

Copyright  
by  
John M. Gonzalez  
2008

**The Dissertation Committee for John Michael Gonzalez Certifies that this is  
the approved version of the following dissertation:**

**OLDER MEXICAN AMERICANS: PERCEPTIONS OF  
MENTAL DISTRESS AND PATHWAYS TO MENTAL  
HEALTH SERVICE UTILIZATION**

**Committee:**

---

Roberta R. Greene, Supervisor

---

Laura Lein

---

King E. Davis

---

Jacqueline L. Angel

---

Marilyn Armour

---

**OLDER MEXICAN AMERICANS: PERCEPTIONS OF  
MENTAL DISTRESS AND PATHWAYS TO MENTAL  
HEALTH SERVICE UTILIZATION**

**by**

**John Michael Gonzalez, B.A.; M.S.W.**

**Dissertation**

Presented to the Faculty of the Graduate School of

The University of Texas at Austin

in Partial Fulfillment

of the Requirements

for the Degree of

**Doctor of Philosophy**

**The University of Texas at Austin**

**August 2008**

## **Dedication**

This dissertation is dedicated to my Father and Mother, and my brother, Willie and my sisters Rose and Monica. I would not be the person that I am and I would not be doing the work that I am doing without my family.

## **Acknowledgements**

Special thanks go to a long list of incredible people. First my dissertation chair, thanks to Dr. Roberta R. Greene for guiding me through this process with timely feedback and support. Thanks to my doctoral committee for their direction, edits, and assistance with analysis of my idea, of my data and of myself. Thanks to my friends that I began this journey with Johnny, Graeme, Olivia, and Youjung. We have kept the Austin baristas employed over the last few years. Special thanks to my best friend David and my life mentor Oscar for the support and taking time to sit and let me just talk it out. Thanks to my brother Willie and my friends Rudy and Lee for the timely breaks and helping me to find my center on the golf course. Finally, I would like to thank the faculty of the School of Social Work at The University of Texas at Austin for helping me progress through my journey.

**OLDER MEXICAN AMERICANS: PERCEPTIONS OF  
MENTAL DISTRESS AND PATHWAYS TO MENTAL  
HEALTH SERVICE UTILIZATION**

Publication No. \_\_\_\_\_

John Michael Gonzalez, PhD

The University of Texas at Austin, 2008

Supervisor: Roberta R. Greene

Abstract: The literature has documented the contention that economic, cultural, and structural barriers have led to lower utilization of mental health services by Latinos when compared to other ethnic groups. With the growth of older Hispanics, the number of people affected by the barriers to health care will grow. Despite barriers, a small number of older Latinos access mental health services. A gap exists in the literature to explain how some older Latinos access mental health treatment. Using qualitative exploration, this dissertation answers the central question what factors influence help-seeking behavior and mental health service utilization of older Mexican Americans. The researcher used a purposive sample and interviewed 20 older Mexican Americans, who completed outpatient mental health services located in Texas. Green's (1999) Adapted help-seeking behavior model guided the ethnographic content analysis. Respondents

experienced a multiplicity of stressors and behavioral signs of mental distress. Among labels used for the problem were depression or *depression*, anxiety, *nervios* or *ansiosa*, also soledad, tristeza and coraje.. The meaning of the language respondents used was important; often times had multiple meanings. Factors that influenced respondents' help-seeking behavior and mental health service use included family with the daughter being most instrumental. Community factors doctors, nurses, social workers, support groups, and housing authority. An overarching theme was the significant relationships with the interaction of these factors. The relationships were characterized as close, family like. The physician was central to the respondents. Agency staff and the group members helped with utilizing services, resolving their problem, and continuing treatment. Other themes included challenges such as lack of education of mental illness and mental health services, language preference, costs of medication, and stigma of mental illness. Recommendations include expanding the workforce of bilingual/bicultural providers and Spanish-speaking providers; community education of mental illness and reduce the cultural distance between older Hispanics and health care providers. Future research should focus on exploring the relationship with the primary care physician, and the language that research and treatment programs use, attitudinal barriers to the treatment of depression among ethnic minorities, effective culturally competent interventions and improving treatment adherence with older Latinos.

## Table of Contents

List of Tables.....	xiii
List of Figures .....	xiv
<b>CHAPTER ONE</b>	<b>1</b>
Introduction .....	1
Barriers to help-seeking and service utilization .....	3
Population Growth .....	5
Latinos .....	6
Older Texans .....	6
Statement of the Problem .....	7
<b>CHAPTER TWO</b>	<b>9</b>
Literature Review .....	9
Culture .....	9
Treatment Preferences .....	14
Help-Seeking Literature .....	15
<b>CHAPTER THREE</b>	<b>20</b>
Conceptual Framework .....	20
Kleinman's Explanatory Model .....	23
Green's Adapted Model .....	27

<b>CHAPTER FOUR</b>	<b>31</b>
Methodology .....	31
Research Questions .....	33
Research Design .....	34
Program Setting & Sites Used.....	34
Program Settings .....	34
Sample Selection Criteria.....	35
Recruiting Strategy.....	37
Procedures .....	38
Sample Characteristics .....	38
Data Collection and Analysis Plan.....	42
Use of Interview Materials .....	42
Data Analysis .....	43
Client Problem Recognition .....	46
Client Problem Labeling and Diagnosis.....	46
Client Utilization of Help Providers.....	46
Problem Resolution .....	46
Standards of Verification .....	48
Peer Debriefing .....	48
Audit Trail .....	49
<b>CHAPTER FIVE</b>	<b>50</b>
Findings.....	50
What are older Mexican-Americans’ perceptions of mental distress?.....	51
Causes of Mental Distress .....	52
Behavioral Signs of Distress .....	58
Name of Illness.....	65

What individual, agency, and system level factors influence help-seeking behavior and mental health service utilization of older Mexican-Americans? .....	67
What is the interaction of these factors with help-seeking behavior and mental health service utilization of older Mexican-Americans?.....	71
Physician .....	71
Family.....	73
Health Care Providers .....	73
Agency Staff.....	74
What is the role of the family and social network in older Mexican-Americans accessing mental health services?.....	78
Family and Problem Recognition.....	79
Family and Treatment Program.....	80
Daughter .....	84
What factors motivate older Mexican-Americans to continue in mental health services? .....	87
Something new .....	87
They Could See Progress .....	88
They Had Solutions for My Problems.....	89
Other Treatment Program Benefits .....	89
Application of Green’s Model of Help-seeking .....	96
Client Problem recognition .....	98
Family.....	99
Physician .....	100
Client Labeling and diagnosis .....	100
Client Utilization of help providers.....	101
Family.....	102
Physician .....	103
Other Health Care Providers .....	104
Friends .....	104

Agency Staff.....	104
Indigenous help providers .....	105
Problem resolution .....	105
The Right Place .....	106
I Know Where to Go .....	107
Medication.....	107
Learned Acceptance .....	108
Other Themes That Emerged .....	109
Knowledge of the program.....	110
Religious Beliefs .....	111
Acculturation .....	113
Challenges .....	115
Summary .....	120
<b>CHAPTER SIX</b>	<b>123</b>
Discussion and Implications.....	123
Summary of findings .....	123
Research Questions: .....	123
Perceptions of mental illness.....	124
Interaction of Factors that influenced utilization .....	125
Role of family.....	128
Treatment experience .....	129
Psychosocial Interventions .....	130
Other Themes That Emerged .....	132
Discussion of Limitations.....	134
Recommendations .....	136
Language preference .....	137
Education of mental illness and treatment services .....	138

Cultural Distance.....	139
Conclusion.....	142
Appendices .....	144
Appendix A .....	145
Appendix B .....	147
Appendix C .....	148
References .....	155
Vita	166

## **List of Tables**

Table 4.1 Sample Characteristics (n = 20) .....	39
Table 5.1 Name of Illness .....	65
Table 5.2 Factors that influenced Help-Seeking Behavior/Mental Health Service Utilization .....	68

## **List of Figures**

Figure 3.1: Green's Help-seeking Behavior Model .....	29
---	----

# CHAPTER ONE

## Introduction

The Surgeon General's Report on Mental Health (1999) identified several ways to improve the nation's mental health services, including tailoring mental health services to the increasingly diverse, age, gender, racial, and cultural make-up of the population. The U.S. Surgeon General also reported that culture has an impact on mental illness and mental health insofar as it shapes how patients communicate and exhibit symptoms, cope with mental illness, and how families and communities cope with mental illness. This dissertation focuses on older Mexican-Americans who utilized mental health services and completed treatment programs. The focus of this dissertation is on increasing understanding of the factors that influence both help-seeking and mental health service utilization of older Mexican-Americans. This group is of considerable significance because age, cultural identity, place in family life, and health status all affect the identification of mental health problems and the use of mental health services.

Utilization rates of mental health treatment for Hispanics with mental illness are low. Fewer than 1 in 11 (9%) of Hispanics with a mental health disorder contact a mental health professional (The Center for Mental Health Services, 1999). Alegria and colleagues (2002) examined disparities in the utilization rates of specialty mental health care, and found a significantly higher

proportion of non-Latino Whites (11.8%) received specialty care than African Americans (7.2%) or Latinos (5.9%). Miranda and Cooper (2004) examined ethnic minority care for depression using data from the Quality Improvement for Depression Project. They found Latinos were less likely to receive specialty mental health treatment than African Americans and Whites and the odds of Latinos receiving any treatment for depression was less than White patients.

Crystal, Sambamoorthi, Walkup, and Akincigil (2003) studied trends in treatment and found that receiving no treatment was higher for Hispanics and other ethnic groups, low income, and those with no supplemental insurance. The researchers added that 50.8% of respondents with no supplemental insurance did not receive treatment, concluding that among those diagnosed with depression, Hispanics and other racial minorities were less likely to receive treatment than Whites. Wang et al. (2005) found that the odds of receiving any 12-month mental health treatment were significantly related to several factors, including being younger than 60 years, non-Hispanic white, not having a low average family income and not living in a rural area. From this data, it is clear that there are important factors that determine help-seeking and service utilization by ethnicity.

Studies found a significant association between depression in older Mexican-Americans and chronic medical conditions. Black & Markides (1999) found depression in older Mexican-Americans to have a high comorbidity with several medical conditions including diabetes, cardiovascular disease,

hypertension, stroke and cancer. Some chronic medical conditions are also predictive of depression in older Mexican-Americans. Medical conditions such as diabetes, arthritis, urinary incontinence, bowel incontinence, kidney disease, and ulcers were predictive of high levels of depression in older Mexican-Americans (Black, Goodwin, & Markides, 1998). The association between depression and chronic medical conditions warrants an understanding of the factors that influence help-seeking and mental health service utilization of older Mexican-Americans.

#### **BARRIERS TO HELP-SEEKING AND SERVICE UTILIZATION**

According to the Administration on Aging (2001), there are numerous barriers to obtaining health care, which separate racial and ethnic minorities including: language, lack of appropriate information, a distrust of the delivery system, low income, and low education level. Minorities face several challenges with regard to accessing health care, which includes mental health treatment.

The literature has documented the contention that economic, cultural, and structural barriers have led to lower utilization of mental health services by Latinos, including Mexican-Americans, when compared to other ethnic groups in the population (Marin, Escobar, & Vega, 2006; Atdjian & Vega, 2005; Vega & Lopez, 2001; Villa & Aranda, 2000). Several barriers at the societal level keep older Latinos from accessing health care, such as degree of acculturation, communication/language preference, and access to insurance, poverty, education, and culture. Older Latinos experience a case of double jeopardy, being both aged

and ethnic minorities and a case of triple jeopardy for those who experience any access barrier (Kart, 1985). The group of older Mexican-Americans in this study navigated their way through the aforementioned barriers. The factors or paths that assisted them in their navigation of their environments are of interest in this study.

In the literature on help-seeking and mental health service utilization, the terms help-seeking and accessing services are frequently used. Andersen and Newman (1973) noted that the concept of “access refers to the means through which the patient gains entry to the medical care system and continues the treatment process” (p.102) in discussing health care service utilization. Rogler and Cortes (1993) define the concept of help-seeking pathways as “the sequence of contacts with individuals and organizations prompted by the distressed person’s efforts, and those of his or her significant others, to seek help as well as the help that is supplied in response to such efforts” (p. 555) in discussing use of mental health facilities. Both definitions share similar meanings. This study is interested in factors or pathways that influence help-seeking and service utilization. These pathways or factors are at all levels: individual, agency, and system. For those who seek help, each individual has life circumstances that lead them to seek help from mental health professionals. Older adults cope with adjustments in a variety of ways, and also access mental health services using a variety pathways. This study explored what influenced older Mexican-Americans’ help-seeking and the

factors or pathways that help them to access mental health services and what helped them get to mental health treatment.

## **Population Growth**

In this dissertation, the terms Hispanic and Latino are used. These terms are not interchangeable. When citing findings from other researchers, the preferred terms of the researchers are used. In some studies, the term Hispanic is used and in others, the term Latino is used. This dissertation focused on one group of Hispanics: Mexican-Americans of Texas. In this dissertation, the researcher used the term Mexican-American when referring to the study group, and used the term Hispanic when referring to the larger ethnic group.

The projected growth in the Latino population will exacerbate the challenges to health care. In 2004, the older population, people age 65 and older, made up 12% of the total population, and Hispanic Americans accounted for 6% of the country's older population (U.S. Census, 2004). Researchers project that by the year 2050, Latino Americans will make up 16% of the older population (Federal Interagency Forum on Aging Related Statistics, 2000). With the growth of older Latinos, the number of people affected by barriers to health care will also grow if something does not change in the delivery of mental health services to older Latinos.

## **LATINOS**

In 2002, older Latinos resided mostly in four states: California (27%), Florida (16%), New York (9%), and Texas (20%) (USDHHS, 2003). Older Latinos are concentrated in these areas because these are the areas to which they originally immigrated. Mexican-Americans are the largest ethnic group in California and Texas because of the close proximity to Mexico. Cubans are heavily concentrated in Florida, as Puerto Ricans are in New York. Latinos are now the nation's largest minority group (U.S. Census, 2002).

## **OLDER TEXANS**

In 2003, the Texas Department of Aging reported demographics of older adults in Texas. They reported over 2.7 million Texans were age 60 or older. They project that the 60-plus population will increase 193% to 8.1 million by the year 2040. Along with these projections come changes in the race/ethnicity breakdown for the 60-plus population in Texas. In the year 2000, the population was Anglo 72%, Hispanics 18%, African American 9%, and 2% other. In 2040, it is projected that the older minority population will make up half of older Texans. The older population is projected, by 2040, to be 44% Anglo, 38% Hispanic, 9% African American and 8% other (Texas Department of Aging, 2003). The projected rapid growth of the older Hispanic population also poses a challenge to health care, particularly in Texas.

## **Statement of the Problem**

The numbers of Hispanics who seek help in outpatient/specialty mental health settings are low compared to other ethnic groups. However, some older Hispanics do seek outpatient mental health treatment, navigating through the aforementioned barriers. The literature does not fully explain how some older Hispanics are accessing outpatient mental health facilities despite the documented barriers. The factors that influenced the help-seeking of this group of older Mexican-Americans are not fully understood. The studies that discuss service utilization of outpatient mental health treatment by older Hispanics have not interviewed the older people that are accessing mental health services.

This study focused on a group of older Mexican-Americans who utilized mental health services and completed the treatment services. In this study, the researcher interviewed older Mexican-Americans to find out what influenced their help-seeking behavior and their mental health service utilization. More specifically, the central question of this dissertation asks, what factors influence help-seeking behavior and mental health service utilization of older Mexican-Americans?

The purpose of this dissertation is to explore and describe the factors that lead older Mexican-Americans to access outpatient mental health treatment and how older Mexican-Americans employ these factors to help seek treatment. Understanding these factors will assist social workers and other health care

professionals that work with older Mexican-Americans in helping families and caregivers to cope with their mentally ill relatives, and will enhance health promotion efforts for this generation of Mexican-Americans and the generations to come.

This dissertation consists of a qualitative exploration of mental health service utilization of older Mexican-Americans collected from clients at outpatient mental health programs in Texas. The goal of the dissertation is to provide an understanding of how older Mexican-Americans view mental illness, an understanding of the factors that older Mexican-Americans used to access treatment for mental health services and the role of the family in this process. This dissertation addressed the following questions:

1. What are older Mexican-Americans' perceptions of mental distress?
2. What individual, agency, and/or system-level factors influence help-seeking behavior and mental health service utilization in older Mexican-Americans?
3. What is the interaction of these factors with help-seeking behavior and mental health service utilization of older Mexican-Americans?
4. What is the role of the family and social networks in older Mexican-Americans accessing mental health services?
5. What factors motivate older Mexican-Americans to continue in mental health services?

## **CHAPTER TWO**

### **Literature Review**

This chapter reviews the literature of Hispanic culture and older adults including family, values, and views of mental illness of Hispanics. This chapter also presents a review of the help-seeking literature when it comes to mental health services utilization—including underutilization of services, service preferences and factors associated with service utilization for older Hispanics.

#### **Culture**

Culture is a factor that can serve as a barrier for older Mexican-Americans and for mental health professionals in bringing them together in the mental health arena. Culture can also serve as a facilitator in accessing mental health services. Culture is important in compliance to medical regimens (Anthsel, 2002). The culture of an older Mexican-American consists of the belief systems among the individual, their family, and their social networks. Older Mexican-Americans bring a diverse culture to the clinical setting. The family unit expresses culture. The family and the values of the culture influence help-seeking behaviors and adherence to medical recommendations.

#### ***Family***

In the Latino culture, the family meets several emotional and psychological needs of their elderly. The family network consists of generations

that include the nuclear family, extended family, the compadrazo system (i. e., godparents), the barrios (i.e., friends and neighbors), and the larger community. The immediate family usually takes care of older Latinos, with assistance from the extended family in their community. Older Latinos have strong connection between their mental health and their health status. When their health status is stressed, their mental health is also impacted (Harris, 1998).

Older Latinos are at the center of the family. When they experience mental distress and aging issues, a strain is placed on the family. Family roles and responsibilities are changed, and at times exchanged or reversed. The older Latino gives up the responsibility of being the caregiver to become the care receiver. The adult children take on the responsibility of caring for their aging parent. This exchange of responsibilities sometimes leads to stress and distress for the family and for the family members involved. The burden of caring for older Latinos eventually falls on their children, particularly daughters. The children of older Latinos take on this caring role in addition to other responsibilities, like raising their own family and maintaining employment (Purdy & Arguello, 1992).

Angel, J. L., Angel, R. J., McClellan, and Markides (1996) in their study of Latino elders, found they preferred to live with their spouse, live alone, or live with family, instead of in nursing homes or institutions. Latino elders are resistant to outside help, and have a strong sense of independence. They often are self-

reliant, desirous of aging in place (their home), and dependent on family support and friends to meet health care needs.

Another family factor affecting care is whether an older adult lives with a family member or lives alone. The number of older Latinos living alone is lower than that of the general population. The number of older Latinos living with other relatives is about twice that of the total older population. In 2000, 68 percent of older Latino males lived with their spouses, 16 percent lived with other relatives, and 14 percent lived alone. For older Latino females, 38 percent lived with their spouses, 34 percent lived with other relatives, and 25 percent lived alone (USDHHS, 2003).

Keeping medical, mental health and other problems in the family is a norm that contributes to the reluctance of taking advantage of available health care services (Magilvy, Congdon, Martinez, Davis, & Averill, 2000). The family system does not take the problems of Older Mexican-Americans outside of the family system (Abramson, Trejo, & Lai, 2002). By recording and analyzing interviews, the researcher learned how belief systems act as a barrier and/or a facilitator in accessing service.

### ***Religious Beliefs***

For many Hispanics, the church is a primary source of support. Hispanics are mostly Christians, the majority being either Roman Catholic or Protestant. Hispanics may be described as fatalistic, because they believe their destiny is in

the hands of God. These beliefs, at times, can act as a barrier to accessing mental health treatment for Hispanics. When Hispanics experience psychiatric distress, they often interpret their symptoms as a deserved punishment for their sins. The belief is often expressed in the sentiment, “*si Dios quiere*,” if God so wishes. Some believe that all they can do is pray for God’s will (Carrillo, 2001). Getting better or worse is interpreted as an act of God’s will, rather than an indicator of how well or not they are living with their symptomology. Many older Mexican-Americans believe that circumstances in life are God’s will and that only God can change them. These elders are generally reluctant to seek out mental health professionals and services – often because of a very strong belief in spirits. This belief is often seen as incompatible with traditional mental health services (Carrillo, 2001). Questions were included in this study to determine the extent to which participant beliefs contribute to their accessing services.

### ***View of Mental Illness***

The recognition of mental distress in older Latinos is sometimes a problem for professionals, as well as for the individual and their family. Two idioms of distress sometimes recognized in Mexican-Americans are *ataque de nervios* and *nervios*. Symptoms include uncontrollable shouting, attacks of crying, trembling, verbal and physical aggression, fainting episodes, and suicidal gestures. *Ataque de nervios* frequently occurs because of a stressful life event. Descriptions of *ataque*

*de nervios* are similar to Panic attacks and presentations of anxiety, mood, dissociative and somatoform disorders (APA, 2000).

*Nervios* is another idiom of distress among Latinos. It includes a wide range of symptoms of emotional distress, somatic disturbance and inability to function. Symptoms include headaches, irritability, sleep difficulties, nervousness, inability to concentrate, trembling and easy tearfulness. It presents like adjustment, anxiety, depressive, dissociative, somatoform, or psychotic disorders depending on the set of symptoms experienced (APA, 2000).

Guarnaccia, Rivera, Franco, and Neighbors (1996) used Kleinman's explanatory model to shape their interviews in a study of distress, or *ataques de nervios*, in Puerto Ricans and other Latinos. A key focus of this analysis was the language used to express emotions, talk about their emotional experience and to discuss others' emotional expressions. The researchers were able to categorize the experience of *ataques de nervios*, in understanding expressions of emotions in Latinos. They developed a prototype to understand *ataques de nervios* that consists of a sense of loss of control, a threat to social order, emotions of sadness and anger, expressions of distress in the form of physical symptoms, aggressive outbursts, and loss of consciousness.

*Nervios* refers to a broad and diverse range of distressing emotional states and illness phenomena. In Mexican-American and other Hispanic cultures, *nervios* is a condition that quite often affects adults who are experiencing difficult

life conditions. Salgado de Snyder, de Jesus Diaz-Perez, & Ojeda (2000) stated that *nervios* is a “cry for help.” It might be a sign of serious mental and physical dysfunction, particularly among those experiencing distress (Salgado de Snyder et al., 2000). The older Mexican-American’s perspective of mental illness is significant to this dissertation. What are older Mexican-Americans’ perceptions of mental distress? In addition, what label do older Mexican-Americans give to mental distress?

#### **TREATMENT PREFERENCES**

Some studies have examined Latinos treatment preferences. In a qualitative study, Lantican (1998) found those who expressed a preference for bilingual/bicultural professional staff alluded to the benefits of feeling better understood in the therapy process when language barriers were overcome. Warda (2000), in a study of professionals and clients, found communication repeatedly identified as a key component of culturally competent care. Adjectives used to describe harmonious verbal and nonverbal communication include humane, respectful, professional, and sensitive. Another finding of the study was that the use of health care professionals’ bilingual abilities positively affects the content of the interaction, and the patient’s recall of the information.

