr>
<tr>
<td>Rueben: Magazines, anything, and do you get those same sources to get mental health information? Or health information about anxiety or depression? For mental health? I think there’s a magazine that’s called ‘Medicine Journal’ or something like that. And it talks about behavioral health problems, addictions, depression, things like that.</td>
<td></td>
<td></td>
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<tr>
<td>One-to-One Interaction</td>
<td>14 (67)</td>
<td>45</td>
</tr>
<tr>
<td>Ricky: I don’t want to talk to somebody over the phone. I don’t want to do anything over the TV, because it’s like you’re talkin’ to someone that’s not even there, like you’re talkin’ to an invisible person. Me, myself, I’m not that type of person. I’m the type of person, I want to go talk one-on-one with somebody, and see ‘em face-to-face, you know? I don’t think the TV helps.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radio</td>
<td>13 (62)</td>
<td>24</td>
</tr>
<tr>
<td>Tino: I think more like the radio than television; I don’t see anything too visual that can convey wanting help. I’ve seen a lot of ‘em. I remember the advertisements, like if you’re going through this, or if you’re going through that, and they’re nice. I like the ones on the radio. It’s more about hearing it, but not actually seeing what you’re, person, I guess? ‘Cause some of the people on the advertisements, I’ve seen they’re either really sad, or you just can’t relate to them.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Newspaper</td>
<td>12 (57)</td>
<td>19</td>
</tr>
<tr>
<td>Bobby: I actually do always try to look at articles, because I know that multiple sclerosis does usually come with depression or symptoms of depression. And, um, it helps you a lot, because it provides a lot of information about other people have gotten over it, and how this needs help, and all that that stuff. And I’ve actually written articles for newspapers about that, about depression and multiple sclerosis.</td>
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<td></td>
</tr>
<tr>
<td>School</td>
<td>11 (52)</td>
<td>28</td>
</tr>
<tr>
<td>Carlos: Maybe in school, providing classes; not necessarily classes, like everyone’s mandatory health class; if it was like what you say you have in high school a mandatory health class, so they could teach there, depression. I thought they were targeting kids at a young age you know, in elementary school, so it’s just educating people. Teach ‘em when they’re little.</td>
<td></td>
<td></td>
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<tr>
<td>Crisis Hotline</td>
<td>10 (48)</td>
<td>21</td>
</tr>
<tr>
<td>Felis: Yeah, because when you call the Crisis Line, I had a problem, because I had to look for an interpreter because my English is not really, really good. And when you look at it, I can speak English; I get nervous, but I say I’m looking for something more effective for that kind of problem.</td>
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Mary: Yeah, they give a lot of classes. And I know they have a lot of flyers, and I know a lot of people come to the library. So I think, you know, with flyers. I know when I lived in the dorms at the U of A, they had a lot of flyers everywhere, different just facts, like this person or these people, or “Are you feeling this way and this way?” And then there’s like this just whole list of symptoms, and if you identify with three or more however many- or more, then you might be suffering from this problem.

Santiago: By going to my folks, by doing, doing time to put that together. I guess like we could send them to the park for an event, get ’em free hot dogs, ’cause people will be coming, and tell ’em why we’re doin’ that and everything, that would help people get to know more information.

Yali: I mean, you could get a movie on that, that deals with that type of stuff from anything out there to related, I think. Yeah, whatever situation they’re going through now. I mean, I think it makes them more comfortable in actually having whatever it is that they’re going through.

Christian: Yeah, you can also get some help at your job. Like at my job, it has a lot of stuff for mental health and substance abuse. And if you need help, you can even go through your benefits. And they help pay for it for yourselves. Your job can give you information.

Television, Internet, books and magazines, in-person information, and radio were the most commonly reported media modes. Most participants reported television (100%) as the preferred media source. Reuben described how television ads informed him about coping with his wife’s illness as well as how a recent televised news event heightened his awareness of mental illness:

I’m not saying she’s crazy. She’s just a nice woman; but, she has, in a way, changed. I don’t know how, but it has changed her and I see it every single year. I see ads on TV and in the newspaper, because we’ve got more people with mental
health problems, and I think maybe they were not really doing enough, right, to help those people with mental health. I just saw on TV, this guy who shot 12 people in Colorado. I think it would help [information on media] because if somebody that reads the newspapers sees this thing on TV about mental health medicine, or something like that, or sees it in the paper on behavior, if they’ve got somebody in their family, or somebody from the distant family, a relative or whatever, you know, it will be a very valuable information in order to help that person, or more persons.

Ricky reported a significant use of the Internet (76%) as a secondary media source, behind television, which is helping him with mental health issues and illness:

Well the way I do it, like I say, I go on the web, you know, and I look for answers. Because I don’t have a doctor I can talk to, and so, I know before in the past, when I have anxiety or different things like that, I would turn towards alcohol or drugs. But I saw where that led me. It led me to incarceration. And I no longer want to live that way, because there’s nothing in being incarcerated. And there’s a lot of people in there that really need help, and they’re not gettin’ the right help, you know? And for me, what works right now is gettin’ on the web, you know, ‘cause I have no one I can call and talk with.

In-person information (67%) was a surprising media source that was not theoretically coded and is often not considered media, but was considered by participants as a means of communication intended to influence widely, and thus added due to the frequency of this source being reported.

Christian reported his preference for in-person information in obtaining mental health information:

Word-of-mouth: I think that’s more, that’s the place to get information out is helping other people. If you go help other people, or help with their family, they will open up and tell about something, and that’s how it started. People, like, the way I’m here is because my wife told me about it. Because she also told my brother-in-law about it. And I found out about, and she told me about it, and that’s how I’m here.

Carlos described obtaining more information about mental health from school (52%):

Cause, like, people are not aware about health and school about how our body and how we, I don’t know, that’s something would should always know. ‘Cause we’re a lot like, we’re always in our bodies. Maybe in school, providing classes; not necessarily classes, like everyone’s mandatory health class; if it was like, what
you say you have in high school, a mandatory health class, so they could teach there. Where the people that surprise me; I thought they were targeting kids at a young age, you know, in elementary school.

Although Mr. C. and Cepeda named television as their primary media, they both also described obtaining information about mental illness from books and magazines. Mr. C. expanded the relevance of print media (43%) by suggesting that others use books and magazines to learn more about mental health:

People walk in, and you’ve got a literature table and chairs right there, and people are walkin’ by, and just a little sign that will catch their attention: ‘services provided here’. And they’d want to come over and ask, “What kind of service do you have?” “We have mental health services.” And it would be more productive. I guess, because I’ve read a lot of books, and I’ve been around a lot of people who have had problems, and been places, and I know how to, when I feel something, and it’s not normal compared to what I’m actually feeling, I know that’s what it is, somewhat what it is.

Several participants also commented that there was a lack of media information available through media sources on mental health issues and illness, and that this area needed to be improved. Tino summed it up in his statement:

I’m sure very few people would know what they do there, or even what they help with. I’m pretty sure they only know it from the help they give out with immigration, as far as that. But that’s one tool that’s underused that could be advertised, like on the Spanish networks, that I’m pretty sure doesn’t get funding, or the back to be able to do that, ‘cause it’s expensive.

**Media influences.** Participants described the influence of media information with regard to their own or a family member’s mental health issues and illness. Initially, normalization, education, and ‘hope’ were theoretically coded as influences, but additional influences were added based on interviews. Media influences, the number and percentage of participants reporting these influences, definition of influences, and selected quotes exemplifying the media influence are presented in Table 4.
TABLE 4. Media Influence on Mental Health Information

<table>
<thead>
<tr>
<th>Media</th>
<th>n (%)</th>
<th>Total</th>
<th>Quote</th>
</tr>
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<tbody>
<tr>
<td><strong>Education/Information</strong></td>
<td>17 (81)</td>
<td>26</td>
<td>Tino: Some of them [TV stars] mention some of the problems they have, or some of the symptoms they might have. They try to explain what’s going on, because I’m pretty sure some of the people are so lost in whatever they’re going through, that they don’t know what to relate to. And once they kind of get into their heads that there’s something they can actually do about it, like talk to somebody, they’re more inclined to go look for help.</td>
</tr>
<tr>
<td><strong>Hope</strong></td>
<td>13 (62)</td>
<td>37</td>
<td>Reuben: I believe it works. We can’t help them. Because if we cannot understand, if somebody has a mental health problem, and we don’t have the information, then how are we going to go about it? How can we help them? How can we understand if we don’t know anything about them, if we don’t have the information? But once we have the information from the mental health to understand those people’s motivations, then we can see a better, clear view of their problems, of their mental health, and what you can do, you know, in the community to help donate money or something. Andrea: I think all the ads that I’ve seen are always optimistic. I mean it’s, “Take this pill and you’ll feel better.” But they always say, “Go and talk to a mental health provider.” And just knowing what I went through the same thing, and how they show on the commercial, how at first the person is down, then they take the pill, then they’re kind of getting into the swing of things. So I think it’s a realistic approach that they use, as opposed to jumping up, you’re doing.</td>
</tr>
<tr>
<td><strong>Media: Normalization</strong></td>
<td>10 (48)</td>
<td>21</td>
<td>Mary: I’ve seen a lot of articles and things; like, they’re kind of like reflective articles. Yeah, it’s kind of like, they’ll tell a story and kind of, at least for me, that’s how it seems to help me, it helps me think about other people around me. And you know, like I think, “This person’s going through the same thing as this story.” Kind of connect what’s going on and then at the end of the story is like, “This person’s receiving help from such doctor.”</td>
</tr>
<tr>
<td><strong>Catalyst for Conversation</strong></td>
<td>5 (24)</td>
<td>5</td>
<td>Mr. C.: I would rather have someone come up to my house, or not going door-to-door, doing the handout kind of, and it doesn’t look like we’re doin’, or they’ll come to a place like this, get here, walk around, and give people pamphlets. And you would be surprised at how many more people call and be like, “[This is] what I’m feeling.” Or to have someone to conversate [sic] with.</td>
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</table>

(Note. n (%) Total: Number of Participants Reporting, (Percent Reporting), Total Responses. Education/Information: Media that increases knowledge about mental health. Hope: Media that provides reassurance, encouragement about how mental illness can be improved with a return to of function and wellness. Normalization: Media that informs understanding that mental illness is a health problem, not a stigma, ‘you’re not crazy, weak, a bad person,’ and that other people also experience mental illness. Catalyst for Conversation: Media that encourages discussion, conversation, and sparks interest in mental health topics and knowledge/awareness.)
The most common media influences were ‘education/information’ (90%), ‘hope’ (62%), and ‘normalization’ (48%). Andrea reported television ads helped her realize she was experiencing mental health issues and illness:

> Just from ads you see for medication; if you’re feeling like this, then I would just having that, “I don’t want to get out of bed; I don’t want to get dressed.” But I would do it. But I just didn’t want to, so I just thought, maybe I’m just being lazy; I’m unmotivated. There were a lot of other factors that I thought were playing into everything. So, when I started seeing some of the TV ads, then I thought, “Oh, maybe there is something going on with me.”

Tino mentioned how watching mental health information on television could inspire hope (62%) for others to seek help:

> I guess the popular shows nowadays. Like I haven’t really seen one and watched it twice, but shows like Dr. Oz and stuff like that, that are big TV shows with celebrities and involving that. Some of them mention some of the problems they have, or some of the symptoms they might have. They try to explain what’s going on. Because I’m pretty sure some of the people are so lost in whatever they’re going through, that they don’t know what to relate to. And once they kind of get into their heads that there’s something they can actually do about it, like talk to somebody, they’re more inclined to go look for help.

Linda found mental health information on the radio that was helpful for her daughter’s normalization (48%) to mental health issues and illness:

> Well, on the radio too, you know, there’s stations where they talk about that, and they send you a CD and you can hear that, and that can help you. I heard on the radio. And my daughter told me about a friend that gave her a CD that you could listen to. Mm, I guess it’s cathartic, or maybe in the TV or whatever it is, when she’s hearing it; maybe there’s a name or a place she could call and get help.

Cepeda noted that seeing mental health information in the media was a catalyst for conversation (24%) in his family about mental health:

> Just television programs. I watched a program, it doesn’t come to me real quickly, but there is that one program, that’s my favorite show: Dr. Oz. And they are the ones that has been the most helpful. I have had a lot of stuff and then I, me and my mom, conversate [sic] and stuff like that.
Research Question 7: How Does Acculturation and Mental Health Experience Influence Media Use for Mental Health Information?

Given the potential for differing reports of media mode use based on demographic variables, participants were grouped based on mental health issue and illness reported and their media mode responses reviewed (Figure 17).

FIGURE 17. Media Responses Based on Type of Mental Health Issues and Illness.
(Anxiety n =5; Depression n =9; Substance Abuse n = 7.)

Participants were grouped based on the number of responses for each of three mental health issues and illness: anxiety, depression, and substance abuse. There were insufficient numbers of participants who reported schizophrenia or bipolar disorder to analyze media mode
preferences. The top five media preferences were the same for the three groups: television, Internet, books and magazines, in-person information, and radio use. Debbie (anxiety group) reported her use of radio for mental health information:

You hear it on the radio, like see, you can be like, “Where was that number?” Or something. I think that advertisements of it would help a lot. Well, like I said, basically, it’s just that thing where they can, the one that I can remember was like, “Do you feel this, this, and that?” And I knew by people seeing that, they’ll recognize it and say, “Ooh, maybe that’s what I have?” And they can go and get that help.

Participants who responded about depression reported increased statements regarding the use of books and magazines (100%), in-person information (78%), and crisis hotline (56%). Andrea (depression) reported how books and magazines were helpful for her in addressing her mental health issues and illness:

I have a really good friend of mine who, I mean she’s the one that recommended that Brooke Shields book to me, and she really supported with me when my daughter was born, because she went through the exact same thing.

Bobby reported what she saw as a lack of information in the media about mental health issues and illness:

I feel like it would be better for them to actually speak about the problem itself, 'cause I don't feel like they do really focus on that [mental health], that much. But I think that it would be better for them to speak about it first. Yeah, providing them with ways to help, because I know that in Spanish there's not really that much help to work with, you know, in the first place.

Given the differences noted in mental health treatment preferences and generational status, a second level matrix was completed, separating the participants into generational groups, and their media mode responses reviewed.

First-generation participants were less likely than second- and third-generation status individuals to utilize Internet (33% vs. 86% vs. 75%), one-to-one-interaction (33% vs. 64% vs.
100%), school information (0% vs. 64% vs. 50%), print resources (0% vs. 57% vs. 25%), or community health events (0% vs. 38% vs. 50%) compared to second- and third-generation participants. First-generation participants described the use of newspaper (67%), crisis hotline numbers (100%), and workplace for mental health information (33%) more than other groups (Figure 18).

FIGURE 18. Media Mode Based on Generational Status.
(1st generation n =3; 2nd generation n =13; 3rd generation n =4.)

Reuben (first-generation) reported how he could use a crisis hotline number for mental health information:

I’ve known a couple of them [mental health numbers] and to me, if there’s an emergency here or something, if I’m in the US, I would get the emergency care here in the US. We have Excel [mental health crisis number], right? Okay, I think,
I believe they’re the only ones that are here in San Luis, Arizona. I haven’t heard anybody else.

Second-generation participants were more likely to report use of Internet (86%), school (64%), and print resources (57%) as media modes to obtain mental health information. Third-generation participants reported use of books and magazines (75%), in-person information (100%), radio (100%), and community health events (50%) as mental health information sources at higher percentages than other groups. Christian (third-generation) reported he used information from the telephone book when looking for mental health information for his alcohol addiction:

I didn’t know about any of ‘em (rehab). I tried calling one time; like I went through the phone book and I saw the rehab place and I called ‘em. And I don’t know what they told me, but, because I was, I tried to reach out one time, and then after that, I kept drinking. Then I wanted to be done with it, so I was tired of it.

There were notable differences in media mode use based on generation status that were reviewed and discussed.

**Media responses and insurance status.** As differences were noted in the mental health treatment preferences reported based on insurance status, a second-order matrix was completed grouping participants based on insurance status and media mode responses were reviewed (Figure 19).
Responses based on insurance type show that participants with AHCCCS report a lower percentage of books and magazine use (29% vs. 71% vs. 100%) and a higher percentage of newspaper use (85%) than the other two groups. Santiago (AHCCCS) reported his use of newspapers for mental health information:

By going to my folks, by doing, going to the newspaper, doing like, doing time to put that. If people are gonna read the newspaper that would help the people.
Participants with private insurance reported in-person information (86%), radio (71%), and school information (71%) more often than the other two groups. Princess (private) reported how obtaining mental health information in school helped her understand not only mental health theories, but how she could help her family member:

And when I went to grad school, I learned about the theories, I learned about the resources, but I was never exposed to it, as I am now. When I started working at this job, I learned a lot and have seen a lot, and I think that’s what’s helped me really have hands-on. Because even, because like, with the situation with that close relative, taking methadone and having all that, I wasn’t really going into the root of the whole counseling or therapist core of the situation.

Media mode response differences based on insurance status were reviewed and discussed.

**Media mode and mental health experience.**

Given the observed differences in mental health treatment preference based on mental health experience (self or immediate family member), a second-order matrix was completed grouping participants based on their reported mental health experience. Their media mode responses were assessed and reviewed (Figure 20).
Participants who experienced mental health illness in themselves reported newspaper (70%) and community health event (50%) more than participants with mental illness in their immediate family members. Christian (self) described the availability of mental health information at his work:

Yeah, you can also get some help at your job. Like at my job, it has a lot of stuff for mental health and substance abuse, and if you need help, you can even go through your benefits.
Participants with family with mental illness more often described use of the Internet (91%), books and magazines (73%), in-person information (91%), radio (73%), and school information (64%) than persons with mental illness. Yali (family) reported how pamphlets in the mail or other areas were helpful for mental health information:

I think pamphlets, pamphlets would help a lot. Um, pamphlets, anywhere, I think. Or what else, I think the meetings, like groups; what other ways? That would be it. I don’t know, I guess just set up somewhere that has to do, I don’t know, maybe somewhere that’s health-related. It was a flyer, was it in the mail I think, that would be good.

Third-Order Matrix

Given noted differences in media mode responses based on mental health treatment experience and acculturation, a third order matrix was completed grouping participants based on their ARSMA-II Acculturation scale scores and report of mental health experience (self or immediate family). Their media mode responses were then assessed and reviewed (Figure 21).
FIGURE 21. Media Mode Based on ARSMA-II Scale and Mental Health Treatment Experience by Self and Family.

Participants were separated into groups based on their acculturation scale score on the ARSMA-II scale and their report of mental illness experience in themselves or their family.
From this, their reported total statements of media resources were then reviewed. Participants who reported family mental health illness and slightly Anglo acculturation reported more responses related to print resources (67%), community health events (100%), and school information (67%) than the other groups. Tino (family, slightly Anglo) reported how print resources provided him information on mental health services in the community.

Yeah, I would say most of the advertisements for hotlines, and you can even go the usual routes with fliers and stuff like that. I guess I’m not expecting them to be posted. And knowing that they have that option instead of not knowing it doesn’t exist, because I can think of the usual way, the advertising, you could put up posters and flyers.

Santiago (family, slightly Anglo) reported community events would be helpful in obtaining mental health information.

I guess like we could send them to the park for an event, get’ em free hot dogs ‘cause people will be coming and tell’ em why we’re doin’ that and everything.

Participants with self-reported mental health issues and illness and slightly Anglo acculturation reported increased responses to print resources (71%), in-person information (85%), crisis numbers (57%), and radio (85%) higher than other groups with self-reported mental health issues and illness. Carlos (self, slightly Anglo) reported the benefits of crisis numbers for assistance with mental health information and resources.

There’s people out there that do have stuff, the hotlines if you’re a teen and feel troubled and if you’ve been a victim of a sex crime or if you know anyone that’s child abuse and you see it all the time, if you’re obviously feeling like you’re one of those and you want to, call, you know, for help.

Reuben (family, Mexican-Anglo balanced) reported he recommended information on mental health be available at work for those needing it.

I believe there should be more around I remember there was couple on my job and you would call in, because their job was a high stressing job and when I, I was in human resources and you have a lot of problems with employees to take
the pressure, I mean it’s understandable, but we had a hotline specifically for everybody.

No notable patterns or differences in the report of participants based on acculturation of mental health experience (self or immediate family) related to media mode use were noted in review of the third-order matrix.

Meaning and Understanding of Common Mental Health Conditions

Research Question 8: How is Understanding Ascribed to Anxiety/Nervousness, Depression, and Substance Abuse?

