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CULTURAL DEFINITIONS OF EMOTIONAL PROBLEMS: IMPACT ON
PROBLEM EXPERIENCE, CARE SEEKING, SOURCES OF CARE, AND
SATISFACTION WITH CARE AMONG LATINO COMMUNITY MEMBERS
LIVING IN THE UNITED STATES

By

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ABSTRACT OF THE DISSERTATION

Cultural Definitions of Emotional Problems: Impact on Problem Experience, Care Seeking, Sources of Care, and Satisfaction with Care among Latino Community Members Living in the United States

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Professor Allan V. Horwitz

The research described in this dissertation explores the impact of cultural definitions of mental health/illness on care-seeking behavior among members of a Latino community living in the United States. Secondary data analysis utilizes survey data from prior research focusing on mental health service needs among Latino community members. The current research is conceptually situated at the juncture of several topics of current interest within sociology. The social construction of mental illness and cultural influences on that construction has gained importance as current topics within the broader sociological rubric of culture and cognition. The research also addresses challenges confronting mental health service providers created by a rapidly growing and increasingly diverse American population requiring appropriate cross-cultural approaches to meet their mental health service needs. Qualitative data presented in this dissertation illuminate several key concerns regarding the Latino community and community members' recognition of, and reaction to, symptoms of mental

disorder. These results underscore how Latino community members conceptualize emotional/mental problems in ways that differ from members of the majority Non-Latino White population living in the U.S. Quantitative analyses of the impact of demographic variables on Latino community members' reports of alternative beliefs about the causes of emotional/mental problems show that three of the variables (age, education, and time living in U.S.) are significant predictors of subjects' alternative explanations for the cause of emotional/mental problems. Analyses of the impact of Latino community members' causal definition of emotional/mental problems also show significant relationships between the definition and Latino community members' perceptions and behaviors related to mental disorder. I discuss the 'Latino Paradox' and propose an alternative explanation based on community members' shared cultural constructs regarding mental health and illness for the apparently lower rate of mental disorder among recently arrived Latino immigrants. I offer recommendations suggested by my research findings that relate to mental health services for Latino community members, and for additional research topics.

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Chapter 1: Introduction and Literature Review of Theory and Research

In the United States today, people of Latino origin comprise the most rapidly growing segment of the population. While community members come from a number of different Spanish-speaking societies, Latinos living in the U.S. tend to share cultural backgrounds that influence their beliefs regarding health and illness. These beliefs may be substantially different from the majority Non-Latino White population (Molina, Zambrana, & Aguirre-Molina, 1994).

One cultural dissimilarity of particular interest within sociology involves Latino's beliefs about mental health and disorder. Within the Non-Latino White U.S. culture, the psychiatric community's symptom-driven taxonomy of mental disorder conveys a disease concept of mental illness accepted by diverse segments of the lay community (Horwitz, 2002a). Latino community members, however, tend to share cultural beliefs that influence their perceptions and definitions of mental disorder. These culturally based understandings of mental disorder may be quite different from those defined within the disease concept of mental illness. For example, Latinos may attribute the cause of emotional/mental problems to the devil or to evil spirits. Some Latino cultures consider behaving in deviant ways as natural or part of nature¹. Latinos may also adopt unique ways of defining mental/emotional problems as idioms of distress which also differ from the psychiatric community's taxonomy of mental disorder (Romero, 2000).

Differences in cultural definitions of emotional and behavioral disorders are important factors contributing to service utilization patterns. Members of

Latino groups who are not conversant with psychiatric culture may be less likely to seek help from professional mental health service providers (Horwitz, 1987).

Little research currently exists that assesses the impact of cultural definitions of mental disorder on care-seeking among Latino community members. Since Latino community members living in the U.S. tend to under-utilize mental health services, research examining the relationship between cultural definitions of mental disorder and professional mental health services utilization can make an important contribution to devising strategies to overcome these problems.

Introduction

This dissertation explores cultural definitions of mental health/illness among members of a Latino community living in the Charlotte urban area of North Carolina. The research focuses on the impact of these cultural definitions on community members' reports of the experience of emotional problems, care-seeking related to these problems, sources of care, and satisfaction with care. The current investigation utilizes secondary data analyses of survey results from prior research on unmet mental health service needs among Latino community members in the Charlotte region. The Mental Health Association of the Central Carolinas sponsored the original research in 2005. The United Way of Central Carolina funded the original investigation.

In this dissertation, I review several topics of current interest within sociology and conceptually locate the current research at the juncture of these themes. The social construction of mental illness and the importance of cultural influences on that formation are current topics within the broader sociological

rubric of culture and cognition. Latino immigrant groups living in the U.S., whose cultural backgrounds do not generally incorporate the widely accepted mental illness model of emotional disorders, demonstrate how cultural understandings work to structure community members' perception of emotional disorder.

Pathways to care and cultural influences on care-seeking decision-making are topics receiving ongoing consideration in mental health services research. Culture exerts a powerful influence on perceptions and definitions of mental illness (Kleinman, 1988), including conceptions of the underlying causal mechanism of such disorders. For example, Molina & Aguirre-Molina (1994) identify research that describes culturally-specific emotional disorders that exist in Latino culture. The authors document Latino community members' reliance on alternative forms of treatment for these disorders, such as folk medicine, religious or spiritual guidance, and self-medication with herbs and home remedies.

My research investigates the impact of Latino community members' cultural definitions of emotional/mental problems on their experience of such problems, care-seeking, sources of care, and satisfaction with care. Specifically, in this investigation I compare differences between community members who identify 'mental illness' as the cause of emotional/mental problems with those who identify other causes, such as 'the devil,' 'evil spirits,' or 'nature.' I also assess the impact of selected demographic characteristics on community members' causal definition of emotional/mental problems (i.e., gender, age, education, time living in the U.S.).

In addition, I consider how culturally-defined emotional problems function as idioms of distress reflecting social and structural inequities existing in the

Latino community. I explore the relationship between Latino community members' causal definition of mental disorder and their reports of culturally specific problems.

Furthermore, this research examines the influence of cultural definitions of emotional/mental problems on the selection of care providers by contrasting community members who report seeking help from mental health professionals with those who elect to seek care from family physicians, religious sources, or folk healers. I explore factors influencing care-seeking behavior, including causal definitions of mental disorder and the occurrence of culturally-specific conditions. Finally, I consider a related topic involving Latino community members' experience of violence-related trauma, emotional problems resulting from the trauma, trauma-related care-seeking, sources of care, and satisfaction with care.

Notably, these research topics have grown in critical importance during the 21st century due to the continuing rapid growth of Latino populations in the U.S. and the well-documented difficulties often faced by community members in obtaining appropriate care for emotional and behavioral disorders (Aguilera & López, 2008; Molina, et al., 1994). Consequently, this research addresses challenges confronting mental health service providers created by an increasingly diverse U.S. population who's members require appropriate cross-cultural approaches to meet their mental health service needs (Guarnaccia & Rogler, 1999).

One major challenge in discussing Latino mental health issues involves the vast cultural heterogeneity of this population. As the population of Latinos in the U.S. grows rapidly, the heterogeneity of Latinos is likely to increase in a

number of ways, including place of origin, cultural values, socioeconomic status, and English-language competency. Although Latinos may share some common characteristics, significant variability can occur (Lara, et al., 2005).

A recent analysis of data from the NLAAS emphasizes the need to address heterogeneity among Latino community members and to conduct research that considers the diversity of Latinos. The authors of this assessment urge researchers to focus on this issue and to utilize strategies in their analyses to address the community's diversity and heterogeneity (Guarnaccia, et al., 2007).