Many ill Mexican-Americans resort to self-care as their initial remedy, and then seek support from their social network if illness persists. Only when these attempts fail will they seek assistance from outside sources (Salgado de

Snyder, Perez, & Gonzalez-Vasquez, 2003). Salgado de Snyder, de Jesus Diaz-Perez, Maldonado, and Bautista (1998) provide a description of the pathways to the utilization of mental health services among rural Mexicans. They noted a pathway that begins with a symptom and self-care. If needed, the path follows until there is alleviation of the symptom. The next step is turning to the social network, which includes the immediate family and the extended family. The next path is informal services including the priest, pharmacist, nurse, and folk healers. Formal services are next, including seeking help from professionals like physicians. The last path is the mental health specialist, psychologist, or psychiatrist. Alleviation of the symptom can occur at any stage in the model. The reason to move to the next path in the model was the lack of success of other paths in alleviating the symptom. When one path did not work, they moved to the next path; the last resort was professional services for alleviation of the symptom (Salgado de Snyder *et al.*, 1998).

#### **HELP-SEEKING LITERATURE**

Torrez (1998) conducted a qualitative study that examined the service utilization patterns of a group of older Mexican-Americans and the barriers encountered when they attempt to access formal services. They found that deteriorating health exacerbated the need for services. As we will see in the findings, many participants in this study had multiple problems including health issues. However, when adult progeny had time constraints, or when there was a

need for transportation, participants were less likely to access services. This study revealed that older adults not only need health and social service information, they also need assistance to access services.

Vega, Kolody, Aguilar-Gaxiola, & Catalano (1999) studied the underutilization of mental health services among urban and rural Mexican-American adults. They reported an overall 12-month rate of utilization of any provider was 28.2 percent. The highest utilization rate was for general medical providers, followed by other professional mental health specialists, and informal providers. We see later that this sample was influenced by their physicians. The highest mental health care utilization came from the most educated respondents. The least educated respondents utilized informal providers the most. U. S born respondents had higher utilization rates for all providers with the exception of informal care. In this study, factors associated with utilization of mental health services included being female, having higher educational attainment, unemployment, and comorbidity. Researchers also concluded that more research is needed in several areas regarding Mexican-Americans and mental health service utilization, including beliefs about mental health problems, ineffective and inappropriate therapies, dearth of Spanish Language mental health care providers, access problems and barriers, and the effects of the family and social network.

Another study by Vega, Kolody and Aguilar-Gaxiola (2001) sheds light on some of the factors that contribute to a person accessing mental health

services. The researchers found that U.S.-born Mexican-Americans had higher utilization of primary care physicians and counselors than immigrants did. They also found that neither group relied heavily on informal network providers to treat psychiatric disorders. In addition, they discovered that knowing where to find a specialty mental health provider increased the likelihood of service use, as did having private insurance. Researchers pointed out two limitations of this study: first, the data did not include other explanatory factors, like the role of medical conditions; also, the use of a cross-sectional design to explain help-seeking processes that is time-ordered. This warrants further investigation into the help-seeking process of older Latinos when it comes to accessing mental health treatment.

Choi and Gonzalez (2005b) identified reasons older minorities drop out of mental health treatment such as initial reluctance, lack of motivation, sense of shame or stigma related to mental illness, fear of mental health treatment, discomfort with therapy, socioeconomic and cultural distances, and lack of support or resistance of adult children, and perception or expectation of a quick cure. They also identified retention contributors to treatment, which included education at the beginning of treatment of the difference between mental illness and physical illness, education of mental illness and treatment for the respondent and the family and community, and assurance of confidentiality. Other contributors identified by the researcher included bilingual/bicultural counselors,

culturally competent therapists, family involvement and education to enable the family to understand mental illness, and realistic expectations about treatment (Choi and Gonzalez, 2005b).

Choi & Gonzalez (2005a) also found several contributors to accessing services like doctors referrals, referrals from social workers, churches, former patients, community outreach, supportive family, bilingual/bicultural clinicians, dual Medicare/Medicaid eligibility, and transportation. This study interviewed practitioners and provided useful insight into the access barriers and contributors for older minorities. Interviewing older minorities who access treatment services and continue in treatment can help to gain more insight into how older Mexican-Americans navigate access barriers and what contributors are significant.

The literature review offers some insights into what is known about Hispanics and older Hispanics. Family is significant in the Hispanic culture. Older Hispanics are respected and turn to the family for help when in mental distress. Usually the children, especially the daughters, take on the caregiving responsibility. What is unknown are the ways that the family helps an older Hispanic when in mental distress. What role does the family play?

The recent help-seeking literature is limited when it comes to older Mexican-Americans and older Hispanics with regard to help-seeking and mental health service use. The literature at times focuses on Hispanics, but not always on older Hispanics, much less on older Mexican-Americans. What is known about

older Hispanics with mental health issues is that they experience many barriers, and that they underutilize mental health services when compared to other ethnic groups. Hispanics also utilize their general medical providers the most, and for older Hispanics, relationships with physicians, social workers and other health care providers contribute to utilizing mental health services. What is unknown about older Mexican-Americans is a pathway to help-seeking when it comes to mental distress and the factors that contribute to that pathway.

## **CHAPTER THREE**

### **Conceptual Framework**

This chapter discusses Kleinman's explanatory model as adapted by James Green in his help-seeking behavior model. Green's model served as the conceptual framework for this dissertation. This help-seeking model guided the examination of factors of the client culture and factors of the professional culture of mental health treatment in older Mexican-Americans accessing mental health care.

*Culture* is a factor that influences older Mexican-Americans' help-seeking behavior. Researchers have reported that culture may be defined as patterns of behavior, ways of viewing the world, a filter, and a shaper of perceptions. The United States Department of Health and Human Services Office of Minority Health (2000) defined culture as "integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social groups" (p.2). From this definition, it can be said that culture is patterns of human behavior and that culture is generational, each generation passing on patterns of behavior or culture to the next. Green states, "culture refers to a process whereby people try to solve their problems" (p.51). In this study, the factor of culture is discussed as more than language or shared ethnicity, but as shared values, expressions, thoughts,

beliefs, meanings, and traditions that may or may not influence an older Mexican-American to seek help for mental distress.

Culture is dynamic and continually changing. People's beliefs and the demands of their environment influence culture (Lopez & Guarnaccia, 2000). In *Mental Health: Culture, Race, and Ethnicity – A Supplement to Mental Health: A Report of the Surgeon General* (USDHHS, 1999), the Surgeon General noted that culture is central to what all people bring to the clinical setting. Culture influences an individual's view of mental illness, their decision whether to seek help, the type of help they seek, their coping styles, social supports, and whether stigma comes with mental illness. Individuals bring diverse cultures to the clinical setting.

Culture gives meaning to mental illness and mental health treatment by exchanges individuals have with the professional culture (Abramson, Trejo, & Lai, 2002). The culture of the clinician and the culture of the service system are part of the clinical equation. The professional mental health culture influences the interaction of the treatment seeking consumer through their diagnosis, treatment, and organization and financing of treatment services. The professional mental health culture that works with older adults includes physicians, psychiatrists, psychologists, social workers, psychiatric nurses and other health care professionals. These professionals work in psychiatric hospitals, acute hospitals, outpatient mental health programs, and in private practices. These services are

financed through health care insurance programs including Medicare, Medicaid, private insurance, supplemental insurance, and private pay (USDHHS, 1999).

The culture of the older Mexican-American consists of language, shared values, expressions, thoughts and traditions, as does the culture of the professional mental health provider system. The culture of older Mexican-Americans consists of the nuclear family as well as an extended family and social network. The social network is comprised of neighbors and friends who live in the community and includes clergy and folk healers. The older Mexican-American gains meaning through interaction with their family and social network. This interaction forms culture for the older Mexican-American. The family and the values of the culture influence help-seeking behaviors and adherence to medical recommendations. For example, keeping things inside of the family might influence an older Mexican-American attending mental health treatment and their participation in such treatment.

The culture of the older Mexican-American, the client culture, and the professional mental health culture can be a barrier for older Mexican-Americans to access mental health treatment. At times, the client culture and the professional culture influence each other. The boundaries of each culture are not so clear. This study is focused on how older Mexican-Americans interact with the professional mental health culture, how older Mexican-Americans cross into the professional mental health culture to seek mental health treatment.

## **Kleinman's Explanatory Model**

Culture affects the way older Mexican-Americans present mental illness. It also affects how they describe symptoms. Culture affects the meaning they attach to mental illness and how they make sense of it (Kleinman, 1988).

Kleinman's Explanatory model (1980) is a model often used to examine help-seeking behaviors and culture. According to Kleinman, an explanatory model encompasses the notions a person has about an episode of illness and its treatment as delivered by all those who engage in the clinical process. Explanatory models examine people's cognitive processes based on their cultural knowledge and idiosyncratic experiences. Popular culture and the media inform explanatory models, as do the health care culture and the social network of the individual. These elements guide the interpretation and action concerning health. Individuals form explanatory models to cope with a specific health problem. Explanatory models determine what important clinical evidence is, how it is organized and interpreted for treatment approaches. Explanatory models assist patients and families in making sense of illness episodes (Kleinman, 1980).

The model distinguishes between the concepts of *disease* and *illness*. *Disease* refers to the malfunctioning of biological, chemical, and/or psychological processes. However, *illness* refers to the psychosocial experiences and meaning of perceived disease. *Illness* also includes communication and interpersonal interaction within the family and social network. The experience of illness is

considered within the context of social systems and rules for behavior; illness is also believed to have cultural influences and to be culturally constructed (Kleinman, 1980).

According to Kleinman (1980), the social context of the culture of health care contains three structural domains: (1) professional, (2) popular, and (3) folk. The *professional domain* consists of doctors, nurses, licensed practitioners and pastors/clergy. The *popular domain* includes family, the social network, and the community—which includes the media. The *folk domain* consists of non-professional healers, such as *curanderas* or herbalists. Each domain has its own explanatory systems, social roles, interaction settings, and institutions. When an individual is coping with an illness, they will utilize the popular domain to find a cure or alleviate the symptoms. They might consult with family, friends, or go to clergy in their community. If illness is unresolved, the individual will take recommendations from the popular domain to enter the professional domain either to visit a doctor or go to the hospital. On the other hand, the individual might visit a folk healer again based on recommendations from their popular domain (Kleinman, 1980).

Patient, family, and physician explanatory models follow five dimensions: (1) etiology, (2) onset of symptoms, (3) pathophysiology, (4) course of sickness including type of sick role – acute, chronic, and impaired – and the severity of the disorder), and (5) treatment (Kleinman, 1980, p.105). Explanatory models (EM)

explore the cause or origin of the illness. EMs explain when and how the symptoms started and the types of physical changes the individual has noticed since the onset of these symptoms. EMs also explain the course of the illness, whether it is acute, chronic or impaired, and how severe the illness is. Treatment is the last dimension covered in the EM. It is the action that one can take to reduce symptoms, or to find a cure for the illness (Kleinman, 1980).

This dissertation explored the factors of the patient EMs and the patient's view of the practitioner EMs that contribute to older Mexican-Americans accessing mental health treatment. Practitioner EMs address most or all of the aforementioned dimensions. Patient and family models differ in the extent of addressing all of the concerns. The interaction between explanatory models of patients and those of practitioners is the fundamental component of health care. The cultural and social structural context affects the patient-practitioner relationship (Kleinman, 1980).

The explanatory model takes into account communication of the patient and the practitioner in their therapeutic relationship. The model incorporates a distinction between disease and illness. The model also takes into account the cultural and social context in which individuals and the health care system reside, the idea that help-seeking is a cross-cultural experience (Kleinman, 1980). This dissertation is interested in this cross-cultural experience for older Mexican-Americans seeking help for mental distress.

A transaction of explanatory models characterizes the patient-practitioner relationship. The transaction consists of a negotiation between the patient EM and the practitioner EM, regarding the clinical realities of each. This negotiation centers on discrepancies between the two EMs. The family EM is also included in this discussion. This perspective is an opportunity for the practitioner to understand the patient EM, and it is an opportunity for the practitioner to educate the patient. It is also an opportunity for the patient to educate the practitioner of the patient's EM. This transaction also consists of the therapeutic values, expectations, and goals of the patient and the practitioner. Large discrepancies between the two EMs affect clinical management and can lead to inadequate or poor care. This negotiation is an important step in establishing trust with the patient, promoting patient satisfaction and compliance to prescribed treatment actions (Kleinman, 1980).

This model is useful to this dissertation because it has been helpful in studies that examine health beliefs of ethnic minorities. These studies demonstrate how Kleinman's Explanatory Model has been valuable in studying how culture influences health beliefs, how health beliefs vary and are complex especially when it comes to language and expressing emotion, and in the blending of two cultures to understand illness. The explanatory model guides the study of the perception of mental illness of older Mexican-Americans.

### **GREEN'S ADAPTED MODEL**

Green (1999) adapted Kleinman's explanatory model (fig. 3.1) into a help-seeking behavior model. Green takes the client explanatory model and labels it the *client culture*, and he labels the practitioner explanatory model the *professional subculture*. The client culture includes problem recognition, problem labeling and diagnosis, indigenous help providers, utilization of help providers and problem resolution. The professional subculture includes professional help providers, minority professionals and professional models. This dissertation is interested in the client culture of older Mexican-Americans, and in how the study group crosses into the professional subculture in accessing mental health services. The study group steps out of the client subculture and into the professional subculture to seek help with their mental distress.

*Client problem recognition* occurs when the client notices a change in their usual functioning or a problem therein. The client labels and diagnoses the problem, *client problem labeling and diagnosis*, based on their knowledge of the illness, which comes from their everyday experience and their cultural experience, and from feedback from their social network including their families, friends, and other community members. The cultural experience might include healers, indigenous help providers in the client community including herbalists, *curanderas*, voodoo practitioners, etc. who may influence help-seeking.

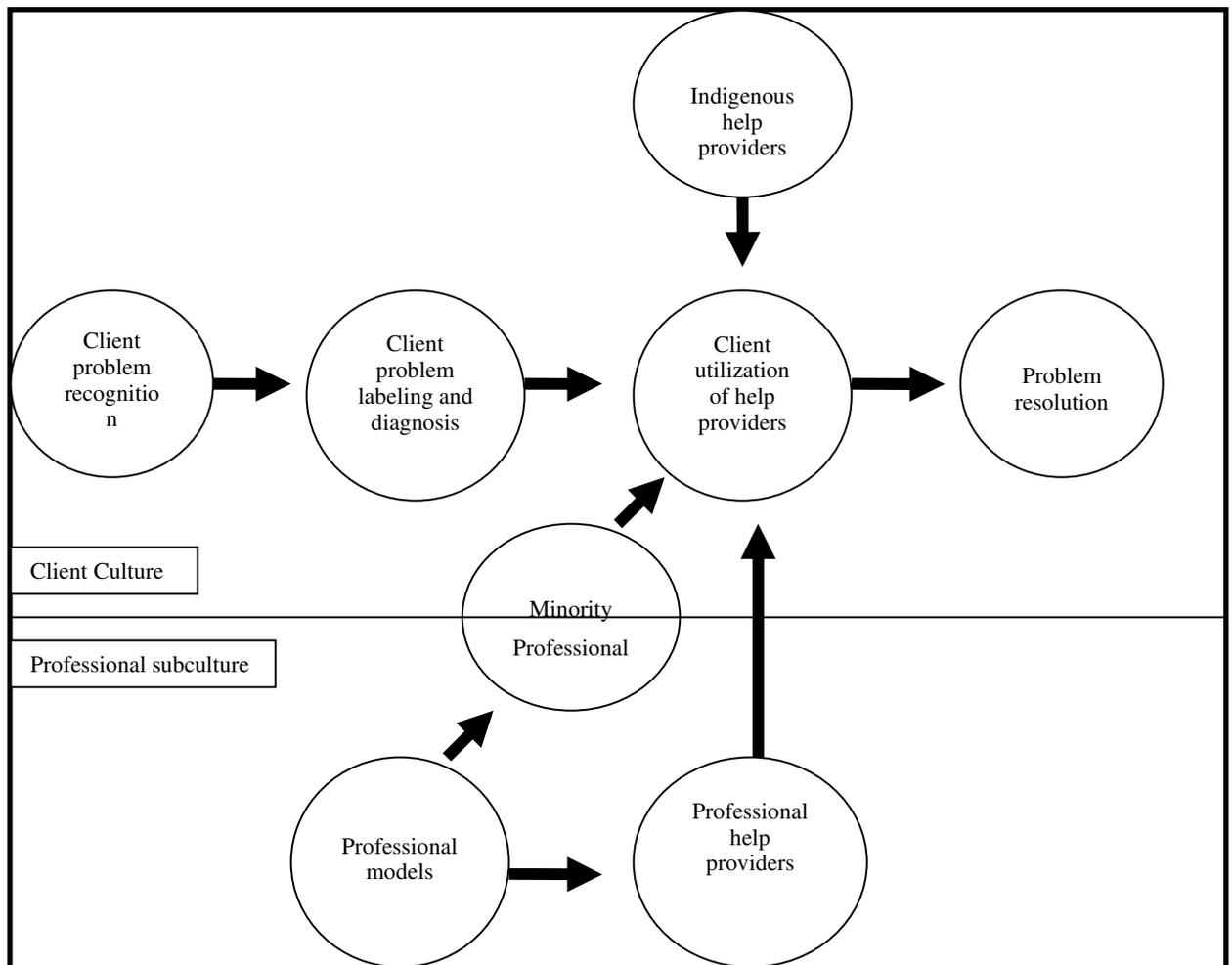
The client uses all information gathered in the client culture, *Client utilization of help providers*, to make the decision to seek and utilize help providers. Clients decide which providers to use based on their previous experience, feedback from friends and family, and community recommendations. Those who have no previous experience with help providers will begin the help-seeking with those important to them such as family, a primary care physician, or even a friend. Clients can decide to utilize indigenous helpers and/or professional help providers. The client gets to *problem resolution*, by utilizing helpers—indigenous and/or professional.

*Minority professionals* are included in both the client subculture and the professional subculture. They are professionals who are bicultural and/or bilingual. This helps in decreasing cultural distance from the client.

The *professional subculture* includes minority professionals, professional models, and professional help providers. *Professional models* are the models with which practitioners assess clients; some professional models are based on the medical model. When practitioners do not use culture, or misuse culture in the model of assessment, a cultural distance can be created between the professional and the client. Assuming that all clients of a similar culture are the same and stereotyping cultural behavior can be a misuse of culture. *Professional help providers* are physicians, nurses, social workers, and licensed practitioners who assist the client in resolving their problem.

This dissertation used Green's help-seeking behavior model (1999) as a conceptual framework. This dissertation is concerned with where the client culture meets the professional culture. More specifically, the model helped explore older Mexican-American's explanatory model when it comes to mental distress, and the factors that contribute to older Mexican-Americans accessing mental health services.

Figure 3.1: Green's Help-seeking Behavior Model



Green's model helped provide an understanding of the interactions of the factors of the client culture of older Mexican-Americans in seeking mental health services. This understanding includes who and what is involved in recognition, labeling and diagnosis of the problem, including indigenous help providers and the utilization of help providers and problem resolution. Green's help-seeking

model helped the researcher illustrate how older Mexican-Americans identify and describe mental distress. The model also helped sort out who provides older Mexican-Americans in mental distress with assistance, and the role of those providers. Also, the model helped understand how older Mexican-Americans used their help providers, indigenous and/or professional, to resolve their mental distress

## **CHAPTER FOUR**

### **Methodology**

The ways in which older Mexican-Americans view mental illness and create meaning from their experience in accessing mental health services can best be studied using a qualitative approach (Padgett, 1998). Qualitative studies use

*thick rich description* to express the multifaceted worlds of respondents in a holistic manner. Qualitative methods are inductive, and occur in naturalistic settings (Padgett, 1998). Creswell (1998) defines qualitative research as “an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The researcher builds on a complex, holistic picture, analyzes words and reports detailed views of informants, and conducts the study in a natural setting (p. 15)”.

Padgett (1998) discusses reasons for doing qualitative research. One reason is to gain “the ‘lived experience’ from the perspectives of those who live it and create meaning of it.” (p. 8). In this descriptive study, the researcher learned multi-faceted and complex accounts of interpretations of mental illness. The researcher presents an understanding of several issues from the perspective of the respondent. This perspective helped the researcher understand perceptions of care, as well as the factors that contribute to accessing treatment services, the factors used to overcome environmental barriers, and how these factors were used. The primary research questions of this ethnographic study focused on the factors that influence help-seeking behavior and mental health service utilization of older Mexican-Americans.

Ethnography describes and interprets a cultural or social group (Creswell, 1998). In this study, the researcher was interested in a group of older Mexican-Americans, specifically their help-seeking behavior and their significant

relationships when it comes to mental health treatment. The researcher interviewed older Mexican-Americans and analyzed the data by using the technique of ethnographic content analysis with Green's help-seeking model as a guide. In this study, the researcher aimed to describe the factors that contribute to older Mexican's access to mental health services. In this study, the researcher explored from the point of view of the older Mexican-American, or the emic perspective (Padgett, 1998). The emic perspective is the perspective of the respondent (Creswell, 1998).

### **Research Questions**

The methods employed in this study looked to answer the following questions.

1. What are older Mexican-Americans' perceptions of mental distress?
2. What individual, agency, and system-level factors influence help-seeking behavior and mental health service utilization of older Mexican-Americans?
3. What is the interaction of these factors with help-seeking behavior and mental health service utilization of older Mexican-Americans?
4. What is the role of the family and social networks in older Mexican-Americans accessing mental health services?
5. What factors motivate older Mexican-Americans to continue in mental health services?

## **Research Design**

### **PROGRAM SETTING & SITES USED**

#### **Program Settings**

The research settings are outpatient mental health programs for older adults. The researcher selected six programs located in Texas: Austin, Cuero, Del Rio, Luling, San Marcos, and Seguin. The researcher selected the programs based on the similarity of programs, geography, and familiarity of program staff. The researcher has developed working relationships with staff at all of the chosen sites. The researcher has worked at two of the programs, in Seguin and San Marcos, as a therapist in the past. The researcher also conducted focus groups for a separate research project in the past at the Austin, Luling, and Seguin sites. Having familiarity with the agency staff helped with recruiting the sample. The agency staff was comfortable with a researcher they knew. Because of contacts at the San Marcos site, Cuero and Del Rio were willing to assist the study. One conflict with having worked at two of the sites was the possibility of interviewing a respondent with whom the researcher had a previous clinical relationship. This only occurred once, and that clinical relationship had ended over 5 years prior to the time of the interview. Based on these established relationships, gaining entry into the selected sites came with minimal difficulty. The selected sites agreed to assist in this study. The researcher provided written assurance of access as part of the Human Subjects Review process.

These outpatient mental health programs for older adults are located in hospitals that provide acute care. Acute hospitals provide inpatient medical care and other related services for surgery, acute medical conditions, or injuries. The treatment for these medical conditions or injuries is usually short term. The staff for the outpatient mental health programs for older adults usually consisted of a registered nurse, two licensed master social workers, two administrative staffers, and one psychiatrist—the medical director. For each older adult admitted as a patient, the program offers group therapy, education groups, and individual counseling as ordered by the medical director. Staff from the six programs assisted this study by helping in the recruiting of sample respondents. Staff identified prospective participants that met the sample selection criteria discussed in the next section.

#### **SAMPLE SELECTION CRITERIA**

The researcher conducted interviews with a purposive sample of older Mexican-Americans, 65 years of age or older, which had completed an outpatient mental health program. The researcher interviewed respondents one time for the study. The researcher interviewed 20 older Mexican-Americans. The researcher began the study with the assistance of four agencies. The study sample was difficult to find as the number of older Mexican-Americans attending treatment programs is low. Two additional agencies were added to help increase the sample.

The researcher stopped at 20 interviews because saturation of the data was reached.

The criteria for sample selection was a respondent who had completed the program in the past 12 months, experienced a reduction of depressive symptoms and scored 24 or above out of 30 on the MMSE. The definition of completed the program was the agency staff's clinical decision. This decision meant that respondents for this study completed the program because they met all clinical goals, and had a reduction of signs and symptoms of a mental disorder interfering with their functioning, for example a reduction of depressive symptoms like depression, anxiety, or sleep problems. Agency staff used the Geriatric Depression Scale (GDS) scores to help confirm a reduction in depressive symptoms. The Geriatric Depression Scale (GDS) is a self-report inventory useful in determining the degree to which older individuals experience symptoms related to depression. A score of five or above indicates probable depression (Sheikh & Yesavage, 1986).