Initially, ‘anxiety/nervousness’ and ‘depression’ were the only categories theoretically coded for mental health issues and illnesses. With additional responses from participants, substance abuse, schizophrenia, and bipolar disorder were added as mental health issues and illnesses. The number of participants reporting these mental health issues and illnesses, the percentage of participants reporting, and the number of responses that were made for each mental health issue and illness is presented in Figure 22.
Twelve-one participants provided a total of 511 statements regarding mental health issues and illness, based on understanding of the experience of depression, anxiety/nervousness, substance abuse, schizophrenia, and bipolar disorder. The following themes emerged from participant interpretation of their experience with anxiety, depression, and substance abuse. Information regarding the quotations made by each participant for the reported mental health issues or illnesses is listed in Appendix H.

Anxiety/nervousness. Major themes that emically described the experience of anxiety/nervousness for participants were ‘panic and overwhelming fear’, ‘daily nervousness and worry’, and ‘loss of control, mind or attitude’. These themes as well as quotes that exemplify the quotes are presented in this section.
Theme: Anxiety as “panic and overwhelming fear:”

Linda: She gets like anxiety attacks or something like that. And that she’s tried to, well, not kill herself, but she wants runs outside. Or when she’s driving, she has stopped at the side of the road and called her husband, and he’s the one that calms her down.

Mr. C.: Yeah, the world that you feel safe in actually, like I said, it becomes your enemy. So your enemy is against you, and keeps inching and inching, until finally, your nervousness, your anxiety turns into a panic attack; a panic attack turns into like, basically, breaking down and kind of losin’ it, though. It just, it’s a whole mess.

Cepeda: I guess she thinks everything is closing in on her and stuff, and that makes her hyperventilate and everything. I hadn’t seen it happen myself though.

Christian: She’s claustrophobic, when she’s around a lot of people. She starts to panic; she gets hysterical and starts screamin’. She doesn’t like be around a lot of people. She doesn’t like to be out in the open, and I don’t know how it affected her. She starts to panic, and she has to get out. That’s what she does; she’ll get out.

Theme: Anxiety as “daily nervousness and worry:”

Princess: So it was really interesting, at the same time sad, that he would get so far and quit. Because he would get attacked again, with anxieties, nervousness, with all that, depression and all that. Anxious, worried, concerned. Assist the nerves to calm them down.

Felis: My husband. He’s ‘ansiedad’ [anxious] because he can see something finished from the situation he’s in; one forces cutting him off, to be okay for himself and for his room on his own; to see when he study for himself, my husband, he’s something that’s um, how would you say, ‘ansiedad’.

Mary: Yeah, but I definitely get a lot of anxiety, you know. In school, there was an exam coming up; I can’t sleep, like, the night before. Or I’m just thinking about, “What if I don’t wake up?” and that kind of thing. Not because of the actual exam; it’s just like, “What if I wake up late and I don’t make it to class?” And even with work, it’s like, when I was working like my first, maybe, week of work, I was like, I couldn’t sleep, because I was thinking, “What if I don’t wake up in the morning?”

Tiger: He was anxious, and he was so desperate that he did things like that, you know? Yeah, you could see it by his movements and how he was moving and everything. Shaking and swaying, and it was bad.
Debbie: It’s horrible because, I mean, I’ve been there. I’ve had it. I don’t get treated for it because I just don’t have the insurance or the time. And it’s just horrible; you feel like you’re gonna have a heart attack, but you’re not. You can’t breathe. Well, I mean, you try not to stress out about it. You’re just like, “I’ll just get out and take a walk.” Try to do something to calm myself down and just pray, pray a lot.

Theme: Anxiety as “loss of mind, control, or attitude:”

Tino: It’s just s state of mind which, you know, they just can’t control their emotions. They just need to really have a grip on. Either it entails religion or they’re more beliefs; or when somebody hits a situation and they just don’t know where to turn. They need something to grip on. It’s just that loss of control, and their belief system just breaks down. And it’s just they could either grip on that or they’d have to find something else.

Julia: My daughter, my daughter has a lot of problems with anxiety. When you get anxious, because I’m never anxious and worried. When I would worry, I’d notice I was feeding on negative attitudes, and negative responses, and everything was negative. I was thinking that this could be my last day; imbalance.

J.: I think everything’s clouded for them. They’re panicking; they’re very, their insides are probably turning 100 miles an hour. Their brain’s probably goin’ 100 miles an hour. You can’t focus. They’re unorganized, they don’t mean to be, but you’re lookin’ at ‘em, they’re suffering. They probably don’t want to live. They probably say things like that, “I don’t want to live, what am I doing here?” So, I don’t think that’s a very good state.

Issues related to anxiety are experienced and described related to worry and nervousness, panic and its physical manifestations, and the loss of control of mind and consciousness related to anxiety. These issues consist of cognitive, physical, and interactional types of understandings related to anxiety.

**Depression.** Major themes derived to describe the participant’s understanding of depression were described as “sad, down, or upset,” “isolation and separation,” and “darkness in state of mind.” The following themes and quotes used to illustrate those themes are presented.
Theme: Depression as “sad, down, upset:”

Felis: Pensé que [I think that] stay at home, in home, no one doesn’t smile, sleep a lot. Yeah, not this, I see these people when they’re sad, and this woman, with this problem, and I cry easy, always sad, never smiles.

Mary: She didn’t want anyone in her family to know. So only like her immediate family knew about it. She would just go crazy if my parents were like, “So, you know, my sister has this, you know.” ‘Cause my mom called me and said, she’s very upset, “Maybe you should talk to her. And she’s just in her room, lying down, and she’s been crying.” So, like, she didn’t even pick up the phone, she didn’t talk to me. She didn’t want to talk to anyone.

Debbie: To be depressed is just to have no will to live, I guess. No hopes or expectations; that life is just life. But I think that’s what people think when they’re depressed. Or sometimes life can just be too overwhelming, I would think. You know, I guess we all have some form of depression, because we would want to do so much, and when we can’t, or when we’re limited to certain things; that, you know, that can cause some form of depression.

Santiago: He’ll start, like, so friendship with him, he’s start, like, talking to me, and he starts crying. He starts crying, saying that like, he don’t want to be here. Yeah, cut up or kill himself, like that. Over the depression, ‘cause they put in him, because of his brain and everything.

Theme: Depression as “isolation and separation:”

Tino: It just hit him hard. And I would see him in his house, locked down pretty much all day. Working all night, ‘cause he worked at his computer, he wasn’t really out that much. And he was out even less after that. He doesn’t like the outdoors or anything, but he’d still want to hang out, go to dinner, something. And at that point, he was just so in his shell that it wasn’t even a possibility to do it.

Bobby: Mm-hm. Especially when I was diagnosed, I couldn't really move. That was one of the symptoms and, I don't know, it was just like, still, couldn’t move, wouldn’t move or speak. I would prefer not to speak to anybody.

Yali: I was really close to her; but after, it was just very different for me. And I mean, I don’t know, it’s really hard to deal with. Like she basically just stares into the wall, like she’s scared. She keeps to herself, doesn’t come out of her room; I don’t know, very hard for her as well.

Cepeda: Because she can’t, you can isolate yourself so much, she can’t get out of that, away from herself. And when she’s out of the house, with people, she feels sad and trapped.
Theme: Depression as “darkness in state of mind:”

J.: To be depressed means that you’re not happy. You’re in another state of mind. Yes, I would say that you were just out of the sunshine, like in the deep corner or something.

Gerardo: TV’s off, radio off, the windows closed, the house in the dark. So I got to learn that, over time that, you know, that if you try to touch her and stuff, it’s more likely that it’s not gonna end up in a good, positive conversation, or it’s just that she has a tendency to eat herself up. You know what I’m saying? Stressing. Being depressed.

Princess: He would sleep a lot in the house. And it’s very dark in the house, so we would try to go in and wake him up, get up, take a shower, go somewhere, go to church after that, go to dinner.

Christian: Depressed? Not to associate with people They get sad; you get a lot of negative thought in your mind, about themselves. Feeling bad about themselves. Making it so that everything is bad. They’re just not good. Uhm, depressed. Uhm, tired. ‘Cause it all they’re overwhelmed, or lazy, and aren’t able to do things for themselves.

Carlos: I guess to fix ‘em is battling, well not battling, well, yes, it could be battling, ‘cause if you’re depressed, I don’t know. If you’re not enjoying life, um, I don’t, really, I don’t know. Someone needs, I guess, affect them bad, like not in a good way. Because someone who’s always like, can never enjoy, I guess, be happy, be calm. Yeah, hard for them to be, well, normal, I guess. ‘Cause depression, I feel, is something in the mind.

With the report of depression understandings, there appears to be a report of sad and upset mood, darkness in mental state, and withdrawal from physical and social activity. A pattern of cognitive changes, behavioral changes, and social and familial interactions were reported in the understanding of depression by participants.

Substance abuse. The following themes were developed regarding the concept of substance abuse- “to cover emotional pain and trauma,” “a craving,” and “stops you from living your life.” The following themes and representative quotes that were used to derive thematic understanding of the themes are presented below.

Theme: Substance abuse “to cover emotional issues and stress:”
Andrea: I was drinking a lot, a lot of wine [chuckles]. And it wasn’t to enjoy a glass of wine; it was just to like, forget.

Mr. C.: So I went to drinking; stuff like that, to calm my nerves, and stuff like that, anxiety. And I was living in Maricopa County at the time, there are services to help, and stuff like that. Down here, there really isn’t much [help].

Gerardo: A lot of people tend to lock up and not say stuff. But just find a way to get ‘em to open up. And there’s probably going to be tears shed and whatnot, things like that. But I think it’s better that way. Because it could prevent…a lot of unnecessary arguments, and drug use, and alcohol, and things like that.

Ricky: When I have anxiety, or different things like that, I would turn towards alcohol or drugs. But I saw where that led me; it led me to incarceration. And I no longer want to live that way because there’s nothing in being incarcerated.”

Tino: I had a DUI four or five years ago, and they made me take some of the classes; they made me take some specialty classes. And when I was in there, some of the people in there really had problems, and I can see how some of those classes that were given by the state, were really helping people out. And I understood that it wasn’t just Alcoholics Anonymous; it was more, what was it, just as a motivator, just to get you to understand that even you either get it now or you’re screwed.

Christian: Well, me personally, I had it a lot. ‘Cause when I was growin’ up, I had in my home, me and my dad. The problem was, my dad was a drug addict. And he used to do a lot of drugs. And he used to over-react and hit me and my mom. So I was fearful to lock the door, and I couldn’t talk to me teachers, or talk to anyone about my dad because of that.

Carlos: I think my sister’s had a lot of problems. Like she had a, I can’t say – problems. Good, so she does, like I said, marijuana. ‘Cause they don’t know how it affects the brain. So she smokes, and feels other levels of more than just her anger. It just calms, like, she was abusing a substance maybe, but like, I’m not gonna say it’s harming her.

Julia: So that’s what I did [got counseling]. I think that if more people would do it, they’d probably, maybe they’d never be on drugs or need alcohol or whatever.

Theme: Substance abuse as “a craving:”

Princess: So he’s been sober for a long time. And that person tells us when he would get depressed, when he would anxious; stuff like that, all because of the drug issue that he went through, wanting to take that drug again.
Tiger: Family, drug addiction, it was hard for me to leave it, and then all the times I did those things that happened. Then I wasn’t high, or the withdrawal that I had; I felt I had something, and I think it affected my side of medical and mental, you know?

Debbie: I think they’re just weaknesses. You know, some people just give in to their weakness. And a lot of people just try to cope, and just try to forget things, and they just take advantage of some things. Oh, they use the fact to take advantage. Or just, like a numbing thing, sometimes.

Theme: Substance abuse “stops you from living your life:”

Tiger: ‘Cause they stop working. They stop sleeping and eating right. And you start doing everything that’s really, you know, like, um, doin’ bad things to get high --and stealing and robbing, you know, trying to sell things, you know, that aren’t yours, and stuff like that.

Christian: They can’t control, they can’t stop using that drug. They need it, even though they know that it’s wrong or they know that it’s affecting ’em. They still do that drug, no matter what. They get, they’re just focused on one thing, and they need that one thing. They don’t care about anything else that’s goin’ on. That’s the way they think.

Reuben: That’s true, because I don’t want any of them to fall into drugs, or to have a mental breakdown or something like that. Then for later on, somebody can come over and tell me, “Hey Rueben, you know, remember that person? Well, they’re in jail now.”

From the reports from participants, substance abuse results in an experience of cravings, a response to stress or emotions, and a functional impairment in everyday life. Reports of cognitive issues in cravings, an emotional response to stress, and an interactional impairment from substance use were the reported understandings of substance use given by participants.

**Bipolar disorder.** Theme: “Angry and irritable:”

Princess: But there are people that do need it [medications], because they’re bipolar, and they’ll flip out of their head, and destroying the place that they’re at.

Ricky: Some people, I know I personally met people that are really, really angry, you know; not depressed, but really angry. And there’s nothing that can help them but medication, like sedate ’em.
Participants reported issues with anger and irritability as their primary understanding of bipolar disorder. These understandings relate to a cognitive and social, functional, or interactional understanding of interactions related to bipolar disorder.

**Schizophrenia. Theme: “Paranoia:”**

Felis: Because I know that he’s very, um, ugly, you know, schizophrenia and paranoid and diabetes type I.

Christian: He was paranoid and anxious. And they gave him, I don’t know what kind of drug, but it helped him to relax and calm down.

From participant reports, understandings of schizophrenia focus on paranoia, as both an internalized mood and externalized social interaction with others, as part of the understanding of this mental health illness.

**Summary**

Data analysis resulted in the reporting of twenty-five mental health treatment preferences that were provided by the participants. The first six mental health treatment preferences: medications, going to the doctor, social and family support, counseling, and herbal medicine were consistent throughout demographic categories and research questions. Differences were noted in further reports of mental health treatment preferences based on the research questions reviewed. Media mode was reported during the interviews with the participants. Participants consistently reported the major media modes of television, Internet, books and magazines, in-person information, and radio. Variations in the utilization of media modes were reported for differing demographic categories among the participants. Media influences and the relationship between media influences and media mode utilization were reported between the varying demographic categories in the study. The review of findings, discussion, strengths, limitations, contributions to nursing, and implications of the current research will be presented in Chapter VI.
CHAPTER VI: CONCLUSIONS

This study focused on developing an understanding and description of the mental health treatment preferences for persons of Mexican heritage. Several research questions that guided this study, addressing (a) mental health treatment preferences of persons of Mexican heritage, (b) media preferences for mental health information of persons with Mexican heritage, and (c) ascribed understanding of mental health issues and illnesses for persons of Mexican heritage. Chapter VI presents a discussion of the research results, reflections on the findings, limitations of the study, and implications for future research.

Mental Health Treatment Preferences

From the reports of the twenty-one participants in the current study, twenty-five treatment preferences were reported during the participant interviews. The twenty-five mental health treatment preferences consisted of a variety of provider prescribed mental health treatments, non-prescribed mental health treatments, and self-management interventions. The most commonly reported mental health treatment preferences across participants were medications, going to the doctor, family and social support, counseling, and herbal medicine. At least eighty percent of the study participants reported these six mental health treatment preferences. These six mental health treatment preferences were consistent among all demographic categories, showing the prevalence for these six mental health treatment preferences for all participants.

The study varies somewhat from previous findings that reported persons of Mexican heritage who preferred non-pharmacological treatments to medication. Medications, in the current study, was reported consistently by 100% of the study participants, and was commented
on most frequently among the mental health treatment preferences, as more statements were made regarding medications than any other mental health treatment preference. This may be an interesting finding given the reports in literature that persons of Mexican heritage prefer counseling over medications for mental health treatment (Barrera, 1978; Keyes et al., 2012; Nadeem et al., 2008). The high level of acculturation of the current study group participants may account for the higher reporting of medications over counseling and other mental health treatment methods, which may limit the transferability of any study findings. Another study showed that acceptance and use of prescription medication increased with increasing acculturation, possibly accounting for the higher ranking of medications than counseling and other mental health treatment preferences in the current study (Espino et al., 1988). Additionally, the U.S. population in general is utilizing increasing amounts of prescription medications as their primary source of treatment for all health issues and illness, increasing the likelihood that persons of Mexican heritage living in the US may report increases in medication use (CDC, 2004). These results may also mimic a concurrent, similar pattern of increased substance abuse with increasing acculturation in persons of Mexican heritage, such that medication or substance abuse is used as a coping mechanism for the allostatic stress of acculturation (Lara, Gamboa, Kahramanian, Morales, & Bautista, 2012; Ortega, Rosenheck, Alegria, & Desai, 2000).

Previous studies show that participants prefer when mental health treatment is obtained at a primary care location, which may account for the high percentage of persons who reported ‘going to the doctor’ as a mental health treatment preference (Vega et al., 2001). This mental health treatment preference was reported at a higher percentage than family support, social support, and counseling. This contrasts with the report of mental health preferences for Mexican Americans consisting more frequently of counseling based therapies (Keyes et al., 2012). This is,
however, consistent with one report in the literature, although date, that the majority of persons of Mexican heritage prefer combinations of medications and therapy- counseling, and so forth, to aid in their mental health issues and illness (Dwight-Johnson et al., 2000). Along with medications and therapy, family and social support has been cited in older literature as assistive in the treatment of mental health issues and illness (Dressler, 1985; Kawachi & Berkman, 2001). It is therefore not surprising to see that these ranked high among mental health treatment preferences for persons with mental health issues and illness, although more recent research may offer other explanations.

As in the literature review, there did not appear to be differences in the first five mental health treatment preferences reported for persons of Mexican heritage in this limited study and those reported by the general population in the US. Studies show that the majority of Anglo patients receiving mental health services in primary care reported preferences for the use of medications, counseling, stress management, healthy living classes, fitness program and similar treatment preferences in a study of 400 persons (Lang, 2005; Wetherell et al., 2004). From the results of this study, the major mental health treatment preferences reported by the study participants may appear to be similar to Anglo reports of mental health treatment preferences.

**Self-Management Interventions**

Besides medication, counseling, and family and social support, there were a number of treatment preferences reported by the participants that do not have a professional foundation in mental health. More recently, the World Health Organization (WHO) has defined mental health as “a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity. Mental Health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to
make a contribution to his or her community (WHO, 2003).” This definition takes into account the overall health and wellness of persons with mental illness in their movement towards mental health and wellness, and in the need for treatment planning efforts towards attaining overall mental health. Self-management interventions were introduced in the past decade in the literature as an effective compilation of modalities to provide support and stability in the ongoing maintenance treatment of persons with chronic illnesses (Newman, Steed, & Mulligan, 2004). Self-management interventions encourage the person experiencing chronic illness to maintain substantial responsibility for the care and everyday management of their chronic illness. Initial studies were completed with chronic medical illnesses (e.g., diabetes, asthma, arthritis) and were shown to increase overall treatment outcomes and self-efficacy in treatment (2004). The Wellness Recovery Action Plan (WRAP) was developed from initial work in the UK regarding self-management interventions in mental health (Copeland, 2004). These WRAP plans incorporate some of the same treatment preferences reported by the participants (e.g., physical activity, healthy eating, small group interaction), and develop a care model for empowering persons with mental illness in their own care and treatment. It is interesting to note that not only persons with insurance, but also those without, reported the acknowledgement of these types of treatment preferences in maintaining mental health and wellness. This may reflect the general move towards holistic mental health practices (Cloninger, 2006), as well as capturing the innate holistic medical and mental health approach of persons of Mexican heritage (James & Prilletensky, 2002; Mendelson, 2002).

**Herbal and Integrative Medicine**

Although the general U.S. population has moved towards embracing integrative medicine, Mexicans, given their history of traditional healing practices, may embrace herbal
remedies and integrative care at higher rates than Anglos. For the current study, 80% of participants reported herbal medicine use as a treatment preference for mental health issues and illnesses, making it the sixth highest percentage mental health treatment preference. This finding was consistent across demographic groups. Participants in the current study reported a higher report of herbal medicine as a mental health treatment preference than those reported by the largest U.S. study on integrative medicine use in the US (Barnes et al., 2008). There was a notable increased report of preferences for herbal medicine, spirituality, integrative medicine therapies, and use of traditional healers versus previous studies. From a qualitative standpoint, the present sample participants reported herbal and integrative medicine therapies would serve as an integral part of their mental health treatment. Additional delineation of what types of integrative medicine therapies preferred by persons of Mexican heritage could result in practices that would improve utilization and satisfaction in mental health services for persons of Mexican heritage.