To address issues of Latino community diversity I analyze survey subjects' country of origin as predictors of the causal definition of mental illness variable (See Chapter 4). I also discuss variations in mental health status and service utilization by community members' country of origin.

Theory & Research Literature Review

In this section I review relevant theory and research to establish a theoretical and empirical foundation for the dissertation. I start with a brief consideration of sociological theory related to the development of medical sociology and the sociology of mental illness. I also discuss the contributions of cognitive sociology relevant to understanding how Latino community members arrive at unique conceptions of underlying causal mechanisms of emotional disorders. Finally, I consider empirical data from mental health services research including specific research focusing on mental health in the Latino community.

Sociological theory and definitions of mental disorder.

Early sociological thinking about deviant behavior and its cultural definition establishes a background for my analysis of Latino cultural definitions of

emotional/mental problems. From the earliest era in sociological thought, concerns about normality and abnormality emerge as primary issues for authors such as Emile Durkheim. This attention to deviance evolves into theoretical models of illness as a form of deviant behavior.

Durkheim posits the need for rules and standards in defining what is normal and what is pathological in order for societal cohesion to exist. He argues that definitions of the pathological are key to sustaining and strengthening normality (Durkheim, 1966 [1895]). For Durkheim, rules that define the normal and the pathological vary according to the values of the social group. Since there is always an element of social control in the application of rules, social control is also necessary for rules defining the normal and the pathological. Durkheim's main concern is about rules of behavior such as crime and wrongdoing, but his analysis also relates to conceptual models of mental disorder which define acceptable behavior in a society. As a result, understanding mental disorder in terms of deviance is one of the primary ways to think about the phenomenon (Busfield, 2001).

Specifically defining illness as a type of deviance is another theoretical development related to my analysis of Latino cultural definitions of emotional/mental problems. Parsons (1951) is one of the first sociologists to conceptualize illness as deviance. A key aspect of Parsons' focus is on how various components of society function to maintain balance in the entire social system. For him, illness constitutes a threat to social cohesion because it inhibits efficient role functioning, a crucial aspect of maintaining social order. Parsons equates health with a person's ability to fulfill normal social roles. Because

illness involves withdrawal from expected roles and responsibilities, he recognizes it as deviance. Parsons also makes clear that the boundaries between health and illness vary between societies and in society over time (Busfield, 2001).

In subsequent analyses, several theorists contribute to a constructionist view of mental illness by explaining the linkage between deviance defined as illness and issues of power and social control. These theories are important in understanding the basic premise of this dissertation—that Latino community members share cultural definitions of mental illness which are substantially different from those of the majority Non-Latino White population living in the U.S., and that these unique understandings influence community members' experience of emotional/mental problems.

While most of the constructionist authors are sociologists, one group, called the anti-psychiatry movement, consists primarily of psychiatrists. Concepts formulated by anti-psychiatry proponents focus on psychiatrists' labeling of deviance as illness and their exploitation of mental illness labels to rationalize the exercise of social control. These views exemplify constructionist theory that is pertinent to my discussion of Latino cultural definitions of emotional/mental problems (Baltrušaitytė, 2003).

The primary American proponent of anti-psychiatry, Thomas Szasz (1974) argues that mental disorder is just a label used by psychiatry to mystify social control. In his view, 'problems in living' is the correct terminology for phenomena labeled as mental illness. For Szasz, defining these 'problems in living' as

diseases and placing them in the province of psychiatry leads to obscuring the exercise of social control.

Labeling theory extends the ideas of the anti-psychiatry movement and emphasizes the importance of stigma. In the labeling theory model, stigma attaches to the label of mental illness and impacts the behavior of the victim. The concept of stigma attaching to the label of mental illness is a key theoretical contribution of labeling theory that has a valuable application related to the analysis in this dissertation. Stigma avoidance plays an important role among Latino community members in their experience of mental disorder. For example, to avoid the stigma of *locura* (madness), Latino community members may adopt culturally defined idioms of distress like *ataque de nervios* which the community accepts as an appropriate response to especially stressful situations (Guarnaccia, Martinez , & Acosta, 2005).

Labeling theory also elaborate concepts related to the social construction of meaning. Labeling theory analyzes the ways in which deviance definitions attach to certain behaviors. Since deviant behavior has no consistent unitary content or essence; it emerges simply as behavior labeled as deviant because the deviant person violates social rules. Powerful, influential or significant social groups exert disproportionate influence in establishing social rules, which in turn define deviance. People labeled as deviant suffer stigmatization, excluding them from normal interactions, and converting their behavior into a distinctive career of deviance.

Since labeling theory draws attention to health and illness as negotiated social concepts, it creates an important critique of the psychiatric model of mental

illness. Labeling theory also emphasizes the necessity of moving beyond an understanding of mental illness simply in terms of cause and effect relationships (Baltrušaitytė, 2003).

According to Foucault (1967, 1987), the social construction of mental illness originates from medical discourses on insanity. He excludes any definition of madness from his discussion because he rejects the assumption that madness is a unitary, constant phenomenon with a continuous history. In his view, medical discourse on insanity creates an apparent unity of the concept. This unifying discourse constitutes the reality of mental disorder and defines knowledge about it. Therefore, Foucault sees madness not as a self-evident behavioral or biological fact, but as a product of socio-cultural practices. His analysis supports my contention that Latino cultural definitions of mental/emotional problems impact community members' understandings of such problems and the decisions they make about sources of care.

Freidson (2000) is another author who supports the notion of the social construction of illness and the importance of power in arriving at social definitions of the abnormal. His view that one can understand illness entirely as a social construct also supports the principal argument of this dissertation. By focusing his attention on the medical profession, Freidson broadens the discussion of the social construction of illness and the exercise of power. He argues that physicians tend to act in their own interests rather than those of the patient, and that the profession of medicine has acquired a vast authority and power in defining who is ill and who is not, as well as what is biologically normal and what is abnormal. For Freidson, illness may or may not have a biological reality, but it

always has a social one. In that sense, it is possible to perceive illness wholly as a social construct.

Furthermore, Pilgrim and Rogers (1998; Pilgrim & Rogers, 1999) present a description of primary themes within constructionist research on mental disorder. One theme ignores the demonstration or rejection of the reality of a phenomenon, focusing instead on social forces that define it. In this way, constructionist discourse refers to the theoretical frameworks of symbolic interactionism. Another emphasis points to the concept of reality as a product of human activity. Consequently, power relationships demonstrate an inextricable connection with definitions of reality.

By expanding the view of the conceptual landscape, sociological theories of mental disorder conceptualize the phenomenon in different terms: as deviance (and therefore focused on behavior), as reason (with its main emphasis on mental processes), and recently as an emotional expression of distress (utilizing a combination of body and mind). These theories stress the importance of social factors in the etiology of mental disorder and criticize the narrowness of biological explanations within psychiatric theories. Furthermore, the socially constructed and negotiated nature of conceptual boundaries of mental disorder focus attention on power relations that impinges upon conceptualizations of normal and abnormal.

The disease concept of mental illness is widely accepted among Non-Latino White populations living in the U.S. Horwitz (2002a) posits that even for non-psychotic conditions, the psychiatric community's symptom-driven taxonomy of mental disorder promulgates a disease concept of mental illness which is widely accepted. His analysis draws attention to the dispersion of the disease

construction of mental illness into the broad U.S. culture and its acceptance by diverse segments of the lay community.