Agency staff also used the Mini Mental State Exam (MMSE), a test of cognitive functioning; this test determines the patient's cognitive abilities (Folstein, Folstein, & McHugh, 1975). The researcher chose a score of 24 or above for participants in the study. The researcher selected these criteria because respondents were more than likely to have few issues that could interfere with the interview process, issues such as cognitive difficulties and/or impairments in

functioning. The respondents were more than likely to be good historians, participate in the interview, and provide in-depth information.

In this study, the researcher examined the perspective of the client; the case record was not of interest to the researcher for the analysis of this study. Therefore, the researcher did not access the case record. The staff accessed the case record to assist in recruiting the sample. The staff reviewed case records to identify patients who met the sample selection criteria.

#### **RECRUITING STRATEGY**

The agency staff that work with the participants of the outpatient mental health programs assisted in recruiting the sample of older Mexican-Americans. Agency staff was best suited to identify the participants of the outpatient mental health programs because they had a pre-existing relationship with these participants. The researcher met with the staff to explain the study's purpose and the sample selection criteria. The researcher provided each staff member an information sheet (Appendix A) as a reminder of the study. The researcher provided the staff with an information letter (Appendix B) that described the purpose of the study and included the researcher's contact information.

The staff accessed patient records to identify participants, older Mexican-Americans that met the sample selection criteria. The staff used the telephone script (Appendix A) provided by the researcher to call the prospective participant to describe the research study. The staff then gave the researcher's contact

information to prospective participants interested in taking part in the research study. The staff also mailed an information letter (Appendix B) that described the study and the study's goals, and the informed consent to the prospective participant.

### **PROCEDURES**

Once the participant contacted the researcher by phone or mailed in the informed consent, the researcher called the participant to schedule an interview. During this phone call, the researcher introduced himself, answered any questions the participant had and scheduled the interview.

The respondent chose the location and time of the interview. The interviews took place in the home of the respondent. The researcher obtained informed consent before the start of the interview. Procedures included reading the informed consent letter to subjects, addressing any questions about participation in the interview, and providing a copy of the signed form to the interview subject. The researcher administered the informed consent and the interview in the language that the participant preferred, English or Spanish or both. The researcher audiotaped the interview with the respondent's consent.

### **SAMPLE CHARACTERISTICS**

The researcher used the demographic information to describe the characteristics of the sample including age, gender, nativity, education, and income, type of health insurance and living arrangements, and household

composition (Table 4.1). The sample was acculturated to the health care system, and they were regular consumers in that system. All of them had a regular physician.

With regard to gender, the sample had more females (18) than males (2). With regard to language spoken during the interviews, two respondents spoke English, 11 respondents spoke Spanish and seven respondents spoke both languages. With regard to nativity, tenure in residency in the United States, thirteen respondents were born in the United States and seven respondents emigrated from Mexico. The marital status of the sample broke down to six respondents being married, nine being widows, and four being divorced; one respondent was never married.

The education of respondents ranged from no education to a Master’s Degree. Eight (40%) respondents had education of at least high school. Twelve respondents (60%) had education less than high school with 8 (40%) having at least 6 years of education and four (20%) had less than 6 years of education.

The income of respondents ranged from an annual income of \$6,000 or less to an annual income up to \$35,000. More than half of the respondents (13) had an annual income of \$10,000 or less.

Table 4.1 Sample Characteristics (n = 20)

<u>Gender</u>		2	18
	Males		Females

<u>Language spoken during interview</u>		
English	Spanish	Both
2	11	7

<u>Age</u>	
65-69	5
70-75	12
80-<	3

<u>Nativity</u>	
U.S. born	immigrants
13	7

<u>Marital Status</u>	
Married	6
Widowed	9
Divorced	4
Separated	0
Never married	1

<u>Education</u>	
Less than high school	12
High school	3
Some college	2
Bachelor's	1
Master's	2

<u>Health Insurance</u>	
Medicare	20

Medicaid	12
Private insurance from employer	3
Private insurance purchased	1
Health insurance for veterans	1
No Supplemental Insurance	3

<u>Income</u>	
Annual	
\$6,000 or less	1
\$6,001 to \$8,500	7
\$8,501 to \$10,000	5
\$10,001 to \$12,500	2
\$12,501 to \$15,000	1
\$15,001 to \$25,000	1
\$25,001 to \$35,000	3

<u>Living Arrangements and Household Composition</u>	
<i>Number of people in the household</i>	
Lives alone	10
Two people in house	3
Three or more people in house	7

<i>Relationship to head of household</i>	
Respondent is head of household	14
Spouse	4
Sister	1
Son-in-Law	1

<i>Did you come to live with them or did they move in with you?</i>	
Lives alone	10
They came to live with me	7
I came to live with them	3

With regard to living arrangements, half (10) of the sample lived alone. The other half (10) of the sample lived with family—three respondents living with two or more family members and seven respondents were living with three or more family members. Three had a son or daughter come to live with them. Two had a son or daughter and their spouse and children come to live with them. Two had daughters and their children come to live with them. One had two of her nieces living with her. One lived with her spouse, and one lived with her sister and cousin.

With regard to health insurance, all respondents had Medicare. Supplemental insurance varied with twelve respondents having Medicaid, three respondents had private insurance or health insurance for veterans. Three respondents reported no supplemental insurance which can result in co-payments for services. Insurance was not so much a barrier for the sample with the exception of the three who did not have supplemental insurance. Paying for the program was not an issue for most of the sample, because they had insurance. This did not impact their attendance to the treatment program.

Normally, if a prospective patient does not have adequate insurance coverage, like Medicare, Medicaid or supplemental insurance, they are responsible for a co-payment. This might influence a prospective patient to attend the treatment program for a short time or refuse to attend because of the costs.

## **Data Collection and Analysis Plan**

### **USE OF INTERVIEW MATERIALS**

The interview schedule (Appendix C) consisted of questions regarding basic demographic information and open-ended questions regarding the participant's mental distress, family involvement in helping them get to services, other sources of help to accessing services and the interaction of these sources of help.

The researcher conducted the in-depth interviews from April 2007 to September 2007. The researcher interviewed participants once, with the interviews lasting between 45 to 60 minutes. At the beginning of the scheduled interview, participants received a \$15.00 voucher to a supermarket, as compensation for the time given to participate in the interview.

The researcher wrote field notes after each interview. The researcher recorded observations and reflected on the interview. Given that the researcher conducted some or parts of the interviews in Spanish, the researcher transcribed the interviews into the language originally spoken, English, Spanish, or a combination of each. This transcription took place soon after the interviews.

Data analysis was in the language spoken in the interview, English, Spanish, or a combination of both. Translation of data, if necessary, took place during the writing phase of the study. Data analysis was ongoing throughout the

interview process and continued through September 2007 when all interviews were completed.

### **DATA ANALYSIS**

Ethnographic content analysis was the approach the researcher used to analyze the transcripts. Ethnographic content analysis centers on concept development, data collection, and emergent data analysis through repeated study of the content or text. Ethnographic content analysis encourages content analysis accounts to emerge from readings of text. The approach works well with categories as well as with narrative descriptions, but focuses on situations, settings, styles, images, meanings, and nuances to be recognizable by the human actors/speakers involved. Ethnographic content analysis follows a recursive and reflexive movement between collection, coding, and analysis and interpretation of data. The aim is to be systematic and analytic, but not rigid. Categories and variables initially guide the study, but others are allowed and expected to emerge throughout the study. It is oriented toward clear description and definition, which is often guided by theory (Altheide, 1996; Stark & Roberts, 2005).

Using Green's Adapted help-seeking behavior model to guide the analysis, the researcher used the components of the model in developing codes and categories and ultimately themes of the data. The components of Green's adapted model from the client culture provided the beginning categories for the data analysis. The beginning categories included client problem recognition, client

problem labeling and diagnosis, client utilization of help providers, and problem resolution. The analysis was not restricted to only components of Green's adapted model, as ethnographic content analysis is recursive and reflexive. As the analysis progressed, the researcher was open to other categories, codes and themes for example stigma was an additional theme. Lastly, the researcher identified factors that older Mexican-Americans use to cross into the professional mental health culture and the interactions of these factors (Altheide, 1996).

The researcher followed the steps Altheide (1996), describes as the process of ethnographic content analysis:

1. The researcher listed several items and categories to guide data collection and draft the interview protocol. The researcher used Klienman's Explanatory model (1980) and Green's model of help seeking (1999). The interview protocol contained questions regarding basic demographic information and open-ended questions regarding the participant's mental distress, family involvement in helping them get to services, other sources of help to accessing services, and the interaction of these sources of help. The sources of help were individual, agency or community resources.
2. The researcher collected data by conducting the interviews with respondents using the interview protocol. The interviews were semi-structured with the protocol guiding the questions. The researcher probed for more description when information was unclear.

3. The researcher examined the data to permit the emergence, refinement, or collapsing of additional categories of Green's help-seeking model. One adjustment the researcher made was to use the categories of the client culture; *problem recognition, problem labelling and diagnosis, utilization of help providers, and problem resolution*. This study is interested in the factors of the client culture; therefore, the researcher did not use the categories of the professional subculture. The researcher noted the interaction with *professional helpers, professional models, and minority professionals* like nurses, social workers, physicians and other professional helpers in the client culture categories. The researcher then completed data collection, analysis began during data collection. The researcher made no adjustments to the survey protocol.
4. In the next step the researcher performed data analysis, including coding the data, refining the concepts and themes that emerged. The researcher read notes and data repeatedly and thoroughly. The researcher placed quotes into categories using Green's model. Each component of the model served as beginning categories of factors that assist older Mexican-Americans. The components of the client culture included client problem recognition, client labeling and diagnosis, indigenous help providers, client utilization of help providers, and problem resolution.

### **Client Problem Recognition**

The category of *client problem recognition* occurred when the client noticed a change in their usual functioning, or a problem therein. This category included quotes of the respondent, the family and professional helpers that observed a behavioral change in the respondent.

### **Client Problem Labeling and Diagnosis**

The category of *client labeling and diagnosis* included quotes of the interactions between the respondent and family members, physicians and professional helpers. The respondent learned to label his/her problem based on their previous knowledge and through interactions with the family member and physicians.

### **Client Utilization of Help Providers**

In the category of *client utilization of help providers*, the quotes involved interactions with minority professionals, or professional helpers, who assisted the respondent in getting to treatment services. These providers were supportive and welcoming in assisting the respondents' use of treatment services.

### **Problem Resolution**

In the category of *problem resolution*, the quotes included interactions and linkages that assisted the respondents toward a resolution of their

problem. These interactions and linkages include help providers from the professional subculture and their family.

The last category in the client culture is *indigenous help providers*, like healers or *curanderas*. During the interviews, respondents did not mention any type of indigenous help provider. Therefore, the researcher did not use this category in the analysis.

The researcher added one category to the analysis. The category titled *other themes* was for data that were significant to the respondents and to the study.

5. In this step of the analysis, the researcher compared and contrasted “extremes” and “key” differences of the codes within each category. The researcher decided on which category’s codes fit best as the analysis progressed. The researcher identified emergent themes within the categories and the interaction of the themes. The researcher also added to the category “other themes” codes that did not fit into the categories from Green’s model.
6. Lastly, the researcher integrated the findings with an interpretation and with key concepts in another draft. The researcher presented the final draft of factors that bring older Mexican-Americans into mental health services.

## **Standards of Verification**

Trustworthiness of the data in a qualitative study is significant. A researcher can characterize a study's trustworthiness by the study's credibility, transferability, confirmability, and dependability (Guba and Lincoln, 1994). *Credibility* "refers to the truth, value and believability of findings" (Leininger, 1994, p. 105). *Confirmability* is the idea of obtaining the same results through observation and interviewing of respondents. *Transferability* refers to whether a researcher can transfer particular findings from one qualitative study to another with similar context or situation, and still preserve the particularized meanings, interpretations, and inferences from the complete study. Transferability focuses on general similarities of findings under similar environmental conditions, contexts, or circumstances. (Leininger, 1994) Transferability refers to the degree to which particular findings from an interpretive study 'can be transferred to another similar context or situation and still preserve the particularized meanings, interpretations, and inferences (Leininger, 1994, p. 106). Koch (1994) states in his discussion that one way *dependability* can be ensured is by providing a written audit trail or decision trail. The study employed peer debriefing and an audit trail to enhance trustworthiness or rigor in this study.

### **PEER DEBRIEFING**

The researcher met monthly with Dr. Lein for peer debriefing sessions to serve as a check on the study. These sessions were a chance for feedback on

interpretations and an opportunity to explore new ideas for interviewing and data analysis (Creswell, 1998; Padgett, 1998). The researcher kept written documentation of the sessions. Debriefing sessions provided fresh eyes and a fresh perspective for the researcher's analysis. These sessions helped determine when the researcher reached saturation, and were a time where new questions arose upon which the study could follow up. Debriefing sessions provided an opportunity to review transcripts, field notes, coding, and analysis. Essentially, these sessions also served as a check on leaving an audit trail.

#### **AUDIT TRAIL**

The audit trail consisted of steps taken in data collection and data analysis, as well as interview transcripts, field notes, notes from peer debriefing sessions, and coding and analysis (Creswell, 1998). The audit trail helped the researcher look back at the steps in this process and review directions that might need consideration in interviewing and analysis. If problems arose in the recruitment of respondents, or in the interview questions, reviewing the audit trail helped in thinking of ideas to remedy them. The debriefing sessions also helped with these same issues. The sessions and the audit trail served as a check on the researcher, with respect to interviewing, coding and analysis.

## **CHAPTER FIVE**

### **Findings**

The purpose of this study was to answer the question “What factors influence help-seeking behavior and mental health service utilization of older Mexican-Americans?” The goal of this data analysis is to explore and describe the factors that led older Mexican-Americans to access outpatient mental health treatment.

This chapter presents the findings for each of the sub questions. The respondents’ perception of mental illness, the individual, agency, and system-level factors that influence respondents help-seeking behavior, the effect of the interaction of these factors on mental health service use, the role of the family and social networks on mental health service use, and the factors that motivated respondents to continue in mental health treatment. Next, the researcher applies Green’s Help-Seeking Model to the findings. In this section, the researcher discusses the categories of the client culture, including client problem recognition, client labeling and diagnosis, client utilization of help providers, and client problem resolution. The chapter ends with a presentation of other factors that influenced the respondent’s help-seeking and mental health service use.

In the literature review of this dissertation, the author presented a discussion of several barriers to mental health service utilization for older Hispanics and older minorities. Barriers to utilization such as acculturation/age of

migration, unsatisfactory communication/linguistics, access to insurance, poverty, education, culture and religious beliefs. In the analysis of the data, one of the key findings is that the respondents did not report the barriers to utilization as discussed in the literature. The respondents reported a different experience with some of these barriers. It is not clear if they did experience the issue as a barrier, or did not admit to one of the barriers being an issue. The researcher presents the findings from the perspective of the respondent.

#### **WHAT ARE OLDER MEXICAN-AMERICANS' PERCEPTIONS OF MENTAL DISTRESS?**

Transcripts revealed that respondents experienced a multiplicity of causes of mental distress, a multiplicity of behavioral signs of mental distress. Respondents had many problems ongoing at one time. These problems occurred one after the other, and at times occurred simultaneously. The multiple problems had a cascading effect on the respondents, leaving them feeling piled on by the time they went to the treatment program to get help with their mental distress. In the answer to this question, the researcher illustrates respondents' causes of mental distress, and gives examples of the different behavioral signs reported. These presentations are simple; the experiences that respondents reported were complicated. In the last section the researcher presents, the label or the name respondents gave the problem is discussed.

### **Causes of Mental Distress**

When asked ‘What do you think caused your problem/sickness?’

Respondents discussed several causes of mental distress. In describing the events surrounding their problem, respondents also described more than one issue that contributed. Along with the perceived cause of their mental distress, respondents also had other on-going issues like health (diabetes or cardiovascular issues), or family problems (a son in prison or a daughter battling an illness). Respondents experienced multiple issues in their lives, leading them to seek help for their mental distress as described in the following examples of respondents’ perceived causes of mental distress.

The perceived causes of mental distress included grief issues, relationship issues, health problems, and physical complaints. Nine respondents reported grief of a loved one—a spouse, sister, or children. Five respondents reported the cause of their distress was a marriage problem —divorce or separation. Two respondents reported health problems—breast cancer, heart attack—as causes of distress. Two respondents reported physical complaints—stomach problems or insomnia—as their cause. One respondent reported financial worries and one reported family problems; her son was in prison.

#### ***Grief of a loved one***

One respondent grieved the death of her husband of 53 years. She missed him, and felt sad and alone. Her sons did not live with her; they have their own

families, leaving her alone. She had several things on her mind, leading to anxiety. Her leg was hurting, she was afraid of losing her leg and ending up in a wheelchair. She thought and thought about how she would make it alone.

Bueno, el problema que me condujo al programa fue de que este murió mi esposo. Entonces me sentía sola y triste porque mis hijos no viven conmigo.

Her body started to hurt all over and she stopped eating. She would cry and cry. She had never had this problem, and did not know about depression. She was not sure if she would get better.

Another respondent's husband passed away after open-heart surgery. She reported that it all happened so fast. He had the heart surgery and looked like he was doing well. The doctor sent him to a nursing home for rehabilitation. While he was in the nursing home, she stayed with him all day and night. Her son paid for the room. Her husband was there for almost two weeks, and she noticed that he was not making progress; he also was not eating well. Her husband developed an infection in his leg, where they took veins for the heart surgery. She decided to spend one night away with some of her friends who invited her to stay at their home.

Cuando regresó al hospital en la mañana, llegó al cuarto y ya se via fallecido mi esposo. Cuando se fueron todos. Cerré la puerta y de plano que hago sola. Entonces fue cuando comencé a llorar. Cuando me sentí completamente sola.

When she returned the next morning, her husband had passed away. Everyone left the room, and she started to cry. That was when she felt all alone.

One respondent first went to the treatment program because her husband had passed away, leaving her anxious and depressed. The program helped her cope with his death. After her first visit to the program, her *nervios*, or her anxiety, went away. She returned to the program two other times after that because of problems with her sons.

Pues yo mis problemas eran, de un principio fue mi esposo. Bueno se me fue, no es que lo olvide. Pero si se me fue, era muchos nervios que yo tenía. Después como le digo mis hijos se fueron por esa droga. Los encerraron, todavía tengo uno allá encerrado. Y ese era pues puros problemas que yo tenía.

Both of her sons have had legal and substance abuse problems that led them to prison. The older son had been in jail for a while and her younger son had been out of jail for a short while and returned to his old behaviors. During the interview, she shared that he was in substance abuse treatment.

One respondent's sister, the last remaining member of her family, passed away. All of her family had passed on: her parents and all of her brothers and sisters. While she was still married and had the support of her daughters and sons, she focused on being the last living member of her family.

La falta de mi hermana. Ella falleció y ya me quede sola. Toda mi familia se murió no mas yo y mi hermana. Ella se me murió mi hermana y la sentí mucho. De atiro me calli muy triste, lloraba mucho y no mas me acostaba y me dormía.

She reported growing extremely sad. She would just cry much of the time and she would lie down and sleep. When she would think of her sister, she would roll up like a little ball and cry.

Another respondent talked about losing her son after his long battle with cancer. She had a difficult time coping with his death, even though she had known he was dying. She had difficulty concentrating because of her grieving. She said she felt like she “was not in reality.” She would sleep and cry all day, and could not get over her son’s death. She said, “I couldn’t even say his name.” She went “through all of those steps of denial and anger and asking why, being very unsure of me and crying a lot.” Her physician recommended counseling and sent her to treatment.

### ***Relationships***

A problem with relationships was another cause of distress. One respondent talked about having much stress in her life—a daughter who had been ill for several months and problems with her husband. She also talked about having anxiety attacks with her body shaking, something she had never experienced before. She shared that she had tried to hurt herself. Then she had a heart attack. EMS arrived and took her to the hospital. Her daughter-in-law told the paramedics that she had also tried to hurt herself. Once in the hospital, a social worker referred her to the treatment program, and she realized that her problem

was “a marriage problem. It is not my children; it’s my husband.” She also shared that she was grateful to her daughter-in-law for telling the paramedics she had tried to hurt herself.

One male respondent talked about his problem separating from his wife. He had been married for 25 years. He decided to move to a new city, a place where one of his daughters lived. He was beginning a new life in a new place and did not have any friends.

Lo que pasó, es que, nos separamos yo y mi senora. Entonces como mi chamaca aquí vive una de ellas me trajeron para acá. (to San Marcos, daughter lives in San Marcos). Y la separación de la señora. Íbamos a completar como veinte y cinco años estar juntos. Eso me tumbo. Cuando vine aquí, pues la renta, el lugar este. No conozco a nadie. Cosas así es que. Pues me callí de atiro.

He felt depressed, very depressed and could not sleep. He did not sleep most of the night. His only support was his daughter and she eventually contacted his doctor and the program.

Another respondent also experienced multiple stressors. She was recently divorced and was losing her eyesight to diabetes. She was feeling overwhelmed and frustrated. She was having a difficult time because of the divorce and her “vision was going down more and I could not handle it.” She did not have much as her husband took many things in the divorce. She had no income. She did have the support of her daughter and some friends. A friend referred her to the treatment program.

### ***Health Problems***

Some respondents' problems began with a health problem like a heart attack or breast cancer, and then another problem developed in coping with that original problem. One respondent's problem started with a diagnosis of breast cancer. Her husband had difficulty accepting his wife after her mastectomy leading to marital problems. "I got cancer and my husband rejected me." She talked about her marriage changing after her mastectomy. Her husband changed from "the perfect husband, the perfect father, the perfect son-in-law, the perfect brother, he is perfect." Their relationship changed, no socializing, everything felt like it was false to her. He never moved out of the bedroom. She felt depressed and very unhappy. She also considered leaving her husband. She then found help at the program.

Another respondent had a heart attack and felt *coraje*, anger. She was not angry with anyone in particular, just angry that she had had a heart attack, "no tenía coraje con nadie no mas con mi porque me pegó el heart attack." Respondent experienced a big change in her way of living, "porque I was used to myself. I was used to going places." Before the heart attack, she was taking care of her sister; now her sister was taking care of her. She became dependant on others for help, something new for her. Her nephew, a physician in the community, recommended the treatment program to her.

### ***Financial Problems***

Finances were the problem for one respondent. “I would have to say that my depression is monetary because we were in debt and I can’t see myself through,” she said. This led to hospitalizations on three occasions. She talked about each time she and her husband were in debt and owed too much money. She usually took care of the bills and kept track of everything on a calendar. Each time the money was low, she would get depressed and anxious, losing interest in everything. She had a hard time seeing how they were going to pay all of their bills. She felt bogged down, and could not see a solution or “a way out.” She would get “a terrible feeling.” Finally, her husband noticed her behaviors and took away the financial responsibilities. Then he took her to the doctor for help.

### **Behavioral Signs of Distress**

Respondents expressed their mental distress, with multiple signs of distress occurring at the same time. Respondents came to the treatment program experiencing multiple signs of depression, anxiety, or both. In the interviews, respondents described experiencing eight behavioral signs of mental distress. The behavioral signs were all similar to symptoms of depression and anxiety. The symptoms that respondents described included depression, anxiety and *nervios*, sleep problems, crying, isolation, lack of energy, appetite problems, loss of interest in activities, and physical complaints. The symptoms that respondents reported centered on depression and anxiety, *nervios*. During the interviews,

respondents discussed experiencing multiple symptoms at a time, for example depression, wanting to sleep all day, and crying. All respondents reported experiencing at least two symptoms. Thirteen respondents reported three or more symptoms of distress.