From the literature review on use of integrative medicine therapies by persons of Mexican heritage, Stuart and Rodriguez (2008) reported the highest percentage in studies, with 77% of Latino subjects reporting use of integrative medicine therapies and 59% percent of Latino subjects reported use of herbal medicines (country of origin, e.g., persons of Mexican heritage were not distinguished in this study). Kronenberg et al. (2006) reported that 18% of persons of Mexican heritage used spirituality as a method of treatment. Ransford et al. (2010) reported a 30% rate of use of traditional healers for Latino subjects surveyed. In the current study, 95% of participants reported a desire for at least one type of integrative medicine therapy as part of their mental health treatments, along with 90% who specifically reported desire for herbal medicine treatments. Eighty-one percent of study participants reported desire for
spirituality practices in their mental health treatment, 62% reported desires for integrative medicine therapies, and 19% reported a desire for traditional healers as part of their mental health practices. These numbers are considerably higher than noted in the general population of Anglo subjects by Barnes et al. (2008). In Barnes’ study, 60% of subjects reported use of integrative medicine therapies, including 38% who reported herbal medicine use, and 74% who reported use of spirituality practices. The current study results may reflect the appreciation and utilization of herbal and integrative medicine therapies as part of mental health treatment preferences for persons of Mexican heritage. The numbers of persons in this small study endorsing herbal and integrative medicine therapies is higher than for reported research on Latinos or persons of Mexican heritage or for Anglo utilization of integrative medicine therapies.

Mental Health Treatment Preferences and Demographics

Demographic indicators in the current study did appear to play a factor in the mental health treatment preferences reported by participants. The demographic indicators chosen for the study included gender, age, education, income, insurance status, employment, and generational status. These indicators were used to determine if there were differing mental health treatment preferences reported for the differing groups. The current study sample is described and compared to the demographic characteristics of Yuma County, Arizona at the time of the study and is presented in Table 5.
<table>
<thead>
<tr>
<th>Demographic</th>
<th>Participant n (Study %)</th>
<th>Yuma County Median %</th>
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<tbody>
<tr>
<td><strong>Gender</strong></td>
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<tr>
<td>Male</td>
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<tr>
<td>Female</td>
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<tr>
<td><strong>Age</strong></td>
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<td></td>
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<tr>
<td>≤ 25</td>
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<td>26-40</td>
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<tr>
<td>≥ 56</td>
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<td><strong>Insurance</strong></td>
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<tr>
<td><strong>Income</strong></td>
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<td>35 – 49K</td>
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(Note. Participant n=21. Median age: Study participants: 34.5 yrs.; Yuma County: 33.8. Yearly Income:
<10K=Less than $10,000; 10-19K=$10,000-$19,000; 20-34K=$20,000-$34,000; 35-49K=$35,000-$49,000; 50-
74K=$50,000-$74,000. Last Grade Completed: ≤6th=Completed grade 6 or less; 7th-8th=Completed 7th or 8th
grade; 9th-12th=Completed between grades 9 and 12; 1-4 College=Completed from 1-4 years of college; Post
Grad=post graduate studies. Generation=Number of generations the individual’s family has resided in the US.
Health Insurance: None=No insurance coverage; Private=Private insurance coverage; AHCCC=Arizona Health
Care Cost Containment System, a public health care assistance program; Mexican=Mexican insurance coverage;
Other=Other insurance coverage. ARSMA-II Scale (Acculturation Rating Scale for Mexican Americans): Mexican-
Anglo=Mexican-Anglo Balanced.)
Physical responses to mental health issues and illness were reported more in men than in women with physical activity, avoiding negative influence and contacting the police with higher frequencies reported for men than women. This suggests an active adaptive coping method for male participants in this study. Female participants reported higher percentages of social interaction based mental health treatment preferences such as small group interaction, activity management, and body-based IM practices. Gender, from the reported mental health treatment preferences, appears to play a role to a lesser extent, to the secondary mental health treatment preferences preferred for mental health issues and illness. Men may prefer more active, adaptive methods of treatment, while women may prefer social/interactional based mental health treatment preferences.

From the table above, the median age of the sample group was 34.5, very close to the median age in Yuma County, Arizona, which was 33.8 (U.S. Census Bureau, 2010). For the participants of the current study, those between 41-55 years of age reported more social and spiritually based mental health treatment preferences, reported social support, counseling, and spirituality at higher rates than other age groups. The youngest participants, under age 25, reported traditional healers, coping skills, and small group interaction, appearing to utilize the social foundation developed during adolescence as a foundation for mental health treatment preferences. Several studies showed younger persons of Mexican heritage were more likely to utilize CAM practices, including traditional healers, than their older counterparts (Gerson-Cwillich, Serrano-Olivera, & Villalobos-Preito, 2006; Lee, Goldstein, Brown, & Ballard-Barbash, 2010). The current study shows that although the general mental health treatment preferences remain the same, age related preferences to mental health treatment may exist and may play a factor.
When reviewing mental health treatment responses based on generational status, it was notable that first-generation participants were more likely to report herbal medicine as a mental health treatment preference than other groups, which appears to coincide with the increased use of herbal and traditional medicines in Mexico (Rodriguez-Fragoso, Reyes-Esparza, Burchiel, Herrera-Ruiz, & Torres, 2008). Third-generation participants reported more self-management mental health treatment preferences, which have been noted in literature to increase with increased generational and acculturation status (Mainous, Diaz, & Geesey, 2008).

There were differences in the mental health treatment preferences based on the insurance status of the participants. Participants with AHCCCS insurance reported the top six mental health treatment preferences, but their responses to subsequent mental health treatment preferences were notably less than the other two groups. Given minimal coverage for payment of mental health services through AHCCCS, participants with AHCCCS coverage reported fewer mental health treatment preferences. With priority given to medications and counseling, potential opportunities for utilization of other mental health treatment preferences for persons with AHCCCS or Medicaid insurances were limited.

**Report of Mental Health Issues and Illness**

Treatment experience with mental health issues in self, immediate family, or others was not a question posed to potential participants at initial contact or used as inclusion criteria for study participation. Through the course of the study, treatment experience was documented, but never factored into purposive sampling decisions or exclusion/inclusion of participants. Interestingly, however, all participants either experienced mental health issues themselves or through a family member of close friend. A number of potential factors may have influenced the high rate of endorsement of mental health issues and illness in self or immediate family members
in this current study. Recruitment flyers stated that this study would be assessing mental health treatment preferences in persons of Mexican heritage. Persons with self or family history of mental health issues or illness may then have been more likely to inquire as to participation for this study.

The rate of mental health issues and illness in persons of Mexican heritage may have also been a factor in the number of participants reporting self or immediate family mental health issues or illness. Mental health issues and illnesses have been estimated to occur at the rate of 26.2 percent, or 1 in 4 persons in the US (Kessler, Chiu, Demler, & Walters, 2005). In this study, 11 participants (52%) reported they experienced mental health problems, and 10 participants (48%) reported they had immediate family members with mental health problems. Although it is reported that 30% of Mexicans experience mental illness in the US, this represents the number of persons diagnosed with a mental disorder, not the number of persons experiencing mental health issues or illness (Alegría et al., 2007). As noted earlier, with only 20% of those persons experiencing a mental health issue seeking mental health services (Vega et al., 2001), it is not unexpected that the reported rate of mental illness was higher in this sample. Recent studies have shown an increasing prevalence rate of mental illness for Mexican-Americans, especially in rural areas, with rates of mental illness reported at 48.7% in Mexican-Americans (Vega & Sribney, 2008). This percentage is quite similar to that found in the current research sample, potentially adding dependability in trustworthiness.

An additional factor may account for the increased reported rate of mental illness in this study. Alegria, Canino, et al. (2008a) reported an increased incidence of mental illness rates in second- and third-generation Latino immigrants, with 38% of participants reporting mental health issues or illnesses. Second- and third-generation persons of Mexican heritage were the
largest percentage of the current study, which appears to reflect an increase in mental health issues related to increasing acculturation (Cook, Alegría, Lin, & Guo, 2009). In the current study, 66% of participants were second-generation and 19% were third-generation residents in the US, for a total of 85% of participants fitting into this category. In the current study, 72% of the participants were rated as slightly to strongly Anglo in acculturation. Based on the work of Alegria, Lin, and Guo (2009), increasing acculturation also increases the likelihood of experiencing mental illness. Other studies also consistently showed that increasing acculturation increases the risk for mental health issues and illness in persons of Mexican heritage (Chang, Garcia, Huang, & Maheda, 2010; Lara et al., 2012; Torres, 2010). The additional acculturation stress faced by second- and third-generational status persons of Mexican heritage may increase the likelihood of mental health issues and illness. In this study, participants having had a personal or family experience of mental health illness may reflect the influence of higher acculturation and likelihood of mental health issues and illness.

Acculturation and Assimilation

In regard to acculturation of the twenty-one participants, 5% reported very Mexican acculturation, 24% reported Mexican-balanced acculturation, 48% reported slightly Anglo acculturation, and 24% reported strongly Anglo acculturation. The effects of increased acculturation on health outcomes have been well studied for the Mexican population living in the US. Negative effects on overall mental health, episodes of depression, and general substance abuse have been shown in a recent literature review of studies (Lara et al., 2012). Lara, Gamboa, Kahramanian, Morales, and Bautista (2012) reported that increased perceptions and awareness of health issues were shown with increased acculturation, perhaps signaling the reason why more acculturated persons may report or identify potential health issues more readily than non-
acculturated persons. With increased understanding and identification of potential mental health issues, acculturated persons were more likely to identify mental health issues and then seek treatment services for these issues. Alegría, Chatterji, et al. (2008) reported that first-generation Mexican immigrants appeared at lower risk of most psychiatric disorders—depression, anxiety and substance abuse, than subsequent-generation Latinos related to resiliency and retention of cultural support systems from Mexico.

Acculturation, from previous literature data as well as results of the current study, is a cognitive indicator of the physiological factors involved in allostatic load. When findings indicate increased acculturation and increased health risks along with decreased health outcomes, persons have attempted to acculturate at an extensive rate, which results in the loss of resilience elements that were protective factors for mental health issues and illness that were notable in first-generation and balanced acculturation persons. As a consequence it can be noted that “too much” acculturation may be attributable to poor health outcomes. So it can be posited that instruction of new immigrants towards the mean of acculturation in their new society may provide for better health and mental health outcomes. Factors that allow the adequate acculturation, while retaining resilience elements, would encourage a Mexican-balanced level of acculturation that would have a protective effect on health outcomes. By maintaining the factors that allowed resiliency while simultaneously participating in acculturation, a group would likely have the best potential health and mental health outcomes possible for persons of Mexican heritage. Current demographic studies show that over 52% of persons of Mexican heritage are at least second-generation status, meaning they were raised in the US with no prior knowledge or experience living in Mexico (Fry & Passel, 2013). Given prevalent research that shows the health status benefits noted in Mexican immigrants dissipate within the first 15 years of U.S. residence,
early intervention and efforts to maintain resilience factors noted in immigrants could be beneficial in continuing their health status (González et al., 2009). Utilizing a model that encouraged the resilience factors observed in first-generation immigrants, while fostering the identification and adaptation to acculturation patterns that facilitated increased utilization of health care services and other needs useful in acculturation may decrease the likelihood of persons of Mexican heritage experiencing mental health issues and illness while acculturating to U.S. society.

**Ascribed Understanding of Mental Health Issues and Illness**

Interviews were initiated with questions regarding health care to allow the participant to become acquainted with the researcher, to feel comfortable responding to questions and to minimize potential stigma in discussing mental health. An interesting note was the responses to questions by participants. All participants reported physical health concerns when responding to the initial questions, although flyers and recruitment papers noted that the study specifically addressed concerns about mental health and treatment preferences. One participant, even reported that she “had no medical problems” on initial questioning, yet later went on to discuss her extensive depression history and use of antidepressant medications to maintain her mood and functional status for the past several years. This leads to the question as to whether participants, and the public still consider mental health as “different and/or separate” from physical health. As stated in earlier discussion, the WHO and CDC definitions of health include the state of complete physical, mental, and social well-being, not merely the absence of disease (WHO, 2013). However, in general thought, mental illness perhaps remains a distinct issue from physical health issues and illness for persons of Mexican heritage. This was also evident in the number of reports the study participants made regarding “people who didn’t get mental health treatment because
they were busy/working/didn’t have time” whereas a physical health challenge would demand
the need for care and treatment. Bobby summed up her observations of why persons of Mexican
heritage may neglect mental health treatment:

Well, make them (persons of Mexican heritage) realize that the work does usually
stress people out and they worry and sometimes get depression, to make them
realize that this community shouldn't subdue themselves to actually be hiding in
their feelings 'cause most of them do. Yeah, they do, they don't really speak out
about how they truly feel, 'cause they're always worried about working and
working and if they would realize that there is hope for them, they would actually
seek it, but, for somebody out there explaining to them that for their self, it would
be beneficial.

This may be a factor in the decreased number of persons of Mexican heritage seeking
mental health treatment—mental health may not be a priority. According to Maslow’s (1943)
hierarchy of needs, persons must have physiological, safety and social needs met before they can
address mental health issues that may deal with esteem and self-actualization. Given the
economic status of most persons of Mexican heritage on immigrating to the US-Mexico border
region, their needs for emotional balance and treatment for mental health issues and illness may
be present, but sublimated, while seeking more basic needs of physiological, safety, and social
needs. This may contribute to the noted disconnect between physical and mental health in the
participant’s report. Additionally, physical health issues and illness may impact a person at the
physiological level of Maslow’s hierarchy of needs, resulting in persons seeking health care for
health issues and illness prior to issues in mental health. Additionally, chronic health and mental
health issues that don’t immediately impair personal functioning, such as diabetes, hypertension,
and depression may result in delays in treatment seeking related to the lack of perception of
physiological or safety needs challenges for these types of health care concerns.
An additional issue apparent in the study includes how we define mental health issues and illness. This study sought to outline the ascribed meanings of anxiety/nervousness, depression, and substance abuse. In the current study, ascribed meanings were theoretically coded, with research questions discussed in depth, and potential responses developed in a codebook prior to the initiation of interviews (Appendix F). During interviews, when significant responses that were not theoretically coded beforehand were presented in interviews, the researcher then added these codes. For mental health issues and illness, the researcher didn’t label the individual participant’s symptoms as an illness or type of mental health disorder. However, DSM-IV-TR symptom clusters were used to aid in delineating depression, anxiety, and substance abuse symptoms as reported by participants (APA, 2000). Symptoms reported by participants were grouped according to the corresponding DSM-IV-TR symptoms pictures for each of these mental health disorders.

DSM-5 is set to be more symptom-based in approach (APA, 2012). This symptom-based approach to diagnosis may more adequately capture nuances of depression and other mental health symptoms. Through the adapted diagnostics methods of DSM-5, the potential to more effectively identify, diagnose and treat persons of Mexican heritage may improve as a symptom-picture based practice is set to be implemented.

As noted in earlier studies and this current study, the reports of minorities and their understanding and experience of mental issues and illness has a more somatic, functional level of understanding rather than the cognitive based report common in Anglos (Cabassa, 2007; Lackey, 2008; Pincay & Guarnaccia, 2007). This somatic based symptom expression of mental health issues and illness has also been seen in other minority groups (Kendrick, Anderson, & Moore, 2007; Phan, Steele, & Silove, 2004). Earlier attempts at effectively addressing minority
perceptual issues of health and wellness included anthropological methods of assessing health and illness. Kleinman, Eisenberg, and Good (1978) outlined seven questions that are thought to be key to understanding someone’s cultural health model. Providing individualized care using culture as a guide increases utilization and satisfaction in health care treatment.

Kleinman, Eisenberg, and Good’s (1978) questions include: (1) What do you think caused the problem? (2) Why do you think it happened when it did? (3) What do you think your sickness does to you? How does it work? (4) How severe is your sickness? Will it have a short course? (5) What kind of treatment do you think you should receive? (6) What are the most important results you hope to receive from this treatment? (7) What are the chief problems your sickness has caused for you? (8) What do you fear most about your sickness?

The current study used similar questioning in interviews with participants, focusing on open ended questions that allowed participants to describe someone with a mental health issues or illness, how the mental health issue or illness materialized, what kinds of treatments would be desired, how would treatment help, how would wellness be returned, and how mental health issues and illness impact an individual experiencing them (Appendix I). The use of the open-ended questions in the current study allowed the exploration of the participants’ understanding of mental health issues and illness and permitted a cultural description of these experiences by the participants in the current study group.

Media Concerns for Mental Health Information

An immediate concern raised regarding the use of media by persons of Mexican heritage was encountered when recruiting subjects. Although efforts were made to reach potential study participants through radio, television, and newspapers in English and Spanish, the overwhelming majority of participants (95%) were recruited through flyers in stores (Appendix B), restaurants,
tiendas, barber and beauty shops, and laundromats placed throughout the community. This provided the researcher with immediate evidence that media outreach and influence with this group might be different from Anglo populations. O’Malley, Kerner, and Johnson noted, in 1999, that persons of Mexican heritage may utilize varying media sources for information based on their length of time in the US and their educational level. Additional recent studies reported the importance of flyers for recruitment and dissemination of health information for persons of Mexican heritage, although the extent to which this was a notable method was not apparent until study participants reported their methods of obtaining recruitment information (Corona, Gonzalez, Cohen, Edwards, & Edmonds, 2009; Mendez-Luck et al., 2011). Additionally, although information may be obtained by the varying traditional media sources, motivation for treatment seeking or research participation seeking may involve differing factors that were not addressed in the scope of this study and should be looked at as possible treatment seeking issues through media for persons of Mexican heritage. Traditional difficulties recruiting minorities for medical research have been documented in studies and methods to attract participation of minority participants for medical research could account for this lack of media response to recruitment methods in this current study (Ejiogu et al., 2011; Larkey, Gonzalez, Mar, & Glantz, 2009).

Media responses and percentages of media mode utilization reported by study participants appear consistent with Pew Research findings that were presented in Chapter III. In the current study, media use was 100% for TV, 76% for Internet, 71% print media, 67% one-to-one interaction, 62% radio, 33% community groups. In the Pew study by Livingston et al. (2008), participants of Mexican descent reported 69% of health information was obtained from television, 41% from radio, 31% from the Internet, 49% used print media, 63% from family or
friends and 32% from church and community groups. Interestingly, participants of English dominant language (an acculturation factor) reported higher rates of provider information (79%), lower use of television, radio, and church/community groups (63%, 35% and 25%), higher rates of family and friends, Internet and print media use (73%, 53% and 56%). This is also similar to the reported media use rates of Anglos in the U.S. where 83% of participants used television for health information, 77% used newspapers and magazines, 71% received health information from family and friends, 24% used the radio, and 15% used the Internet as a primary source of health information (Dutta-Bergman, 2009).

What is currently being done for media outreach about mental health education, information and resources availability may not be reaching the target audience to whom information was intended. This lack of effective media placement of information may be affecting access and utilization (O’Malley, Kerner, & Johnson, 1999). Although participant recruitment included TV commercials, newspaper advertisements, and advertisements in English and Spanish radio, only one highly acculturated participant responded to the newspaper advertisement. All other participants responded to the placement of flyers in their neighborhoods and community stores and markets. Indeed, three participants were obtained while the researcher was actually posting the flyer in a designated location, as the participants came up to read the information and interact with the researcher and immediately signed up to participate in the study.

A review of the literature in February 2013 revealed no research in the past twenty years regarding media mental health seeking information for persons of Mexican Heritage. Munoz, Glish, Soo-hoo, and Robertson (1982) reported the benefits of television as an education method of teaching mental health information on depression. He also noted the potential ability to
communicate mental health information through the large personal social networks that many persons of Mexican heritage maintained. Hsia (1987) reviewed health media marketing appeals made specifically towards persons of Mexican heritage living in West Texas. Communication issues such as cultural bias, lack of information in Spanish, poor distribution of media messages other than on television, and poor communication of benefits of treatment-seeking were factors limiting the effect of media in a rural Texas border community. O’Malley et al. (1999) questioned whether health media appeals to minorities were reaching their target audiences.

Surveys of media use for health information showed less-acculturated Mexican-Americans were more likely to use Spanish language television than more acculturated groups, although no other notable differences were seen. Lorence, Park, and Fox (2006) reported the “digital divide” for mental health information on the Internet remained for persons of Hispanic background from 2000-2004, despite the increase utilization of computers and Internet for this group.