However, in societies not fully accepting of the disease concept of mental illness, fuzzy boundaries tend to exist around mental disorder categories, along with greater variation in cultural-driven definitions of mental disorder (Wakefield, 2002). Immigrant groups whose cultural backgrounds do not generally incorporate the mental illness model, especially those recently arrived in the U.S., demonstrate how cultural factors shape community members' perception of mental disorder, including their understanding of the causal mechanism of such disorders. In the U.S., segments of the Latino community exemplify immigrant groups whose members share cultures that incorporate alternative conceptions of mental disorders (Romero, 2000).

Cognitive sociology: Culture and cognition.

Within the broad rubric of culture and cognition, I identify several key concepts relevant to this dissertation research. These concepts are useful in understanding how Latino community members arrive at unique conceptions of emotional disorders' underlying causal mechanisms as something other than the disease of mental illness.

Theories of broad mental structures applicable to representing and integrating information include those of worldview, schemata, and frames. These theories provide useful conceptual models in understanding how Latino community members arrive at unique understandings of underlying causal mechanisms of emotional disorders. They are also useful in analyzing how Latino community members conceptualize disorders and adopt culturally specific

explanatory models that do not currently appear in taxonomies of mental illness commonly used in the U.S.

Schemata are complex concepts representing diverse types of knowledge that range from basic information to multifaceted ideas. Further, one can connect and organize schemata to create inclusive constructs (Cerulo, 2002). While a culturally shared worldview establishes general cultural understandings, schemata translate worldviews into everyday thinking, feeling and action (Schwartz & Kim, 2002). The organization of information, opinion and attitudes into schemata accomplishes this result. Finally, social schemata provide frameworks that help humans interpret new information (DiMaggio, 2002).

In contrast, frames are fixed structures that characterize stereotyped interactions or situations. Erving Goffman's (1974b) original concept of frames defines frames as basic cognitive structures which guide the perception and representation of reality. People apply a collection of situational and interactional frames that comprise a set of expectations which they use to evaluate new situations (Cerulo, 2002).

Cognitive sociologists make distinctions regarding how cognitive science and cultural sociology view thinking, information processing, accumulation, and organizing of thought. Within cognitive science, an emphasis is on thought produced by biochemical processes in the brain, how information processing functions, and universal rules for organizing and storing thought. In contrast, cultural sociology emphasizes how situated interaction creates thought, how social settings specify information processing systems, and how the sociocultural context distinguishes organization and storage management. An important

consideration for the current topic of this dissertation is that sociocultural context explains why certain cultural constructs, such as those shared by members of the Latino community, function to shape shared definitions of reality and patterns of social action (Cerulo, 2002).

When Wakefield (2002), writing in “Fixing a Foucault sandwich: cognitive universals and cultural particulars in the concept of mental disorders,” simultaneously applies cognitive science and cultural sociology to analyze mental illness, he identifies a model for finding common ground between these seemingly disparate disciplines. Wakefield further suggests a universal basis for mental disorder, and then situates mental disorders in their sociocultural context. After defining mental disorder as a “harmful internal dysfunction” (p. 256), he examines the cultural aspects of mental illness by posing questions about the effects of time and place, social attention and action, and power and exploitation. In applying this model, Wakefield creates an explication of culture’s impact on cognition (Cerulo, 2002).

Horwitz (2002b) builds on Wakefield’s model by drawing attention to the critical relationship between symptoms and disorders, and to the consequences that arise from stressful structural conditions. Since idioms of distress experienced by Latino community members appear to provide powerless group members a means of expressing the anguish of their stressful life circumstances, this analysis contributes to understanding the utility these disorders provide.

Horwitz’s analysis clarifies how culture works to structure symptoms of mental disorder to expose an internal dysfunction. He writes that “symptoms of mental disorder are symbolic representations of underlying vulnerabilities that are

structured to fit dominant cultural models of ‘appropriate’ disorders in particular times and places” (p. 268). Further, he suggests that this model calls attention to consequences normal people experience as the result of dealing with stressful structural conditions such as socioeconomic inequality and racial/ethnic discrimination.

Viewed as a body of sociological work, the authors I review emphasize the importance of a social and cultural basis for understanding and responding to mental/emotional problems. In this dissertation, I contend that Latino community members’ cultural beliefs about such problems have an impact on their care-seeking decisions, including choices they make regarding sources of care and their satisfaction with that care. The under-utilization of professional mental health services by Latino community members, which is documented in the following section, may be one result of these cultural understandings.

Mental health services research.

Mental health services research, informed by social science research, focuses on a need to comprehend the importance of cultural understandings incorporated in social and institutional processes associated with the delivery of such services (Mechanic, 1987). Many factors account for variations in mental health services utilization among disordered members of different ethnic groups. Sociologists identify differences in cultural definitions of personal problems, such as emotional and behavioral disorders, as important contributors to service utilization patterns. Horwitz (1987; 2002a) notes that members of ethnic groups who are not conversant with psychiatric culture, including some Latinos, are less likely to seek help from professional mental health service providers. For

example, Mexican community members are one cultural group that tends to underutilize mental health services.

Kleinman (1980) describes cross-cultural psychiatry as an interdisciplinary research approach which integrates anthropological methods and conceptualizations with traditional psychiatric and psychological approaches. This model encourages researchers to respect indigenous illness categories and recognize limitations of accepted psychiatric typologies, such as depression and schizophrenia. In addition, cross-cultural psychiatry distinguishes between disease as a “malfunctioning or maladaptation of biological or psychological processes,” and illness as “the personal, interpersonal, and cultural reaction to disease” (López & Guarnaccia, 2000, p. 572).

As reported in the *World Mental Health Report* (Desjarlais, Eisenberg, Good, & Kleinman, 1996), research points to a link between mental illness, behavioral problems, and the social world. One example involves the social disruption that occurs when adolescents and young men migrate from rural communities to urban cities. Cultural shock, lack of social supports, inability to find steady employment, and substance abuse are among the many risk factors predictive of mental disorder (López & Guarnaccia, 2000).

Recent findings highlight the importance of immigration in understanding mental health and mental illness. For example, various reports show that Mexican-born Mexican Americans have significantly lower prevalence rates across a wide range of disorders than US-born Mexican Americans (a phenomenon often referred to as the Mexican or Latino paradox). The social and psychological mechanisms responsible for differing prevalence rates among immigrant groups

are unclear. Consequently, acculturation and other immigration issues are worthwhile areas for investigation to better understand the interrelatedness of the social world and psychopathology (López & Guarnaccia, 2000).

Latino community in the U.S. and mental health.

Molina, Zambrana & Aguirre-Molina (1994) point out that changing demographics of the United States population have a substantial impact on health care and public health issues. Predictions indicate this trend will continue for decades into the future. Among diverse population groups, the influence of cultural beliefs on health-related behavior, and the process of group members' acculturation into majority cultural beliefs, are issues of major concern.

Prevalence of mental illness.

In general, the rate of mental disorders among Latino Americans is similar to that of Non-Hispanic White Americans. However, Latino youth experience proportionately more anxiety-related and delinquency problem behaviors, depression, and drug use than do Non-Hispanic White youth. Culture-bound syndromes identified in Latino Americans include *susto*, *nervios*, *mal de ojo*, and *ataque de nervios*. Adult Mexican immigrants have lower rates of mental disorders than Mexican Americans born in the United States, and adult Puerto Ricans living in Puerto Rico tend to have lower rates of depression than Puerto Ricans living on the mainland ("Fact sheet: Latinos/Hispanic Americans," 1999).