### ***Depression***

Thirteen respondents reported the symptom depression. One respondent described her depression as thinking of her husband who had passed on. She also was having problems with her leg because of diabetes. Her depression began with symptoms such as appetite problems, crying, and physical complaints.

Entonces no quería comer, lloraba, y me sentía triste tu sabes. Estaba sola. Yo pensaba mucho porque yo creía no iba sobrevivir. Ya empecé con eso que me dolía mucho el cuerpo, no quería comer, llorar. Todo eso lo sentía y todavía no sabía que era depresión.

Her whole body started to hurt. She would not eat; she did not want to eat. She just cried. She was feeling very sad. She did not think that she would survive. She did not know what depression was at the time.

### ***Anxiety, nervios***

Ten respondents talked about anxiety or *nervios*. A respondent reported always suffering from *nervios*. She would suffer from anxiety, not depression. She talked about coping with living alone, her husband having moved to a nursing home. She also talked about her sons not visiting her. In the past year, she thought

she was going crazy, and experienced intense anxiety. She talked about walking around her apartment in circles.

A mi me daban los nervios, pero no la depresión. La ansiedad. Y eso no me había dado a mi. A mi me dio con fuerza. Y no sabía yo que era. Por eso yo caminaba y caminaba. Y encerrada aquí. No salía para ninguna parte.

She also mentioned two other symptoms: sleep and appetite problems. She would not stop to eat dinner or lay in bed. She was not sleeping or eating. She would walk and walk around in her apartment. She did not leave her apartment at all.

### ***Sleep problems***

Sleep problems, occurring with depression, were another symptom that respondents experienced with mental distress. Seven respondents talked about sleep problems during the interview. Five of those respondents also talked about depression. One respondent wanted to stay sleeping because of her depression “a mi, mi depresión fue querer estar dormida.” She felt depressed because one of her sons was in prison. She would always think about him. This was her reason for wanting to sleep so much. She would only get out of bed when her other children visited her.

Another respondent, who was grieving her husband, reported having sleep problems, depression, and problems with her arthritis. She thought she had some illness; she did not know what was wrong with her. She did not want to go outside, just wanted to sleep. “Yo creía que era una enfermedad. No quería salir

afuera, quería estar dormida. Algo así sentía yo.” She did not think there was a remedy for her condition. She just wanted to stay in bed.

On the other hand, the respondent who had separated from his wife and moved away to begin a new life, reported depression and sleep problems. He would not sleep. He stayed awake all night “no dormía. Me pasaba toda la noche despierto, se me iba el sueño.” He would spend nights thinking about his wife and his new life. He would not get sleepy and spent his nights awake.

### ***Crying***

Six respondents talked about the symptom crying, which occurred with depression and anxiety, *nervios*. One respondent would cry and roll up like a little ball, when she thought of her sister that had passed away, “me acostaba como una bolita chiquita. Y me dormía mucho, y ya no sabía que me estaba pasando.” Every time she thought of her sister she would go to her bed, lay down, and just cry. Her husband would tell her not to lie down but she would anyway.

Another respondent that reported depression and crying talked about crying when she would grieve for her husband. She did not know what was happening to her. She had never had this illness and did not know what it was, “nunca vía estado en una enfermedad de esas. No sabía que fuera.” She missed her husband very much.

### ***Isolation***

Five respondents talked about the symptom of isolation. Respondents would not leave their home or apartment. Four respondents who reported depression also reported isolation. Respondents talked about having no desire to go outside or leave their home. Three respondents who talked about isolation also reported the symptom sleep problems. Respondents reported isolating themselves from their families and friends. One respondent who was dealing with a recent divorce and complications from diabetes described her isolation.

I am the type, if I start getting depressed, I start shutting the house up. I will stay in my room back there and just don't bother me. I won't answer the phone, I won't answer the door. I would not do anything but stay in my room.

She would lock her self in her room and not talk to her family or friends who would attempt to get her to come out of her room.

### ***No energy***

Four respondents talked about having no or low energy. Two of the four respondents also reported depression and two of the four respondents reported anxiety. One respondent who talked about depression and anxiety had no energy. She talked about the stressors that led to her heart attack—problems with her husband, her daughter battling a long illness. She felt overwhelmed, and did not want to be bothered. She did not have the energy to listen to others or watch television.

I didn't have energy and didn't want to do things. I didn't want anybody to bother me. I would stay in my room and lock the door. I would not hear everything; I would watch TV but not know what they were saying. I would only focus on the light, a small focus.

### ***Appetite problems***

Four respondents talked about having appetite problems, having no desire or will to eat. One respondent who experienced depression because of the loss of her husband talked about such problems. She also experienced crying. She did not want to eat; she would cry and feel sad. "Entonces no quería comer, lloraba, y me sentía triste tu sabes. Estaba sola."

### ***Loss of Interest in Activities***

Three respondents talked about losing interest in activities, activities such as family time and everyday activities. Family activities like going to gatherings or family dinners and everyday activities like cooking or hobbies such as reading and watching television. One respondent described such a loss. She also experienced the symptom of depression due to marriage problems. She stopped doing her regular activities with her family, like shopping and going to dinner.

I just wanted to be just by myself. I didn't think about my children, my brothers or sisters. They would invite me to the store and I would do nothing. "Let's go and eat mom, no, I don't want to go." I was so depressed with myself that I didn't care for nothing.

She would tell her family “no” when invited to dinner or to shop. She had no desire to spend time with her children. She also talked about losing interest in everyday activities like cooking. She had a difficult time coping with depression.

Another respondent, who was divorced, talked about having depression and adjusting to a new home. She had recently moved to a different state, and was new to her community. Though she had the support of her sister, she stopped “watching television, listening to the radio or reading, things that I enjoy doing.” She also reported problems with sleep and isolation.

### ***Physical complaints***

Five respondents reported having physical complaints, like stomach problems, head and body aches as symptoms that occurred with depression and anxiety. Three respondents were U.S.-born, and two were immigrants. The respondents that complained of physical complaints had lower education and lower income. One respondent reported stomach problems and depression. She had pain in her chest, close to her heart and stomach.

Oh no, yo en veces traigo una cosa aqui asi (she motions to her chest, below her heart and above her stomach). Como un depressed, como ahorita a las cuatro se iba ir mi hijo. Y me dijo que me iba hablar antes que se fuera por que el bus salía a las cuatro. Y no me hablo. Y pues me dio... me sentí muy mal.

This would happen when she thought of her son, who had been to prison in the past and was in a substance abuse treatment program. She would pray for him to change his ways.

Another respondent who reported anxiety and crying talked about physical complaints. She would get headaches when she would think of her sister “en veces me dolía la cabeza por que pensaba mucho de ella.” She would spend much of her time thinking about her sister. She was the last member of her family to pass on. She could not forget her.

**Name of Illness**

When asked what name they gave their problem, respondents reported different names. Among the names used for the problem that led them to treatment were depression or *depresión*, anxiety, *nervios* or *ansiosa*, also *coraje*, *soledad*, and *tristeza*.

Table 5.1 Name of Illness

<i>Depression – Depression</i>
<i>Ansiosa/Nervios – Anxiety</i>
<i>Tristeza – Extreme Sadness</i>
<i>Soledad – Extreme Loneliness</i>
<i>Insomnio – Insomnia</i>
<i>Coraje – Strong anger held inside and it is hard to let go of or get over.</i>

Eight respondents used the name depression for their problem, “depression was the best word to use.” One respondent talked about feeling depressed, “yo lo sentía que tenía depression.” Six respondents used the name *depresión*.

Respondents described their depression or *depresión* using symptoms like having no energy, no desire to interact socially with their family, and wanting to stay in bed and sleep all day.

Three respondents used the term anxiety, one used *ansiosa*, nervous, and five used the name *nervios*. Respondents described anxiety or *nervios* as having anxiety attacks, loss of interest in everyday activities, and having no energy. One respondent shared she has always had nerves, “yo todo el tiempo a padecido de los nervios.” Another respondent shared that she had *nervios*, not depression. For her it was anxiety. “A mi me daban los nervios, pero no la depresión. La ansiedad.”

One respondent who was grieving her husband called her problem *soledad*, loneliness. Another respondent that lost her sister, the last remaining family member called her problem *tristeza*, extreme sadness.

One male respondent used the name *insomio*, “no, mi problema era no dormir. Falta de sueño. Se le llama insomnio.” He did not use the word depression or *depresión* in the interview. He just reported having problems sleeping.

One respondent called her problem *coraje*. The respondent used the term to mean more than just anger or rage. The anger she described is strong anger held inside, hard to let go of or get over. It is more than a feeling of anger. To her *coraje* is something that she has, something she is experiencing. She blamed the *coraje* for her mental distress. The respondent was very angry because she had a heart attack, limiting her independence. This was a big change in her life, “si, un cambio muy grande. Por eso me agarró mucho coraje.” The change was the

reason she had so much anger. Her *coraje* grabbed hold of her. She blamed losing her independence on having the heart attack, and could not let go of this anger. Her sister told her she was depressed.

**WHAT INDIVIDUAL, AGENCY, AND SYSTEM LEVEL FACTORS INFLUENCE HELP-SEEKING BEHAVIOR AND MENTAL HEALTH SERVICE UTILIZATION OF OLDER MEXICAN-AMERICANS?**

Several factors influenced respondents' help-seeking behavior and mental health service use (Table 5.2). The factors that influenced respondents were the recommendations of family, friends and former patients of the treatment program, physicians and other healthcare providers. Respondents made the decision to go to treatment after listening to their physician, their family or friends, and other health care professionals. Respondents reported several paths using the factors listed (Table 5.2). The only clear paths reported involved the physician and the family, with either being a starting point. The paths were not necessarily linear; rather, they were dependent on who the respondent talked with about their mental distress. Respondents also had discussions with others i.e. other healthcare providers and friends with the discussion always coming back to the family and the physician.

Many of the respondents, particularly those with little education, did not know about depression until their physician or family told them, or learned about depression after they arrived at the program. The physician was a key person in the network of referrals. Respondents with more education had an easier time making the decision to go to treatment. The family members respondents

mentioned as having influenced their mental health service utilization included spouses, daughters, sons, sisters, nephews, and grandchildren. Respondent's daughters (14) had the most influence on service utilization. The health care professionals that respondents mentioned as having influenced their mental health service utilization included physicians, nurses, social workers, and support groups.

Table 5.2 Factors that influenced Help-Seeking Behavior/Mental Health Service Utilization

Family – Spouse, Daughters, Sons, Sister, Nephew, Grandchildren
Physician
Other Health Care Providers – Home Health Nurses, Hospital Social Workers, Support Groups
Friend/Former Patients
Cable TV Information Channel

***Family***

Respondents talked about family, friends, and health care professionals in the community who helped them. All respondents had help from their family, except for one who had no living family. Family members working in health care helped respondents get to the treatment program. One respondent's daughter

worked at the hospital where the treatment program is located. She called the treatment program and made an appointment for her mother. Another respondent who suffered from depression because of a heart attack was referred to the program by her nephew, a physician in the community.

### ***Physician***

A respondent's physician was significant factor to their utilization of services. The physician would direct family and other healthcare providers in helping respondents get to the treatment program. Half of the respondents (10) went to the treatment program after physician referral. Physicians told respondents they needed to get treatment because they had done all they could for them, like laboratory tests and thorough examinations—particularly those respondents who complained of stomach problems. One respondent told of her doctor sending her to the treatment program after such measures had been exhausted. "I didn't have no choice, my doctor sent me there. My doctor told me that was the place for me to go." In another case, the physician talked with the respondent and her husband about entering the treatment program, "He recommended it and we talked about it. We thought it was a good thing to enter this program."

### ***Other Health Care Providers***

These health care providers had a working relationship with each other. They were the help providers in the respondents' community. The help providers

knew the treatment program staff, and referred their clients to the treatment program regularly. They also worked with the physicians in the respondents' community.

Home health staff that worked with respondents also recommended the treatment program, as was the case for two respondents. One respondent talked about the home health nurse that recommended the treatment program to her "las enfermerda de home health viene para chequiar cada ocho dias." The nurse explained to the respondent the treatment program, and contacted the program manager.

### ***Friends***

Two respondents had friends tell them about treatment. Both friends were former patients of the program. One respondent's friend, from a nutrition site she attends, referred her to the treatment program, "ella tambien estaba allí en el programa." Another had a friend who had completed treatment told her about the treatment program, "my friend Victor recommended me to the program."

### ***Cable Television***

One respondent learned about the program while watching television. She had tuned in to a cable channel that provides local information.

One day I was watching TV and they put out a local announcement. I happened to flip to that channel and it advertised the program. At that time, I was feeling very depressed. And I would get anxiety, when I get

the anxiety it lasts two or three weeks. I get into a fetal position, I can't get out.

In her depression and anxiety, she would watch television and flip through the channels on cable television.

**WHAT IS THE INTERACTION OF THESE FACTORS WITH HELP-SEEKING BEHAVIOR AND MENTAL HEALTH SERVICE UTILIZATION OF OLDER MEXICAN-AMERICANS?**

The interactions of the factors listed above (Table 5.1) centered on the theme of relationships. The relationships respondents had developed were significant. It was important to respondents to experience close, family-like relationships with health care professionals involved in their care. Respondents discussed several relationships that worked together and with each other to help them get to the treatment program. The relationship with their physician was central to the respondents.

**Physician**

For many respondents, the physician managed their care, particularly when it came to attending mental health services. Respondents had long, trusting relationships with their physicians. The physicians could tell how their patients were doing. Eight respondents said their physician told them that they were depressed. Respondents talked about how their physicians knew when they were not their usual selves.

He knows me. Like he told my daughter, I know your mother and your mother is not a complainer. This person here is not your mother.

For respondents that complained of stomach problems (4), their physician would run medical tests, like checking their blood, before telling them there was nothing wrong with their stomach or their body. The physician had done all that he could for them and told them they were depressed. The physicians then discussed the option of the treatment program and explain to the respondent that the treatment program would help them. These respondents did not know or did not understand that they were experiencing depression and these feelings gave them stomach pains. These respondents also had little education and low income. They did have family support.

One respondent talked of her physician who sent her to a cardiologist and other specialists. Her physician told her that physically she was well, that she was depressed and he wanted her to go to a treatment program for help.

Entonces le dije yo, porque doctor yo no estoy loca. Nadien a dicho que estas loca, tu eres una persona que hablas muy bien. Eso es depresión. Dijo, yo quisiera que fueras (al programa).

She was reluctant about going to treatment at the beginning, and told her physician she was not crazy, *loca*. The physician also assured the respondent that she was not *loca*, crazy because she needed treatment for her depression.

Another respondent talked about her physician prescribing her different medication for stomach problems. The medications did not help her and she

ended up in the hospital. Her doctor told her there was nothing wrong with her stomach, “he told me, what is wrong with you is you’re depressed, anxiety.” She also talked about having anxiety attacks. He recommended that she go to treatment for her depression, that it would help her.

### **Family**

The respondent’s relationship with their family was also significant because of the role of the family in their lives. Respondents also discussed the relationship their family had with their physician. Some family members were in direct contact with the respondents’ physicians.

The family and doctor had the most interaction. The doctor would talk with the family, primarily with the daughters, and talk about respondents not being themselves. In one instance, the nephew of one respondent was also a physician in the community and had a good history of referring patients to the program. He had an established relationship with the psychiatrist of the program. In another instance, the doctor of a respondent had an existing relationship with the manager of the program.

### **Health Care Providers**

Another relationship respondents discussed was with other health care providers. The relationship between the physician and health care providers with the treatment program was also significant to respondents. This relationship helped facilitate referrals of the respondents to treatment services. These different

relationships helped by letting all involved know the status or progress of the respondent.

The relationships of the health care providers with the respondent and with other providers helped respondents make the decision to go to mental health treatment, by giving them support with their health care issues and mental distress. These providers also gave respondents education on mental illness and mental health services. Respondents had thoughts of going to a treatment program meaning that they were “crazy or *loco/a*”. Health care providers helped respondents overcome any stigma by assuring them that they were not “crazy”.

### **Agency Staff**

The agency staff also developed warm, caring relationships with the respondents. The agency staff helped make the program simple and straightforward to the respondents by treating respondents like family and creating an environment that was inviting to the respondents. The relationship with the agency staff also motivated the respondent to continue in the treatment program.

### ***Treated Like Family***

A theme that respondents described with all of these relationships was that it felt like “family.” This was significant in the interactions with their health care providers. The staff showed much respect to the respondents that attended their program. The staff was very attentive, explaining the things they learned in-

group, and helping respondents understand the reason for their mental distress, anxiety or depression. Respondents described the staff as good people— caring, attentive, and patient. This included the psychiatrists of the treatment programs. One respondent talked about the way the staff treated her and all group participants. They were very attentive and treated her well. She felt comfortable with them, like they were family. She put her trust in them, and they gave her motivation. She felt like she gained much from the program.

Me atendieron muy bien, las enfermeras y todos y el doctor. Muy bien que lo tratan a uno. Yo estaba bien agusto con ellos. Como si fuera mi familia. Mucha confianza que les puse. Por mi parte yo si estaba muy agusto y los quiero mucho a ellos. Quiero bastante. Porque primeramente ellos fueron los que me animaban de vivir. Yo saque mucho del programa.

Another respondent talked about her relationship with a therapist felt like she had a big sister. She felt listened to and understood.

Like my sister. She helped me not only in a professional sense but also in a very personal sense. Because I could talk to her about any thing that I wanted, she would listen, and she would understand.

She could open up to the therapist. She also talked about how this feeling helped her in the group therapy.

### ***Caring and Attentive***

Respondents reported that staff was attentive, caring and respectful. This made respondents feel warm, comfortable, and safe. One respondent shared her

experience with the staff and her feelings. The staff took care of her, if she wanted a snack or coffee, they would bring it to her.

They made me feel warm. They were very attentive and caring, respectful. Whenever I needed something, I would ask and they were there to help. I knew right away that I was safe.

One respondent shared that she felt happy because of the way staff treated the group, “Everybody was nice and treated you good, the staff and the members. We would do different things in the groups. I was happy.”

### ***Patience***

Respondents talked about the staff having patience to explain things in the groups and to help them understand their situation. One respondent talked about the therapist explaining to her that she needed to accept her situation and let go of her feelings of anger.

Y el doctor era muy bueno, Dr. Salas (therapist). He could explain everything to us y todo eso. Y eso fue lo que me ayudo. Ya no tengo coraje, no mas lo que tengo a aceptar. Ya lo acepte, pero poco a poco estoy aceptando mas lo que me paso.

The respondent shared that she learned to accept her situation regarding the anger she had over suffering a heart attack and losing some of her independence. After accepting her loss of independence, her anger went away.

Another respondent shared that the staff helped her understand her depression. They taught her how to think and look at the reality of her life. Respondent was depressed for a long time because her son was in prison.

Yo allí fue donde yo empecé a entender mi situación. Pues ellos están ayudando. Enseñando yo creo a pensar, a darme cuenta. La realidad de la vida. No soy la única que tengo este problema. Entonces porque tengo que estar así.

She realized that she was not the only one who had problems. She realized that her son was still living and would one day get out of prison.

### ***Psychiatrist***

The psychiatrist of the treatment program was a factor that respondents discussed. The psychiatrist respected the respondent's beliefs about treatment and medication. The psychiatrist also gave the respondent a choice when it came to treatment decisions. Respondents also noted the communication style of the psychiatrist.

One respondent talked about her experience with the psychiatrist. The respondent did not want to take medication for mental illness, though she would take medications for other medical conditions, "that is the only thing I fight with the doctors [about]."

Another respondent discussed the choice her psychiatrist presented her with in attending group therapy. The psychiatrist asked the respondent to try group therapy for a couple of weeks and if she did not like it, she would take the respondent out of the groups. The respondent found the groups very helpful.

At first when Dr. Castro (psychiatrist) suggested the groups, I said no I just want to talk to you, one to one. She said, I think they will do you a lot of good. Why don't you try it she said and if you don't like it we can just pull you out. I said OK so I went.

One respondent told of the way the psychiatrist communicated with her. She felt comfortable and understood talking to the psychiatrist, as if talking to a friend.

She comes down to where you are, meets you at that level. And that helps. She gets on a one to one, well, have you done this? Have you tried this other? Like you are talking to a friend, instead of a professional.

The factors that influenced older Mexican-Americans' mental health service utilization worked together with the respondents and with each other. Respondents described the relationships they formed with each of the factors as respectful, caring, attentive, and family like. These relationships influenced help-seeking and helped get respondents to mental health services.

#### **WHAT IS THE ROLE OF THE FAMILY AND SOCIAL NETWORK IN OLDER MEXICAN-AMERICANS ACCESSING MENTAL HEALTH SERVICES?**

The family was involved with respondents throughout the process of help-seeking and accessing mental health services. Family members helped respondents recognize their mental distress by noticing behavior signs and working with their physician. The family shared feedback with the doctor to help facilitate the respondent making the decision to go to treatment. The family motivated respondents by recognizing and acknowledging changes and progress in the treatment program.

### **Family and Problem Recognition**

Respondents reported that family members noticed their mental distress. Seven respondents said their families told them they were depressed. The family members included husbands, daughters, sons, a sister, a daughter in law, and a nephew. One respondent described how her family noticed the change in her behavior, and were glad that she acknowledged her problem. Two nieces lived with the respondent at the time. The nieces and the respondent's daughter could see her depression. The family grew tired of making plans with the respondent who would then change her mind and refuse to participate. Her nieces saw results as the respondent began the treatment program.

I think they were tired of me moping around and not wanting to do anything. After the first two weeks, they said, you know we can tell the difference. We can tell the difference, you are coming alive again. I said, "I think you are right."

Another respondent described that her daughters could see that she was having problems. She was adjusting to eye surgery and losing her eyesight. She tried to make a cup of coffee and had an accident. Her daughter could see her in distress. The daughter contacted her sisters, and they told the respondent, "mama you need to do something." Her daughters had seen respondent have problems with depression in the past, and, knowing her history, contacted her doctor for help.

One respondent said her sister told her she was depressed. She had suffered a heart attack, affecting her independence. She was adjusting to doing things with assistance.

I didn't want to believe her because why would I be depressed? I didn't have a reason or could not figure out what I was depressed from.

She felt angry about losing her independence, and did not want to believe that she was depressed. Her sister contacted their nephew, a physician in the community. Her nephew was familiar with the treatment program. He talked with the respondent and told her she needed the treatment program, that it would help her.

Another respondent discussed her husband seeing her depression returning "he always knows when I am low; he always keeps an eye on me. He realized that I was going through something that I had had before." Her husband remembered the two other times that she had become depressed. She was depressed because of finances, and because her husband had been in the hospital recently himself. She worried about his care if she went get help for her problem.

### **Family and Treatment Program**

The family helped respondents get to mental health treatment in several ways. The family provided support and encouragement as respondents attended the treatment program. The family gave respondents feedback after noticing progress, such as behavioral changes, in them. The family helped with decision making by holding family meetings.

### ***Decision making***

The family helped respondents make the decision to go to the treatment program, as well as other decisions. One respondent talked about her daughters helping her make the decision to get help for her depression and go to the treatment program. They helped her understand the treatment program and overcome any doubts she had. They helped her “to make the decision and [showed] how I would benefit.”

Another respondent said she makes her own decisions and her children provide support. If she needs help, she asks her children for help, particularly with big decisions.

Ellos me dicen que me tienen mucho respeto siempre me han apoyado. Y decisiones yo. Ahora tengo mi decision yo. Antes todo me dejaban a mi. Ahora no. Yo soy yo. Tengo mis decisiones. Tengo mi vida mia, nada mas. Se necesito algo me ayudan. Yo para hacer una cosa, la prueban ellos.

Family meetings are one way that families helped respondents make decisions. One respondent talked about having Sunday dinner with her son and his family. At this dinner, the son and his family bring dinner to the respondent.