To address participant preferences for more one-to-one interaction for mental health information dissemination, a number of methods can be employed. More direct to consumer marketing of mental health information can be done by mental health care providers, such as flyers on the car, in store and restaurant windows, laundry mat bulletin boards, beauty and barber shops, as well as the local White Pages, a free, weekly magazine distributed widely in the rural county areas along the US–Mexico border. These places of distribution may be more feasible for persons of Mexican heritage to obtain entry information, contact numbers, and educational information, without the potential for scrutiny by others to maintain privacy. Messages in media marketing could utilize English and Spanish speakers, but also note the potential benefits and promotion of potential treatment. For younger generations and more acculturated persons, Facebook, Twitter, and website-based information may be placed on the on the Internet,
information provided in want ads, and other sources that might reach more persons of Mexican heritage than television.

   Additional methods of improving community-based access to mental health information include in-person interaction with those in the community. To do this, mental health providers can participate in community health fairs, festivals, outdoor activities, and community celebrations, for example, Cinco de Mayo or the Somerton Tamale Festivals. Additionally, programs that utilize community members to disseminate mental health information have been shown to be more effective at communicating with the general population. Cristancho, Garces, Peters, and Mueller (2008) reported that the utilization of trained lay-community health workers, such as mental health promotoras, would allow improved interaction of health care professionals with community members to increase access, utilization, and satisfaction in mental health care services. Mental health community lay workers, promotoras, provide for door-to-door interactions with mental health lay community workers and group meetings at community centers, and have shown to be helpful in the dissemination of diabetes and depression information (Reinschmidt & Chong, 2007).

   Strengths of the Current Study

Mental Health Treatment Preferences

   The current study was the first noted to provide one-to-one interviews of 21 participants to ascertain their mental health treatment preferences. This sample size yielded a rich description of mental health treatment preferences, media mode utilization and influence, and ascribed understanding of mental health issues and illness. Previous mental health treatment preference studies had been conducted by printed or phone surveys, not in-person interviews. In a comparison between print and personal interviews, personal interviews allow for complex
questioning, observation of attitudes or behaviors regarding the research questions, and allow for the exchange between researcher and participant (Super Survey Knowledge Base, 2005).

**Theoretical and Open Coding**

Initially, theoretical codes were developed by the researcher based on the research questions. This allowed a construction of a codebook to guide initial interview questions and theoretical coding. Open coding was used to add mental treatment preferences suggested by participants. This allowed for the full exploration of participants’ responses to the questions and furthered the rich description obtained in the study. The resultant mental health treatment preferences and themes obtained in the current study address Sandelowski’s (2000) goal of a thick description in the everyday language of the participant.

**Reflexivity: Comment on Dr. Guarnero’s Report**

Reflexivity journaling was completed from the initiation of the research project in July, 2012 until the completion of data analysis in December, 2012. Reflexivity documents “the degree of influence that the researcher exerts, wither intentionally or unintentionally, on the findings” (Jootun, McGhee, & Marland, 2009, p. 42). The reflexivity notes were reviewed by Dr. Peter A. Guarnero of the University of Texas Health Science Center at San Antonio. Dr. Guarnero, an objective nursing professional of Mexican heritage, was selected as the reflexivity reviewer. Dr. Guarnero stated that “we keep the Reflexivity report in front of ourselves to note our biases as we’re going along and aid us in an objective research process” (personal communication, January 23, 2013).

Several comments on the current research study were reported after reviewing the reflexivity journals, much of which aligns with previously discussed concepts. From Dr. Guarnero’s observations, there is a reported dichotomy continuing in the lives of Mexicans
versus Mexican-Americans. Along the border, Mexican-Americans may at times attempt assimilation in a method to aid their perceived separation from Mexicans. Dr. Guarnerro noted an underlying distinction in northern Mexican and southern Mexicans that appeared related to skin tone (personal communication, January 23, 2013). Northern Mexicans, as Spaniard descendants, could consider themselves “White or Anglo,” whereas southern Mexicans are more closely related to Indians, and therefore “Brown” in terms of race. There were hints at a racial segregation in Mexico that continued in Mexican-American culture, where lighter-skinned Mexicans were at a higher socio-economic level in Mexico and subsequently, more easily assimilated into Anglo society in the US. This continued disparity allowed lighter-skinned Mexican-Americans to “label themselves as White,” and more fully assimilate into Anglo society in the US, while darker-skinned Mexican-Americans were relegated to a, lesser, acculturated integration into U.S. society. This report corroborates earlier studies that showed assimilation was possible for those of lighter skin tone for most other ethnicities, but, for those of darker-skinned tones, acculturation, a secondary level of societal integration, was their only integration option. Additionally, as persons acculturate or assimilate, traditional health practices, such as traditional healing, may be regarded as “ignorant or backwards” as persons begin their interface with Anglo culture. This may lead to the abandonment of potentially resilient factors in the maintenance of health for persons of Mexican heritage, and research has been scarce as to whether this is an Anglo or Mexican imposed abandonment. Conversely, Anglos have adopted some Mexican-American customs and as Dr. Guarnero reported “the Americanization of Mexican holidays” also has implications of how not only persons of Mexican heritage, but Anglos view acculturation and assimilation (personal communication, January 23, 2013). Cinco de Mayo, although not a notable holiday in Mexican culture, has been adapted as a holiday in the
US. However, as Dr. Guarnero pointed out, this day is characterized not by celebrations of the end of oppression of Mexico by its former French rulers, but by the consumption of beer and all-night party ‘fiestas’. Interestingly, this Americanized Cinco de Mayo appears to play on prejudicial stereotypes of the Mexican-American community- “drinking beer and partying” -that have little to do with the original intent of the independence celebration. This is similar to the co-opting of the rap movement within the African-American community by young Anglos, but only in glamorizing violence, baggy clothing, substance abuse and the objectification of women, not normally considered positive aspects of the African-American or indeed, rap, community. Dr. Guarnero’s statements and reflections are similar to findings of the current study in regard to acculturation/assimilation and the issues plaguing persons of Mexican heritage during the acculturation process. His report and validation of reflexivity logs confirm the likelihood that the reported mental health treatment preferences of the participants were appropriately assessed, and cultural issues addressed through the reflexivity exercise.

Limitations of the Current Study

Sample

Although research data saturation appeared to be met (Mason, 2010), the sample was limited to only twenty-one participants. A study with a larger sample size may have been able to obtain additional mental health treatment preferences for additional richness in the description of participant’s reports, potential additional mental health treatment preferences, media modes, and ascribed mental health of mental health issues and illness; additional participants may have strengthened trustworthiness to the research findings. Therefore, the reported results of this study must be reviewed in view of the small, limited number of participants that were interviewed.
Fifty percent of the current study participants had some college education, although in the general population, only 38% of persons of Mexican heritage have college education. The sample in the current study was fairly acculturated, with most participants slightly Anglo or strongly Anglo. Although there were no notable findings reporting what the average level of acculturation is for the population living along the US-Mexico border, participants in this current study may have been more acculturated than the general population living along the US-Mexico border, limiting transferability of findings. Additionally, 86% of the participants in the current study reported at least second-generational status. Current demographic studies show that over 52% of persons of Mexican heritage are at least second-generation status (Fry & Passel, 2013). The current study had a higher number of participants with at least second-generational status than the general population of persons of Mexican heritage. Therefore, conclusions based on this current study must be reviewed based on the relatively small sample size, and the apparently skewed education, acculturation, and generational status of the study sample.

**Number of Interviews**

For the current study, only one interview was completed with each of the participants. Opportunities for follow-up interviews were not developed as part of the methods of this study. An additional interview would have allowed the participant an opportunity to reflect on previous questions, develop additional treatment preferences, media modes, or influences, and to allow verification of his/her prior report during the first interview. Although an additional interview may have allowed for bias from the participant, as s/he would have been asked similar questions previously, the additional information may have enhanced the study and improved trustworthiness of the study results.
Theoretical Coding

The participants’ responses were initially theoretically coded and identified in a codebook developed prior to the initiation of participant interviews (Appendix F). Initial theoretical codes were determined from the research questions rather than from the initial report of the participants. Although open coding was employed in the study, the foundation of theoretical coding may have allowed for researcher bias in developing codes. Additionally, theoretical coding and open coding were conducted simultaneously, and therefore may have led to non-systematic coding.

Recruitment

For the current study, participants were not questioned as to their mental health experience history—having mental health issues or illness themselves or in an immediate family member. This question may have been off putting and potentially stigmatizing for some participants, the resultant participant sample may have provided differing responses as to their mental health treatment preferences, media modes and ascribed meanings for mental health issues and illness if the complete participant pool had experienced mental health issues and illness themselves. Although the current study sample contained almost equal numbers of persons who experienced mental health issues and illness or had an immediate family member with mental health issues and illness, a sample of just those experiencing mental health issues and illness may have yielded differing results.

Media Mode and Language Influences

Questions regarding media use and influence based on language (English or Spanish) were initially part of the interview questions posed to study participants. However, a lack of specificity in question structure prevented the collection of sufficient responses from participants.
to assess whether language use in media was an influencing factor in either mental health treatment preference or media influence for persons of Mexican heritage. Some participants reported media information in Spanish may have a more positive effect in motivating treatment seeking, but there was not data saturation in regard to this question to allow for analysis of this potentially intriguing concept. Additionally, the proximity to the border may have an effect on media use and influence for persons of Mexican heritage. Media from the US and Mexico is available without cable in English and Spanish; therefore prevalence and use between the two may be less, making it more difficult to discern nuances in media preference and influence without more pointed questioning.

Media Influences in Participant Response

A number of pertinent media issues regarding mental health occurred just prior to the initiation of data collection. The Aurora, Colorado movie theater shootings in July, 2012, the New York 4th of July shootings in 2012, and the Miami homeless man’s eating of another homeless man’s face in May, 2012 started a nationwide focus on mental health, violence, substance abuse, resulting in a potentially increased media monitoring given the graphic and startling nature of those attacks. One participant mentioned the Aurora shootings in his interview, and issues such as these may have led to differing responses regarding mental health treatment preferences from the participants. For example, contacting the police was a noted mental health treatment preference that could have been given increased relevance secondary to these recent media events. Additionally, media mode responses and media influences may have been impacted by the media coverage of these events.
Integrative Medicine as a Mental Health Treatment Preference

For the current study, integrative medicine was not divided into its more commonly reported subtypes—mind-body medicines (relaxation, imagery), physical medicines (acupuncture, tai chi), other integrative practices (spirituality, energy healing) to allow for specific delineation amongst integrative medicine therapies. Potential delineations could have been made for persons of Mexican heritage for the differing types of integrative medicine therapies, which may have varied from Anglo reports.

Research Implications

Potential for Transferability

The sample in the current research study is notably similar to the demographics in Yuma County, Arizona (see Table 5). One notable difference from the general income statistics for Yuma County, Arizona, was that research participants for this study ranked slightly higher than Yuma County demographics in education. Income is similar to the average yearly income of $14,500/year for persons living along the US-Mexico border (United States-México, 2011). Therefore, the sample for this research study was very similar, not only to the demographics of persons of Mexican heritage living in Yuma County, but also to persons of Mexican heritage living along the US-Mexico Border, based upon their income, insurance status, and generational status.

Educational data for the group show that one participant (5%) had only elementary education, one participant (5%) had middle school education, seven participants (33%) had high school education, eight participants (38%) had some college education, and four (19%) participants completed college or graduate school. These statistics reflect a higher level of educational status in the sample group than the current Yuma County, Arizona (reference table).
This higher level of education in the participants of this current study possibly reflects the tendency of more educated persons to consent to participate in research (Trauth, Musa, Siminoff, Jewell, & Ricci, 2000). Along with the rest of the US-Mexico border, border region inhabitants average three fewer years of education than non-border area inhabitants (United States-México, 2011). Nationwide, the percentage of residents with less than a middle-school education is 0.5%, but is 20% along the US-Mexico border region (PAHO, 2007).

Employment for the group participants reflected the current economic issues related to life on the US-Mexico border. Eight participants (38%) were employed at the time of their interview; 13 participants (62%) were unemployed. During the summer of 2012, Yuma County Arizona had the nation’s highest unemployment rate and the highest reported unemployment rate in the US since the Great Depression at 32% (Bureau of Labor Statistics [BLS], 2012). An additional point is that students are considered unemployed in Bureau of Labor Statistics data. If students were considered in the ranks of the employed, the unemployment rate would have been 47%, still well above the reported unemployment rate for Yuma County, Arizona.

Generational status of the participants was recorded for this study. Of the twenty-one participants in the study, three (14%) were first-generation immigrants (born in Mexico), fourteen (67%) were second-generation immigrants (had parents that were born in Mexico) and four (19%) were third- generation immigrants (had grandparents that were born in Mexico). The U.S. Census Bureau (2012) estimates 25% of Yuma County residents were first-generation (born in Mexico). Pew Hispanic studies show 11% of Hispanics are first-generation, 52% are second-generation, and 37% were third-generation or higher, which was largely reflected in our demographic findings (Fry & Passel, 2013).
Of the participants interviewed in this study, seven participants (33%) were uninsured; seven participants (33%) had private insurance; seven (33%) had AHCCCS/Medicaid insurance. Although the U.S. Census Bureau (2010) reported 19.7% of general population in Yuma County had no health insurance, 30% of Mexicans in Arizona lacked health insurance. Of those with insurance in the general population of Yuma County, 42% had private insurance, and 35% had AHCCCS insurance, which is commensurate with findings in our study for persons of Mexican heritage (2010). Along the U. S. border counties, 25-30% of the border population was uninsured, with 40% of border residents with private insurance versus 60% on non-border areas in the same states (United States-México, 2011).

Given the similarities in the demographics of the current study and the US-Mexico border region near Yuma, the results of this study may be transferable to other persons of Mexican heritage living along the US-Mexico border. Similar mental health treatment preferences, preferences and utilization of media, and ascribed meanings of mental health issues and illness may be similarly applicable to these populations. Someone reading the rich thick description could also see the similar characteristics of this sample in their population. Another researcher reading the rich think description presented here could also see the similar characteristics of this sample in their population.

The “Community-Based Health Care Stop”

Although preferences and utilization of cross-border health care services were not analyzed in the current study, sufficient information was obtained to allow for future study of these data. Interestingly, the desire for a one-stop shop for health care and services was reported almost as often as financial resources as a motivation for seeking health care services in Mexico. Noted by several participants was the ease of obtaining full health care services-labs, radiology,
pharmacy, and other procedures all in one building, minimizing travel, time and distance, and maximizing convenience and continuity of care opportunities. As a notable motivator for treatment/treatment seeking in Mexico, more information regarding the feasibility of these types of health care centers in the US would be helpful in encouraging utilization and satisfaction in health care. Would they be available in the US, especially in border areas or areas with large populations of persons of Mexican heritage? Would these types of health care services increase access, utilization, and satisfaction in health care services provision for persons of Mexican heritage?

**The Need for Mental Health Education/Information in Schools and Workplaces**

A notable research finding was the high percentage of participants reporting they obtained mental health information/education in school or work settings, as well as participants who felt those were legitimate places for such information to be disseminated. A number of participants reported that this information should be provided as part of an overall health based education, including topics such as mental health, mental illness, and how to identify mental health issues and illness in order to seek help. A theme obtained from participant responses was “If you don’t know what mental health is, you don’t realize you’re mentally ill or how to help someone you know with mental illness.” Education in health and mental health was reported as vital to not only educate the next generation in mental health and ways to obtain and maintain it, but also to be aware of signs/symptoms of mental illness related to mental health issues and illness. Additional opportunities for exploring this data in future studies would potentially serve to address continued health inequities in the Mexican community.
ARSMA-II Appreciation/Valuation of Culture Scale II

The ARSMA-II Acculturation Scale (Appendix A) was used to gauge relative acculturation of the study participants. Scale II of the ARSMA-II results were not used in the current study. Scale II questions reviewed prevalent ideas of Mexican versus Anglo culture, and acceptance, appreciation and valuation for cultural reference. Given the previous discussion regarding loss of valuation of Mexican cultural identity during the acculturation process, further review of these data could show additional delineations in regard to acculturation, assimilation, and mental health treatment preferences, media utilization, and ascribed understanding of mental health issues and illness.

Mental Health Treatment Seeking for Persons of Mexican Heritage

Data were obtained during the current study on potential factors related to treatment seeking for mental health for persons of Mexican heritage. These data were not analyzed in the current study. The data addressed how persons arrive at the decision, choice, or provocation to initiate encounters with mental health agencies for treatment of mental health issues and illness. Issues related to facilitators and barriers to mental health treatment seeking were discussed by the participants. Further study and secondary analysis may elucidate patterns in treatment seeking and barriers to mental health service utilization that can be helpful in future clinical implementation research studies for persons of Mexican heritage. Although not analyzed in this study, two prevailing patterns emerged from data requiring further analysis: the person with mental illness is unaware, the people around them identify or point them to mental health services, and persons come to a turning point in their lives that prompts them to seek treatment. For reasons that will require further identification and analysis, some persons do not reach a ‘turning point’ that motivates them to seek treatment. They are unaware of their plight and have
to be told by others that “they require mental help.” A review of the potential factors, including mental health experience (self or immediate family), that may mediate those turning points or intervention of others will need further explication.

**Significance to Nursing Practice**

The mental health treatment preferences reported by persons of Mexican heritage in this current study provide a unique insight into the current status of mental health service provision and needs for this group. Their responses illustrate the inherent desire of most persons, despite ethnicity, to desire similar types of mental health services in assistance with mental health issues and illness. However, the extent to which self-management interventions and integrative medicine therapies are also desirable for treatment of mental health issues and illness was also revealed in their reports in this study. This holistic balance of mental health treatment preferences is in keeping with the bio-psycho-social aspects traditionally inherent in the profession of nursing and more recently co-opted by the general medical literature. The acknowledgement and encouragement of these types of practices for the treatment of mental health issues and illness will be a necessary point for future mental health intervention in order to achieve optimal participation, utilization, and satisfaction with mental health service provision for persons of Mexican heritage.

The ongoing plight of those experiencing mental health issues and illness continues to plague the US in general and persons of Mexican heritage in particular. Recent media events continue to highlight the difficulties persons experience in accessing and effectively utilizing mental health services in their care and treatment for mental health issues and illness. Disparities in mental health among ethnic minority groups have actually increased since the 1990s, with
persons of Mexican heritage currently the least likely of minority groups to receive adequate mental health care services (Ruiz & Primm, 2009).

The current study outlines mental health treatment preferences that were reported by twenty-one participants during one-to-one interviews. Allopathic medications and therapies, self-management interventions, and integrative medicine therapies can serve as effective components in mental health service provision for persons of Mexican heritage. Nurses and mental health care providers must understand and accept the importance of these types of mental health treatment preferences for persons of Mexican heritage. It will be important for providers to assess for, acknowledge, and encourage the utilization of these mental health treatment preferences in those persons who report use of them, and to introduce these mental health treatment preferences for those persons who may be unaware of their potential benefit for mental health issues and illnesses.

The psychiatric-mental health nurse practitioner, trained in allopathic medicine and holistic nursing models, can specifically affect the implementation of integrative medicine therapies for persons of Mexican heritage. This is a natural extension of the IOM’s mandate to allow advanced nurses to practice through the full scope of their abilities, while enhancing mental health treatment services to needed vulnerable populations. Clinical rotations including integrative medicine therapies have been a fundamental part of psychiatric-mental health nurse practitioner training (Maizes, Rakel, & Niemiec, 2009; Roberts, Robinson, Stewart, & Smith, 2009). Psychiatric-mental health nurse practitioners could be instrumental in the development of community-based mental health center models that employed a number of the mental health treatment preferences discussed in the current study. Additionally, the in-person information model for dissemination of information could be initiated through psychiatric-mental health
nurse practitioner based teams supervising community health workers and providing educational
talks, lectures and communication during community health events.

From the study findings, effective media utilization can serve to educate, inform, and encourage treatment seeking for mental health issues and illness despite the number of barriers to mental health treatment seeking faced by persons of Mexican heritage. Current media strategies may not be reaching persons of Mexican heritage or providing sufficient information, education and “hope” in potential benefit for mental health treatment to overcome current barriers to mental health treatment seeking. Mental health providers and public health workers will need to utilize diverse methods to outreach persons of Mexican heritage and customize media and social marketing attempts to address specific concerns of persons of Mexican heritage. The utilization of one-to-one interaction attempts through in-person, community health events, or social media may increase the access to mental health information seeking for persons of Mexican heritage without the social stigma that is particularly problematic for this group. Increased mental health information seeking may then transfer to increased mental health treatment seeking for persons of Mexican heritage. Gonzalez, Alegría, Prihoda, Copeland, and Zeber (2011) reported a similar increase in health care treatment seeking through tailored information to diverse communities as a corroborating report that these types of direct media marketing interventions can prove beneficial in reducing stigma, increasing mental health care literacy, and thereby, mental health treatment seeking for mental health issues and illness.