Research findings indicate a possible association of first-generation immigrant status and low English-language proficiency with a reduced risk for substance use disorders, and with a lower overall risk for psychiatric disorders. The finding that immigrant status appears to exert a protective effect on mental

health problems across Latino groups is consistent with the so-called Latino paradox. This paradox involves the finding that although an association exists between low socioeconomic status and inferior health outcomes, the health status of Latinos in low socioeconomic categories is better than that of Non-Latino Whites in the same categories, and the health status of Latino immigrants is better than that of US-born Latinos (Alegría, et al., 2007).

Importance of cultural factors.

Kleinman (1987) observes that culture not only shapes illness, but also determines the ways one conceives of illness. Even in similar countries, dramatic differences exist in the way patients present to clinicians, in the interpretation of medical tests, and in the types and formulations of treatments.

The influence of culture plays an important role in shaping one's view of mental illness. Many culturally relevant factors influence Latinos' perceptions about mental health and their utilization of mental health services. Specifically, Latinos' perception of mental illness may play an influential role in their underutilization of mental health services. Individuals who endorse religious or supernatural causes of mental illness are less likely to utilize mental health services. Because religion plays an important role in the lives of many Latinos, they often seek help for medical and mental health needs from religious organizations. Latino community members may also seek the assistance of spiritual leaders to help them resolve their daily problems, regardless of acculturation level. Some Latinos will seek mental health assistance from folk healers (Curanderos). These folk healers use power of suggestion, persuasion, direct advice, massage, herbs, rituals, prayer, and the client's sense of guilt and

sin. Nonetheless, the use of folk healers and religious organizations may limit Latinos' utilization of community mental health programs (Lara, Gamboa, Kahramanian, Morales, & Bautista, 2005).

Suárez (2001) emphasizes the importance of cultural forces in motivating Latino community members to seek folk and spiritual remedies for health problems. She notes the characteristic ways that ethnic groups socialize members in defining and responding to their problems. When problems occur, the culture provides distinctive ways of understanding the trouble, and of deciding if group members need to take action to address the difficulty, including what kind of assistance they should seek and where they need to look for help. Latinos living in the U.S. often incorporate these beliefs into elements of Non-Latino White popular medicine. As a result, etiological concepts and resource utilization often reflect multicultural influences.

The persistent arrival of new immigrants from Latin America to the U.S. functions to keep long-standing, traditional cultural practices alive. It is also common for Mexican immigrants living near the border in the U.S. who experience emotional problems to return to Mexico to obtain treatment from folk healers or other community sanctioned sources (Suárez, 2001).

Garrison (1977) provides examples of Latino community reliance on traditional faith-healing systems. Her research shows Puerto Rican community members living in New York City frequently respond to powerful cultural messages that motivate them to seek help for emotional problems from *espiritista* (folk healers) rather than from psychiatric professionals. In similar research, however, *espiritista* and other folk healers often refer community members to

orthodox health care practitioners, and even collaborate directly with mental health professionals in the treatment of emotional disorders (Suárez, 2001).

Romero (2000) reports that ways in which Latino community members understand and attribute causes of mental disorder influence service utilization patterns among community members. Lay understandings of illness causation among Latino community members incorporate a holistic view of illness, which often attributes illnesses to supernatural causes, environmental causes (such as “bad air”), or strong emotions (Molina & Aguirre-Molina, 1994).

Comas-Días (2006), in her discussion of the need to culturally adapt mainstream psychotherapy to Latino populations, observes that Latinos’ cognitive style is highly reactive to imagery and fantasy. She also notes that research has shown Latinos use more fantasy, magical thinking, and dissociation than their Non-Latino White and African American counterparts. Further, she identifies the literary genre “magical realism” as an example of belief in the supernatural found in Latino culture.

Cultural values also influence how community members perceive treatment options and make treatment-seeking decisions. Dana (1993) emphasizes the need to understand Latinos as a cultural group and Latino individuals as cultural beings in her assessment of the impact of culture on mental health. His research suggests that service providers can utilize local preferences for folk healers or spiritual healing to develop more culturally sensitive approaches to mental health services.

Gender differences in care-seeking reflect cultural conceptions of appropriate gender-related behaviors. Very low mental health service utilization

rates for men are consistent with cultural norms that depict men as strong and capable of independently controlling their emotions. Other contrasting cultural norms portray women as weaker and more appropriate victims of illness, and consequently, a greater likelihood exists for women to report mental-illness symptoms and to utilize mental health services (Romero, 2000).

Guarnaccia, Martinez, & Acosta (2005) provide a recent overview of mental health in the Latino immigrant community. They report the prevalence and incidence of disorders among specific ethnic sub-populations, analyze patterns of service utilization, and identify barriers to care. Their findings point to differences in social and cultural backgrounds of each of the four largest groups (Mexicans Americans, Puerto Ricans, Cuban Americans, and Dominicans). Furthermore, they describe substantial intra-cultural differences within each group, and varied experiences after migrants arrive in the U.S.

The authors review several major studies that examine Latino mental health status in the United States. In summary, their data indicate the Mariel Cubans have the highest rates of disorder across all four diagnoses considered (Major Depression, Panic Disorder, Phobia, and Alcohol Disorders). Mexicans and Cubans have higher rates of alcohol problems, and all four studies report high rates of phobias. However, in all of these studies, methodological problems exist. An example of these difficulties involves high rates of reported phobia which may reflect the subjects' real concerns about immigration issues (Guarnaccia, et al., 2005).

Additional research compares rates of mental/emotional disorder among immigrant populations and non-immigrant Latino groups. Results generally show

lower rates of disorder among the non-immigrant groups and increasing levels of problems in immigrant communities—levels that approach those of Non-Latino White populations. However, in another recent study, Alegría et al. (2008) suggest immigrants benefit from a protective context in their country of origin, possibly inoculating them against risk for mental disorders, particularly if they immigrate to the U.S. as adults. One such protective factor involves supportive family networks. Family disruption is a common aspect of immigration, and may contribute to increasing levels of disorder (López & Guarnaccia, 2000).

Access to care.

Giachello (1994) identifies issues of health care access among Latino populations living in the United States as the greatest single problem faced by group members in obtaining health care. Financial, cultural, and institutional barriers contribute to this lack of access. Latino community members tend to underuse mental health services and to resort more often to crisis-oriented mental health care than to other types. Community members' reliance on alternative sources of treatment, and barriers to care within the mental health services sector, inhibit access by community members, contributing to underutilization of mental health services (Treviño & Rendón, 1994).

Data from the *Surgeon General's Report*, "Fact sheet: Latinos/Hispanic Americans" (1999) indicate that among Latino Americans with a mental disorder, fewer than one in eleven contact mental health specialists, while fewer than one in five contact general health care providers. Among Latino immigrants with mental disorders, fewer than one in twenty use services from mental health specialists, while fewer than one in ten use services from general health care providers.

While accurate estimates of the use of alternative treatment sources by Latinos living in the U.S. do not exist, one study found that 4% of its Mexican American sample consulted a *curandero*, *herbalista*, or other folk medicine practitioner within the past year, while use of alternative sources of care from other studies range from 7% to 44%. Folk remedy usage is more common than consultation with a folk healer. Use of these remedies generally complements mainstream care ("Fact sheet: Latinos/Hispanic Americans," 1999).

Research on mental health services utilization for Mexican Americans generally indicates very low rates of service use. When Chicanos do seek help for mental health problems, they show a preference for general medical settings as sources of care. Cubans living in Miami and Puerto Ricans living in Puerto Rico have utilization rates similar to the general U.S. populations. Research also suggests that reducing or removing barriers to care significantly increases utilization rates for some community members—especially for out-patient services (Guarnaccia, Martinez, & Acosta, 2005).

Importance of acculturation.