Generalmente son mis hijos. Mis hijos me ayudan hacer decisiones. El domingo es cuando viene el y esta aqui todo el dia. Aqui comen conmigo ellos traen la comida. Y le llamamos a mi otro hijo.

After dinner, they call her son who lives in another city. Both sons give her feedback.

### ***Support***

Four respondents reported that their families did not know about the treatment program. Mental health treatment was new to some families, as was the idea of a program for older adults. Families supported the respondents' decision to attend the treatment program. One respondent shared that her husband, son, and daughter supported her decision to get help, "mi esposo y mi hijo y mi hija."

Once the respondents started the program and the family noticed changes, they became supportive of the respondent attending the treatment program. One respondent reported her family did not know of the treatment program. Once they learned of the treatment program, they were supportive of respondent in the treatment program and they were happy that she was getting help.

They didn't help me because they didn't know either about the program. When they found out about this program, they agreed. They were happy for me to get that kind of help.

Respondents talked about their family being encouraging of their attending the treatment program. The family continued the encouragement after they could see progress in the respondent. One respondent shared that her family could see the treatment program helping her. The family noticed the difference in her.

When they found out about this program, they agreed. They were happy for me to get that kind of help. The first time they visited me and they noticed the difference in me, from one day to the next. They said, mom you look good.

Another respondent said her family encouraged her to keep attending the treatment program because they could see she was getting better.

Ellos me dijeron que siguiera yendo. Porque yo me estaba componiendo. Que no dejara de ir.

Her family did not want her to miss a day of going to the treatment program. They told her that it was good for her to keep going.

### ***Noticed progress***

Respondents talked about how their families recognized the behavioral changes in them. The family observed respondent getting back to being their usual self, their usual behavioral functioning. One respondent said her family noticed the changes quickly. The family could see that she was looking better and was back to doing things like going out, cooking, and watching television.

Mi familia noto la diferencia en mi. Ahora miro el televisor y hago cena. Y todavia rezo. No a olvidado mi hermana.

Another respondent said her family saw that she had more energy and that she was not as anxious, “that I was OK. I have more energy, I am not as anxious.”

One respondent talked about getting motivation from her family because they noticed the change in her, “Pues no mas me animaban bastante.”

Spouses also helped respondents by giving feedback. One respondent talked about her husband noticed changes in her. He saw that I was not afraid any longer and said I was looking better, “ya no tengo miedo. Estoy mucho mas

mejor. Mi esposo me dice El mira mi cambio.” Another respondent said that her husband was happy that she was better. He could see the change in her face, “el esta muy satifecho por que el dice hasta en mi cara nota el cambio.”

One respondent talked about her son telling her that she was making progress in the program, he too saw it on her face: “Mi hijo me dice que si le esta hacienda bien el programa. Hasta en su cara se le nota.”

### **Daughter**

The daughters of respondents were instrumental in helping them get to mental health treatment. Fourteen respondents (70%) reported that a daughter or daughters helped them the most. Daughters helped by calling the treatment program and encouraging respondents to attend the program. Daughters also contacted programs, worked with physicians and went with the respondent to initial appointments. They explained the program to the respondent and helped get respondent to appointments and ran errands.

One respondent told about her daughter seeing her though her problem, to the extent that she took the respondent to the treatment program. She talked about her daughter being there for her and seeing her at her worst, through her anxiety attacks.

I felt so bad; I could not help having the anxiety attack. She saw it. She felt bad because she could not do anything for me. So, luckily, we got through it.

Her daughter was helpful in the respondent's learning about and, ultimately, going to the treatment program.

One respondent talked about how her daughters, who live out of town, came to help her after she had moved to a different city. Two of her daughters took leaves of absence from their jobs to help her settle into her new place and find the treatment program for her.

She took a leave of absence from her job. I have four daughters. Then she went home and another daughter came for two weeks to help me.

After both of her daughters had left, two of the respondent's granddaughters came to stay with her and help her out. One came from Colorado and the other from New Jersey. It was when "the last granddaughter left, [that] I entered into the program."

***Worked with physician***

One respondent talked about his daughter working with his doctor to help him get to help. His doctor called his daughter and recommended the treatment program for him. She then called the program to set up an appointment for him.

Pues me ayudo mucho. Yo creo que fue el doctor el que llamo a mi chamaca. Y luego mi chamaca me llamo y dijo que iba ir una enfermera para alla para la casa de ella para hablar conmigo tocante de un programa. Bueno, entonces yo fui.

A nurse from the treatment program visited the respondent to talk with him about the program, and then he decided to go.

***Told her to go to treatment***

One respondent said her daughter told her to go to the program “ella si me decia que fuera.” Another respondent talked about how all of her daughters preferred that she was attending the treatment program. “Tengo tres hijas y las tres prefieren que yo estuviera en el programa.

***Called the treatment program***

Daughters helped respondents by calling the treatment program and making an appointment for the initial assessment. One respondent said her daughter told her that a nurse would visit her. Her daughter told her to go to the program because it would help her feel better.

Mi hija me dijo. Y una señora me visitó con ella y me dijo del programa. Y mi hijo me dijo “Mom por que no vas para sentirte mas bien?”

Another respondent’s daughter was visiting from out of town and talked to the respondent about going to the program because of her depression. The daughter called and made the appointment for the respondent. That was how she started the program.

Cuando mi muchacha estaba visitando, me platicaron como me miraba y entonces ella hizo la aplicacion. Yo empece alla.

***Helped until she was used to program***

A respondent talked about her daughter going with her to the program at the beginning of treatment. Her daughter would drive her to the program and walk

her into the agency. She did this until the respondent was used to attending the program, when respondent would enter the program alone.

Yo, yo quería ir. Primero mi hija, pero ya cuando estaba empuesta entonces yo. Ya me levantaba por si. Y llegaba sola hasta adentro. Primero no quería ir sola, tenía que entrar mi hija conmigo. Y ya después yo sola entraba.

#### **WHAT FACTORS MOTIVATE OLDER MEXICAN-AMERICANS TO CONTINUE IN MENTAL HEALTH SERVICES?**

Several factors motivated respondents to continue in mental health services. Respondents reported the treatment program being something new, something to which they could look forward. Respondents also could see progress in themselves, and that the treatment program had solutions for them. The group therapy experience also motivated them; talking to others who were in a similar situation was beneficial. The education that respondents received also contributed to their motivation to continue in treatment. Respondents achieved a resolution to their mental distress; this was an important factor to their motivation and reasons for continued attendance. The treatment program worked for them.

#### **Something new**

The treatment program motivated respondents. This was something new to respondents—talking out their problems with others of similar age who have similar problems. Respondents became motivated because they were getting and giving help, and because they could see the progress in each other. They were

feeling better emotionally, learning to cope with their mental distress.

Respondents did not want to miss a day of group.

To me this was something new. It would make me get up and get dressed, and get ready to go. They were picking me up in the van to go to the program and they would bring me back home.

Those transported by the treatment program made sure they were dressed and ready to go before the van arrived. They could see progress in them selves as they felt better and learned to cope with their mental distress. This was something they could not wait for.

### **They Could See Progress**

Respondents could see progress in themselves. They were feeling better.

This motivated respondents to continue attending the treatment program, which had program helped, giving them something to which they could look forward.

Respondents had structure, a place to go to, and something they needed.

I could see the progress in me. I would tell the counselors this. Just the fact that you get up in the morning and you have a place to go and you are expected to be there at a certain hour. It helps you. I would get up and I would dress and I would look forward to it. I keep going because I saw that I was progressing and I felt like I needed their counseling. I needed it.

Another respondent noted how the program was helping her. She could see many changes, was feeling better about herself, and communicating well with her family. She participated everyday and did not miss a group.

Eso, por que me gustaba. Veia que tenía muchos cambio que me estaba ayudando. Por eso no, ni una solo ves deje de ir. Porque yo sentía que estaba yo teniendo cambios. Me estaba ayudando el programa. Yo participaba mucho, mucho en la programa.

### **They Had Solutions for My Problems**

One respondent said the reason she kept going back to the treatment program was that they had solutions for her problems. She learned to cope with her depression, and started getting out of the house.

I kept going back to learn more, to learn how to control myself. I would have problems and they would have the solutions for me. I just kept feeling good. Because for months, I had not been going out, I was just at home. I started going and feeling better.

Another respondent talked about dedicating herself to doing what she learned in order to get well, “yo voy hacer las cosas a curarme porque quiero aliviarme.”

Another respondent talked about her commitment to get better. She paid attention in the groups and remembered what she would hear. She did not want to fall back into the depression caused by her husband’s death.

Y trato de superar. Yo puse mucho atención allí y me seguí adelante. Y ahora estoy viuda de mi esposo y yo recordaba de las palabras que nos dijeron para no recaer. No quiero recaer.

### **Other Treatment Program Benefits**

Respondents talked about other benefits, such as group therapy, nutrition and transportation. These benefits influenced the motivation of respondents to attend the program. In group therapy, respondents had a chance to get to know others, share problems and feelings, and become family. The treatment programs

offer snacks like crackers and peanut butter and drinks like coffee and tea in between groups and lunches that followed doctor's orders for diet restrictions after the last group. The treatment programs offer transportation to all group participants, particularly to those who can no longer drive. The programs send vans in the morning to transport group participants, and return them home after lunch.

### ***Group therapy***

The interaction between the respondent, the group therapists, and the group members also helped respondents continue to utilize treatment services. The therapist created an environment that was safe and comfortable for respondents, one where they felt free to accept help as well as to help others in the group. Respondents liked being in-group around others with similar issues.

I think what worked for me was the therapy, the group. The sessions here were the ones that helped me.

One respondent reported that he liked group therapy, getting to know, sharing with, and helping others. Listening to others helped. "The talking helps you take out your feelings."

The respondents reported liking the questions that therapists asked, because they helped respondents think of their mental distresses. They also liked that therapists taught them how to cope with those distresses. The respondent also made sure they paid attention to the staff out of respect for their time. In group

therapy, the respondents were in a group with others like them who had similar problems, getting to know others, talking about their feelings; the group became a family.

### *Therapists*

Respondents talked about the questions that therapist asked in the groups. One respondent noted the questions asked helped her to talk during group. She talked about her feelings, current and past, which helped her understand how to live. After she let all of her past feelings out, she started to get better.

Las preguntas que nos hacen ellos comienza hablarle. Le sacan a uno todo lo que siente. Lo que sintió antes también. Trata mas de que, como vivio uno su vida. Como subio y todas estas preguntas las hacian, fuimos, llorabamos, fue para mi y mi fuerza. Cuando yo ya habia hechado todo para fuera este me fui recuperando.

One respondent talked about things the staff did, such as writing questions on the chalkboard or ask the group questions for discussion. The discussion would include the meaning of the answers to the discussion questions. Questions like where does your depression come from? Or what are the reasons for my anger?

Pues con lo que nos decian ellos alli, los estudios que nos daban, las palabras que escribieron en el pizaron. Y las cosas que nos preguntaban y las contestas de todos. Que quiere decir esto o que significa y yo les contestaba. Porque me venia la depresion o porque me ponía con coraje.

Respondent said the group therapy and teachings were clear and easy to understand “las terapias eran muy claras, muy facil de entender. Aparte de que me gustaba, yo participaba.” That was the reason she liked to participate in the group.

Another respondent talked about coping skills he learned to do in place of feeling sad or sleeping. He learned that he could get out of the house, go for a walk or talk to a neighbor.

Pues hablándonos allí diciéndonos que era lo que teníamos que hacer cuando sentimos con tristes o nomas dormidas. Pongase a platicar con su vecina, que sálganse para fuera, que hagan esto. Cualquier cosita pero que estuviéramos estrallamos, no pensando en dormir.

One respondent talked about how the handouts from groups were beneficial. She kept copies of all handouts in a notebook and would review the information and her notes.

### ***Group Members***

Respondents found other people who had the same problem, or they felt that others had problems worse than they did. One respondent said when she attended the group she found other people whose problems were just like hers.

Uno, muchas veces piensa que uno tiene más problemas que alguien más y no es eso. Oye todos las problemas de lo de más y ellos oyen los de nosotros.

Another respondent talked about learning from other group member that she was not the only person to have problems “I learned a lot from the other members, that I am not alone. I learned that others have it worse than I do.”

Feeling they were not alone was important to respondents and was a reason they attended group therapy. One respondent was enthusiastic because she was around others with similar problems, “I had the enthusiasm to go because I was going to be around people who had the same type of problem.”

Respondents felt understood in the group because they were in group therapy with others who had similar problems and situations, like grief of a loved one. One respondent said she felt understood because other group members were facing similar situations. She felt like she could say something and be understood.

Somos señoras que estamos en la misma situación sin esposo, sin hijos en la casa. Eso también me ayuda porque si yo digo algo ellas me entienden. Porque están en la misma situación mía. Las que estamos allí en el problema sentimos de otra manera

Another respondent talked about other group members who also had problems “hay muchas señoras y señores que pasaron por una cosa también. Todos te ayudan.” They would all help each other because they shared similar experiences.

Respondents talked about getting to know each other in group therapy being helpful. They would share their problems with each other and help each other by giving feedback. One respondent liked the group because he had the chance to talk about what he was feeling and listen to others. He also talked about how the group had a nice relaxing feeling when a group member would say something funny or tell a joke.

Listening and talking. Hablando de lo que yo sentía. Se me hace que es muy importante decir lo que uno sentio. En veces que salian chistes and that would relax you more.

Another respondent said talking in the group about what she was learning helped her. Talking about feelings also helped her. “con las platicas con los que explicaban. Pues como nos sentiamos. Todo me ayudo.”

Respondents took the treatment program seriously, making sure they paid attention to the teachings of the staff, and practicing the things they learned. One respondent shared that she liked paying attention to the group and staff, and that she liked practicing what she learned, “hasta me gustaba poner mucho atencion y practicar las cosas. Porque si no los practicaba, es como que no estaba haciendo nada.” She felt if she was not practicing what she was learning, she was doing nothing to get better.

One respondent talked about the group feeling like a family. When she started the program, despite the fact that she knew others in the group, she was embarrassed and did not want others to know things about her. The group taught her to trust, and eventually she felt they were family.

Porque no queria que supieran nada di me. Eso era la verguenza que me daba. Y si tenia conocidas alli pero no queria que supieran lo que senti. Pero nos enseñaron a tener confiansia como una familia.

One group member also learned to trust others in the group. After a while, she saw the group in a different light and started feeling better. “No se si yo ya agarre

mas confianza alli que yo los veo mejor. Porque ya en menos tiempo yo me senti mejor.”

### ***Nutrition***

Food was a benefit for the group participants whether it was lunch or the snacks given during the breaks. One respondent talked about having a nutritious meal for lunch because she had lost interest in cooking and did not step into her kitchen.

I thought that was very important, at least one good meal that you would have. Especially for those that was living by themselves or not able to. For me I was not able to go into the kitchen. You know, you lose interest.

Another respondent reported that she liked the time in between groups, the break. During this time, the staff would leave the room and give the group a ten-minute break. Group participants could have a snack or a drink at this time. During the breaks, she said that group participants would keep talking with each other about their feelings and the stresses with which they were coping. This also happened during lunchtime.

Pues me gustaba mucho por que cuando teniamos una quevrada. Platicabamos, nos reiamos, platicabamos de lo que sentianos. Y cuando comiamos la misma cosa. Era muy bonito, estaba muy bonito.

After groups, the staff serves the group participants lunch and leave the room. Participants sat at tables of four to five participants, talked to each other about

their feelings, and helped each other by talking about what they learned in-group and laughing with each other.

### ***Transportation***

Two respondents shared that the van rides home give them an opportunity to see the other areas of town and the outlying towns. On the ride home, the talking and listening continued. They would talk about the group and what they learned. One respondent who had recently moved to the area shared that he would say ‘yes’ when asked if the van driver could drop him off last.

Bueno otra cosa es que venían a levantarte. Eso era muy bueno. Y yo no concia aquí en Kyle no conocía para Wimberley. Varias veces me decían no quieres ir por un ride. “Yes. I’ll go.” Me iba con ellos. Era bonito porque se salía uno para fuera a ver allá. Y iban todos platicando.

He would say yes so that he could see the other small towns. This helped the van drivers in getting group participants home in a timely manner.

Another respondent shared that the transportation was a good thing. She could no longer drive because of doctor’s orders, and her husband could not drive because he was recovering from surgery, “*It is a very good thing that they have transportation.*”

### **Application of Green’s Model of Help-seeking**

In this section, the researcher applies Green’s model of help-seeking to the data. Emergent themes for this analysis centered on the categories of the model. Specifically, the categories in the client culture of the model. Green’s model of

help-seeking follows the respondent in a linear process beginning with client problem recognition, then client labeling and diagnosis, moving into client utilization, and ending with problem resolution. This analysis followed respondents through this process, although, for respondents, this process was not necessarily linear.

The professional subculture of Green's model consists of clinical models, professional helpers, and minority professionals. In the analysis, the categories from the professional subculture are not the focus. Respondents' interactions in the categories of the client culture also show interactions with the professional subculture. Professional helpers, including minority professionals, are involved with respondents in all categories of the client culture. Professional helpers are involved with the respondents throughout the process. This presentation is focused on the factors involved in each category for the respondents.

One theme that emerges in all of the categories is that of relationships, which characterized the interactions in all of the categories of the client culture. Relationships are important to all of the respondents including those with family and friends. Respondents' relationships with healthcare providers were significant, described as trusting and family-like. These relations were involved in the respondents' referral to treatment, and influenced respondents' adherence to treatment recommendations. A close personal relationship with a physician was central to utilization for all respondents. Respondents listened to the feedback and

prescriptions of the physician. If the physician thought it was a good idea, the respondent would agree to the idea. Respondents would also agree with recommendations of family members. These relationships helped respondents get through the process of help-seeking, from problem recognition to problem resolution. These relationships helped respondents adhere to physician prescriptions for attending the treatment programs and taking medications for mental illness.

#### **CLIENT PROBLEM RECOGNITION**

*Client problem recognition* occurs when the client notices a change in, or problem with, their usual functioning. This category included quotes of the interactions with the family or with professional helpers who noticed a behavioral change in, or problem with, a respondent's usual functioning. Some respondents recognized a change in their behavior because of their mental distress. Family also told respondents about their depression or anxiety after observing the change. For some respondents, their physician noticed a change in their behavior. These relationships with their family and physician helped inform respondents by giving feedback on behavioral signs of mental distress.

Respondents reported several perceived causes of mental distress. The causes included grief and relationship issues, health problems, and physical complaints. In describing the events surrounding their mental distress, respondents described a multiplicity of issues. Along with the cause of their

mental distress, respondents reported other issues that exacerbated their mental distress. Respondents had on-going issues, like health or family problems. Respondents also described experiencing multiple behavioral changes or multiple signs of depression and anxiety, or both. For example depression, wanting to sleep all day, and crying. Respondents reported eight behavioral signs of mental distress, similar to symptoms of depression and anxiety. The behavioral signs included depression, anxiety and *nervios*, sleep problems, crying, isolation, no energy, appetite problems and loss of interest in activities. These behavioral signs are what the respondent recognized as a change in their behavior. The family and the physician also recognized these behavioral changes.

### **Family**

Respondents reported that family members noticed the mental distress. Seven respondents said their family told them they were depressed. The family members included the husbands, daughters, sons, a sister, daughter in law, and a nephew. One daughter called the treatment program to make a referral. Family told the respondent they were depressed. Family members made appointments with the doctor.

One respondent talked about how her daughters observed that she was having problems. Respondent was adjusting to eye surgery and losing her eyesight. She tried to make a cup of coffee and had an accident. Her daughter could see her in distress. Her daughters had seen the respondent have problems

with depression in the past. They knew her history and they knew to call her doctor to get their mother some help.

### **Physician**

Some respondents originally went to their physician complaining of a physical complaint; eventually the physician told the respondent they were depressed. The physician would run medical tests, like checking their blood before telling them there was nothing wrong with their stomach or their body, “he told me, what is wrong with you is you are depressed, anxiety.” Their physician had done all that he could for them and told them of their depression. Other times the physician recognized the patients were not themselves behaviorally and would explain to them that they were depressed and refer them to the treatment program.

### **CLIENT LABELING AND DIAGNOSIS**

The client labels and diagnoses the problem, *client problem labeling and diagnosis*, based on their knowledge of the illness, which comes from their everyday experience and their cultural experience, feedback from their social network, including their families, friends, and other community members. The *client labeling and diagnosis* category included quotes involving interactions between the respondent, family members, and physicians. Respondents received feedback from family and physicians that helped them label their mental distress. When asked what name they gave their problem, respondents reported different labels and names. One such respondent reported depression as the label for her

problem, “depression was the best word to use.” Another respondent also talked about feeling depressed, “*yo lo sentia que tenia depression.*” Among the names used for the problem that led respondents to treatment were depression or *depresión*, anxiety, *nervios* or *ansiosa*, also *coraje*, *soledad*, and *tristeza*.

The interactions with the family and their physicians helped respondents with labeling and diagnosing their problem. Respondents also had some knowledge of depression and anxiety to label their problem. It is not clear if the knowledge came before the treatment program or after.

#### **CLIENT UTILIZATION OF HELP PROVIDERS**

The client uses all information gathered in the client culture, *Client utilization of help providers*, to make a decision to utilize help providers. Quotes in this category included interactions with family, physicians, other health care providers, and the agency staff and group members. Clients decided which to use based on their previous experience with mental health treatment, feedback from family, friends, physicians, and other health care providers. Respondents who had no experience with the mental health system relied on their physician and family for education and information to help make the decision to go to treatment.

Because the sample was familiar with the healthcare system, they were open to attending mental health service upon the recommendation of their physician and families. Respondents with less education relied more on their children and their physician to help with decision making and to educate them about mental illness

and treatment. The family gave feedback and provided support and encouragement to the respondent to continue utilizing the treatment program. Another significant relationship was the treatment staff and the group members.

### **Family**

The family did several things to help respondents get to mental health treatment. The family helped with decision making by holding family meetings. The family provided support and encouragement as respondents attended the treatment program, or once attending the treatment program. The family gave respondent feedback after noticing progress in the respondents. The family could see the changes in the respondent.

The daughter was instrumental in helping respondents get to the treatment program. The daughter provided help in several capacities. Daughters helped by contacting physicians and agency staff to set up initial appointments. Daughters also helped explain mental illness and mental health treatment to respondents, and even went with respondents to the treatment program until the respondent was comfortable attending the treatment program. In one instance, daughters who lived out of town helped a respondent. Once the daughters left to go back to work, granddaughters came in to help, with one granddaughter staying until the respondent began the program.

### ***Decision making***

The family helped respondents make the decision to go to the treatment program and with other decisions as well. They helped respondents understand the treatment program, and the benefits therein. Family meetings were one way that family members helped respondents make the decision to go to mental health treatment.

### ***Support***

Family members supported the respondents' decision to attend the treatment program. Some family members became supportive after observing changes in the respondent. For some, family members became supportive after they learned of the treatment program and understood the program.

### **Physician**

Respondents' interaction with their physician influenced their help-seeking and mental health service use. Respondents' relationships with their physicians were trusting. The physicians knew their patients, and observed changes in respondents' behavior. Respondents listened to their physicians and followed the physician's orders to go to mental health treatment for help. Some physicians told respondents they were depressed, the respondents believed their physician. Respondents listened to the physician's recommendation to attend the treatment program.

### **Other Health Care Providers**

Respondents interacted with other health care providers, who helped in utilizing treatment services. Referrals to the treatment program came from different resources in the community, like family who worked in health care, former patients of the treatment programs, home health staff, and the community hospital. One referral came from the leader of a grief support group that was affiliated with a hospital and one hospital referral. One respondent talked about how the home health nurse recommended the treatment program to her, explained it, and contacted the program manager.