Understanding ascribed meanings based on somatic changes and functional status of persons of Mexican heritage may assist mental health care providers in appropriately assessing, diagnosing, and treating persons of Mexican heritage. Previous reports as well as the current study highlight the differences in ascribed understanding of mental health issue and illness for
persons of Mexican heritage. Recognizing this functional status basis in mental health issues and illness also has an implication in outreach to persons of Mexican heritage in enabling the recognition that mental health issues and illness impair functional status and therefore overall ability to complete daily living tasks effectively. Recognition of the need for care may be enhanced by outreach that informs persons of Mexican heritage that rather than waiting for physiological dysfunction, treatment seeking at the recognition of functional status change may minimize overall negative impact on the individual and facilitate recovery of function through mental health treatment at a faster rate. The current diagnostic strategies may be inaccurately labeling persons of Mexican heritage in such a way as to discourage continued mental health service utilization. Structural changes to assessment and diagnosis of mental health issues and illness in the upcoming DSM-V may serve to enhance mental health provider’s abilities in accurately addressing the mental health needs of persons of Mexican heritage.

Conclusion

In summary, this was the first study to provide an interview format in the assessment of mental health treatment preferences, media influences in mental health, and ascribed understanding of mental of mental health issues and illness. Persons of Mexican heritage report the desire for the same types of allopathic care including medications and counseling as Anglos in the US. Additionally, self-management interventions and integrative medicine therapies were reported as integral to the holistic treatment process of obtaining help for mental health issues and illness. Ascribed meanings of mental health issues and illness focus on the somatic and functional status of persons experiencing mental health issues and illness. Media influences tailored to the one-to-one interactions deemed important to persons of Mexican heritage may be
more effective in providing education, information and encouragement in mental health treatment seeking for persons of Mexican heritage living along the US-Mexican border.
APPENDIX A:

ARSMA-II ACCULTURATION SCALE
### Acculturation Rating Scale-II (ARSMA-II)

#### English Version

| Name: __________________________ |
| Male: ______ Female: ______ |
| Age: ___ DOB: ___/___/____ |
| Marital Status: ______________ |
| What is your religious preference? ______________ |

(a) Last grade you completed in school: *(Circle your choice)*

1. Elementary-6
2. 7-8
3. 9-12
4. 1-2 years of college
5. 3-4 years of college
6. College graduate and higher

(b) In what country? ______________

[(Circle the generation that best applies to you. Circle only one.)

1. 1st generation = You were born in Mexico or other country.
2. 2nd generation = You were born in USA; either parent born in Mexico or other country.
3. 3rd generation = You were born in USA, both parents born in USA and all grandparents born in Mexico or other country.
4. 4th generation = You and your parents born in USA and at least one grandparent born in Mexico or other country with remainder born in the USA.
5. 5th generation = You and your parents born in the USA and all grandparents born in the USA.]

#### Versión en Español

| Nombre: __________________________ |
| Masculino: ______ Femenino: ______ |
| Edad: ___ Día de Nacimiento: ______________ |
| Estado Civil: ______________ |
| Cual es su religión predilecta? ______________ |

(a) ¿Hasta que grado fué a la escuela? *(Indique con un círculo la respuesta)*

1. Primaria-6
2. Secundaria 7-8
3. Preparatoria 9-12
4. Universidad o Colegio 1-2 años
5. Universidad o Colegio 3-4 años
6. Graduado, o grado mas alto de Colegio o Universidad

(b) ¿En qué país? ______________

[(Indique con un círculo el número de la generación que considere adecuada para usted. Dé solamente una repuesta.)]

1. 1a. generación = Usted nació en México u otro país [no en los Estados Unidos (USA)].
2. 2a. generación = Usted nació en los Estados Unidos Americanos (USA), sus padres nacieron en México o en otro país.
3. 3a. generación = Usted nació en los Estados Unidos Americanos (USA), sus padres también nacieron en los Estados Unidos (USA) y sus abuelos nacieron en México o en otro país.
4. 4a. generación = Usted nació en los Estados Unidos Americanos (USA), sus padres nacieron en los Estados Unidos Americanos (USA) y por lo menos uno de sus abuelos nació en México o algun otro país.
5. 5a. generación = Usted y sus padres y todos sus abuelos nacieron en los Estados Unidos (USA).]
## SCALE 1

**[Circle a number between 1-5 next to each item that best applies.]**

**[Marque con un círculo el numero entre 1 y 5 a la respuesta que sea más adecuada para usted.]**

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<td>2</td>
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<td>2</td>
<td>I speak English</td>
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<td>3</td>
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<td>1</td>
<td>2</td>
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<td>I enjoy speaking Spanish</td>
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<td>4</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
</tr>
<tr>
<td>4</td>
<td>I associate with Anglos</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
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<tr>
<td>5</td>
<td>I associate with Mexicans and/or Mexican Americans</td>
<td>1</td>
<td>2</td>
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<td>1</td>
<td>2</td>
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<td>5</td>
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<tr>
<td>6</td>
<td>I enjoy listening to Spanish language music</td>
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<td>3</td>
<td>4</td>
<td>5</td>
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<td>2</td>
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<td>4</td>
<td>5</td>
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<tr>
<td>7</td>
<td>I enjoy listening to English language music</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8</td>
<td>I enjoy Spanish language TV</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9</td>
<td>I enjoy English language TV</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
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<tr>
<td>10</td>
<td>I enjoy English language movies</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>1</td>
<td>2</td>
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<td>11</td>
<td>I enjoy Spanish language movies</td>
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<td>2</td>
<td>3</td>
<td>4</td>
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<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>12</td>
<td>I enjoy reading (e.g., books in Spanish)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
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<tr>
<td>13</td>
<td>I enjoy reading (e.g., books in English)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>1</td>
<td>2</td>
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<tr>
<td>14</td>
<td>I write (e.g., letters in Spanish)</td>
<td>1</td>
<td>2</td>
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<td>5</td>
<td>1</td>
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<tr>
<td>15</td>
<td>I write (e.g., letters in English)</td>
<td>1</td>
<td>2</td>
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<td>5</td>
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<tr>
<td>16</td>
<td>My thinking is done in the English language</td>
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<td>2</td>
<td>3</td>
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<td>5</td>
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<tr>
<td>17</td>
<td>My thinking is done in the Spanish language</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>1</td>
<td>2</td>
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<td>4</td>
<td>5</td>
</tr>
<tr>
<td>18</td>
<td>My contact with Mexico has been</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>1</td>
<td>2</td>
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Note: The numbers 1-5 represent the scale of adequacy.
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<td>19. My contact with the USA has been</td>
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<tr>
<td>20. My father identifies or identified himself as 'Mexican'</td>
<td>1</td>
<td>2</td>
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<tr>
<td>21. My mother identifies or identified herself as 'Mexicana'</td>
<td>1</td>
<td>2</td>
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<tr>
<td>22. My friends, while I was growing up, were of Mexican origin</td>
<td>1</td>
<td>2</td>
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</tr>
<tr>
<td>23. My friends, while I was growing up, were of Anglo origin</td>
<td>1</td>
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<tr>
<td>24. My family cooks Mexican foods</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>25. My friends now are of Anglo origin</td>
<td>1</td>
<td>2</td>
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<tr>
<td>26. My friends now are of Mexican origin</td>
<td>1</td>
<td>2</td>
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<td>27. I like to identify myself as an Anglo American</td>
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<tr>
<td>28. I like to identify myself as a Mexican American</td>
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<td>29. I like to identify myself as a Mexican</td>
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<td>30. I like to identify myself as an American</td>
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end of Scale 1  *Estadounidenses de origen Mexicano
### SCALE 2

**[Use the scale below to answer questions 1-18 below.]**

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**[Utilice la escala que sigue para contestar preguntas 1-18.]**

1. Tengo dificultad aceptando ideas de algunos Anglo Americanos.
2. Tengo dificultad aceptando ciertas actitudes de los Anglo Americanos.
3. Tengo dificultad aceptando algunos comportamientos de los Anglo Americanos.
4. Tengo dificultad aceptando algunos valores que tienen los Anglo Americanos.
5. Tengo dificultad aceptando ciertas costumbres entre algunos Anglo Americanos.
6. Tengo, o creo que si tuviera, dificultad aceptando Anglo Americanos como buenos amigos.
7. Tengo dificultad aceptando ideas de algunos Mexicanos.
8. Tengo dificultad aceptando ciertas actitudes de algunos Mexicanos.
9. Tengo dificultad aceptando algunos comportamientos de los Mexicanos.
10. Tengo dificultad aceptando algunos valores que tienen los Mexicanos.
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<td>11. I have difficulty accepting certain practices and customs commonly found in some Mexicans.</td>
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<td>11. Tengo dificultad aceptando ciertas costumbres entre algunos Mexicanos.</td>
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<td>12. I have, or think I would have, difficulty accepting Mexicans as close personal friends.</td>
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<td>12. Tengo, o creo que si tuviera, dificultad aceptando a Mexicanos como buenos amigos.</td>
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<td>13. I have difficulty accepting ideas held by some Mexican Americans.</td>
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<td>13. Tengo dificultad aceptando ideas de algunos Mexicanos-Americanos*</td>
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<td>14. I have difficulty accepting certain attitudes held by Mexican Americans.</td>
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<td>14. Tengo dificultad aceptando ciertas actitudes de algunos Mexicanos-Americanos*</td>
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<td>15. I have difficulty accepting some behaviors exhibited by Mexican Americans.</td>
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<td>15. Tengo dificultad aceptando algunos comportamientos de los Mexicanos-Americanos*.</td>
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<td>16. I have difficulty accepting some values held by Mexican Americans.</td>
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<td>16. Tengo dificultad aceptando algunos valores que tienen Mexicanos-Americanos*.</td>
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<td>17. I have difficulty accepting certain practices and customs commonly found in some Mexican Americans.</td>
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<td>17. Tengo dificultad aceptando ciertas costumbres entre algunos Mexicanos Americanos*.</td>
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<td>18. I have, or think I would have, difficulty accepting Mexican Americans as close personal friends.</td>
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<td>18. Tengo, o creo que si tuviera, dificultad aceptando Mexicanos Americanos* como buenos amigos.</td>
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*Estadounidenses de origen Mexicano

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APPENDIX B:

RECRUITMENT FLYER
Mexican heritage?

Share your opinions on health care!!

Tell us what services you want for mental health care!

Are you-
• of Mexican background?
• able to speak and read English?
• 18 or older?

Participate and you will receive payment for the two and one-half hour interview.

Call Tanya Sorrell, University of Arizona Doctoral Candidate in Nursing, at 928-304-3866 or trsorrell@gmail.com for more information and to participate.
APPENDIX C:

RECRUITMENT SCRIPT
Recruitment Script

“My name is Tanya Sorrell. I am a nurse and a doctoral nursing candidate at the University of Arizona. I am leading a research project to learn more about treatment preferences for health and mental health in persons of Mexican heritage. People who are English-speaking, 18 years or older and of Mexican heritage are eligible for participation.

More specifically, I am interested in what types of help you would prefer for health and mental health. If you agree to participate, you will be asked to consent to be interviewed by me in person for approximately two hours about your personal information, experiences, feelings, and thoughts about mental health treatment. You will be asked to consent to audio-record your interview. You will receive a $20 Visa gift card as payment for the two and one-half hour interview. No one will know you are participating except me and everything we talk about will be kept confidential. If you are interested in participating we can see if you’re eligible for the study. Would you be interested in participating?
APPENDIX D:

INFORMED CONSENT
Informed Consent

Treatment Preferences for Mental Health in Persons of Mexican Heritage

Introduction
You are being invited to take part in a research study. The information in this form is provided to help you decide whether or not to take part. The researcher will be available to answer your questions and provide additional information. If you decide to take part in the study, you will be asked to sign this consent form. A copy of this form will be given to you.

What is the purpose of this research study?
You are being invited to participate voluntarily in the above-titled research project. The purpose of this study is to explore preferences for mental health treatment in Mexican adults. This is because mental health treatment may not take into account the cultural preferences of Mexican heritage persons when providing mental health treatments. Results of this study will be used to improve health care for Mexican adults wanting treatment for mental health issues.

Why are you being asked to participate?
You are being invited because you are of Mexican heritage, 18 years old or older, and are able to speak and read English.

How many people will be asked to participate in this study?
Approximately 20 persons will be asked to participate in this study.

What will happen during this study?
If you agree to participate, you will be asked to consent to be interviewed by the Principal Investigator, Tanya Sorrell, in person for approximately two and one-half hours about your personal information, experiences, feelings, and thoughts about mental health treatment after you sign the consent form. You will be asked to consent to audio-record your interview.

How long will I be in this study?
About 150 minutes of time will be needed to complete this study.

Are there any risks to me?
The questions you will be answering have no known physical risk. You can take a break at any time if you begin to feel tired. A number will be used to identify your interview and your real name will not be used in any of the study reports. You may feel that some questions I ask about your private information, your personal insights, and/or your sensitive issues associated with preferences for treatment of mental health issues and length of interview will be stressful or upsetting. If this occurs you can stop participating immediately. We can give you information about individuals who may be able to help you with these problems. You can also ask that some information not be used in the study reports.
Are there any benefits to me?
You will not receive any benefit from taking part in this study. The potential benefits of this study to society may help nursing and other health care professionals to understand the preferences for mental health treatment in persons of Mexican heritage. It may also be beneficial for health care professionals and to their patients if the results of this study contribute to improvement of mental health care practice for health promotion related to persons of Mexican heritage.

Will there be any costs to me?
Aside from your time, there are no costs for taking part in the study.

Will I be paid to participate in the study?
You will be paid $20 by Visa gift card for your participation.

Will video or audio recordings be made of me during the study?
Yes. We will make an audio recording during the study so that we can be certain that your responses are recorded accurately only if you check the box below:

[ ] I give my permission for audio recordings to be made of me during my participation in this research study.

Will the information that is obtained from me be kept confidential?
The only persons who will know that you participated in this study will be me, Tanya Sorrell, the researcher. Your records will be confidential and your real names will not be identified in the records. You will not be identified in any reports or publications resulting from the study. It is possible that representatives of the Federal Government or the Human Subjects Protection Program may access your records to ensure quality of study data and conduct.

What if I am harmed by the study procedures?
This research will have no known physical risk and minimal risk for fatigue or psychological discomfort. Therefore, no medical treatments are available if injury occurs.

May I change my mind about participating?
Your participation in this study is voluntary. You may decide to not begin or to stop the study at any time. Your refusing to participate will have no effect on your health status or employment. You can discontinue your participation with no effect on your social status or employment. Also any new information discovered about the research will be provided to you. This information could affect your willingness to continue your participation.

Whom can I contact for additional information?
You can obtain further information about the research or voice concerns or complaints about the research by calling the Principal Investigator Tanya R. Sorrell, NP-C, at (928) 304-3866 or e-mail trsorrell@gmail.com. If you have questions concerning your rights as a research participant, have general questions, concerns or complaints or would like to give input about the
research and can't reach the research team, or want to talk to someone other than the research team, you may call the University of Arizona Human Subjects Protection Program office at (520) 626-6721. If you would like to contact the Human Subjects Protection Program by email, please use the following email address http://www.irb.arizona.edu/suggestions.php.

Your Signature

By signing this form, I affirm that I have read the information contained in the form, that the study has been explained to me, that my questions have been answered and that I agree to take part in this study. I do not give up any of my legal rights by signing this form.

____________________________
Name (Printed)

______________________________
Participant’s Signature Date signed

Statement by person obtaining consent

I certify that I have explained the research study to the person who has agreed to participate, and that he or she has been informed of the purpose, the procedures, the possible risks and potential benefits associated with participation in this study. Any questions raised have been answered to the participant’s satisfaction.

__ Tanya R. Sorrell ______________
Name of study personnel

______________________________
Study personnel Signature Date signed
APPENDIX E:

DEMOGRAPHIC QUESTIONNAIRE
Demographic Questionnaire

Are you (check all that apply):  Working full-time ____
                  Working Part-time ____
                  Unemployed ____
                  Disabled ____
                  Full-time Student ____
                  Part-time Student ____

What kind of job are you employed in? _______________________

How long have you lived in the United States? _________ years

Do you have health insurance? _______________________

How many years have you had a health care provider?
      None______________
      Less than one year_______
      One-three years__________
      Three-five years__________
      More than five years_______

Do you have a mental health care provider? Yes_______ No________
APPENDIX F: CODEBOOK
CODE BOOK

Definitions of Mental Illness
Defined- Symptoms, behaviors and notable changes in a person when affected by mental illness. From the participant’s perspective of what they see in someone else or experience in themselves when affected by mental illness.

Meaning- Anxiety/Nervousness
Defined- report of symptoms of a state of apprehension, uncertainty, and fear resulting from anticipation an event or situation, affecting physical and psychological functioning including worry, nervousness, stress, uneasiness.

Meaning- Depression
Defined- report of symptoms of a state of sadness affecting physical and psychological functioning including an inability to concentrate, insomnia, loss of appetite, anhedonia, feelings of guilt, helplessness and thoughts of death.

Meaning- Mental Health Issue/Illnesses
Defined- report of symptoms of various conditions with notable impairment of an individual's physical and psychological functioning including cognitive, emotional, behavioral, social changes affecting overall quality of life.

Meaning- Substance Abuse
Defined- report of symptoms of a state of overindulgence in, misuse of, and dependence on an addictive substance, alcohol or narcotic drugs.

Treatment Preference - Activity Management
Defined- Participation in indoor/outdoor, solitary, or group activities that may be useful in addressing emotional, social, and interactional needs.

Reported Mental Illness in Family
Defined- Symptoms, behaviors and notable changes that participants report they have seen or observed in a family member.

Reported Mental Illness in Self
Defined- Symptoms, behaviors and notable changes that participants report they have experienced themselves.

Treatment Preference - Avoiding Negative Influences
Defined- Use of active, adaptive avoidance of negative interactions, people, and places in order to maintain mental health and prevent substance abuse.

Treatment Preference - Body-Based IM Practices
Defined- Activities promoting self-care, esteem, and awareness, such as manicures, pedicures, facials, and non-therapeutic health care procedures.

Treatment Preference - Contacting Police
Defined- Interaction with the police or jail in order to obtain mental health services.
Treatment Preference - Coping Skills
Defined- Methods of treatment for mental illness as positive ways of solving personal problems by reducing stress and anxiety and managing negative emotion.

Treatment Preference - Counseling
Defined- Use of individual or group therapy and interaction with a trained mental health professional.

Treatment Preference - Healthy Eating and Appetite
Defined- Healthy eating in relation to types of food, portions; better food choices that maximize health and wellness through nutrition.

Treatment Preference - Herbal Medicine
Defined- Use of herbal remedies in the form of teas, potions, or compounds obtained over-the-counter or by trained providers.

Treatment Preference - Inpatient Facility
Defined- Facility other than on an outpatient basis, Group homes, halfway houses, or other facilities that provide milieu.

Treatment Preference - Integrative Medicine
Defined- Methods of treatment for mental illness as integrative or alternative therapies, classified by NCCAM.

Treatment Preference - Journaling
Defined- Writing, journaling, or recording by hand life or emotional experiences that are designed to improve mental health outcomes.

Treatment Preference - Medications
Defined- Use of pharmacologic agents prescribed by a health care provider.

Treatment Preference - Mental Health Assessment
Defined- Interaction with a crisis or mental health team that evaluates a person's risk for self-harm and determines need for inpatient placement or other mental health dispositions.

Treatment Preference - Mental Illness Prevention
Defined- Any activity performed proactively for the purpose of promoting mental health/wellness and preventing mental health issues and illness.

Treatment Preference - Physical Activity
Defined- Any form of exercise or physical activity.

Treatment Preference - Positive Energy
Defined- Feelings of emotional or mental energy or personal strength that affect and improve overall wellbeing.

Treatment Preference - Reading
Defined- Use of book, magazine, or print material as a positive coping skill to minimize stress or negative emotion or affect.
Treatment Preference - Small Group Interaction
   Defined- Therapeutic interactions with a group leader and a number of non-related participants experiencing similar mental health issues.