González-Ramos & González (2005) address mental health disparities in new Latino immigrant populations and consider issues of acculturation. Acculturation is the process through which an immigrant adapts to a new cultural environment. Because this process of acculturation impacts learning, behavior, values, and social activities, it usually takes three to four years. Furthermore, it requires a complex adaptation involving cognitive, behavioral, and affective changes (Fuertes, Alfonso, & Schultz, 2005).

In addition, the authors discuss the importance of the acculturation process and the extent to which becoming more acculturated makes community members increasingly vulnerable to higher rates of mental health problems. Although a strong association exists between acculturation stress and migration, mental health service providers often ignore culture shock and other migration readjustment experiences (Fuentes, et al., 2005).

Violence-related trauma among Latino immigrants.

The experience of trauma is an important factor among several population sub-groups in the Latino community. Many refugees from Central America, for example, report first-hand experience with civil war-related trauma in their homelands. Studies indicate rates of post-traumatic stress disorder among Central American refugee patients, ranging from 33% to 60% (Fact sheet, 1999).

Eisenman et al. (2003) report that Latino immigrants receiving primary care in Los Angeles have a high prevalence of exposure to political violence before immigrating to the U.S., and they exhibit associated impairments in mental health and health-related quality of life. In another study, Engstrom & Piedra (2005) point out that even though stress and trauma among Central American refugees are well documented, members of this population remain underserved. The authors attribute this lack of access to obstacles such as documentation problems and lack of health insurance. They also identify institutional factors that hinder service utilization, such as a lack of translators and a perplexing bureaucracy. Stigma associated with the violence-related trauma may also play a role in underutilization.

Trans-border immigration from Mexico also places Latino community members at risk for violence-related trauma. Recent research documents a culture of extreme violence affecting trans-border migrants who often experience serious brutality such as beatings, kidnappings, and rape. Documentation problems associated with their illegal entry into the U.S., and shame regarding the details of the abuse, may constrain the willingness of victims to seek mental health care (Jácome, 2010).

Additional theory and research discussion.

In each of the following chapters, I review theory and research specifically relevant to the dissertation topic discussed in that chapter. In Chapter 2, I focus on the data and methods used in my dissertation project. I also summarize statistical information about the Latino population living in the U.S., in the state of North Carolina, and in Mecklenburg County and in Cabarrus County of North Carolina. This summary estimates the impact of undocumented Latino population groups and includes research information on the increasingly multicultural composition of the Charlotte region. I continue by summarizing information about the original study which created the data analyzed in the current research. I then discuss data and methods used in the current research.

Chapter 2: Research Data and Methods

My dissertation research examines cultural definitions of mental health/illness among members of a Latino community living in the United States and assesses the impact of these cultural understandings on reporting an experience of emotional problems, seeking care for the problem, sources of care, and satisfaction with that care. Secondary data analyses utilize survey data from prior research focusing on mental health service needs among Latino community members living in Mecklenburg and Cabarrus Counties, North Carolina. My research also explores qualitative data from key informant panel discussions and focus group participants' responses collected as part of the earlier research.

In this chapter, I present information on data and methods used in my dissertation project. First, I summarize statistical information about the Latino population living in the United States, in the state of North Carolina, and in Mecklenburg County and Cabarrus County of North Carolina. My summary considers the impact of undocumented Latino populations and includes research information on the increasingly multicultural composition of the Charlotte Region.

I then summarize information about the original study which created the data analyzed in the current research. I include research objectives and methods used in the original research. In the balance of the chapter, I discuss data and methods used in the current research. Topics include the selection of variables for the current analyses, hypotheses tested in the current analyses, selected sample data summary, and the scope and limitations of the current research. I end with a brief summary of the contents of this chapter.

Latino Populations Living in the United States: Data Summary

In this section, I summarize available data, including population statistics, on the Latino population living in the U.S. Accurate population statistics for the Latino community are difficult to estimate because of the large undocumented segment of the population. I use data from the Pew Hispanic Center and the Office of Immigration Statistics, U.S. Department of Homeland Security, as resources to estimate undocumented Latino population statistics for the U.S., North Carolina, and Mecklenburg and Cabarrus Counties in North Carolina.

National Latino population data summary.

Table 2.1 summarizes national Latino population statistics for the years of 2000 and 2008 compared to other racial/ethnic groups living in the U.S. The Latino segment of U.S. population increased from 12.5% in 2000 to 15.4% in 2008, and the total Latino population reached 46,822,476 people in 2008 ("A statistical portrait of Hispanics at mid-decade," 2008).

Table 2.1

Summary of National Latino Population Statistics by Race/Ethnicity, 2000 and 2008 (in millions)

Population Groups	2000 Pop.	2008 Pop.	% 2000	% 2008
Hispanic/Latino	35.2	46.8	12.5	15.4
Native born	21.1	29.0	7.5	9.5
Foreign born	14.1	17.8	5.0	5.9
White alone, not Hispanic	194.5	199.0	69.1	65.4
Black alone, not Hispanic	33.7	36.8	12.0	12.1
Asian alone, not Hispanic	10.1	13.2	3.6	4.4
Other, not Hispanic	7.9	8.3	2.8	2.7
Total	281.4	304.1	100.0	100.0

Note. Adapted from "A statistical portrait of Hispanics at mid-decade" (2008). *Pew Hispanic Center reports and factsheets*. Retrieved 7/27, 2008, from pewhispanic.org/reports/middecade/

Population estimates which incorporate corrections for undocumented (unauthorized) Latino groups inflate the total Latino population size considerably. Passel (2006), from the Pew Hispanic Center, estimates 11.5 to 12 million total U.S. unauthorized population as of March 2006. Unauthorized migrants from Mexico and the rest of Latin America represent 78% of the overall unauthorized population. He also estimates that 56% of the unauthorized population is from Mexico, and 22% of the unauthorized group comes from the rest of Latin America, primarily from Central America. Using these estimates, the undocumented Latino population in the U.S. was about 9.2 million in 2006.

According to the Office of Immigration Statistics, U.S. Department of Homeland Security, the total number of unauthorized immigrants living in the U.S. in 2008 was 11.6 million, but the total decreased to 10.8 million in 2009, due largely to the U.S. economic downturn. In this estimate, the four largest unauthorized immigrant groups by country of origin are from Latin America. See Table 2.2 for a breakdown of unauthorized immigrants by country of origin in Latin America. Groups from the Central American countries of Guatemala (65%) and Honduras (95%) increased the most rapidly from 2000 to 2009 (Hoefer, Rytina, & Baker, 2010).

Table 2.2

Country of Birth of the Unauthorized Immigrant Population, January 2000 and 2009 (in millions)

Country of birth	Estimated population		% of total		% change
	Jan. 2000	Jan. 2009	2000	2009	2000 - 2009
All countries	8.5	10.8	100	100	27
Mexico	4.7	6.7	55	62	42
El Salvador	0.4	0.5	5	5	25
Guatemala	0.3	0.5	3	4	65
Honduras	0.2	0.3	2	3	95

Note. Adapted from “Estimates of the unauthorized immigrant population residing in the United States: January 2009,” by M. Hoefer, N. Rytina, & B. C Baker (2010). Washington, DC: Office of Immigration Statistics, Policy Directorate, U.S. Department of Homeland Security.

Applying the estimated undocumented Latino population proportions from Passel (2006), the 2008 undocumented Latino population in the U.S. is approximately 9.1 million or about 19% more than the Census Bureau’s estimates of the documented segment of the population. I estimate the total Latino population in the U.S by including undocumented groups. This total is approximately 55.9 million, or 18.4% of the total U.S. population in 2008.