### **Friends**

A couple of respondents told of their interactions with friends who were former patients of the program. In both instances, the friend gave the respondent support and education of the treatment program. These friends influenced respondents' utilization of the treatment program.

### **Agency Staff**

The respondents' relationship with the agency staff contributed to continuing in the treatment program. Respondents reported that the agency staff was respectful, attentive, caring, and patient. This made respondents feel warm, comfortable, and safe. Respondents described the staff as good people. Respondents felt comfortable with the staff, felt like they were family. The factors that influenced older Mexican-Americans mental health service use worked

together with the respondents and with each other. Respondents described the relationships they formed as respectful, caring, attentive, and family-like. Respondents had several relationships that helped them utilize mental health services, Relationships with their family, friends, their physician, and other health care professionals helped them get to mental health services. The relationships with the agency staff and the group members helped respondents continue attending the treatment program.

#### **INDIGENOUS HELP PROVIDERS**

The category of *indigenous help providers*, are part of the client culture in Green's help-seeking model. Indigenous help providers include healers, herbalists, curanderas, voodoo practitioners, etc. that influence the client's help-seeking. During interviews with the respondents, none of them mentioned an indigenous help provider when asked about those who helped them get to mental health treatment. That is not to say that respondents do not use indigenous help providers. There was not a direct question to respondents regarding their utilization of indigenous helpers.

#### **PROBLEM RESOLUTION**

The category of *problem resolution* included quotes from interactions with family, agency staff, and physicians that helped the respondent resolve their mental distress. Some themes that respondents reported that helped them get to problem resolution were the treatment program being the right place, knowing

where to go if they relapse, the medications that the program psychiatrist prescribed, and learning to accept their depression.

Respondents in this study completed the treatment program. They felt better and noticed the changes in themselves. One respondent compared herself to before she entered the treatment program to her self now. Before the program, she would isolate from her family and turn down invitations to activities like dinner. Her depression kept her from saying yes. Now she has the desire to do things that she did not do before, like sing and dance with her grandchildren.

When I had it, I just wanted to be just by myself. I didn't think about my children, my brothers or sisters. They would invite me to the store and I would do nothing. "Let's go and eat mom, no, I don't want to go." I was so depressed with myself that I didn't care for nothing. Now I feel much, much better. I clean and sing now. I didn't sing before. I dance with my grandkids, before I didn't have the desire to do that.

Another respondent who was depressed from grieving for her sister said the most important for her was that her sadness was gone. She does not forget her sister, but the sad feelings have disappeared. She is sure that she feels better, normal.

Bueno lo mas importante fue que me quitaron toda la tristeza que tenia. No la olvide. Pero se me desaparecio. En veces me dolia la cabeza por que pensaba mucho de ella. Estoy segura que me siento mas bien. Ya normal.

### **The Right Place**

The interactions between the respondents and the agency staff and group members helped respondents get to problem resolution. Respondents needed to

talk; they needed to talk to someone about their mental distress, depression or anxiety. One respondent was looking for a place where the group understood her, “I wanted to go to the right place.” The treatment program was the right place for respondents to talk about their feelings and let things out.

### **I Know Where to Go**

A result of respondents’ attendance in the treatment programs was learning where to go if their symptoms of depression and anxiety returned. The relationship that the respondent formed with the agency staff helped by teaching respondents what to do if they relapsed. Ten respondents said they know where to go. One respondent talked about feeling much better after attending the program. She also talked about knowing where to go if she relapses, “Me siento muy bien. Y se si vuelvo a recaer, a donde ir.”

### **Medication**

The interaction between the respondent and the program psychiatrist was important. This relationship was significant to the respondent’s adherence to prescribed medication. The program psychiatrist explained to the respondent the reason for the prescribed medication and explained how the medication would help. Taking medications was a factor in respondents getting to problem resolution. Thirteen respondents talked about medications help them feel better. One respondent whose problem started with her stomach, talked about how once

she started taking medication she no longer had a stomach problem. She also said it helped her anxiety.

My stomach problem went away the second day I was there. The medication calmed me down so I would not be getting any anxiety.

Another respondent talked about isolating herself from family and friends when she was depressed and anxious.

I functioned better with the medication. I functioned even better once I started at the program. It is like a puzzle it all fits. Now I don't panic.

Respondent said that with medication she spends time with her family and takes care of her self with no problems.

### **Learned Acceptance**

Acceptance was something that respondents discussed in problem resolution. Respondents talked about accepting life and their depression. Five respondents talked about acceptance as something that helped. One respondent talked about how the group and staff taught him to accept life the way it is, "*me enseñaron a aceptar la vida.*" Another respondent talked about learning from the group members that she was not sick, she needed to learn to accept things the way they were.

No es que estoy mal, lo que tengo que hacer es saber aceptar las cosas. No esta en mis manos arreglar las cosas como yo las quiera. Asi son y yo las tengo que aceptar.

She learned that things are not always how she would like them to be.

Respondents talked about how accepting their depression, the changes in their life, like a loss of independence, was a benefit. “Understanding and accepting the fact that’s that was wrong with me. That is what helped me more.”

Another respondent who started with stomach problems shared that she did not believe she had depression.

I still didn’t believe that I was having mental problems, depression. Until I started taking that medication, then I had to accept the fact that was what was wrong.

Respondents did get to problem resolution with the assistance of the interactions with their family, their physician, and the treatment staff.

Respondents were happy to feel better, and were happy that they found the treatment program, the right place, the place to go if their symptoms returned.

Respondents also took the prescribed medications for their mental distress that respondents reported helped them feel better.

Green’s Help seeking model helps us understand the process and how it is somewhat linear. The key to understanding the help seeking process that the study group followed comes from the factors within the categories. There was variation among the respondents with the categories of the model suggesting multiple pathways and/or factors to help seeking and mental health service utilization.

#### **OTHER THEMES THAT EMERGED**

Respondents reported other themes that did not fit into the research questions or fit into the categories of Green’s model of help-seeking. The author

presented some of these themes as barriers to mental health service use earlier in the literature review. However, the respondents presented a different view from that of the literature. In this section, the author presents a discussion that involves respondent's knowledge of the program, religious beliefs, acculturation experience, and challenges such as language preference, stigma of mental illness, insurance costs, confidentiality, and caregiving.

### **Knowledge of the program**

The lack of knowledge of mental illness and knowledge of mental health services was a theme. Respondents had little knowledge and understanding of mental illness and mental health services prior to involvement in the treatment program. Respondents also reported that their family members did not know about the program until they were referred to it or entered it. Respondents learned of the treatment program from their physician or other professional helpers. Respondents reported that they did not know where to go for help or did not know that treatment existed. Thirteen respondents said they did not know about treatment. There were no differences in knowing about treatment with regard to nativity. Those with little education used their physician and family to learn about their problem and to learn about the treatment services. Those with more education had an easier time making the decision to go to treatment.

Respondents did not learn about the treatment program until the doctor referred them for an assessment. In a couple of cases, respondents did not

understand the treatment program until the program manager explained it to them at the initial meeting.

The initial meeting is the point at which the relationship between the respondent and the family with the agency staff began. One respondent reported that she did not learn about the program until “Nurse Valerie [the project manager] came over” to assess her. “I didn’t even know it existed here.” Another respondent talked about not knowing the treatment program existed, and did not learn about treatment until her doctor sent her to it, “I didn’t even know it existed until he (physician) sent me there.”

Families also did not know where to go for help. Four respondents reported that their families did not know about treatment. Once families learned about the treatment program and saw the changes in the respondents, they became supportive of the treatment program.

They didn’t help me because they didn’t know either about the program. If they knew this before I went to the hospital, they probably would have helped me. When they found out about this program, they agreed. They were happy for me to get that kind of help.

### **Religious Beliefs**

Religious beliefs were a factor that respondents talked about during the interviews. Respondent answered “no” to questions regarding their religious beliefs and health care decisions: 1. Have you disagreed with doctor’s orders because they were different from your religious beliefs and 2. Did your religious beliefs affect your decision to come to the program? Nine respondents said

“Thank God” for getting them to treatment, the group, the things they learned, and the staff for helping them out of their depression. There were no differences when it came to nativity of the respondents. Thanking God was important to respondents that had lower education and lower income. Those with higher education and income made no mention of religion. That is not to say that religion was not important to them.

### ***Getting to treatment***

One respondent gave thanks to God for getting her to the hospital, “thank God that you brought me into the hospital and he brought me in for some reason.” She attributed her reason for going to the hospital to God. Another respondent thanked God for giving her the illness so that she could get the help she needed, “so you le dio gracias a Dios porque lo me puese eso para darme the help that I needed. “ Another respondent talked about the reaction she had once she arrived at the treatment program.

When I get there and they put me inside the Pavilion. I hear those doors slam, I said “Thank God, I am in good hands.” Not to know who was there, what kind of help I was going to get, but I know that I was in good hands.

### ***For the group***

One respondent thanked God for the therapists and the group members. She appreciated the discussions the therapists led in group and the talking with the group members. The group members were nice people and provided much help.

Lo mas que me ayudo fueron las personas en los grupos. Gracias a Dios, ellos eran muy amables. Todo que hacemos en el programa y todas las conversaciones. Las lecturas y todo eso. Yo aprendi mucho de las clases. Ellos tratan la gente con mucho amor, so muy amables todas.

She felt that the staff treated the group members with much love, taught them many things in groups, and were nice.

### ***Education***

One respondent talked about thanking God for the classes the staff taught group participants about things to help them felt better and coping skills so they would not relapse.

Como le digo a Jaime, gracias a Dios ustedes aqui nos dan clases para superarnos y para entender para no caer.

### ***They brought me out of depression***

One respondent was thankful to God that the program staff helped bring her up out of her depression. The things they said gave her energy and motivation, “alli en el programa me levante. Gracias a dios y a ellos, me levantaron de sus palabras de ellos son muy buenos, el animo.”

Another respondent was thankful to God because she talked about all of the problems she had on her mind, “my chest was empty. I said, ‘Thank God for this.’ The staff they helped me.”

### ***Acculturation***

Respondents who immigrated to the United States reported having little stress living in the U.S., and had positive things to say about their life experience.

The group of respondents reported they experienced few problems. Economic and medical issues were the only problems that respondents discussed during the interviews. One respondent reported that she grew accustomed to any stress, she got used to it. It became her way of living in the United States.

Pues ya me impuse. Pero no tension. Para mi ya esta es mi manera de vivir.

Besides language, respondents have acculturated to the health care system and, it appears, to their community. Respondents who immigrated to the U.S. lived in Del Rio, Texas, which is on the US-Mexican border. The community in Del Rio is bilingual with Spanish being the primary language spoken. The respondents have acculturated enough to get along in their community. In the program, respondents recognized others who had immigrated as they did. They could hear it in the way they spoke Spanish.

Casi todas las personas que estabamos alli eramos gente que habiamos venido de Mexico. No me lo dijeron, el espanol me lo decia. La manera de hablar me lo decia.

The respondents in the study sample did not report acculturation as a barrier or a stressor. These respondents came to the United States, became citizens, and held employment that qualified them for Medicare benefits. It is possible that some respondents did experience issues with acculturation in their lifetime, and if they did, they did not report it. For the most part, these respondents were happy to be in the country.

## **Challenges**

Respondents did have a few challenges to mental health utilization. However, respondents did not view them as such. During the interviews when asked directly “what kinds of problems or challenges they encountered, all respondents said they had none.” One respondent said, “I didn’t have challenges, I didn’t really care. I just wanted something to help me.” Six respondents did talk about problems like language preference, stigma of mental illness, medication costs, worries of confidentiality, and caregiver worries. Again, respondents did not consider these issues as problems.

## ***Language***

Respondents reported no difficulties when asked directly “have you had any difficulties communicating with your health care providers.” One respondent, who is bilingual with Spanish being her first language, reported that she liked being in a Spanish-speaking group. One treatment program offered a Spanish-speaking group when there were enough group participants.

En veces nos juntabamos cuando eramos poquitos. Si era nomas en ingles, yo no entendia todo. Cuando cambiamos los dos grupos y uno era en espanol. Estaba muy bonito.

When she was in the English-speaking group, she did not understand everything. She preferred the Spanish-speaking group.

Another respondent that was fluent in both English and Spanish talked about the need for a Spanish-speaking therapist. She talked about some group

participants that were Spanish speaking who would say they understood the groups in English when they really did not understand everything said in the group.

Like my parents, they say they understand some English, and it is true they understand some. But they don't understand everything. They will just smile and say "uh huh."

She talks to friends of how she benefited from the program; they ask if the program has a Spanish-speaking therapist. This would help the program and the Spanish speaking community.

The only thing is that they don't have a Spanish speaking therapist. It would be good if they did. The first thing one of my friends will say is that they don't have someone who speaks Spanish. That would help the community.

### ***Stigma of Mental Illness***

Stigma of mental illness was something that respondents considered in making their decision to go to mental health treatment. Respondents mentioned a few phrases related to stigma of mental illness and misconceptions of mental health treatment when discussing mental distress or the problem that led to treatment. Among the phrases were *crazy*, *loco or loca*, *manicomio* or *insane asylum*, and *white jackets*. The U.S. born respondents used the terms *crazy* and *loco/loca*. Immigrant respondents used the term *manicomio*. Many of these terms came from the community where the respondents live or from their personal or family experiences with mental health treatment.

Six respondents used the word *crazy* when discussing mental distress. One respondent shared that she did not consider stigma in her decision to go to the treatment program.

Well, some people don't consider mental illness as an illness. They think of it as your being crazy. I didn't think that way

Four respondents reported the word *loco/a*. One respondent talked about hearing from others at the nutrition site she attended, upon telling them that that she was attending the treatment program, that she was going to the house for crazy people "ya vas a la casa de los locos." At her senior housing complex, she would hear, "hay viene el camioncito de los locos," here comes the van for the crazy people.

One family explained the treatment program in words she could understand, and assured the respondent that she was not crazy. The daughter, a doctor of education, explained to her mother the treatment was for her nerves, her *nervios*

Mi hija es doctora de educacion y ella sabe de todo. Entonces ella dijo, "esta bien Mama, vaya." Es para los nervios. Ya estube explicando en palabras que yo entendiera. Son nervios, ese soledad que tiene usted. Aqui en la casa porque no quiere venirse con nosotros. Entonces, vaya, no es para el locos.

Respondent's daughter and her son encouraged her to go to treatment. They told her she would get the help she needed.

One respondent heard from her sister, who was not supportive of the decision for treatment. Her sister was not happy with her attending a treatment program. Her sister told her, “it is just for crazy people and that there is nothing wrong with me.” Her sister wanted her to just keep working and keep herself busy and she would not think about it. The sister’s opinion did not influence respondent’s decision to get help.

### ***Misconceptions of Treatment***

Three respondents noted the word *manicomio* or insane asylum in the interviews. Respondents had thought their doctors would send them to an insane asylum because they were crazy. One had thoughts of her doctors sending her to an asylum because of her *nervios*.

Los nervios so muy feos. Bastante feos. Yo pensaba que me iban a mandar a San Antonio, al manicomio.

One respondent talked about the thoughts she had of going to a treatment program. She thought of “white jackets, people bouncing off the walls.” She thought “they are going to put a white jacket on me;” this was the first thing that came to her mind. Another respondent talked of a woman telling her what she expected to see at a treatment program. She told her that she was going to a place where they would watch her all of the time and they would have her make blankets.

Una senora me dijo No alli nomas estan mirando, y estan diciendo que va hacer, que vas reiunda. Te van a poner hacer colchas.

Two respondents shared that stigma is different now from in the past. If you admitted to mental illness or treatment, a job could be lost. They viewed mental illness in a different way than in the past.

If you talked about mental illness, they thought you were crazy. It was very different then.

Currently, things are different when it comes to treatment for mental illness. According to three respondents, it is easier to talk about mental illness and going to mental health treatment; it has become easier to talk about it out in the open.”

One respondent, who has a master’s in theology and is an ordained minister, shared her opinion about stigma and mental illness.

I don’t think that mental illness should carry any kind of a stigma. I think it should be an illness like all the others.

This respondent also had family history of mental illness that included her father and mother.

### ***Costs***

The cost of medication was an issue for four respondents. Respondents talked about the co-payments for their prescriptions. One respondent reported that medications were expensive, particularly those for mental health problems, “the medications are very expensive especially those that I am taking right now for the anxiety and stress.” She talked about the doctors helping her by giving her

samples to help with the cost of medication, which helped make them more affordable, “sometimes my doctors give me samples of the medications. I can afford them once, but not more than that.”

### ***Confidentiality***

One respondent talked about feeling skeptical about going to the treatment program. She was worried about the confidentiality of the group. She had attended a support group in the past and a group member broke confidentiality.

At first I was kind of skeptical, because I had been in a program before with family outreach. It was a support group and one of the ladies said some things out of the group. So, I was kind of hesitant.

### ***Caregiving***

Another respondent worried about leaving her husband, who was recovering from triple bypass surgery, alone while she was at the treatment program. She felt that she needed to care for him.

I thought that I needed that, although I would be away from home. That was from 8 to 12pm that I would be away from ah...not being able to help. It was a big concern of me going and leaving him here by himself when he needed my help.

Her husband encouraged her to get help, and assured her that he did not mind staying alone while she attended the program.

### **SUMMARY**

In this chapter, I presented findings to answer the central question of this study, “What factors influence help-seeking behavior and mental health service

utilization of older Mexican-Americans?” Several themes arose from the interview data. The first theme was that respondents came to treatment with a multiplicity of stressors and a multiplicity of behavioral signs of mental distress. Respondents had several ongoing issues that piled on them, leading them to seek help for their mental distress.

The next theme was that of relationships in treatment with the staff and group members helping in getting respondents to continue attending treatment. Relationships involving these factors helped in two ways: 1. The relationships of the family, the physician, and other healthcare providers getting the respondent to treatment. 2. Relationships in treatment with the staff and group members helped in getting respondents to continue attending treatment.

To respondents, these relationships felt family-like. Respondents described the agency staff as caring, attentive, respectful, and patient. Respondents benefited from this relationship with the agency staff because they found solutions for their problems and learned how to better cope with their mental distress.

The family was involved in the help-seeking process with the respondent. The family helped with recognizing the problems, some helping give the problem a label, and assisted the respondent in going to the treatment program and seeing them through problem resolution. The family helped with decision making to seek help, offered support and encouragement, and noticed progress as respondents felt

well. The daughter was the most instrumental family member that helped respondents get to the treatment program.

Lastly, there were some other themes of importance. There was a lack of knowledge of mental health services and mental illness reported by some respondents, who also reported their families had no such knowledge either. Another theme was a language preference. Some respondents reported that having treatment groups in Spanish would help the Spanish speaking in their communities. Respondents also reported the theme of stigma. Stigma of mental illness still persists in the community.

The help-seeking process for this study group was not linear. There are several factors that older Mexican-Americans draw on when in distress. The pathways that they select depend on their physician, family, community, along with their education level.

In the next chapter, I present a review of the findings, and a discussion of implications and recommendations for future research.

## **CHAPTER SIX**

### **Discussion and Implications**

In Chapter 5, the author reported detailed findings for this qualitative study. This chapter begins with a brief overview, and moves into a discussion of the limitations of the study. The dissertation concludes with implications for social work practice and recommendations for future research.

### **Summary of findings**

The dissertation sought to explore and describe the factors that influence Older Mexican-Americans' help-seeking behavior and mental health service utilization. This dissertation consisted of a qualitative exploration of mental health service utilization of older Mexican-Americans collected from clients at outpatient mental health programs in Texas. The researcher interviewed 20 older Mexican-Americans who participated in these treatment programs. The central question of this dissertation asked what factors influence help-seeking behavior and mental health service utilization of older Mexican-Americans. This dissertation addressed the following sub questions:

#### **RESEARCH QUESTIONS:**

1. What are older Mexican-Americans' perceptions of mental distress?

2. What individual, agency, and system level factors influence help-seeking behavior and mental health service utilization of older Mexican-Americans?
3. What is the interaction of these factors with help-seeking behavior and mental health service utilization of older Mexican-Americans?
4. What is the role of the family and social network in older Mexican-Americans accessing mental health services?
5. What factors motivate older Mexican-Americans to continue in mental health services?

#### **PERCEPTIONS OF MENTAL ILLNESS**

Respondents reported many causes of mental distress, the problem that led them to seeking mental health treatment. One theme was that respondents came to treatment experiencing multiple stressors and multiple behavioral signs of mental distress, for example, problems with grief of a loved one like a spouse and medical conditions like diabetes and experiencing depressed mood, sleep problems and appetite problems. The causes of mental distress included marriage problems, separation and divorce, family problems, health problems, and financial problems. The behavioral signs reported were similar to symptoms of depression and anxiety, symptoms included depression, anxiety and *nervios*, sleep problems, crying, isolation, lack of energy, appetite problems, loss of interest in activities, and physical complaints. These behavioral signs were also similar to Guarnaccia,

Rivera, Franco, and Neighbors (1996) study of *ataques de nervios*, in Puerto Ricans and other Latinos. They developed a prototype to understand *ataques de nervios* that consists of a sense of loss of control, a threat to social order, emotions of sadness and anger, expressions of distress in the form of physical symptoms, aggressive outbursts, and loss of consciousness.

Among the names or labels used for the problem that led respondents to treatment were depression or *depression*, anxiety, *nervios* or *ansiosa*, also *soledad*, *tristeza* and *coraje*. At times, the language respondents used had multiple meanings. Respondents had difficulty with their mental distress because the loss of independence due to aging. Accepting the fact that they had grown old was taxing for respondents. They have had control of their lives for years and now rely on their children or spouse to meet their needs. Many of the respondents were females who had taken care of their spouse and children with some working full-time jobs. Relying on others and accepting help was also part of their mental distress. Respondents had trouble moving out of a caregiving role to a care receiving role.

#### **INTERACTION OF FACTORS THAT INFLUENCED UTILIZATION**

There was no clear pathway for older Mexican-Americans utilizing mental health services; there were several factors or pathways that influenced their help-seeking behavior. The family members that respondents mentioned included their spouse, daughter, sons, sister, nephew and grandchildren. The community factors

that respondents discussed included doctors, nurses, social workers, support groups, and housing authority. The professional helpers and family members worked together to help the respondents in making the decision to use mental health treatment. Respondents made the decision to go to treatment after listening to their physician, their family or friends, and other health care professionals. Many respondents did not know about depression until their physician or family told them or until they arrived at the program.

Relationships were an overarching theme among respondents. The interaction of these pathways or factors depended on relationships. The relationships respondents had developed were significant to them. It was important to respondents to feel a close, family-like relationship with the health care professionals involved in their care. Respondents discussed several relationships that work together and with each other.

The relationship with their physician was central to the respondents. This relationship helped by letting each party know what is going on. The doctor talked with the family primarily the daughters. These relationships helped by giving the respondents support, education into mental illness, and helped overcome any stigma.

Respondents also discussed a relationship with other health care providers. Another relationship that was significant was the physician and health care providers with the treatment program. This relationship helped facilitate referral

of the respondents. The relationship with their physician and other health care providers helped respondents in recognizing their problem and utilizing services.

The last significant relationship was the respondent and the treatment program. The relationship with the agency staff and the group members were two other relationships that helped with utilizing services and resolving their problem. These relationships were important to attending and continuing the treatment program. The agency staff developed a warm, caring relationship with the respondents, treated them like family, and created an environment that was inviting to the respondents.

To respondents, these relationships felt family-like. Respondents described the agency staff as caring, attentive, respectful, and patient. Respondents benefited from this relationship with the agency staff because they found solutions for their problems and learned how to cope better with their mental distress.