Treatment Preference - Social Service Agency
   Defined- Seeking services and treatment through a non-mental health social assistance service agency.

Treatment Preference - Social Skills Training
   Defined- Training in social inclusion and interacting positively with others from a licensed provider.

Treatment Preference - Social Support
   Defined- Interaction with friends and non-professional verbal discussion and validation.

Treatment Preference - Traditional Healers
   Defined- Use of faith- or other-based cultural healers.

Media - Books and Magazines
   Defined- Information obtained by books or magazines of any type.

Media - Community Health Event
   Defined- Formal group activity in which mental health information is disseminated

Media - Crisis Hotline
   Defined- with a formal crisis hotline or helpline or other communication line

Media - In-Person Information
   Defined- Mental health and illness information provided in person, in real time through person-to-person interactions, including information conveyed by "word of mouth".

Media - Internet
   Defined- Any information obtained from any source of Internet through computer, phone, or other communication method.

Media - Movies
   Defined- Mental health information obtained through films shown in a movie theater or public showing.

Media - Newspaper
   Defined- Any activity read from mass printed or distributed media.

Media - Print Resources
   Defined- Flyers, handouts, billboards, and other printed material used to disseminate mental health information, other than books and magazines.
Media - Radio
Defined- Any activity heard as taking place through listening to the medium of radio.

Media - School
Defined- Any classroom or lecture hall information associated with enrollment in a course or program offered by an educational institution.

Media - Television
Defined- Any activity seen or heard as taking place through the medium of television.

Media - Work-
Defined- Mental health information obtained through any media in the workplace.

Media Influence - Catalyst for Conversation
Defined- Media which encourages discussion, conversation, and sparks interest in mental health topics and knowledge/awareness.

Media Influence - Education/Information
Defined- Media that increases knowledge about mental health.

Media Influence - “Hope”
Defined- Media that provides reassurance, encouragement about how mental illness can be improved with a return to of function and wellness.

Media Influence - “Normalize”
Defined- Media that informs understanding that mental illness is a health problem, not a stigma, ‘you’re not crazy, weak, a bad person,’ and that other people also experience mental illness.
APPENDIX G:

QUOTES OF MOST REPORTED TREATMENT PREFERENCES
**Most Commonly Reported Mental Health Treatment Preference Quotes of the Participants**

**Medications**

*Codebook definition: Reports of methods of treatment for mental illness including the use of pharmacologic agents prescribed by a health care provider.*

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<td>Andrea</td>
<td>He [doctor] recommended medication, and I took it because I thought anything to make myself feel better, especially when he started to explain all the chemical imbalances and stuff like that. So then I had kind of some sound medical information telling me why it is you’re probably feeling this way, that the medication’s gonna help regulate.</td>
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<tr>
<td>Reuben</td>
<td>They help her out with the depression, for the drugs, they gave her, for the bi-polar. They’ve been giving her some medicine; she’s doing a little bit better though.</td>
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<td>Linda</td>
<td>I guess she’s taking some medication, but I don’t know what kind. And one time I went over there, last year, huh? I went over there and she told me she wasn’t drinking her medication.</td>
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<td>Mary</td>
<td>I know, like I said, medications. I know there’s medication for depression or other mental health issues, to kind of help balance, like, impulses that may make other people think you’re crazy, or just acting out, or whatever it is; you know, being upset.</td>
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<td>I don’t know exactly what the medication is for, but I definitely think it helps, so that way, I know the medication makes you feel a little bit better.</td>
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<td>Mr. C.</td>
<td>Like, physically, on the inside, not mentally, but mentally, pills can be healthy. ‘Cause they can release; ‘cause people can have chemical imbalances.</td>
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<td>Some people need the medications, ‘cause there’s no other outlet for ‘em. Their imbalance is so lopsided; that the chemicals they are prescribing you actually help you get to that point.</td>
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<td>Gerardo</td>
<td>Yes, because some people never take medicine. Some people don’t have to. And I think the diet and our stress has a lot to do with our bodies.</td>
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<td>Cepeda</td>
<td>Take medication as indicated. I wouldn’t know how to react to maybe what kind of medication they would give me. If I can’t read it, I’m not gonna take it.</td>
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<td>Felis</td>
<td>Because you know that he’s had all the medicine [for schizophrenia]; he’s probably on a lot of the medicine to help everything.</td>
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<td>Sometimes he’s drinking one medicine, then he’s not; he’s doing one things at different hours.</td>
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<td>Princess</td>
<td>Yeah and he was well, I think he was still on depression pills and anxiety pills. He was doing methadone as well; but after that, he’s been great.</td>
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<td>Get depression pills. Take ‘em; get whatever you need to get.</td>
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<td>It [medication] keeps him calmed down. But when he’s off, he’s back to the same.</td>
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<td>Pedro</td>
<td>It works quicker and the medicine’s helping them quicker, or just they’re used to it.</td>
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<td>It works stronger, some of the medicines, a lot of them.</td>
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| Tiger | It was fine. It [medication] took away my anxiety and depression that I had. ‘Cause being on
Drugs, it ain’t fun. Cause [with medication] I stopped doing drugs, so I would feel alright, and that helped me kick heroin, little by little.

**Ricky**

But it [medication] helped me go to sleep at night, you know; but like I have a hard problem going to sleep. I tried that and that was okay.

But like, with my stress and the life I’ve led, I need something to help me out here.

**Tino**

I talked to him and advised him to just go see a psychiatrist, and I guess it helped out. He was prescribed a couple of medications in between those. He was on antidepressants; some are changing moods.

Yeah, and after that you need some kind of medication person.

**Bobby**

It makes me, like, I guess that’s what antidepressants do, they make you really happy and they did actually help me feel fine, like I was myself again.

Well, when I first started taking the antidepressants, I started talking more.

**J.**

I guess a treatment would be, pills, I think, um, antidepressants. They would make a person more happy.

Yeah, like they would have to figure out what’s goin’ on, so maybe they could prescribe them a medication.

**Christian**

I think they’re like, if people are anxious or going through something. Like I have a friend that was into drugs for a long, long time. When he was coming off drugs, he was paranoid and anxious and they gave him, I don’t know what kind of drug, but it helped him to relax and calm down.

They talk about medication, “If you’re going through this, take the medication.”

**Yali**

Well, [the medications] just reduce the actual feeling of nervousness to a point where they are available enough for you to speak with them. But not always are you able to know that dose almost immediately.

I think there’s some medications for it, and there’s a reason why there’s medications.

He was taking his own medication and he was, he knew exactly what the medication was for. He felt comfortable with the disease that he had, and I think he would pretty much would be good on his own independent life. I don’t know, I think he was, I don’t know.

**Debbie**

It [medication] did help her a lot. She lost a lot of weight. She was on Topamax or something. So that gave her motivation again, but with her it really helped her.

Well, she says that her anxiety was controlled; ‘cause she said she was also feeling the heart palpitations and she wasn’t scared as much. So, I mean I’m sure that’s what helped her.

**Carlos**

Well, as a nervous person or a person who has anxiety, I don’t know who would you see or what type of medication they offered for anxiety. ‘Cause I know they’ll give you, they tell you, they give you your illness diagnosis. With anxiety you’d get prescribed, for instance, I don’t know what type of pills they’d prescribe for anxiety. But I’m sure that the alternative, cannabis, could be used for one of them, and I don’t know, I feel that helps with depression as well.
Santiago  
If you eat your pills, you forget about it, so you can chill.  
Well, the medication helps, that what I heard. What my brother told me that, they give them to him, you go to sleep.  
So they can like, it works something on the brain, so they can forget about that stuff, it’s like that. ‘Cause he needed some pills, so he knows that if he goes bad, he’s really gonna hurt himself.

Julia  
I was not only put on antidepressants…I’ve been put on the medicine, now that I’m aware of what it is, I can help it, I can help myself.  
If you’re put on the right medications, to feel better, you can have a chance to live a normal life.

---

**Social Support**

*Codebook definition: Report of methods of treatment for mental illness including interaction with friends, family and non-professional verbal discussion and validation*

Andrea  
I think it’s just that social support system, knowing that you have somebody to talk to that has the same, maybe they’re going through the same rough patch that you are. And so I know that’s what helps them, and we could talk about it…It’s just nice being able to talk about. I think because they would just say, “Oh, I’m glad, I feel better when I talk to you about that. You’re going through the same thing and that makes me feel better.”

Reuben  
Just by listening to them, their problems, you know, it really helps them a lot. It’s a good support, because the vast majority of them are young people…It’s like we make them feel good, that they’re being accepted.

Linda  
Or talking to a friend, maybe the friend could help. Maybe she could think through it, or she knows somebody that can do it.

Mary  
I think her friends helped her out a lot. Like, “Come on, let’s go to the game. It’s gonna be fun.” So her friends encouraged her, that kind of thing. So for other people, I think it’s the same as like me going to my friend who I think might be depressed, you know, “Do you have a problem? Is there something you want to talk about?” And then they talk about it, “And maybe you can go and call me if you need something else.”

Mr. C.  
I’m conversating [*sic*] with people, and people that actually listen to you, without lookin’ at you and judgin’ you, it’s a lot, helpful.  
That companionship I keep going back to, is a real good help, and to give them that extra kick of what they need right now.

Gerardo  
But now I’ve got to find out that people who talk to you will not put you down; it makes you feel alive.  
Then you can tell your friends, you know, you go somewhere and you talk about your problems.

Cepeda  
Once you break out of that, you can be more social; you can be better off with your life. Not only just your life, but your family’s life, your friends, your coworkers, acquaintances, and everything else.
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<tr>
<td>Felis</td>
<td>Or when you have a friend or something that had what happened with you, will help you with your things. And maybe the friend has information a little bit you can know, “I can give you a phone call.” You are a support the other person.</td>
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<tr>
<td>Princess</td>
<td>He had new friends at church which was a big awesome. Yes, I do, I have a close friend that does.</td>
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<tr>
<td>Pedro</td>
<td>There was this lady that, she lost three of her kids; she had three boys and she lost them all. And she was a person that we related to, like me and my wife, and just that bond clicked. Because she’d been through it. By talking to somebody. You have to talk to people. Yeah, by just listening.</td>
</tr>
<tr>
<td>Tiger</td>
<td>I was worrying about him, I’ve known Steve since he’s my friend, and I know exactly what he’s going through. So I just try to give him some good advice and some help as a brother. So, he can get out of the heroin thing, know what I mean?</td>
</tr>
<tr>
<td>Ricky</td>
<td>I can call and talk with, I have my best friend, but, you know, he’s known me for 30-some, but mentally, I still think I need to talk to somebody, too.</td>
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<tr>
<td>Tino</td>
<td>Just there’s just somewhere to channel your energy, so you’re getting everything you have within you out there, and you do not expect anything back. You’re not really expecting the person that you’re talking to judge you, just to walk you through what you’re feeling.</td>
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<tr>
<td>Bobby</td>
<td>It’s just like letting them know that there is somebody there for them. I would imagine just having other people surrounding you, that actually boosts your self-esteem.</td>
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<tr>
<td>J. Christian</td>
<td>Well I knew that person very well, I knew her through church. And she was, she was a family friend before, for about a year or two, and so I kind of, I trusted her. So when they told me that, you know, “I’m gonna call this lady.” And I told, like, my wife was going to call this lady, so my wife felt good about it, because she was gonna help me.</td>
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<tr>
<td>Yali</td>
<td>Well, yeah, just developing relationships with people and helping them express themselves, even to the point where they’re able to express the reason for being there. But to get to that actual state is kind of, like, difficult. I know they give each other phone numbers, in case they feel, like, they need somebody to talk to. And they use one another for counselors and for counseling. It’s just like friends when you need somebody to talk to.</td>
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<tr>
<td>Debbie</td>
<td>Well, just by their experiences. I’m sure that there’s people out there who have gone through the same thing. And when you share with someone. I think that opens the door for communication and then, “Well, you know what I have? --So-and-so.”</td>
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<tr>
<td>Carlos</td>
<td>I would try to talk to him. You’re talking with people that would be with the sad face. You’d be listening to what I’m saying, and processing it and, like, and speaking to me. I don’t know, like, if I’m talkin’ to someone, they’re gonna look at me, and I’m gonna talk to them.</td>
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‘Cause I was telling him that he needed to calm down; he needed to calm down. And I know that he listened to me, because he texted me, “You were right, bro. I’m talking about this.” And I told him, “Bro, like me.” So he looks at me and says, “Look, Bro, me, sometimes I start crying for my baby, what happened, bro.” Like, I told him that, and he’s like, “Yeah, Bro, I know how you feel.” I told him, exactly like I told him that that, I told him, “The same thing for me, Bro.”

I would love to participate. I’ll do anything to help people. And if I have to go talk to somebody, I’ll go talk to somebody. I’m not afraid, but they’re a lot of people out there that are.

I probably need to go talk to her, I think that was my [laughs] sing my song and go talk to her.

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**Counseling**

*Codebook definition: Report of methods of treatment for mental illness including the use of individual or group therapy and interaction with a trained mental health professional.*

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Andrea

I found a really good therapist. In fact, when I was working with her, she taught some really good coping skills. And I was even able to get off my medication for a while. So, I just kind of learned, so it really worked well for me.

All the research I’ve done shows that, like, behavioral modification in conjunction with medication works best.

Reuben

They (EXCEL counseling) help her out with the depression, they talk to her and they ask her, “How’s your husband? Is he helping you out as well?”

Linda

Mary

Um, therapy, I think helps a lot, that’s what I wanted, so I think therapy. Or even like kids talking to their school counselors, you know, to lead ‘em to their school psychologist or therapists in the community.

If I go to therapy, then I can talk about whatever’s going on, or whatever’s causing anxiety, or depression, or whatever it is. And then I can hear it from a professional, like, you know, “Maybe this is gonna help.” Or “It’s gonna be okay; that’s normal.”

Mr. C.

I was tryin’ to give her little helpful hints to go, like, seek counseling, or take some kind of behavioral health specialist or something like that. I just told her, “Go get some kind of counseling.”

Some that’ll hit certain areas that you need the help in, if it’s for your anxiety, there’s that for your anxiety. Or if it’s just counseling, to get over old wounds that haven’t healed, you can do that.

Gerardo

Cepeda

First and foremost, more contact with your doctor for hypnosis, therapists, whatever, however that person may be.

More interaction, I think would probably help a lot of people in their interactions.

Felis

For the therapy, and I will see her and I will be more relaxed. Uh, therapy with a good therapist and trying to make change in your life. Talk to him and relax, like a couple hours and maybe [then] come back home.
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<tr>
<td>Princess</td>
<td>He was receiving services, at a mental health specialist with counselors, like counseling, like something to stabilize them at a home, where they’re supervised.</td>
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<tr>
<td>Pedro</td>
<td>Just a lot of help, because you get counseling or medical, and that’s attention’s very good for a person to the first part, in wanting to change. ‘Cause where there’s a will, there’s a way.</td>
</tr>
<tr>
<td>Tiger</td>
<td>Therapy works different because it allows you to work on yourself, you know, as opposed to it you trying to figure out everybody else’s problems. You can’t figure out everybody else’s problems; you have to try to figure out your own problems.</td>
</tr>
<tr>
<td>Ricky</td>
<td>Some of the counselors would talk to them, and walk ‘em through it, or show them how much alcohol really is not the best choice. A lot of the people there had a lot to deal with, and they would help ‘em out through a lot of difficult situations that I can’t even imagine myself going through.</td>
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<tr>
<td>Tino</td>
<td>She was really nice. She was really, like, interested in me talking to her, and actually, it felt kind of weird. But I had more --how would you say-- more trust in somebody that I barely knew, instead of my parents. I actually felt like I could talk to somebody. I don't know; she changed the way that I thought, 'cause she felt interested.</td>
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<tr>
<td>Bobby</td>
<td>Therapists could give them therapy. And advice can make you better yourself, better yourself. And make you solve your own personal or business issues.</td>
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<tr>
<td>J.</td>
<td>A therapist, um, that’s somebody to talk to, somebody to help think a certain way, or focus on certain things. Well they’ll send somebody, or there’s somebody out there for that person, can give that other person to show them, and can really talk to them, or help them in their struggle.</td>
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<tr>
<td>Christian</td>
<td>Um, where they can even talk about the reasons why they feel that they’re afraid or like, feeling like that. Because a lot of people really don’t trust to you that information. From a psychologist or psychiatrist, they’d be more, like, equipped to deal with the situation.</td>
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<tr>
<td>Yali</td>
<td>Then she had a counselor; she had people coming to her house. And once she was able to get that help of counseling, she was able to see things differently, and she understands why she behaved the way she did. And, you know, that’s how it helped her a lot.</td>
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<tr>
<td>Debbie</td>
<td>They come and talk to you to tell whether you want to hurt yourself, “Do you want to be here? Do you, like, see stuff when you’re sleeping? Or when you’re awake?” And they take you out to eat, and they all figure what to do with you. They take you out to eat and chill.</td>
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<tr>
<td>Carlos</td>
<td>Yes, I think personally, they can also help build a person’s self-esteem. Because maybe they’re not all to par, they may not think they’re not all to what they can be and they’re down. There’s a lot of things down right now with the economy, et cetera, so I think counseling’s a really good thing.</td>
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# Going to the Doctor

**Codebook definition:** Report of seeking methods of seeking help through a doctor’s office, clinic or other medical type practice.

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<tr>
<td>Andrea</td>
<td>Because sometimes even just going to your medical doctor, they just fill out a prescription and just give it to you. In my history, it’s been, like, I’m seeking help from everybody, “Should I do this? Should I do that?” I would be going to an informed person to kind of lay out all the options for you.</td>
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<tr>
<td>Reuben</td>
<td>What I’ve learned is that they feel comfortable with certain doctors, because they’ve known that doctor for so many years, or because somebody in the family, or another friend recommended them that doctor.</td>
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<tr>
<td>Linda</td>
<td>That would help me, to go see a doctor and talk to him about it. Hmm, well it means that if you go, you’re gonna get better, you know, or at least try to.</td>
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<tr>
<td>Mary</td>
<td>So, I think once she heard that from the doctor, from a specialist, she was, like, okay, “So I’m gonna do this and I’m gonna be okay.” I think it made her feel more comfortable. So then you go to your doctor, and you tell them what’s going on, and they’re, like, “It might be this, but it might be that; I can’t tell you for sure.” So maybe if you go to this other person, you know, they can start helping you out.</td>
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<tr>
<td>Mr. C.</td>
<td>Unless you find out that right one, there’s good doctors and then there’s bad doctors. There’s doctors that actually want to get to know you, and actually want to help you. And then there’s ones that just look at you, and it’s a job, and take your number, take a seat. You got two hours, tell me what’s wrong, and then go home.</td>
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<tr>
<td>Gerardo</td>
<td>I would go call up all the numbers, call doctors and specialists; it depends on the person. Well, I’d like to see more involvement [in outpatient care] from the doctors.</td>
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<td>Cepeda</td>
<td>It is [to go to the doctor] to explain [the] situation; because you can go, and you know what, “I’ve had this problem, you know what, because the people may know maybe, say to you something wrong or you not maybe say.” No, TV and these things don’t help you.</td>
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<tr>
<td>Felis</td>
<td>They don’t tell you, okay, you’re gonna diagnose a person, and give ‘em, send ‘em to a doctor, and that doctor will medicate ‘em.</td>
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<tr>
<td>Princess</td>
<td>Anything to do with the doctor, they’re like, “I’m not so good at that, because my wife takes care that.” But when it comes to something that, goin’ to the doctor when there’s, when there’s talking and stuff like that, it’s just always that they can count on ‘me and my wife’, but when it comes to something like that, goin’ to the doctor.</td>
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<tr>
<td>Pedro</td>
<td>Just a lot of help, because you get counseling or medical, and that’s attention’s very good for a person to the first part, in wanting to change. ‘Cause where there’s a will, there’s a way.</td>
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<tr>
<td>Tiger</td>
<td>Uh, well, I would probably search around, and try to find a doctor or somebody that works with that, anxiety and depression, and you know I would try to seek out a professional, someone that really knows how to solve those challenges. Like me, for example, I’m tryin’ to seek that out.</td>
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<td>Tino</td>
<td>Yeah, after that, I guess I really had a lot of respect for people in that line of work. Counselors, psychiatrists, psychologists, a lot of the people there had a lot to deal with. And they would help ‘em out through a lot of difficult situations that I can’t even imagine myself going through.</td>
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<tr>
<td>Bobby</td>
<td>I’ve never really heard of other ones. Yeah, ’cause that was the only one that my doctor mentioned to me when we started. And it seemed like it would actually make everything better, and it did.</td>
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<tr>
<td>J.</td>
<td>The doctor would have to check ‘em out and see what’s really going on on top of their head. Just by referring them to a clinic, and then the clinic could get them a prescription.</td>
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<tr>
<td>Christian</td>
<td>A doctor or therapist, um, that’s somebody to talk to, somebody to help think a certain way, or focus on certain things.</td>
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<td></td>
<td>Well, when I found out, they took me to the hospital, and when I found out, the doc, they taught me.</td>
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<tr>
<td>Yali</td>
<td>From a psychologist or psychiatrist, I don’t know, well, they’d be more, like, equipped to deal with the situation. Probably be a little bit more difficult for them; they’d have to like, proper techniques to use, or maybe not, I don’t know.</td>
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<tr>
<td>Debbie</td>
<td>I would definitely say go to your doctor, right away, sooner than later. Because I think a lot of her years of suffering could have been avoided by just, you know, breaking the stigma and just asking for help.</td>
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<tr>
<td>Carlos</td>
<td>So maybe they can call someone, a doctor. I would see a doctor, first thing, ‘cause obviously, someone knows more, but um, a professional. Yeah, doctors, seek them and then they [can] talk about it.</td>
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<tr>
<td>Santiago</td>
<td>Yeah, you can go to a doctor, ’cause, well, the doctor can sign this paper where he can send them to, so where you can get the help. Yeah, they can go and talk to their doctor, and he’s gonna help you.</td>
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<tr>
<td>Julia</td>
<td>I was like, wow, he not only, like, talks to them, gets them to the doctor, but then he helps them through it. He helps them get some real help, and pays for it, maybe they can’t afford it. So, yeah, I’m like, wow, there’s no reason why people can’t get help.</td>
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**Herbal Medicine**

*Codebook definition: Report of methods of treatment for mental illness including use of herbal remedies in the form of teas, potions, compounds obtained over-the-counter or by trained providers.*

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<tbody>
<tr>
<td>Andrea</td>
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<tr>
<td>Reuben</td>
<td>I had a kidney stone. I didn’t want surgery, so my mother said, “I’m gonna get you some herbal stuff from Mexico, that you’ll take, a special tea.” So she bought it for me, I drank it for a whole week, and it destroyed the kidney stones.</td>
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<td>Uh-huh, it cured it. I don’t have nothing now, I’m cured.”</td>
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<tr>
<td>Linda</td>
<td>I spoke to a friend of mine, and she brought me some medicine from Mexico. And she recommended that tea and it helped. Well, I don’t have pain anymore.</td>
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<tr>
<td>Mary</td>
<td>Within my community, I know people drink teas and a lot of herbal medicines, and kind of, at least</td>
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my parents do. It helps me relax.