North Carolina Latino population data summary.

North Carolina’s Latino population has grown dramatically over the last two decades. Data from a study by the Pew Hispanic Center, *The new Latino South: The context and consequences of rapid population growth* (Kochhar, Suro, & Tafoya, 2005), show the North Carolina Latino population with a 394% increase—the highest rate of increase in Latino population of any state in the U.S. between 1990 and 2000.

Latino immigrants in North Carolina are predominantly foreign-born (57%), mostly men (63%) and young (median age 27). Most of these immigrants (62%)

lack a high school diploma, and 57% do not speak English well, or do not speak it at all. More than half of these immigrants entered the U.S. between 1995 and 2000, and most lack legal status (documentation). North Carolina, with roughly 300,000 undocumented immigrants in 2000, ranked eighth among states with the largest undocumented populations (Kochhar, et al., 2005).

In Table 2.3, data estimating North Carolina's Latino population from 2000 to 2008 reflects continuing growth of this segment of the population, with a 79.8% increase for documented Latino residents by 2008. Furthermore, by applying the undocumented Latino population estimates from Passel (2006), total estimated Latino population in North Carolina is about 807,000 including both documented and undocumented groups, which represents approximately 8.8% of the total North Carolina population.

Table 2.3

North Carolina Latino Population Summary Statistics Including Estimated Undocumented Groups, 2000 and 2008 (in thousands)

	Total	2000 Latino	2008 Latino	% Change	% Latino
<i>Documented:</i>	9,222.4	377.1	678.0	79.8	7.4
<i>Undocumented:</i>			128.8		1.4
Total:			806.8		8.8

Note. Adapted from "A statistical portrait of Hispanics at mid-decade" (2008). *Pew Hispanic Center reports and factsheets*. Retrieved 7/27, 2008, from pewhispanic.org/reports/middecade/

Mecklenburg and Cabarrus Counties, NC, population data summary.

Mecklenburg County, North Carolina, includes the city of Charlotte, and was home to nearly 700,000 people in 2000. Its Latino population increased from less than 7,000 in 1990 to nearly 45,000 in 2000, a growth rate of 570% (Kochhar, et

al., 2005). More recent data from 2008 show Mecklenburg County with a Latino population of 96,214, or 10.8% of the total county population. Cabarrus County, located east of Mecklenburg County, had 15,065 Latino residents in 2008, or 8.9% of the total county population according to these data (*Sociodemographic characteristics of the general population in North Carolina*, 2008).

See Table 2.4 for a summary of recent estimates of North Carolina Latino population size for Mecklenburg and Cabarrus Counties. Applying the undocumented Latino population estimates from Passel (2006), the combined Mecklenburg and Cabarrus Latino population total, including an estimate for undocumented residents, is about 132,422, or 18.8% of the combined total population of both counties.

Table 2.4

Mecklenburg and Cabarrus Counties Latino Population Summary Statistics, 2000 and 2008 (in thousands)

	Total	2000 Latino	2008 Latino	% Change	% Latino
Mecklenburg:	611.6	45.9	96.2	110	10.8
Cabarrus:	94.6	6.7	15.1	124	8.9
Total (with undocumented):			132.4		18.8

Note. Adapted from *Sociodemographic characteristics of the general population in North Carolina* (2008). Raleigh, NC: N.C. DHHS.

Charlotte's rapidly changing multicultural population.

Charlotte, North Carolina, the county seat of Mecklenburg County and the largest city in the region, recently (since 1990) experienced a rapidly growing Latino population that observers consider unprecedented for a community like Charlotte which previously had little experience in dealing with a large number of international migrants (Deaton, 2008). A report on Charlotte's changing

multicultural population and the social and cultural issues related to the transformation, *Charlotte: A welcome denied*, focuses on the need for Charlotte to adapt to this changing population dynamic. The report dramatizes the changes in Charlotte in the following portrayal:

On Monday, April 10, 2006, more than a million Latino immigrants took to the streets in cities across America to call for immigration reform that would make legal the status of millions more undocumented immigrant workers in this country. On that sunny spring afternoon in Charlotte, N.C., a crowd estimated by organizers at ten thousand gathered uptown in Marshall Park and joined the nationwide chorus with shouts of “*Si se puede!*” It was a sight that a decade ago would have been unimaginable—a metaphor for Charlotte’s transformation from a traditional New South city to a multicultural *mélange* with a distinctly Latin flavor (Deaton, 2008, p. 4).

Data from a University of North Carolina, Charlotte, Urban Institute study of Latino community needs summarize a number of key sociodemographic challenges faced by new Latino immigrants. The report summarizes these difficulties which include:

- Most Mecklenburg County Latinos are foreign born (68.2%) and not U.S. citizens (57.9%), and 57% do not speak English well, or not at all.

- Most Latinos in Mecklenburg County have less than a high school diploma and are employed in low average-wage jobs.

- A high proportion of the adult Latinos settling in Mecklenburg County have only limited formal education and are functionally illiterate in their own native language.

- Compared to other Mecklenburg County residents, Latinos suffer economic disadvantage at higher rates. For example, 22.5% of Latinos live in

poverty and 34.9% live in crowded conditions (Harrison, Friend, Furuseth, & Smith, 2006, p. vi).

The study also examines Latino residential patterns and notes the majority of Mecklenburg County Latino residents live in three suburban areas in Charlotte and Mecklenburg County. This residential configuration results in a spatial mismatch between where services are available and where Latino community members live, creating a barrier to service access (Harrison, et al., 2006).

The report summarizes Latinos community members' responses to questions about the difficulties and challenges of living in Mecklenburg County.

The highest ranking challenges or barriers reported are:

- Inadequate English language skills.
- Discrimination/anti-immigrant attitudes.
- Immigration, especially undocumented status.
- Lack of education/literacy.
- Lack of Spanish language service providers.
- Cost and access to healthcare services.
- Well paying jobs.
- Access to transportation and transportation coverage (Harrison, et al.,

2006).

Charlotte is the city of choice in North Carolina for the resettlement of refugees groups, including refugees from Latin America. These refugee groups are more likely to confront additional problems. For example, refugee populations are more likely to experience violence in their native countries.

Violence and its associated trauma are major health concerns for many refugees in the Latino community (Norris, 2009).

The North Carolina Refugee Assistance Program reports that 2,043 refugees came to North Carolina in 2007, and the majority (529) of these expatriates were resettled in Charlotte/Mecklenburg (Myers, 2010). Catholic Social Services of the Diocese of Charlotte operates The Refugee Resettlement Office which has assisted in the resettlement of more than 10,000 refugees in Charlotte from 27 nationalities since 1975 (Ponce, 2010).

Original Research Data and Methods

Survey response data and qualitative information used as secondary data for analyses in this research come from a study conducted in Mecklenburg and Cabarrus Counties, North Carolina, in 2004-2005. The Mental Health Association of Central Carolinas (MHA) sponsored the original research and authorizes this secondary analysis of the data.

Objectives of the original study.

The MHA identified an information void in the Charlotte, NC, region regarding knowledge of mental health service needs within the Latino community. By conducting a study that used survey data and focus group responses from a diverse sample of Latino community members, the MHA intended to make a significant contribution to closing this information gap. The study explored how community members understand, experience, and respond to mental health problems.

The original research question was: What are the unmet mental health service needs of the Latino community in Mecklenburg and Cabarrus Counties, North Carolina?

Mental health providers and Latino community stakeholders in Mecklenburg and Cabarrus Counties received results of the original study. The MHA also developed programs of information, education, outreach, and advocacy addressing concerns identified by the research.

Methods used in the original study.