*Personalismo* and *respeto* were values that respondents reported in the relationships with healthcare professionals. These values were the reason older Latinos accepted mental health services. *Personalismo* stresses the significance of personal relationships rather than institutional relationships (Trevino, Moyer, Valdez, & Stroup-Benham, 1991). This includes the physical space between the patient and the practitioner, appropriate physical contact, and short conversations concerning the family not related to health care. This helps in establishing the

personal relationship and trust (Flores, Abreu, Schwartz, & Hill, 2000). *Respeto* (“respect”) directs respectful behavior toward others based on age, gender, and authority (Arredondo et al., 1996). The family and the values of the culture influence help-seeking behaviors and adherence to medical recommendations. *Familismo*, *personalismo*, and *respeto* can affect patient adherence to treatment services as well as health outcomes (Barron et al., 2004). Latinos are less likely to adhere to treatment recommendations if they distrust their healthcare provider (Christensen, 1992). Involving the family in treatment decisions and treatment planning is a way to incorporate *familismo* (Flores et al., 2000).

For the older Mexican-Americans in this study, the staff conveyed these values to them. This made the older Mexican-American make a commitment to themselves about attending the program and participating in the groups. They felt that if the staff was going to go to the trouble to help them, they should return the favor.

#### **ROLE OF FAMILY**

The relationship with their family was also significant because of the role of the family in their lives. The family was involved with respondent throughout the process of help-seeking. The family helped respondents by working with their physician. The family shared feedback with the doctor to help facilitate the respondent making the decision to go to treatment. Respondents’ relationship with their family helped them get to mental health services. The family helped with

recognizing the problems, some family members helped give the problem a label, and assisted the respondent in going to the treatment program and seeing them through problem resolution. The family helped with making the decision to seek help, offered support and encouragement, and noticed progress as respondents felt better. Respondents also discussed the relationship their family had with their physician. Some family members were in direct contact with the respondents physicians. As in most Hispanic families, the daughter was the most instrumental family member to respondents. Most respondents relied on their daughters with the family roles being reversed. The daughter became an educator and a liaison for their parent often times speaking for the respondent. Daughters were helpful to the respondents in several capacities including communicating with the physician and the treatment program, reducing stigma of mental illness and educating respondents on mental illness and mental health treatment, and helping their parent make the decision to go to the treatment program. Their assistance was the most important to respondents.

#### **TREATMENT EXPERIENCE**

Respondents discussed several factors that motivated them to continue mental health treatment. Factors reported include relationships with the agency staff, relationships with group members, education, and group therapy.

Respondents described the relationship with the staff as genuine, trusting, nurturing, warm, and caring, family-like. Respondents liked the education they

received from the staff during group therapy. The relationship with the group members was another factor respondents noted as reason to continue the treatment program. Respondent came away with knowing where to go if relapse occurs.

### **Psychosocial Interventions**

Group therapy worked for the respondents along with the health care community in which they are involved. The members of their health care community worked together to treat respondents health care needs including their mental distress. This is consistent with other findings that psychosocial interventions are effective with older Latinos. Interventions such as integrated and collaborative care or case management, in conjunction with cognitive behavioral therapy, have shown promise in working with older adults and older Latino.

Integrated care involves site sharing and a partnership between mental healthcare and primary care providers (Katon et al., 1997). Bartels et al. (2004) reported older adults are more likely to accept collaborative mental health treatment within primary care settings, and that integrated care could improve underutilization of mental health services for older Latinos.

Collaborative care or case management as an intervention for older adults with late-life problems improves physical function more than usual care (Callahan et al., 2005). In a study that compared Spanish speakers with English speakers, case management, along with cognitive-behavioral therapy, is associated with lower dropout rates and greater improvement in depressive symptoms and

functioning for Latinos. Arean et al. (2005) compared cognitive-behavioral group therapy, clinical case management, and the combination of both to treat low-income older adults with depression. They found that the combination of group therapy and case management resulted in significantly lower depressive symptoms than group therapy alone. The authors concluded that low-income older adults benefit from greater access to social services.

Researchers concluded that case management improves retention in traditional mental health outpatient care, and can improve outcomes for Latinos (Miranda et al., 2003). Case management programs that include cognitive-behavioral therapy have shown improved health outcomes and reduced unmet need for appropriate care among Latinos (Wells et al., 2004).

Respondents' health care community worked collaboratively, although not formally. The treatment programs involved in this study provide cognitive therapy as part of the treatment regimen. Respondents liked the questions that therapist posed as part of group therapy and this kept respondents coming back. The treatment programs also provide case management for respondents as part of the treatment and for discharge planning. There was no formal case management services offered prior to utilizing the treatment program. The treatment program acts like an integrated model only after the respondent was admitted to the program. The health care community acts like the collaborative care model even though it does so informally, it was beneficial to the respondents.

### **OTHER THEMES THAT EMERGED**

Respondents did have a few challenges to mental health utilization. They, however, did not view them as challenges. The challenges included lack of education of mental illness and mental health services, language preference, costs of medication, and stigma of mental illness. There was a lack of knowledge of mental health services and mental illness reported by some respondents, who also reported their families had no knowledge either. Stigma of mental illness was something that respondents considered in making their decision to go to mental health treatment. Stigma of mental illness and misconceptions of mental health treatment still exist in the communities in which they live.

Respondents in this study overcame the lack of knowledge of mental health services and mental illness with the help of their family and physician. Both the family and physician took time to explain to respondents their mental illness and the treatment services. This education by the family and physician also helped respondents overcome stigma of mental illness. The programs offer transportation with a van that has the hospital's name on it and not the programs name. One hospital offers transportation to other hospital services and had designated times for patients attending the mental health program. This also helped decrease stigma of mental illness in the community.

Respondents noted that medications, particularly the ones for mental distress, are expensive. Respondents also discussed how medications helped them

feel better, which is contrary to Cooper et al.'s (2003) finding that Latinos were less likely to find antidepressant medication acceptable. This implies a change in the attitude of medication for mental health issues. Psychiatrist at the treatment programs would provide samples of medications and discount coupons when possible to respondents to help with the cost of medications.

Another theme was a language preference. Some respondents reported that having treatment groups in Spanish would help the Spanish speaking older adults in their communities. Morales et al. (1999) examined patient ratings of communication with healthcare providers and noted that Latino Spanish speakers reported more dissatisfaction than Latino English speakers. And both Latino Spanish speakers and Latino English speakers reported more dissatisfaction than Whites. One conclusion drawn from this study is that dissatisfaction with communicating with healthcare providers puts older Latino with limited English proficiency at risk for making poor healthcare choices.

Language is also a factor that affects adherence. In one study, Spanish-speaking clients who required an interpreter had lower adherence rates and poor medical outcomes (Rivadeneira et al., 2000). Lago and Thompson (1996) believe that the professional's task is to take the responsibility to communicate in a language the client prefers, and to create an understanding, which 'evokes trust.' Respondents in this study overcame the challenge of language with the assistance of Spanish Speaking therapist at two of the treatment programs. At times, the

programs offered some groups in Spanish or the group would be given in English and Spanish. One program would translate parts of the topics being discussed to include respondents with limited English speaking ability.

### **Discussion of Limitations**

This study has some limitations. One limitation is generalizability, referring to the extent to which findings of a study are generalizable to similar settings and populations. The study sample was purposive, which makes it difficult to generalize to all older Mexican-Americans. The sample was limited because respondents are from one state, Texas. The findings provide insights into the Mexican-American culture of Texas. Although generalizability is a limitation, the idea of transferability of the study is an important consideration.

*Transferability* refers to whether a researcher can transfer particular findings from one qualitative study to another study with a similar context or situation and preserves the particularized meanings, interpretations, and inferences (Leininger, 1994). This study is transferable because of its focus on Mexican-American culture. Although Mexican-Americans are concentrated in several disparate regions of the United States, they share many cultural similarities. Mexican-Americans share similarities such as values, beliefs, family, traditions, and language. The study is transferable to other regions of the United States in the study of older Mexican-Americans' help-seeking behavior when it comes to

mental health services. Older Mexican-Americans in a different state/region may share the same experience as the group in this study.

Another limitation of this study is that those who did not access or did not complete the outpatient mental health programs are not included. This population was not included because of the difficulty in finding these participants. The agencies that participated in this study reported a 70-80% completion rate of patients that enter the treatment programs. Agencies do not track those who had problems getting into the program. This population would have been ideal for comparisons. In missing this group, the study lost the perspective of those who were unable to access treatment, missing the issues that made services unattractive and the challenges encountered in the process of help-seeking and mental health service utilization. These participants may have had a negative or an uncomfortable experience in attempting to access treatment services by experiencing access barriers. The researcher did not hear of the experience they may have had in not accessing treatment services. The researcher missed what challenges this population encountered in accessing services. Some challenges might have been family or family dysfunction, or, perhaps, values and beliefs. Another challenge might be having an unsupportive relationship with their primary care physician. Their view of mental illness and treatment was missed, as was what they tried in dealing with these challenges. The researcher missed understanding what kept them from adhering to recommendations from

physicians, social workers or other health care professionals for treatment services.

Unlike other studies that have a comparison group to identify differences, this study only looked at one group. This study focused on a group of older Mexican-Americans that crossed into the professional mental health culture. This study identified the strategies that helped this group's use mental health services. This study helped identify this group's perception of mental illness and mental health services. This study also identified the informal and formal network of providers who help in accessing treatment services. Ultimately, this study group helped to answer the overall research question of what factors brought older Mexican-Americans into for treatment what factors motivated them to continue in treatment.

The interview guide worked well to help get the respondent started on their narrative, and provided timely probes during the semi-structured interviews. A more structured interview would help respondent focus on duration and frequency of their mental distress. All respondents did have a DSM-IV diagnosis as is a requirement of the treatment program.

## **Recommendations**

As older Latinos turn to mental health services, they often face several problems in the environment, including language and cultural distance. In order to decrease this cultural distance, the social worker needs to take into account the

factors that contribute to distancing, building an understanding of what is associated with cultural distance for each client and performing accurate assessments. The recommendations include expanding the workforce of bilingual/bicultural providers and Spanish speaking providers; provide community education of mental illness to older adults and families; and to give information to help reduce the stigma of mental illness and the cultural distance between older Hispanics and health care providers.

### **Language preference**

A recommendation to listen to the meaning of the language spoken will help older Latinos and improve the communication between older Latinos, and social workers and other health care providers. Social workers providing treatment to older Latinos also need to understand the mechanisms of cultural distancing within themselves to treat older Latinos effectively. Mental health providers need to offer services in Spanish, which is the primary language for some older Hispanics. To provide services in Spanish the workforce of Spanish speaking or bilingual/bicultural providers needs to increase. To do this we need to recruit bilingual/bicultural students to become health care providers. We also need to recruit students who are Spanish speaking, or encourage students to learn the Spanish language. Language influences the bilingual client's ability to communicate thoughts, feelings, and emotions. Language also influences the clinician's understanding of the client's verbal and nonverbal communication

(Malgady & Zayas, 2001). Zuniga (1987) notes the Spanish-speaking client can benefit from catharsis when speaking his or her native language. At the same time, the Spanish-speaking worker can interject *dichos*, cultural anecdotes, to enlighten and maintain the flow of therapy. These familiar phrases enhance the client's feelings of being understood, and add to the helping process, while making the treatment process less complicated.

### **Education of mental illness and treatment services**

Another recommendation for social work and health care providers is to increase education on mental illness and services to older Latinos and their adult children and families. Providing education will help increase the understanding of mental illness and mental health services. For example, older Latinos and their families need education concerning the insurance benefits for which they qualify for mental health services, plus general information about mental health.

Another need is to reduce stigma of mental illness and mental health treatment. To do this, we need to provide community education on mental illness and mental health services. There exists confusion of what mental illness is. Ageism adds to this confusion. The current older adults grew up thinking that having mental illness meant, "I am crazy." Today, we understand that mental illness is a part of life. At times in our lives we need help with transitions, particularly the transitions that come with getting older, like the death of a spouse or change in health condition. Targeting the children of older adults will help

reduce the stigma of mental illness and provide the opportunity to educate the community of mental illness and mental health services.

### **Cultural Distance**

With the current population growth, the barriers and needs of older Latinos will need ongoing assessment. Assisting older Latinos identify the barriers they are experiencing is vital to these assessments. Older Latinos might not identify a challenge as a barrier. In working with older Latinos, social workers need to consider the degrees of acculturation, language skill and preference, as well as adherence to traditional customs, values, and norms of those being treated (Santiago-Rivera, 1995).

Professionals need to move beyond holding a simplistic view of culture (i.e creating a physical atmosphere and hiring people who speak the language), to one that incorporates the multiple dimensions of culture in a more detailed way (Bernal & Castro, 1994). For social work professionals, some suggestions for moving beyond a simplistic view of culture include cultural competency training focused on the language and culture of the region. Professionals need to understand and learn that Spanish exists in different dialects, that Latinos come from different countries, and that Latinos have lived different lifestyles and have different life experiences. Understanding the language that older Latinos are using will improve services for both the professional and the patient.

To decrease this cultural distance, planners need to take into account both factors of the linguistic minority clients and the factors of the professionals who will be working with them. Professionals need to understand the cultural distance for each individual client, and to provide accurate assessments. Professionals providing treatment to linguistic minorities need to understand these considerations within themselves to do so effectively. In a pilot study, Choi and Gonzalez (2005a) found contributors to access of older minorities included physician social worker referrals, churches, former patients, and community outreach. They also noted having a supportive family, and the treatment agency having bilingual/bicultural clinicians were also contributors (Choi & Gonzalez, 2005a).

In social work, we are taught to meet the client where they are. In working with older Mexican-Americans, there are times where there exists much cultural distance. Incorporating the values of *personalismo*, *respeto*, and *familismo* into services can help decrease this distance. For example, one thing to do for an older Mexican-American who has limited command of English is to translate keywords of the topic that is presented. This helps the older Mexican-American feel respected because the staff took the time to personalize services. This type of service helped respondents commit to the treatment services. *Familismo* is significant in the culture for older Mexican-Americans. When they find services that are family-like, adherence to prescriptions and treatment recommendations

will be more likely. Adding the values of *personalismo*, *respeto* to practice makes services feel like family. The services also feel less like western medicine and more like something traditional or something that the older Mexican-American is used to.

### ***FUTURE DIRECTIONS FOR RESEARCH***

The President's New Freedom Commission on Mental Health (2003), addresses the special mental health needs and strengths of older Latinos. One of the most studied reasons for Latinos under utilization of mental health services is the lack of linguistically and culturally relevant services (Lopez, 2002). The design of services for older Latinos needs to be relevant to the community where they live. Future research should focus on improving mental health services for the older Latino. Services will need to address cultural competency and be linguistically appropriate.

Research is needed on how to improve education on mental illness and mental health treatment for the caregivers of older Latinos, their health care providers (i.e., their adult children), and the communities in which they reside. Education on mental illness and treatment will help reduce the stigma of mental illness, and improve adherence to treatment for older Latinos and Latinos in general (Gonzalez, 2006).

The language that research and treatment programs use is another area in need of research. Professionals and researchers need to understand and learn that Spanish is regional, and exists in different dialects. Latinos come from different regions of the United States and emigrate from different countries. Along with linguistic needs, increasing the number of bilingual/bicultural health care providers would improve treatment and research (Gonzalez, 2006).

In addition, future research should focus on attitudinal barriers to the treatment of depression among ethnic minority patients (Cooper et al., 2003). Research on access and retention of minority older adults in mental health treatment is also a need (Choi & Gonzalez, 2005a). The types of services effective in engaging older Latinos and the value of community supports are two areas of research that could strengthen delivery of mental health services to older Latinos (Brennan, Vega, Garcia, Abad, & Friedman, 2005).

To improve the accessibility of services, research needs to be done on culturally competent interventions that are effective with older Latinos (Choi & Gonzalez, 2005a; Marin et al., 2006). Studies need to focus on improving treatment adherence and on developing methods for engaging patients (Delgado et al., 2006; Choi & Gonzalez, 2005a; Marin et al., 2006).

## **CONCLUSION**

When it comes to mental health services, some older Hispanics adults have needs that must be met: language preference and, at times, being culturally distant from the providers of mental health care. The number of older Hispanics also continues to increase, as does the population of older adults in the United States. For mental health care to be effective for older adults, practitioners must consider, address, and understand the culture from which the older adult comes (Abramson, Trejo, & Lai, 2002).

Mental illness needs recognition as equal to other medical conditions. Signs of depression in older adults can be difficult to identify, because often times older adults experience multiple stressors from life events, which include medical illness (APA, 2003). According to the APA, psychological factors like depression, anxiety, or somatization drive 70 percent of primary care visits. Treating mental illness does cost money. Not treating mental illness could result in this number rising. Older adults are large consumers of the health care system. Their satisfaction should be of equal importance to that of the generations they have spawned.

## **Appendices**

## APPENDIX A

### Information Sheet

- Research Project Name:** Older Mexican-Americans: Meeting the professional culture of mental health
- Researcher:** John M. Gonzalez, LMSW,  
Doctoral Candidate,  
School of Social Work,  
University of Texas at Austin  
P. O. Box 2301  
Austin, Texas 78703  
(512) 757-3020
- Participant Pair Selection Criteria:** Older Mexican-American, Age 65 or older who has completed the program in the past 12 months, experienced a reduction of depressive symptoms and scored above 24 on the MMSE. And the people most instrumental in helping them get treatment services.
- Participant Requirements:** Consent to participate in an in-depth interview to be conducted in the home of the participant or in a place convenient to the participant. One interview will be conducted with the older person. The interview schedule will questions: regarding the participants' views of mental illness, role of the family in accessing services, resources to accessing services and the relationship between the resources. Interviews will be conducted in English and/or Spanish according to participant's preference. Duration of interview is estimated at 45 minutes. Participants will be paid \$15.00 for a completed interview.
- Study Site Instructions:** (1) Staff will assist in the recruitment of prospective participant.

(2) Staff will access patient records to identify prospective participant using the sample selection criteria.

(3) Using the telephone script provided by the researcher, staff will phone prospective pair to describe the study.

(4) Staff will mail information sheet, which contains researcher's contact information, and informed consent to prospective participant.

**Telephone script:**

Good Morning/Afternoon. May I speak with (name of prospective participant respondent)? My name is (Staff member name) and I am calling from the (name of program). Mr/Mrs (name of prospective respondent), May I have a few minutes of your time.

I would like to tell you about a research study that our agency is helping with. A doctoral student is studying older person who have attended and completed programs, like ours. The doctoral student's name is John Gonzalez. John would like to interview you and a relative or friend who gave you support while you were attending our program. This study will help us understand how you were able to come to the program and what helped you get better. This will help us develop ideas of how to get other older persons into a program like ours. The interview is about an hour. At the end of the interview, he will give you a \$15 gift card for HEB, because your time is valuable. Do you have any questions?

May I mail you information so that you can read more about the study and then you can contact John by phone, mail or e-mail.

Thank you for your help conducting this study. Questions or concerns about the project May be directed at any time to John M. Gonzalez at the telephone numbers listed above. Results of the study will be shared with participating organizations when completed.

## **APPENDIX B**

### Letter to Prospective Participants

Dear Sir/Madam:

My name is John M. Gonzalez and I am a Doctoral Candidate with the University of Texas at Austin, School of Social Work. I am conducting a study of older Mexican-Americans who have successfully completed outpatient mental health programs.

I am studying the experiences older Mexican-Americans and their families had in attending programs like the Heritage Program. I am interest in listening to how you learned about the program, who was involved in helping you understand the program and your thoughts of these types of services. I am also interested in hearing from the family member or friend who was most helpful in you getting to the program. You will be helping me understand how you used the program to help you get better.

I will conduct one interview with the older person who attended the program. The interview will be conducted at a convenient place of your choice and last about an hour. Your identity and all the information that you decide to share with us will be kept in strict confidence. I will protect your privacy. I will provide a \$15 HEB gift certificate in appreciation of your participation in the interview.

If you have questions about the study and your participation, do not hesitate to contact me at (512) 757-3020 or by e-mail [johnm.gonzalez@mail.utexas.edu](mailto:johnm.gonzalez@mail.utexas.edu).

If you are willing to be interviewed, please sign the Informed Consent Form, put it in the attached envelop and seal it, and drop it in the mail to me.

Thank you for your time,

John M. Gonzalez  
Doctoral Candidate  
School of Social Work  
University of Texas at Austin

## **APPENDIX C**

### Interview schedule

Hello, my name is John Gonzalez and I am a doctoral candidate conducting a research study. I am studying older Mexican-Americans and their experiences in mental health treatment. I appreciate you taking the time to meet with me. At any time, if you have a question, do not hesitate to stop and ask me.

The following questions are about your general background.

### Demographics

1. Respondent's gender: Male\_\_\_\_ or Female\_\_\_\_ (Interviewer's observation)
2. Language spoken during interview. English \_\_\_\_ Spanish \_\_\_\_ or both \_\_\_\_\_. (Interviewer's observation)
3. Where were you born? City, State, Country\_\_\_\_\_ (If country is US then USBORN is Yes, if another country is listed, USBORN is No.)
4. What is your age? (in years)
5. What is your marital status?  
 Married  
 Widowed  
 Divorced  
 Separated  
 never married  
 Don't know  
 Refused

### Education

1. What is the highest grade or year of regular school that you have completed? \_\_\_\_\_

Insurance

1. What kind of health insurance do you have? Do you have
- Medicare
  - Medicaid
  - Private insurance from (previous) employer
  - Private insurance purchased with own money
  - Health insurance for veterans
  - Other (Specify):
  - Don't Know
  - Refused

Income

1. About how much is your yearly household income for the past year?

(Give card to respondent)

Yearly	Monthly	Response
\$6,000 or less	\$0 - \$500	
\$6,001 to \$8,500	\$501 - 708	
\$8,501 to \$10,000	\$709 - \$833	
\$10,001 to \$12,500	\$834 - \$1,042	
\$12,501 to \$15,000	\$1,043 - \$1,250	
\$15,001 to \$25,000	\$1,251 - \$2,083	
\$25,001 to \$35,000	\$2,084 - \$2,917	
\$35,001 to \$50,000	\$2,918 - \$4,167	
\$50,001 to \$75,000	\$4,168 - \$6,250	
\$75,001 to \$100,000	\$6,251 - \$8,333	
\$100,001 or more	\$8,334 or more	
Don't know		
Refused		

Card

About how much is your yearly household income for the past year?

Yearly	Monthly	Response
--------	---------	----------

\$6,000 or less	\$0 - \$500
\$6,001 to \$8,500	\$501 - 708
\$8,501 to \$10,000	\$709 - \$833
\$10,001 to \$12,500	\$834 - \$1,042
\$12,501 to \$15,000	\$1,043 - \$1,250
\$15,001 to \$25,000	\$1,251 - \$2,083
\$25,001 to \$35,000	\$2,084 - \$2,917
\$35,001 to \$50,000	\$2,918 - \$4,167
\$50,001 to \$75,000	\$4,168 - \$6,250
\$75,001 to \$100,000	\$6,251 - \$8,333
\$100,001 or more	\$8,334 or more
Don't know	
Refused	

Living arrangements LIVING ARRANGEMENTS AND HOUSEHOLD COMPOSITION

How many people live in the household?

1. Lives alone- 1 person in house
2. Two people in house
3. Three or more people in house
4. Refused

Relationship to head of household

1. Respondent is head of household
2. Spouse
3. Son/Daughter(including Stepchildren)
4. Son-In Law/Daughter-In-Law
5. Grandchild
6. Parent
7. Brother or Sister
8. Nephew or Niece
9. Aunt/Uncle
10. Friend

11. Boarder or Roomer
12. Other Non-Relative
13. Sister/Brother-In-Law
14. Don't Know
15. Refused

Did you come to live with them or did they move in with you?

1. Move in with others
2. They came to live with me
3. other
4. Don't know
5. Refused

I would like to know how the other people who live with you are related to you.  
(INTERVIEWER: ASK FOR RELATIONSHIP, SEX, AND AGE OF EACH PERSON)

Now I would like to understand how you experience mental distress, the problem that led you to the program.