My culture, or at least within my family, they trust it a lot, and like, “If you’re feeling tired, drink this tea, and it’s gonna help you sleep.” Or, “If you’re having cramps, drink this tea.” Or for a headache, or whatever. Everything you have can be cured with, like, a tea or medicinal herbs.

Mr. C. You can go and drink some relaxing teas, or stuff like that are actual, there’s like mood enhancement that can come from plants, herbs that you can get. And they’re all different kinds of plants, and that can boost your immune system to help you mentally and physically to get you goin’ in the morning.

Okay, it’s, there’s no really harmful side-effects.

Gerardo A very, very good way of treating your stresses, and yeah, I’m sure there’s things out there like herbal medicines and whatnot to do that.

Cepeda They believe more in herbs and more of faith, things like that.

They believe maybe it’s certain kind of herb teas, I don’t know what kind. Certain medications, certain shots, certain practices.

Felis Tea is good medicine. Yeah, diabetes, I say, “No, because even my son,” who one time I give a gallon of water with a little tea. I boil and they give it, he drink this water.

Princess So we, in America have had changed our culture. We want healing fast. And the herbs and all those natural resources, you have to, it’s gonna take time. You have to go get it; you have to go plant it, and water it, and insure it will grow. The herbs and the teas, all that, because they’re plants, they’re natural.

Pedro They take it, yerba buena. My mom and my dad, they’re Mexicans, right? And they believe in all those things, so. They’re always taking that, and they’re 100% Mexican, so.

Tiger I take teas, medicine, things like that. For calm, relaxing. I cook them, and then I do them, and then I drink them, and they just mellow me out. Maybe it’s just in my mind; I know it helps.

Ricky Like, you know, for the muscles and the stress, herbal teas. I drink tea; it helps me a little, or herbal teas or whatever, you know there are different ways of doin’ it.

Tino I guess that’s where I’ve heard about it, and talking about how it’s a replacement for medications, for medicine in the West. You know how it’s I’m not gonna infer, but, it’s referred how medication here in the Western Hemisphere is taken a little bit more lightly than any other country. It’s more preventive, instead of trying to cure whatever their problem is you already have. And I guess every, they try, in some places, they try to use a little bit more of an herbal.

Bobby Yeah, ’cause there is this other man, too, who was diagnosed with multiple sclerosis. And he would go to healers, you know I mentioned that, he would go to healers that would make him teas and stuff and give him, I guess massages and stuff, that would actually make his voice work again.

J. Christian Like a green-tea or something that helps you.

It helps your metabolism, it helps your health, ’cause I think physically that you’re healthy, it just helps them.
Yali  And my mom’s into it; she’s like a member of that botanica thing, I don’t know, which is like this herbal supplement thing. If it is approved, then, cool. I know a lot of, like, remedies from my own culture. I don’t know. Yeah, I mean it’s like if they could actually make a difference, like in some temperamental disease, I don’t know. Who knows?

Debbie  My mom would be big on the teas, the chamomile; I know it’s a hot tea that will calm me down. For everything, she drinks it now, as long as she has anxiety, too, but she’s like, “No, just drink a cup of tea and you’ll be fine.” My sister picked it up, she has little collections, a comfort thing to her, but it would be okay, so that’s what they would use.

Carlos  Chamomile is, like the basic, helps you to sleep or calm you down. There are all kinds of plants that we don’t know about, that are still used in rituals, spiritually. Like to treat depression, the mushroom, they call ‘em magic mushrooms, ‘cause psilocybin is the chemical that, well it gets into the brain. It’s a lot, like people of different cultures use it. And there is ways to self-medicate one’s self, and there’s like, ‘cause it comes from, we are from the earth.

Santiago Julia

Family Support

Codebook definition: Report of assistance for mental health treatment in the form of interaction and support from immediate and extended family members

Andrea  My husband’s awesome! He listens to me, and I can tell him if I’m having a down day. And even if it’s over something silly, he’ll listen to it. So I feel like I have him to support me in that area; and so I just kind of use him. And then he’ll give me a break from our daughter if she’s driving me crazy, and that just kind of helps me to mellow out.

Reuben  They ask her, “How’s your husband? Is he helping you out as well?” And I do it because I understand her, her condition, and try to put my feet in her shoes so that way I will understand what she’s going through. Because I don’t confront her [wife]. When you take the oxygen out of the fire, the fire goes down. It works.

Linda  I always call her and try to see how she’s doing or what’s going on.
I don’t know if she has gotten any help. All I know is that she said that when that happens, she calls her husband, and he’s the only one who can calm her down.

Mary  I feel like, when they respond to me, I know I’m going to be okay. And it just makes me automatically, for some reason, helps me relax, and helps me realize, why am I, why is this happening? Because it’s happened every time, and every time, it’s been okay. So then I just try to forget about it, and move on. And for me, I always talk to my mom or my sister, so I have a cousin that I’m very close to.

Mr. C. Gerardo  When my mom walks into my house, my mom is stressed out or whatever, I want to take her, like, “Let’s go for a walk, but not let’s go for a little walk, let’s go for a fast walk. Let’s sweat a little bit.
And when we’re done, tell me what you think, what’s on your mind.”

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<tr>
<td>Cepeda</td>
<td>If it’s too much for you to be even and ask one of your family members can check for you. You can get that for, you can get that real support network.</td>
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<tr>
<td>Felis</td>
<td>Because [starts crying, handed a tissue], I’m sorry. Because I don’t have many family with me, and my little boy is with schizophrenia. He’s 26 already, but I don’t have to, you know sometimes it’s better when you have your sister is with you, your mom, or more family?</td>
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<tr>
<td>Princess</td>
<td>My mom is a very big support; she’s very supportive. She’s very confident with him. She tends not to speak negative or try to reinforce him. I think more people skills, and more love from parents, more attention to our kids, and we can get back to those basics.</td>
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<tr>
<td>Pedro</td>
<td>But, like going to ask for help or something like that, I’m not that good at that; I don’t know where to go. This is something, personally [family] what I’m saying right now, it’s what I would say. Your family’s always gonna be there for you.</td>
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<td>Tiger</td>
<td>Family, drug addiction, it was hard for me to leave it. And then all the times I did those things that happened. ’Cause they started like, to come to me, we’re close, a close family. ’Cause when I’m on drugs, I’m separate from them, I’m apart.</td>
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<tr>
<td>Ricky</td>
<td>My wife is on SSDI and I deal with her being bipolar almost every day now. I deal with that on a daily basis, and with that. I’m growing patient, really patient, but it wears me down. Yeah, she cries, she’s depressed. You know, I try to bring her out of it, you know. But at the same time, I know that by that, that’s kind of like I just self-medicate myself, because I’m helpin’ her, but it also helps me.</td>
</tr>
<tr>
<td>Tino</td>
<td>If you have a pretty strong family background, they can be there for you. They can be there to hear you out. They can either back you up with helping out and trying to walk you through whatever you’re going through, ’cause most of them are older than you and might have gone through the same thing.</td>
</tr>
<tr>
<td>Bobby</td>
<td>I feel like I have other people to relate with. Because I do have an aunt, that she actually told me she had depression. And it’s kind of nice talking to her and discussing that she’s that way. Somebody in their family that has depression, that they would be actually helping the other people to know that there is help.</td>
</tr>
<tr>
<td>J.</td>
<td>Well, their family has to lookin’ out for them, so to make them good, a good person. Or, I mean, a good family would always do something to help out their own.</td>
</tr>
<tr>
<td>Christian</td>
<td>At first, he was kind of nervous about it, like he didn’t really want to get help, and then treating him. His mother talked him into it, and then he got the help he needed. So I did tell me wife about it, and she, she knew of that one rehab center that I should be taken.</td>
</tr>
<tr>
<td>Yali</td>
<td>Well, I encouraged her; I said like, “You know, those are, these are the most important years of his life. Will you take an effort? And we did come from Yuma to visit you.” It didn’t really work. We ended up just taking her outside. Me, my brother, my nieces, and nephews, and some cousins.</td>
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They were just, like, I don’t know, giving her support and, but slowly but surely, you could say like 11, 12 years later it would make a difference, but, it’s been a long process.

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<tr>
<th>Name</th>
<th>Statement</th>
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<tr>
<td>Debbie</td>
<td>The family, to me, is helpful, because I wouldn’t be able to function without my family. I don’t see as much as I would want to of them, so the time that we do have together, we really just kind of, you know, be together as much as possible. A lot of times, just by listening and just, by, you know, letting them know that you’re there, and whatever you can do to help, you will, and knowing that we’re family.</td>
</tr>
<tr>
<td>Carlos</td>
<td>The family is like the closest thing. ‘Cause you’re born, you’re connected with them somehow or ways. Sometimes I feel that, well, I mean, what’s love, I guess? I don’t know about the family, they can support more. Like if they’re going out, or if they take you out, try to shake you up, I don’t know, I guess.</td>
</tr>
<tr>
<td>Santiago</td>
<td>Because also your family comes and sees you. Well, just like try to talk to them, and put ‘em in like what my brother used to be in.</td>
</tr>
<tr>
<td>Julia</td>
<td>Where is your family? You know, you have to have family. Or if you don’t, you have to have something in life.</td>
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### Spirituality as a Treatment

*Codebook definition: Reports of any use of religion, prayer, meditation or faith assistance for mental health treatment.*

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<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Andrea</td>
<td>“That’s the support,” I’ve told her. “Go to church.”</td>
</tr>
<tr>
<td>Reuben</td>
<td>“That’s the support,” I’ve told her. “Go to church.”</td>
</tr>
<tr>
<td>Linda</td>
<td>“That’s the support,” I’ve told her. “Go to church.”</td>
</tr>
<tr>
<td>Mary</td>
<td>I know they have, like, a little basket, and there’s like smoke coming out of it. And they’ll say a few words or something. So, I don’t know if they say their words are kind-of like a prayer, or something like that, you know.</td>
</tr>
<tr>
<td>Mr. C.</td>
<td>If they can’t help you, then believing in God can. They put it in God’s hands.</td>
</tr>
<tr>
<td>Gerardo</td>
<td>If they can’t help you, then believing in God can. They put it in God’s hands.</td>
</tr>
<tr>
<td>Cepeda</td>
<td>If they can’t help you, then believing in God can. They put it in God’s hands.</td>
</tr>
<tr>
<td>Felis</td>
<td>And that when some tough days, sometimes I’m really tired, and that’s how I pray for somebody; I pray for myself.</td>
</tr>
<tr>
<td>Princess</td>
<td>Thinking about religion, well not really a religion, our relationship with God. Because I saw the results when he believed. Because he saw that God set him free. He was free, not anxious, or depressed, or stressed. Just like the air, he wouldn’t see it; but he would see what the air can cause and do, that was the same with God.</td>
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<tr>
<td>Pedro</td>
<td>Hmm, just like, I’ve learned these couple years that, in church, my leader is my brother-in-law. And</td>
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</table>
he has been faithful to God for years, and I’ve seen a difference in him. And when I have a little problem, and I can’t turn to anybody else, then, it’s God first, but then, you know.

Tiger

And just like I prayed and asked Jesus for his help; I think that that did a lot to help me, you know. And that way, you start setting your mind on something good, positive, and you start to think about all that’s bad in you, you know?

Ricky

It’s kind-of a teaching tool, you know, from God. I believe in God. It’s just a teaching tool, you know, because I believe in prayer.

Tino

I’ve never been a religion type of guy, but I can totally understand that some of ‘em get that backup to some people. My aunt used to go to a church, and they would talk about what was going on in their lives. I guess they didn’t really have anybody to hear them out, and they’d talk about it, and I guess they cried, but he felt a lot better.

Bobby

It’s kind-of a teaching tool, you know, from God. I believe in God. It’s just a teaching tool, you know, because I believe in prayer.

J. Christian

Knowing that I’m not alone. Knowing that God is with me all the time, so I would get a version of the Bible that showed me that knowing that it would give me something that’s positive more than negative.

Yali

I know that, at least at our church, where you can just go and talk with someone and help get prayed for. If they see the need, they’ll refer them out to, you know, a specific counselor that would help.

Carlos

And it’ll, like people used to pray, or bless, or say grace for their food; they like say pray over their food, even the majority of people are Christian, Catholic, whatever type religion, before. When I was younger, we used to pray, say grace. The real reason why people say grace is that people would pray to their food. And if you go back, back in time to our ancestors, to when we first would hunt for food. I don’t know who they would pray to or worship, or bless.

Santiago

‘Cause God gave me this skin, this body. ‘Cause the Bible says not to hurt yourself. That’s why I stick to the Bible, I listen to the Bible.

Julia

They help them get their life in order, and not only through God, but everything, every aspect. I’ve seen them pull people out who don’t know where to turn, you know. So, they help those people a lot, they’re really good, their resources are just bigger than I thought, God is bigger than anything.

Physical Activity

Codebook definition: Any form of exercise or physical activity.

Andrea

But I have started going to the gym and working with a trainer. A lot of my friends work out, so that’s really helpful for them.

Reuben
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<th>Name</th>
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<tr>
<td>Linda</td>
<td>I think exercise helps; I think exercise helps really a lot of things. It helps to relax, and it helps you feel better, feel healthier. It’s good, it helps you get distracted. Sometimes you can even hang out with other people who are doing exercises, other people who take fitness classes, and like I said, just the kind of interaction.</td>
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<tr>
<td>Mary</td>
<td>Just basic outlets, exercising, running, if that’s what calms you and helps you, then that’s a good way. Exercising for an hour helps you, calms you. Little things like that, and you’ll notice a change within yourself. Stuff like that.</td>
</tr>
<tr>
<td>Mr. C.</td>
<td>So, exercise is a very, very big deal. I believe a balance between mind and body, bein’ active is also a very, very good way of treating your stresses.</td>
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<tr>
<td>Gerardo</td>
<td>You have to keep yourself moving, at least an hour, the bottom line is exercise.</td>
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<tr>
<td>Cepeda</td>
<td>Well, the person was to, like, maybe the ‘mar’ when you are, to walk on the beach.</td>
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<tr>
<td>Felis</td>
<td>Yes, yes, because exercising helps your heart, and it helps your health, helps yourself to maintain a better healthy life and eating.</td>
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<tr>
<td>Princess</td>
<td>I walk right now.</td>
</tr>
<tr>
<td>Pedro</td>
<td>The new friends are doing exercises, active.</td>
</tr>
<tr>
<td>Tiger</td>
<td>Exercise takes your mind off of things, and it actually makes you really tired, like you work out the stress.</td>
</tr>
<tr>
<td>Ricky</td>
<td>Most definitely, actually. And now that I’ve been getting more into fitness and I’ve seen how being able to have an escape, like any type of fitness, or any type of physical activity, actually helps you channel any kind of left out energy you may have or anger.</td>
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<tr>
<td>Bobby</td>
<td>Swimming, doing exercise, has been helpful in a way that it keeps me active and I get to stay out of the, like the hot temperature.</td>
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<tr>
<td>J.</td>
<td>So, it [ju-jitsu] helps me mentally. Because we wrestle around and it does a lot of choking, choking so you cannot breathe, so you learn not to panic, so it helps you. So it helps you, if you’re going through something, to just calm down and focus.</td>
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<tr>
<td>Debbie</td>
<td>I’ll just get out and take a walk.</td>
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<tr>
<td>Carlos</td>
<td>You see kids my age walking, as long as they’re still walking, they have friends who are exercising.</td>
</tr>
<tr>
<td>Santiago</td>
<td>But when she got the motivation to start exercising.</td>
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</table>
Julia: Yeah, I would exercise. And then I found out I needed exercise; they say that that would help it. I was, like, wow.

**Integrative Medicine**

*Codebook definition: Methods of treatment for mental illness as integrative or alternative therapies, classified by NCCAM.*

Andrea: I’m trying to find the name of a doctor, her name is Marcia. She’s American, Anglo.

Reuben: She works, she lives in the United States, but she works in Mexico. She has her own lab, and she takes care of rheumatitis [sic] and anything that has to be related with lupus [using alternative medicine].

Linda: Yeah, I think massages help a lot. It helps you relax, and it helps, like for me, when I get a massage, it just helps me feel better automatically; like, it helps me rest. Most of all it helps me rest and, kind of like, when I’m getting a massage, it kind of helps me meditate, and relax, and reflect on whatever’s going on. So I feel rejuvenated every time I get a massage. And we talked about acupuncture, and I’ve been wanting to learn more about it; only I hear a lot of people go for it for help. And like my cousin’s pregnant, and she’s going to like acupuncture to not be out of it, and all these things, and I’m just all, “Really does that help?” And she’s like, “Yeah, it’s helping.” And I don’t believe in it, because I think I’ve never experienced it, and I don’t know a lot about it, but I do hear a lot of people speaking out for acupuncture.

Mr. C.: I’m conversating [sic] with people, and people that actually listen to you, without lookin’ at you, and judgin’ you, it’s a lot, helpful.

That companionship I keep going back to, is a real good help, and to give them that extra kick of what they need right now.

Gerardo: I believe a balance between mind and body.

Cepeda: They can talk to people that are in that field. Acupuncture, hypnosis, [need] more contact with your doctor for hypnosis.

Felis: So we, in America have had changed our culture to be used to having everything fast. We want healing fast; and the herbs and all those natural resources, you have to, it’s gonna take time. You have to go get it. You have to go plant it, and water it, and insure it will grow.

Princess: But they can be sometimes I’ve heard massage on my arms or legs you know, it would be nice, though.

Pedro: I’m sure there’s other things out there, alternatives, other ways of getting’ the right medicines. I don’t think that medication is the only way, like you said; other people have said acupuncture or
Tino: I guess that’s where I’ve heard about it, and talking about how it’s a replacement for medications, for medicine in the West.