The MHA recruited and supported a research team responsible for designing and implementing the study in 2004-2005 of Latino community members in Mecklenburg and Cabarrus Counties, North Carolina,

Key informant panel and focus group research methods.

Professional informants selected for the key informant panel are representatives of regional mental health agencies, local Latino community-service organizations, and members of the local Latino community. The following is a listing of the panel members by title and program affiliation:

Executive Director, *Mi Casa Su Casa*; Executive Director, *Central Avenue Bilingual Preschool Program*; Program Director, *Our Lady of Guadalupe Catholic Church*; Program Director, *Mecklenburg County Area Mental Health*; Program Director, *Piedmont Behavioral Healthcare*; Executive Director, *Latin American Coalition*; Program Director, *Centro de Salud Betesda*; Pastor, *Iglesia Bautista Camino del Rey*; Mental Health Clinician, *Mecklenburg County Area Mental Health*; Board Member, *Mental Health Association*; and Program Director, *Catholic Social Services, Programa Esperanza*.

The key informant panel met in February 2005 at the Mental Health Association of Mecklenburg County offices, Charlotte, NC. The Research team developed and used a topic guide to organize the discussion around topics of interest in planning the research project and in developing survey research questionnaires and focus group discussion guides.

MHA staff recorded and transcribed the panel discussion. The transcript identifies responses from individual panel members (N = 11) to facilitate accurate quotation of their comments. However, I do not identify key informant panel members' quotations included in this dissertation by name for reasons of confidentiality.

Survey subjects (N = 21) who identified themselves as having personally experienced emotional/mental problems and who volunteered to participate in follow-up discussions comprised the focus group meetings. Seven subjects attended each of three focus group meetings. Focus groups met at the offices of Our Lady of Guadalupe Catholic Church, *Centro de Salud Betesda*, and *Mi Casa Su Casa*.

A mental health professional, who is a member of the Latino Mental Health Advisory Committee, conducted each focus group in Spanish. Group facilitators followed a discussion guide prepared by the research team which established specific topics for the group to consider.

A second mental health professional attended each focus group meeting to monitor and record participants' responses to discussion topics. Mental health professionals carefully monitored focus group participants during the discussions to identify any distress or emotional problems they might experience as a result of

their participation and all focus group participants received information regarding mental health service providers in Mecklenburg and Cabarrus counties.

Focus group participants were anonymous and their identity and personal information were not recorded or disclosed to protect their privacy, especially in regard to their mental illness history and uncertain immigration documentation status. I do not identified individual focus group participants in this dissertation for reasons of participant confidentiality.

Survey research methods.

After a review of literature relevant to Latino community mental health issues, the research team formed a Latino Advisory Committee (advisors) consisting of Latino community representatives, and a Latino Mental Health Professional Key Informant Panel (key informant panel) comprised of mental health service professionals who were also Latino community members (See Appendix for listing of members of the Latino Advisory Committee and the Latino Mental Health Professional Key Informant Panel).

The key informant panel provided community-specific information which informed the original study design. The advisors reviewed the Spanish-language questionnaire, advised the research team on Latino cultural issues, and assessed the study's results.

The researchers developed a questionnaire in English organized around issues identified by the key informant panel and literature review. An advisor translated the questionnaire into Spanish. The advisors reviewed the Spanish-language questionnaire. Researchers revised the questionnaire to incorporate

recommended changes, and field tested it (See Appendix for copies of the English-language and Spanish-language questionnaires).

The research team recruited volunteer Spanish-speaking interviewers from participating community organizations (See Appendix for a list of participating community organizations and interviewers), and trained interviewers in using the questionnaire. Volunteer interviewers conducted four hundred interviews with community members at participating organization's locations.

The survey sample was a non-probability, purposive sample with a goal of interviewing at least 400 Latino community members. Researchers identified survey subjects from members of a diverse selection of participating community organizations, and verified that the subjects came from various geographic areas dispersed throughout Mecklenburg and Cabarrus Counties. A zip-code analysis of subjects' residential location in the counties illustrates the geographical diversity of subjects within the two-county area (See Appendix for details of the zip-code analysis). Researchers concluded survey subject recruitment when they reached the goal of 400 interviews.

Subjects had the option of completing the survey in English or Spanish, and questionnaires were available in both languages. All of the subjects elected to use the Spanish version of the questionnaire, and no subjects chose the English version. Although there were no additional questions in the survey regarding language preferences or usage, selecting the Spanish option suggests that the subjects were more comfortable using their native language.

All subjects in the original research are anonymous. There is no identity information of any type in the records of the study. Also, all of the subjects in the original study were adults.

Two of the referring groups were religious organizations (Our Lady of Guadalupe Catholic Church, and *Iglesia Bautista Camino del Rey* Baptist Church). I address concerns regarding potential biases among these survey subjects resulting from their church membership in the analyses section of the dissertation (See Chapter 4).

I also address concerns regarding the heterogeneity of the sample and cultural diversity within the Latino community by comparing responses of survey subjects from Mexico, Central America, and other Latin American countries. See the analysis section Chapter 4 for results of this comparison.

Current Research Data and Methods

The research presented in this dissertation utilizes selected questionnaire responses from the original data for secondary analyses based on each response's relevance to the current research questions. The current research also considers descriptive information generated by the focus groups and the key informant panel.

Selection of variables for analyses.

The following section summarizes survey questions selected for secondary analyses. Each question's relevance to the research hypotheses is the basis for selection. See Appendix for a copy of the complete questionnaire in English and Spanish.

An initial survey question asks what the respondent thinks causes someone to act very sad (depressed), very strange (anti-social), bizarre (hallucinations) or self-destructive (suicidal). Additional questions ask if a respondent's family member experienced an emotional/mental problem, and if so, where they sought help for the problem, and if they felt satisfied with the help they received.

Additional questions ask respondents if a family member experienced an emotional/mental problem found in Hispanic culture, and if so, where they sought help for the problem, and if they felt satisfied with the help they received. Respondents also answered questions about a family member's experience of trauma from political violence, natural disaster, or other abuse, and about whether the trauma resulted in emotional/mental problems. They also responded to questions about where they sought help for trauma-related problems and about whether they felt satisfied with the help they received.

Demographic questions include: country of origin, years lived in the U.S., education level, age group, gender, current family residence ZIP Code, and respondent's referral source (Religious/Non-Religious).

Research hypotheses.

Based on issues identified in the literature review and data from the original research, including inputs from the key informant panel of Latino mental health professionals, I define the following research hypotheses for testing in the current analyses. The hypotheses predict relationships between variables selected from survey responses for secondary analyses. These hypotheses, with a focus on social construction of mental illness and cultural influences on

that construction, reflect theoretical inferences developed from the body of literature reviewed in the areas of cognitive sociology and Latino mental health services research.

Hypothesis related to subject's causal definition of mental/emotional problems.

Based on reports in the literature of substantial cultural differences in understanding about the causes of mental/emotional disorder between Latinos and Non-Latino White U.S. populations, I hypothesize that Latino community members responding to the survey are more likely to define the cause of mental/emotional problems as something other than mental illness.

Hypotheses related to subject's demographic characteristics.

Based on specific epidemiological evidence which show younger Latinos report higher rates of past-year disorders compared to older age groups (Alegría, Mulvaney-Day, et al., 2007), I hypothesize that Latino community members responding to the survey who are younger (<35 years of age) are more likely to define mental illness as the cause of emotional/mental problems.

Based on specific epidemiological evidence which show Latinos with more than a high school education report higher rates of past-year disorders compared to groups with less than high school educations (Alegría, Mulvaney-Day, et al., 2007), I hypothesize that college educated Latino community members responding to the survey are more likely to define mental illness as the cause of emotional/mental problems.