What happened?

What brought you to the program?

Probes:

What do you call the sickness/problem that led you to the program?

What name does it have?

What do you think caused your problem/sickness?

Why do you think it started when it did?

What happens when you have this problem/sickness?

Probe:

How bad did it get? How long did it last?

When this happens, what are the main problems your sickness caused?

When this happens, what do you do?

### Service utilization

Now I would like to ask you how you learned about the program.

What are some reasons that you decided to come to this program?

Probes:

What was happening that made you ask for help?

Who was involved when this was happening?

Who else might have been involved in helping when this happened?

How many times have you received help with this type of problem?

How many times have you tried to come to the program?

What types of problems/challenges kept you from coming those times?

How is this time different?

Now I would like to hear about your sources of help.

What type of support helped you make a decision to get help?

Probes:

Who was involved in your decision to get help? How did they help you make that decision?

How were they supportive?

How did your family help in you getting to the program?

Which family member gave you the most help?

How did they help you get to the program?

What did they do to help you?

What happened after the help?

What was most important about the help?

Now I would like to ask you if you had any problems or challenges getting to the program.

What kinds of problems/challenges did you encounter? (i.e. communication, insurance, payment, stigma of mental illness, fear or distrust of the mental health system,)

Probes:

Have you disagreed with doctor's orders because they were different than your religious beliefs?

Did your religious beliefs affect your decision to come to the program?

Have you had any difficulties communicating with your healthcare providers?

Do you have many out of pocket costs?

Have you ever decided against having medical treatment because of the costs?

If not US Born, Has living in the United States been stressful?

What types of stress have you encountered? Can you give me an example?

How did you to overcome these problems/challenges?

Probes:

Who helped you to overcome these problems/challenges?

What did they do to help you overcome challenges/problems?

How did the sources of help overcome challenges/problems?

Now I have some questions about your experience in the program.

Tell me about your experience in groups/therapy?

Probes:

What contributed to your experience in groups/therapy?

What does the group call the problem that brought them to the program?

What did you think of depression?

Who or what kept you going back to groups/therapy.

Any other thought come to mind? Any other questions?

That completes the interview. Thank you very much for your cooperation!

## References

- Abramson, T. A., Trejo, L., & Lai, D.W.L. (2002). Culture and mental health: Providing appropriate services for a diverse older population. *Generations*, 26 (1): 21-28.
- Administration on Aging (2001). *Cultural Competency*. Retrieved on February 1, 2002 from [www.aoa.gov/may2001/factsheets/Cultural-Competency.html](http://www.aoa.gov/may2001/factsheets/Cultural-Competency.html)
- Alegria, M., Canino, G., Rios, R., Vera, M., Calderon, J., Rusch, D. & Ortega, A. (2002). Inequalities in use of speciality mental health services among Latinos, African Americans, and Non-Latino Whites. *Psychiatric Services*, 53, 12: 1547-1555.
- Altheide, D. L. (1996). *Qualitative Media Analysis: Qualitative Research Methods Series 38*. Sage Publications: Thousand Oaks.
- American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders, 4<sup>th</sup> edition, Text Revision*. American Psychiatric Association: Washington, DC.
- American Psychiatric Association (2003, July). Mental Health Care and Older Adults: Facts and Policy Recommendations. Retrieved April 21, 2008, from <http://www.apa.org/ppo/issues/oldermhfact03.html>.
- Andersen, R. & Newman, J. F. (1973). Societal and individual determinants of medical care utilization in the U.S. *Milbank Memorial Fund Quarterly*, 51 95-124.
- Angel, J. L., Angel, R. J., and Markides, K. S. (2002). Stability and change in health insurance among older Mexican-Americans: Longitudinal evidence from the Hispanic established populations for epidemiology study of the elderly. *American Journal of Public Health*, 92 (8): 1284-1272.
- Angel, J. L., Angel, R. J., McClellan, J. L., and Markides, K. S. (1996). Nativity, declining health, and preferences in living arrangements among elderly Mexican-Americans: implications for long-term care. *The Gerontologist* 36(4): 464-473.
- Antshel, K. M. (2002). Intergrating culture as a means of improving treatment adherence in the Latino population. *Psychology, Health, & Medicine*, 7 (4): 437-438.

- Arean, P. A., Gum, A., McCulloch, C. E., Bostrom, A., Gallagher-Thompson, D., & Thompson, L. (2005). Treatment of Depression in low-income older adults. *Psychology and Aging, 20* (4): 601-609.
- Arredondo, P., Toporek, R., Brown, S. P., Jones, J., Locke, D., Sanchez, J. et al. (1996). Operationalization of the multicultural counseling competencies. *Journal of Multicultural Counseling & Development, 24*(1), 42–78.
- Atdjian, S. & Vega, W. A. (2005). Disparities in mental health treatment in U. S. racial and ethnic minority groups: Implications for psychiatrists. *Psychiatric Services, 56* (12): 1600-1602.
- Barron, F., Hunter, A., Mayo, R., & Willoughby, D. (2004). Acculturation and adherence: Issues for health care providers working with clients of Mexican origin. *Journal of Transcultural Nursing, 15* (4): 331-337.
- Bartels, S. J., Coakley, E. H., & Zubritsky, C. (2004). Improving access to geriatric mental health services: A randomized trial comparing treatment engagement with integrated versus enhanced referral care for depression, anxiety, and at-risk alcohol use. *American Journal of Psychiatry, Vol 161*(8), 1455-1462.
- Bernal, M. & Castro, F. (1994). Are clinical psychologists prepared for service and research with ethnic minorities? *American Psychologist, 49* (9): 797-806.
- Berry, J. W. & Kim, U. (1988). Acculturation and mental health. In: *Health and Cross-Cultural Psychology: Towards Application*, Dasen, P., Berry, J.W., & Satorius, N. eds. London: Sage, pp. 207-236.
- Biegel, D. E., Shore, B., & Silverman, M. (1989). Overcoming barriers to serving the aging/mental health client: A state initiative. *Journal of Gerontological Social Work, 13* (3/4), 147-165.
- Black, S. A., Goodwin, J. S., & Markides, K. S. (1998). The association between chronic diseases and depressive symptomatology in older Mexican-Americans. *Journals of Gerontology: Medical Sciences, 53A*, (3): M188-M194.
- Black, S. A. & Markides, K. S. (1999). Depressive symptoms and mortality in Mexican-Americans. *Annals of Epidemiology, 9* (1): 45-52.

- Callahan, C. M., Kroenke, K., Counsell, S. R., Hendrie, H. C., Perkins, A. J., Katon et al. (2005). Treatment of depression improves physical functioning in older adults. *Journal of American Geriatrics Society*, 53(3), 367–373.
- Callan, A. & Littlewood, R. (1998). Patient satisfaction: ethnic origin or explanatory model? *International Journal of Social Psychiatry*, 44 1-11.
- Carrillo, E. (2001). Assessment and treatment of the Latino patient. In, *The Latino psychiatric patient: Assessment and treatment*. Lopez, A. G. & Carrillo, E. (Eds.). American Psychiatric Publishing, Inc.: Washington, D. C.
- Choi, N. G. & Gonzalez, J. M. (2005a) Barriers and contributors to minority older adults' access to mental health treatment: Perceptions of geriatric mental health clinicians. *Journal of Gerontological Social Work*, 44(3/4) pp. 115 – 135.
- Choi, N. G. & Gonzalez, J. M. (2005b). Geriatric mental health clinician's perceptions of barriers and contributors to retention of older minorities in treatment: An exploratory study. *Clinical Gerontologist*, v. 28 (3): 3-25.
- Christensen, C. (1992). Multicultural competencies in early intervention: training professionals in a pluralistic society. *Infants and Young Children*, 4 (3): 49-63.
- Collins, K. S., Hughes, D. L., Doty, M. M., Ives, B. L., Edwards, J. N., and Tenney, K. (2002). *Diverse communities, common concerns; Assessing health care quality for minority Americans*. Findings from the Commonwealth Fund 2001 Health Care Quality Survey. New York, New York.
- Cooper, L. A., Gonzales, J. J., Gallo, J. J., Rost, K. M., Meredith, L. S., Rubenstein L., (2003). The acceptability of treatment for depression among African-American, Hispanic, and White primary care patients. *Medical Care*, 41, 479–489.
- Creswell, J.W. (1998). *Qualitative Inquiry and Research Design: Choosing among five traditions*. Sage Publications: Thousand Oaks.
- Delgado, P. L., Alegria, M. Canive, J. M., Diaz, E. Escobar, J. I., & Kopelowicz, A. (2006). Depression and access to treatment among U.S. Hispanics:

Review of literature and recommendations for policy and research. *Focus: The Journal of Lifelong Learning in Psychiatry*, IV(1), 38–47.

- Derose, K. P. and Baker, D. W. (2000). Limited english proficiency and Latinos' use of physician services. *Medical Care Research and Review*, 57 (1): 76-91.
- Dunlop, D. D., Song, J., Lyons, J.S., Manheim, L. M., & Rowland, R. W. (2003). Racial/ethnic differences in rates of depression among preretirement adults. *American Journal of Public Health*, 93, 1945–1952.
- Federal Interagency Forum on Aging Related Statistics (2000). *Older Americans 2000: Key indicators of Well-being*. Retrieved February 1, 2002 from [www.agingstats.gov/chartbook2000/population.html](http://www.agingstats.gov/chartbook2000/population.html)
- Flores, G., Abreu, M., Schwartz, I., & Hill, M. (2000). The importance of language and culture in pediatric care: Case studies from the Latino community. *Journal of Pediatrics*, 137 (6), 842–848.
- Folstein, M. F., Folstein, S. E., & McHugh, P. R. (1975). Mini-mental state: A practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research*, Vol 12(3), pp. 189-198.
- Freimen, M. P. & Cunningham, P. J. (1997). Use of health care for the treatment of mental problems among racial/ethnic subpopulations. *Medical Care Research and Review* 54: 80-101.
- Gonzalez, J. (2006). Older Latinos and mental health services: Understanding access barriers. *Journal of Human Behavior in the Social Environment*, 14(1/2), 73–93.
- Gonzalez, H. M., Haan, M. N., & Hinton, L. (2001). Acculturation and the Prevalance of Depression in Older Mexican-Americans: Baseline Results of the Sacramento Area Latino Study on Aging. *Journal of American Geriatrics* 49 (7): 948-953.
- Grant, B. F., Stinson, F. S., Hasin, D. S. Dawson, D. A., Chou, S. P., & Anderson, K. (2004). Immigration and Lifetime Prevalence of DSM-IV Psychiatric Disorders among Mexican-Americans and Non-Hispanic Whites in the United States: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Archives of General Psychiatry*, 61, 1226-1233.

- Green, J. (1999). *Cultural awareness in the human services: A multi-ethnic approach*. Allyn and Bacon: Boston.
- Guarnaccia, P. J., Rivera, M., Franco, F., & Neighbors, C. (1996). The experience of *Ataques de nervios*: Towards an anthropology of emotions in Puerto Rico. *Cultura, Medicine and Psychiatry*, 20: 343-367.
- Guba, E. G. & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research*. (pp. 105-117). Thousand Oaks, CA: Sage.
- Hargraves, J. L. & Hadley, J. (2003). The contribution of insurance coverage and community resources to reducing racial/ethnic disparities in access to care. *Health Services Research* 38 (3): 809-829.
- Harris, H. L. (1998). Ethnic minority elders: issues and interventions. *Educational Gerontology*, 24(4) pp. 309-324.
- Health Care Financing Administration. (2000). Office for civil rights' policy guidance on limited English proficient persons. Retrieved October 2, 2003, from <http://www.hcfa.gov/medicaid/smd83100.htm>
- Henry J. Kaiser Family Foundation (1999). *The Faces of Medicare*. Retrieved on January 24, 2002 from <http://www.kff.org/medicare/1481-index.cfm>.
- Hovey, J. D. (2000). Acculturative Stress, Depression, and Suicidal Ideation in Mexican Immigrants. *Cultural Diversity and Ethnic Minority Psychology* 6 (2): 134-151.
- Jezewski, M. & Poss, J. (2002). Mexican-Americans' explanatory model of type 2 diabetes. *Western Journal of Nursing Research*, 24 (8): 840-858.
- Juarbe, T. (1995). Access to health care for Hispanic women: A primary health care perspective. *Nursing Outlook*, 43(1), 23-28.
- Kart, C. S. (1985). *The realities of aging: An introduction to gerontology*. Boston: Allyn and Bacon.
- Katon, W., Von Korff, M, & Lin, E. (1997) Collaborative management to achieve depression treatment guidelines. *Journal of Clinical Psychiatry*, Vol 58(Suppl 1), 1997. pp. 20-23.

- Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, L. R., & Walters, E. E. (2005). Lifetime Prevalence and Age-of-Onset Distributions of DSM IV Disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, *62*, 593-602.
- Kessler, R.C., Chiu, W. T., Demler, O., & Walters E. E. (2005). Prevalance, severity, and comorbidity of 12-month DSM-IV disorders in the national comorbidity survey replication. *Archives of General Psychiatry*, *62*, 617-627.
- Kleinman, A. (1988). *The illness narratives: Suffering, healing, and the human condition*. Basic Books: New York.
- Klienman, A. (1980). *Patients and healers in the context of culture: An exploration of the borderland between anthropology, medicine, and psychiatry*. University of California Press: Berkeley.
- Koch T. (1994) Establishing rigour in qualitative research: the decision trail. *Journal of Advanced Nursing* *19*, 976–986.
- Lago, C. and Thompson, J. (1996). *Race, culture, and counseling*. Buckingham: Open University Press.
- Lantican, L. S. M. (1998). Mexican-American clients' perceptions of services in an outpatient mental health facility in a border city. *Issues in Mental Health Nursing*, *19*: 125-137.
- Leininger, M. (1994). Evaluation criteria and critique of qualitative research studies, Ch 6 pp.95-115. *In Critical issues in qualitative research methods*, Morse, J. M. (Ed). Sage Publications: Thousand Oaks, CA.
- Lopez, S. R. (2002). Mental health care for Latinos: A research agenda to improve the accessibility and quality of mental health care for Latinos. *Psychiatric Services*, *53*, 1569–1573.
- Lopez, S. R., & Guarnaccia, P. J. (2000). Cultural psychopathology: Uncovering the social world of mental illness. *Annual Review of Psychology*, *51*, 571–598.
- Magilvy, J. K., Congdon, J. G., Martinez, R. J., Davis, R., & Averill, J. (2000). Caring for our own; health care experiences of rural Hispanic elders. *Journal of Aging Studies*, *14* (2) pp. 171-191.

- Malgady, R. G. & Zayas, L. H. (2001). Cultural and linguistic considerations in psychodiagnosis with Hispanics: The need for an empirically informed process model. *Social Work, Vol 46*(1): pp. 39-49.
- Marin, H., Escobar, J. I. & Vega, W. A. (2006). Mental Illness in Hispanics: A review of the literature. *Focus, 4* (1): 23-37.
- Miranda, J., Azocar, F., Organista, K. C., Dwyer, E., & Areane, P. (2003). Treatment of depression among impoverished primary care patients from ethnic minority groups. *Psychiatric Services, 54* (2): 219-225.
- Miranda, J. & Cooper, L. A. (2004). Disparities in care for depression among primary care patients. *Journal of General Internal Medicine 19*: 120-126.
- Miranda, A. O and Matheny, K. B. (2000). Socio-psychological predictors of acculturative stress among Latino adults. *Journal of Mental Health Counseling, 22* (4): 306-317.
- Morales, L. S., Cunningham, W. E., Brown, J. A., Lui, H., & Hays, R. D. (1999). Are Latinos less satisfied with communication by health care providers? *Journal of General Internal Medicine, 14*, 409–417.
- O' Hagan, K. (2001). *Cultural competence in the caring professions*. Jessica Kingsley Publishers: Philadelphia, PA.
- Padgett, D. (1998). *Qualitative methods in social work research: Challenges and rewards*. Sage Publications: Thousand Oaks, CA.
- Padilla, A. M. (1980). *Acculturation: Theory, models, and some new findings*. Boulder, CO: Westview Press.
- President's New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America: Final report* (DHHS Pub. No. SMA-03–3832). Rockville, MD: U.S. Department of Health and Human Services.
- Purdy, J. K. & Arguello, D. (1992). Hispanic familism in caretaking of older adults: Is it functional? *Journal of Gerontological Social Work, 19* (2) 29-43

- Rivadeneira, R., Elderkin-Thompson, V., Silver, R. C., & Waitzkin, H. (2000). Patient centeredness in medical encounters requiring an interpreter. *American Journal of Medicine*, 108 (6):470-474.
- Santiago-Rivera, A. L. (1995). Developing a culturally sensitive treatment modality for bilingual Spanish-speaking clients: Incorporating language and culture in counseling. *Journal of Counseling and Development*, 74: 12-17.
- Salgado de Snyder, V. N., de Jesus Diaz-Perez. M., Maldonado, M., & Bautista, E. M. (1998). Pathways to mental health services among inhabitants of a Mexican village. *Health & Social Work*, 23 (4), 249-261.
- Salgado de Snyder, V. N., de Jesus Diaz-Perez. M. J., & Ojeda, V. D. (2000). The prevalence of *nervios* and associated symptomatology among inhabitants of Mexican rural communities. *Culture, Medicine, and Psychiatry*, 24: 453-470.
- Salgado-de Snyder VN, Díaz-Pérez MJ, González-Vázquez T. (2003) A model for integrating mental healthcare resources in the rural population of Mexico. *Salud Pública de México*, 45:19-26.
- Sheikh, J. I. & Yesavage, J. A. (1986). Geriatric Depression Scale (GDS): recent evidence and development of a shorter version. [Clinical Gerontologist](#) Vol. 5 No. 1-2 pp.165-173.
- Smart, J. F. & Smart, D. W. (1995). Acculturative stress: The experience of the Hispanic immigrant. *The Counseling Psychologist*, 23: 25-42.
- Stark, R. & Roberts, L. (2005). *Content analysis*. Chapter 19 pp. 303-313. In *Social Work Research and Evaluation: Quantitative and qualitative approaches*. 7<sup>th</sup> ed. Grinnell, R. m. & Unrau. Y. A. Eds. Oxford Press: New York.
- Texas Department of Aging (2003). *Texas Demographics: Older Adults in Texas*. Office of Aging Policy and Information.
- The Center for Mental Health Services (1999). *Facts Sheets – Latinos/Hispanic Americans*. Retrieved January 9, 2002 from <http://www.mentalhealth.org/cre/fact3.asp>

- Timmins, C. L. (2002). The impact of language barriers on the health care of Latinos in the United States: A review of the literature and guidelines for practice. *Journal of Midwifery & Women's Health*, 47 (2): 80-96.
- Torrez, D. J. (1998). Health and social service utilization patterns of Mexican-American older adults. *Journal of Aging Studies*, 12 (1): 82-99.
- Trevino, F., Moyer, M., Valdez, R. & Stroup-Benham, C. (1991). Health insurance coverage and utilization of health services by Mexican-Americans, mainland Puerto Ricans, and Cuban Americans. *Journal of the American Medical Association*, 265(2), 233–237.
- Tulane Hispanic Health Initiative (2002) *Hispanics/Latinos in the United States General Health Status*. <http://www.som.tulane.edu/thhi/hstatus1.htm>.
- United States Bureau of the Census (2000). *The Hispanic Population: Census 2000 Brief* <http://www.census.gov/prod/2001pubs/c2kbr01-3.pdf>
- United States Bureau of Census (2002). *American Community Survey Profile*. retrieved 10/02/03  
<http://www.census.gov/acs/www/Products/Profiles/Single/2002/ACS/Tabular/010/01000US1.htm>.
- United States Census Bureau (2004). *2004 American Community Survey: Population 65 years and over*.
- United States Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.
- United States Department of Health and Human Services (2003). *A Statistical profile of Hispanic older Americans aged 65+*. Administration on Aging.
- United States Department of Health and Human Services, Health Care Financing Administration (HCFA). (1999). *Medicare and you, 2000*. Washington, DC: HCFA.
- United States Department of Health and Human Services Office of Minority Health (2000). *Assuring cultural competence in health care:*

*Recommendations for national standards and outcomes-focused research agenda.* Washington, DC: U.S. Government Printing Office.

- Vega, W. A., Kolody, B., and Aguilar-Gaxiola, S. (2001). Help Seeking for Mental Health Problems Among Mexican-Americans. *Journal of Immigrant Health, Vol. 3, No. 3:* 133-140.
- Vega, W. A., Kolody, B., Aguilar-Gaxiola, S., Alderate, E., Catalano, R., & Carveo-Anduaga, J. (1998). Lifetime prevalence of DSM-III-R psychiatric disorders among urban and rural Mexican-Americans in California. *Archives of General Psychiatry, 55,* 771-778.
- Vega, W. A., Kolody, B., Aguilar-Gaxiola, S., & Catalano, R. (1999). Gaps in Service Utilization by Mexican-Americans with Mental Health Problems. *American Journal of Psychiatry, 156 (6):* 928-934.
- Vega, W. A. & Lopez, S. R. (2001). Priority issues in Latino mental health services research. *Mental Health Services Research, 3 (4):* 189-200.
- Villa, V. M. & Aranda, M. P. (2000). Demographic, economic, and health profile of older Latinos: implications for health and long-term care policy and the Latino family. *Journal of Health and Human Services Administration, Vol. 23 No. 2:* 161-180.
- Wang, P. S., Lane, M., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Twelve-month Use of Mental Health Services in the United States. *Archives of General Psychiatry, 62,* 629-640.
- Warda, M. (2000). Mexican-Americans' Perceptions of Culturally Competent Care. *Western Journal of Nursing Research, 22 (2),* 203-224.
- Wells, K., Sherbourne, C., Schoenbaum, M., Ettner, S., Duan, N., Miranda, J., Jurgen Unutzer, J., & Rubenstein, L. (2004). Five-Year Impact of Quality Improvement for Depression Results of a Group-Level Randomized Controlled Trial. *Archives of General Psychiatry. 61:378-386*
- Williams, C. L. & Berry, J. W. (1991). Primary prevention of acculturative stress among refugees: Application of psychological theory and practice. *American Psychologist, 46:* 632-641.
- Zuniga, M. E. (1987). Mexican-American clinical training: A pilot program. *Journal of Social Education, 23,* 11-20.

## **Vita**

John Michael Gonzalez was born in Corpus Christi, Texas on December 8, 1964, the son of William and Victoria Gonzalez. After completing his work at Foy H. Moody High School he attended the University of Texas at Austin and graduated with a B. A. in Psychology and Sociology. He then worked in the substance abuse field for ten years and entered graduate school.

In May 2000, he graduated with his MSW from the School of Social Work at Texas State University-San Marcos (formerly Southwest Texas State University). During graduate school he transitioned from substance abuse to the field of gerontology. He has worked with older adults in outpatient mental health settings for the last 8 years. In 2002, he entered the PhD program at the School of Social Work at the University of Texas at Austin. He has worked as a Teaching Assistant at the University of Texas School Of Social Work and as an adjunct instructor for the School of Social Work at Texas State University-San Marcos.

In 1998, he was awarded a research grant from the Texas Long Term Care Institute at Texas State University for a study titled "Humor Interventions with Elderly in Nursing Homes." He was also awarded "Achievement in Research" from the College of Health Professions 1998 Research Forum for the same study. In 2002, he was awarded a research fellowship from the Council on Social Work Education Minority Fellowship Program. In 2006, an article he co-authored was awarded the Rose Dobrof Award for best article in the Journal of Gerontological

Social. He also authored and co-authored publications on older Latinos and mental health services, older adults overcoming oppression, resiliency and Mexican immigrant youth, and home school education programs.

Permanent address: 1648 W. 6<sup>th</sup> Unit B, Austin, Texas 78703

This dissertation was typed by the author.