Bobby: Yeah, ’cause there is this other man, too, who was diagnosed with multiple sclerosis and he would go to healers. You know I mentioned that, he would go to healers that would make him teas and stuff and give him, I guess massages and stuff, that would actually make his voice work again.


Yali: You know, my mom had an experience with acupuncture once, and she hated it. So I really don’t know anything about it.

Carlos: It’s pretty interesting, but then there’s people that believe you can purify all this stuff with your mind. And, like, there’s a doctor who does that Chinese water study, like, to be like, ah, channel our energies or diseases, too, food to like, anything.

Well, acupuncture, well I’ve never actually experienced it myself or done it, but yeah, I’ve heard that it’s a really good form of; it’s cleansing or something like that? ‘Cause there’s also different forms of healing. I hear myself, I’m unsure what it’s called, but, a study where you can cure yourself or a few people with massage; also stones, that contain certain energies, like from the earth, rubbing them on our bodies, made up of iron, water, and all that weird stuff in our bodies. Like there’s stones that can heal you, and that’s just a natural form of healing. They say it’s like meditating, like you can, you should, meditating is, like, I don’t know what the studies are, but yeah, they take you, you can channel your energies to clean them.

Julia: I’ve heard people say you can lose weight through getting acupuncture. I don’t want nobody poking at me, so I probably wouldn’t go and do that one, but if I did need help.
APPENDIX H:

QUOTES OF ASCRIBED MENTAL HEALTH ISSUES
## Understanding Ascribed to Mental Illness from Participants.

### Depression

**Andrea**
I mean I’ve been diagnosed with depression, and I’m on Lexapro. So I just have a tendency to just go down in the dumps more than the average person. And it’s not any event that causes it, it’s just like a mood, you know. I think I just wasn’t, like I didn’t feel as bitter and moody, bitter, like just thinking, “Oh, poor me.” And looking at people when they’re happy and thinking, “I can’t really be that happy how are people that happy? I don’t understand it.” And knowing that I was getting better. At my worst point, not wanting to get out of bed, crying every day. I was drinking a lot, a lot of wine [chuckles]. And it wasn’t to enjoy a glass of wine; it was just to like, forget.

**Rueben**
Her mother passed away about a year ago, and that sent her into a depression mode. And another thin that I also forgot to tell you, she’s bi-polar, so she has to take her bi-polar medication, too. And you know, we’ve talked about, this is the third time that we’ve talked about her case.

**Linda**
I think it’s like, to me, it’s because you’re lonely, or because you have a lot of problems at home. Maybe you don’t have enough money to take care of your kids, I wouldn’t know. Well, I see that she suffering, and she wants to sleep all day, and she don’t like to talk to nobody, so that’s what happens.

**Mr. C.**
When I feel depressed, I feel down. I don’t feel like myself. I don’t feel like doing anything. I just want to lay around. I just want to sleep. And that’s when I know I’m depressed. It’s usually I’m more like I want to go do something and be happy, wake up early in the morning.

**Gerardo**
TV’s off, radio off, the windows closed, the house in the dark. So I got to learn that over time that, yo know, that if you try to touch her and stuff, it’s more likely that it’s not gonna end up in a good, positive conversation, or it’s just that she has a tendency to eat herself up. You know what I’m saying stressing? Being depressed. And sometimes it’s not that bad.

**Cepeda**
Because she can’t, you can isolate yourself so much she can’t get out of that, away from herself. And when she’s out of the house, with people, she feels sad and trapped.

**Felis**
Pensé que [I think that] stay at home, in home, no one doesn’t smile, sleep a lot. Yeah, not this, I see these people, when they’re sad. And this woman, with this problem, and I cry easy.

**Mary**
Um, I think being depressed is, like I said, my sister was there, she was depressed for a period of time. She was pushing everyone away and just wanted to be alone. And you know, she’s just always upset. She was just like, “Well, if I can’t eat this, and I’m gonna be on a diet, and I have to exercise, then I can’t enjoy whatever I like, kind of, what’s the point in being here?”

**Princess**
He would sleep a lot in the house, and it’s very dark in the house. So we would try to go in and wake him up, get up, take a shower, go somewhere, go to church after that, go to dinner. Yes, a lot of loneliness, and yeah, it was wrong.

**Pedro**
She was really, really sad. I don’t know if you can call it anxiety or depression or what she had. But me, as a man, I felt I couldn’t take it out on her, what she was goin’ through. ‘Cause if not, that’s when you go into depression and darkness, and anxiety, you know.

**Tiger**
I’ll roll around, roll around a little, I might. For example, last night, I may have gotten four hours of sleep. And it’s been happenin’ like that. I don’t get much sleep, and I stay up all day. Yeah, she cries, she’s depressed, you know.

**Tino**
I guess in a rough patch in his life when he lost a lot of his friends, though he was my friend, too, but I guess I don’t really take death that much as he did, as bad. So when his friend died, he was, it was in a car accident, and it just hit him hard. And I would see him in his house, locked down pretty
much all day, working all night, ‘cause he worked at his computer, he wasn’t really out that much. And he was out even less after that.

P14: Bobby
I would be angry all the time. Well, ever since I was little, I always have been a very angry person. But yeah, I would just stay quiet, and I wouldn't talk to anybody, ‘cause I felt like nobody could help me. I would imagine that it would be actually to listen to somebody. I feel like most people who have depression feel like they're alone, and they feel like they're not gonna get better, but, just like enabling them to know that they have somebody that's interested in their problems can help.

J.
Mmm, well she gets into arguments with her daughter, and so that’s what makes us believe that she has depression. I would say that you were just out of the sunshine, like in the deep corner or something.

Christian
They get sad, you get a lot of negative thought in your mind, about themselves. They’ll just dwell on whatever they’re depressed about, ‘cause they’re so self-hating about themselves, so things to associate with other people. They like to be by themselves, don’t want to associate with no one.

Yali
She, it was very extreme. Like she would hesitate to let anyone change her son and, like, even touch him. She felt very uncomfortable, she felt like she couldn’t trust anybody. She basically just stares into the wall, like she’s scared. She keeps to herself, doesn’t come out of her room, I don’t know, very hard for her as well. But we go over there, and she’s still in her robe, I mean from what I can tell; now she comes out and says hi.

Debbie
She was sleeping a lot. She wasn’t paying very much attention to her kids, and that was very weird, because her kids were like number one for her all the time. In that she didn’t want to be with the family anymore, we’re very big on family and she would just be like, “I’m tired, I’m going to sleep.”

Carlos
‘Cause depression, I feel is something in the mind, obviously, clearly, like it’s substance abuse. I guess it all comes down to the mind, but I don’t know. I guess to fix ‘em is battling, well not battling, well, yes, it could be battling, ‘cause if you’re depressed, I don’t know. If you’re not enjoying life, um, I don’t really, I don’t know, someone needs, I guess affect them bad, like not in a good way, because someone who’s always like, can never enjoy, I guess, be happy, be calm.

Santiago
Yeah, cut up or kill himself like that. Over the depression, ‘cause they put in him because of his brain and everything. He’ll start, like, so friendship with him, he’s start, like, talking to me, and he starts crying. He starts crying, saying that like, he don’t want to be here.

Julia
Probably can’t get up out of bed, after she had the twins, I really believe that messed up her, bad. I mean she was whacked out, so she was crying all the time, hysterically, going off on everybody. Tired, I mean, she looked pretty bad. When I saw that, and it made me sad that all I could do was help her, and it seemed like the more I did, the meaner she got.

Anxiety/Nervousness

Andrea
I seem to get anxious about this, about financial things. Like I know a lot of people do, but I do that a lot. When that statement comes to me, and I have to defer it again, because I just can’t afford to pay it. And it always happens around summertime, and that’s when I’m most excited, because I have all this time off and vacation, but then it just worries me.

Rueben
She gets, like, anxiety attacks, or something like that. And that she’s tried to, well, not kill herself, but she wants runs outside, or when she’s driving, she has stopped at the side of the road and called her husband, and he’s the one that calms her down. But as far as I know, she goes to the doctor, but I don’t know what kind of medication she takes.
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<tr>
<td>Mr. C.</td>
<td>Yeah, the world that you feel safe in actually, like I said, it becomes your enemy. So your enemy is against you, and keeps inching and inching until finally, your nervousness, your anxiety turns into a panic attack. A panic attack turns into like, basically, breaking down and kind of losin’ it, though, it just, it’s a whole mess.</td>
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<tr>
<td>Gerardo</td>
<td>So, I kind of had to get away from that, because that’s all I had. It was like throwing all that away, but what comes next? You know, I was almost afraid, and now I’m very good at that, straying away from inactivity, and aggression, and things like that. I’m very easy at spotting that and getting away from it and dealing with it.</td>
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<tr>
<td>Cepeda</td>
<td>I guess she thinks everything is closing in on her and stuff, and that makes her hyperventilate and everything. I hadn’t seen it happen myself though.</td>
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<tr>
<td>Felis</td>
<td>My husband. He’s <em>ansiedad</em> [anxious] because he can see something finished from the situation he’s in, one forces cutting him off, to be okay for himself and for his room on his own, to see when he study for himself. My husband, he’s something that’s um, how would you say, <em>ansiedad</em></td>
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<tr>
<td>Mary</td>
<td>Yeah, but I definitely get a lot of anxiety. You know, in school, there was an exam coming up, I can’t sleep, like, the night before, or I’m just thinking about, what if I don’t wake up and that kind of thing. Not because of the actual exam, it’s just like, “What if I wake up late, and I don’t make it to class?” And even with work, it’s like, when I was working like my first, maybe week of work, I was like, I couldn’t sleep, because I was thinking, “What if I don’t wake up in the morning?” I always get very nervous because of that, I have two alarms and even, I mean, at this point, if it’s my first day, I’ll have my mom call me in the morning, or my sister or something. But, I don’t know, I just…</td>
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<tr>
<td>Princess</td>
<td>So it was really interesting, at the same time sad, that he would get so far and quit. Because he would get attacked again, with anxieties, nervousness, with all that, depression and all that. Anxious, worried, concerned. Assist the nerves to calm them down-</td>
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<tr>
<td>Pedro</td>
<td>Ah, I don’t know what you want to call it, anxiety or, but my wife a couple years ago, we lost our son. She was really, really sad, I don’t know if you can call it anxiety, or depression, or what she had. But me, as a man, I felt I couldn’t take it out on her, what she was goin’ through.</td>
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<tr>
<td>Tiger</td>
<td>He was anxious, and he was so desperate that he did things like that, you know? Yeah, you could see it by his movements, and how he was moving and everything. Shaking and swaying and it was bad.</td>
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<tr>
<td>Ricky</td>
<td>You know, but I don’t know where anxiety comes from, I wish I knew. Maybe I could work on that, so maybe I can search up on it. But I know maybe in the past week or so, I’ve been having really bad dreams, and wake up, and my heart’s beatin’ so fast, and I’m sweaty, and just, you know.</td>
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<tr>
<td>Tino</td>
<td>To me, what I got out of it, because I don’t believe I got a lot of explanations out of my professors or my peers, but to me somebody that’s anxious or depressed, it’s just a state of mind which, you know, they just can’t control their emotions. They just need to really have a grip on. Either it entails religion, or they’re more beliefs, or when somebody hits a situation, and they just don’t know where to turn. They need something to grip on, it’s just that loss of control and their belief system just breaks down, and it’s just they could either grip on that or they’d have to find something else.</td>
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<tr>
<td>Bobby</td>
<td>And that was always the issue when I was in school. I would always be anxious and stressed out. That was a constant worry, that she was scared that I was gonna get sick again. Yeah, and for no reason at all. Just really anxious. Well, with multiple sclerosis, my hands trembled, but I realized when I was stressed out or anxious, my hands would tremble even more.</td>
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<tr>
<td>J.</td>
<td>Nervous mean that you’re in danger. Maybe somebody’s out to rob a store, and you’re there, and you’re scared. It feels like, hmm, it feels like a rush, that’s a word that we use, rush.</td>
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<tr>
<td>Christian</td>
<td>She’s claustrophobic, when she’s around a lot of people, she starts to panic. She gets hysterical and</td>
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starts screamin’. She doesn’t like be around a lot of people. She doesn’t like to be out in the open, and I don’t know how it affected her. She starts to panic, and she has to get out, that’s what she does, she’ll get out.

Yali

I think, from what I’ve heard, like, “Oh, she’s just going through anxiety.” “Oh well, okay, well show me her in a week, she’ll calm down.” Well, just reduce the actual feeling of nervousness to a point where they are available enough for you to speak with them.

Debbie

Well, she says that her anxiety was controlled, she wasn’t feeling, you know, ‘cause she said she was also feeling the heart palpitations and she wasn’t scared as much. So, I mean, I’m sure that’s what helped her. I think when I’m nervous, I can’t breathe or fidgeting. Just it’s a waste of time, I can think of a person who has anxiety, hates waiting in doctors’ offices, or just with people around him, you know I would think that would be an obstacle for them also.

Carlos

Yeah, he does that, he does shake. I just thought that’s funny, he shakes for me, he’s, I don’t know, he’s just kind of shaky, I don’t know what that is, I don’t know. I don’t really go and ask him, like I’m not really, the people that I know that you have like anxiety, there’s people I know who have anxiety and I tell ’em to smoke, like I mean, I tell ’em, ‘cause they say they have anxiety or panic attacks. Like I have a friend, but I’ve never seen him have a panic attack, I’ve never actually seen ‘em.

Santiago

My daughter, my daughter has a lot of problems with anxiety. When you get anxious, because I’m never anxious and worried, when I would worry, I’d notice I was feeding on negative attitudes and negative responses and everything was negative. I was thinking that this could be my last day, imbalance, and cannabis is one thing and I say.

Substance Abuse

Andrea

I was drinking a lot, a lot of wine [chuckles]. And it wasn’t to enjoy a glass of wine. It was just to, like, forget.

Rueben

That’s true, because I don’t want any of them to fall into drugs, or to have a mental breakdown, or something like that. Then for later on, somebody can come over and tell me, “Hey Rueben, you know, remember that person?”

Linda

So I went to drinkin’; stuff like that to calm my nerves and stuff like that, anxiety and I was living in Maricopa County at the time.

Gerardo

Make them bring a friend, give them homework, put ’em in front of the class, and put them on the spot and say, “Okay, well let’s talk.” A lot of people tend to lock up and not say stuff, but just find a way to get ’em to open up, and there’s probably going to be tears shed and whatnot, things like that. But I think it’s better that way, because it could prevent a lot of domestic violence, and a lot of unnecessary arguments, a lot of [giggles] and drug use and alcohol and things like that.

Cepeda

Felis

Mary

It seems like because he drinks a lot, it kind of helps me learn about it, and identify some signs of maybe, like, they might need help. And so my cousin and I talked to my mom, ‘cause my mom’s very close to him, so, that way I know he’s going to listen to my mom, to maybe seek out help.

Princess
Pedro
I got a friend who did some heroin, and I by seeing him the other day, and he wasn’t himself. So he was skinny, long hair, long beard, you know? And he was a real good friend of mine, and he was hooked on addiction when he was young, so now by kicking the habit, little by little, day-by-day. I see him and I feel bad, and that’s like a vision for me, to not be that way anymore, you know?

Ricky
You know, and I look for answers, because I don’t have a doctor I can talk to. And so, I know before in the past, when I have anxiety or different things like that, I would turn towards alcohol or drugs. But I saw where that led me. It led me to incarceration and I no longer want to live that way. Because there’s nothing in being incarcerated,

Tino
I guess substance abuse, more than the rest, I have been familiar with, because I had a DUI four or five years ago. And they made me take some of the classes, they made me take some specialty classes. And when I was in there, some of the people in there, really had problems. And I can see how some of those classes that were given by the state, were really helping people out.

Bobby
They would be, maybe they have a drinking problem and it’s always good to stop being drunk, so.

Carlos
Well, depending on if you take substances, if you abuse substances, well a few people know how to do an intervention. Depression, I don’t know, I would imagine it’s the same way. People don’t want to be depressed. Or people have a chemical imbalance or whatever, in the brain. But I feel like cannabis is a real, very medicinal in many different ways. People are still unsure of how it affects the brain. I mean the body does have cannabinoid receptors, like compounds like cannabis. And so I feel like, we’re, we in this time, we consume a lot of stuff, and other things that affect the body, which could lead to depression, I think that there’s a chemical.

Santiago
Boot camp helps ’em by the same thing, not letting them go outside the back and just use it, I think. They begin with lunch and right there. But that, too, if they want to drive a car, too, they can’t drive because they can’t turn it on with the key, they put the breathalyzer to blow on it, before the car can go on too.

Julia
I don’t drink, don’t go out, so it’s like, I didn’t have that problem. Because people, that would be a problem, if people were alcoholics and couldn’t stop drinking. So, I just believe in taking medication. But, I think therapy is probably better, if you don’t like taking a bunch of pills. I think therapy can help.

Schizophrenia

Andrea

Rueben
Linda

Mr. C.

Gerardo Cepeda

Felis And I see everything that they, when the people have schizophrenia, everything what they can do, where they compartimientos, behaviors, and the people, everything is like my son, oh my God, so yes he is. Because I know that he’s very, um, ugly, you know, schizophrenia, and paranoid, and diabetes type I.

Mary Yeah, because you don’t want to, like let’s say if I’m schizophrenic and everyone’s makin’ fun of me and saying I’m crazy, and if I go to a doctor and he or she confirms it. And they’re like, yes, I’m schizophrenic. They’re just like telling everyone else. And other people knowing that I actually went to the doctor and the doctor said I am. Then, it’s just like, “You are crazy, I told you!”

Princess To put the picture right, but there’s people that do need that help, but I really, you know, like, schizophrenia or bi-polar or… Well, there is, like I said, there is people that do need treatment, that they are very highly schizophrenia, they’re…

Pedro

Tiger

Ricky

Tino

Bobby

J.

Christian

Yali P: Well, when it’s attached to something else, like schizophrenia or, I don’t know, any other disease, it kind of multiplies it, the feeling, I believe, by a lot. Yeah and it dealt with more, I guess, lesser, I guess depression, and I think anxiety and depression. I don’t think it sounded like schizophrenia or dementia or anything like that. I think places like Excel are more equipped to handle people like that.

Debbie

Carlos

Santiago

Julia

Bipolar Disorder

Andrea

Rueben Her mother passed away about a year ago, and that sent her into a depression mode. And another thing that I also forgot to tell you, she’s bi-polar, so she has to take her bi-polar medication, too

Linda
To put the picture right, but there’s people that do need that help, but I really, you know, like, schizophrenia or bi-polar or… But there are people that do need it, because they’re bipolar, and they’ll flip out of their head, and destroying the place that they’re at.

P: My wife. My wife is on SSDI and I deal with her bipolar, her being bipolar almost every day now. And she takes several medications. And you know, I deal with that on a daily basis and with that.
APPENDIX I:

INTERVIEW GUIDE
Interview Guide

1. Tell me about a recent situation where you were concerned about your health. What did you do about your concerns? What treatments did you prefer to use?

2. Tell me about someone you know that is nervous/nervios, anxious/ansiedad or depressed/deprimido? Describe this person. What did they do or say that made you think s/he was nervous, anxious or depressed? If you had one of these problems, what would you imagine yourself doing or saying?

3. What does that mean to someone’s life when s/he is nervous/nervios, anxious/ansiedad or depressed/deprimido?

4. How did s/he get help for his/her nervousness/nervios, anxious/ansiedad or depression/deprimido? What kind of treatment helped for his/her nervousness/anxiety/depression? How could you tell s/he was getting better? What was s/he like when they were well again?

5. What are your treatment preferences for nervousness/nervios, anxiety/ansiedad or depression/deprimido? What does it mean to get different types of help for nervousness/nervios, anxiety/ansiedad, or depression/deprimido? How do you know what types of help are available for nervousness/nervios, anxiety/ansiedad or depression/deprimido? What meaning is there in needing to reach out for the mental health treatment you prefer?

6. What kind of help would you have recommended for that person? What kind of treatment would you have recommended? Tell me more about why you would have recommended that.

7. What does it mean to have to seek treatment for nervousness/nervios, anxiety/ansiedad or depression/deprimido?

8. How do you get health information? How do you get mental health information?

9. Do you find TV radio or newspaper helpful in providing health information? Mental health information?

10. For what reasons would you travel to Mexico for health or mental health care? What would you expect if you went to Mexico for health or mental health care? How would you expect help in Mexico for health or mental health care to be different than in the US?

11. Is there anything else you’d like to share with me about treatment preferences for mental health care?
REFERENCES