Based on specific epidemiological evidence which show Latinos with more time living in the U.S. report higher rates of past-year disorders compared to

groups with less time living in the U.S. (Alegría, Mulvaney-Day, et al., 2007), I hypothesize that Latino community members responding to the survey who have lived in the United States for more than five years are more likely to define mental illness as the cause of emotional/mental problems.

Based on specific epidemiological evidence which show female Latinos report higher rates of past-year disorders compared to male Latinos (Alegría, Mulvaney-Day, et al., 2007) , I hypothesize that female Latino community members responding to the survey are more likely to define mental illness as the cause of emotional/mental problems.

Hypotheses related to subject's referral source and country of origin.

Based on the assumption that survey subjects referred to the study from religious organizations are more likely to adopt spiritual explanations for mental/emotional problems, I hypothesize that Latino community members responding to the survey referred from a religious group are less likely to define mental illness as the cause of emotional problems.

Based on cultural constructs supporting beliefs in the supernatural identified among people of Mexican origin, such as *sanación* (belief in spirituality) (Comas-Díaz, 2006), I hypothesize that Latino community members responding to the survey who report Mexico as a country of origin are less likely to define mental illness as the cause of emotional problems.

Hypotheses related to subject's reporting of mental/emotional problems and culturally defined problems.

Based on constructionist perspectives and theories from cognitive sociology, I hypothesize that Latino community members responding to the

survey who define mental illness as the cause of emotional problems are more likely to report an episode of an emotional/mental problem.

Based on constructionist perspectives and theories from cognitive sociology, I hypothesize that Latino community members responding to the survey who define the cause of emotional problems as something other than mental illness are more likely to report an episode of a culturally defined emotional problem.

Based on constructionist perspective and theories from cognitive sociology, I hypothesize that Latino community members responding to the survey who define the cause of emotional problems as something other than mental illness are more likely to report an episode of specific culturally defined emotional problems (*ataque de nervios, susto, angustia, and mal de ojo*).

Hypothesis related to subject's causal definition of mental/emotional problems and care seeking.

Based on theoretical perspectives and mental health service utilization data, I hypothesize that Latino community members responding to the survey, who report an emotional/mental problem and define the cause of mental/emotional problems as mental illness, are more likely to seek care.

Hypotheses related to subject's causal definition of mental/emotional problems and sources of care.

Based on theoretical perspectives and mental health service utilization data, I hypothesize that Latino community members responding to the survey who report an episode of emotional/mental problems and define the cause of

mental/emotional problems as mental illness are more likely to seek care from a mental health professional.

Based on theoretical perspectives and mental health service utilization data, I hypothesize that Latino community members responding to the survey who report an episode of emotional/mental problems and define the cause of mental/emotional problems as something other than mental illness are less likely to seek care from a mental health professional.

Hypothesis related to subject's causal definition of culturally defined problems and satisfaction with care.

Based on theoretical perspectives and mental health service utilization data, I hypothesize that Latino community members responding to the survey who report an episode of culturally defined problems and define the cause of mental/emotional problems as something other than mental illness are more likely to indicate the care provided for culturally defined problems meets the needs of the victim.

Hypothesis related to subject's report of violence-associated emotional problems.

Based on theoretical perspectives and mental health service utilization data, I hypothesize that Latino community members responding to the survey who report an episode of violence-related emotional problems and define the cause of mental/emotional problems as a cause other than mental illness are less likely to seek care and less likely to seek care from mental health professionals.

Selected sample data summary.

The following Table 2.5 summarizes the demographic characteristics of survey subjects. Included are gender, age, education, country of origin, years living in U.S., and referral source. I list country of origin data by frequency. The most frequently reported country of origin is Mexico (59.7%), with Central American countries (El Salvador, Honduras, Costa Rica, Guatemala, and Nicaragua) the next most frequent group of countries reported (23%).

Table 2.5

Demographic Characteristics of Survey Subjects (N = 400)

Characteristic	<i>n</i>	%
Gender		
Male	194	48.5
Female	206	51.5
Age		
18-24	74	18.5
25-34	165	41.25
35-44	104	26
45-54	38	9.5
≥ 55	19	4.75
Education		
Elementary	129	32.25
Secondary	147	36.75
College	120	30
No Formal	4	1
Country of Origin		
Mexico	239	59.7
El Salvador	47	11.75
Honduras	31	7.75
Colombia	12	3
Dominican Rep.	11	2.75
Ecuador	11	2.75
Puerto Rico	11	2.75
Cuba	6	1.5
Other	6	1.5
Venezuela	6	1.5
Costa Rica	5	1.25

Guatemala	5	1.25
Nicaragua	4	1
Years Living in U.S.		
≤ 5 or Less	195	48.75
6 to 10	145	36.25
11 to 15	28	7
16 to 20	16	4
> 20	16	4
Referral Source		
Religious	148	37
Non-Religious	252	63

Although Latino community members participating in the survey do not comprise a random sample, and results of the survey cannot be generalized to the larger Latino population living in the U.S., a comparison of the key demographic characteristics of the sample group to the national Latino population may provide an indication of the similarity of the groups and identify potential biases in the sample. Comparisons include country of origin, education, age, and gender. I use data from the PEW Hispanic Center's 2008 American Community Survey (2009) to make these comparisons. National data on time living in the U.S. are not available for comparison.

One difficulty in making comparisons with national population statistics involves the apparent exclusion of undocumented population members in official statistics (Passel, 2006). It is likely that Latino community members participating in the survey included a substantial number of undocumented individuals, raising questions about the comparability of these data sources.

Country of origin comparison.

Table 2.6 shows a comparison between the survey sample and national Latino population statistics for key country-of-origin groupings.

Table 2.6

Comparison of Country of Origin, Survey Sample and National Latino Population (Percent)

Country	Survey Sample	National Latino
Mexico	59.7	65.7
Central Amer.	23	8.2
Puerto Rico	2.75	8.9
Cuba	1.5	3.5
Other Latino	13.05	13.7

Note: Data on national Latino population are from the PEW Hispanic Center 2008 American Community Survey (2009).

Compared to national Latino population statistics, the survey sample consists of a smaller proportion of Mexican-origin survey respondents and a greater proportion of respondents with Central American origins. Also, in comparison to the national Latino population, a smaller proportion of survey respondents have Puerto Rican or Cuban origins.

Among possible implications for the survey sample, research shows Central American immigrants to the U.S. have elevated levels of trauma caused by political violence and report more mental disorder problems than other Latino groups (Eisenman, et al., 2003; Engstrom & Piedra, 2005). Regarding Cuban and Puerto Rican groups, Mariel Cubans are thought to have higher levels of mental disorder (Guarnaccia, et al., 2005), and Puerto Ricans and Cubans are more likely to use mental health services than Mexican Americans (Guarnaccia & Martinez, 2002). Puerto Ricans are also more likely to report *ataque de nervios* (Guarnaccia, et al., 2010). In regards to the 'Latino Paradox,' lifetime mental illness prevalence rates between immigrant and U.S. born Puerto Rican subjects show no differences (Alegría, et al., 2008), and Puerto Ricans exhibit similar

rates of mental disorder as U.S. born Non-Latino White groups (Guarnaccia & Martinez, 2002).

While an overrepresentation of Central Americans in the research sample may contribute to elevated reports of violence-related trauma, underrepresentation of Cuban and Puerto Rican groups may reduce biases resulting from heterogeneous characteristics found in these populations. See Chapter 4 for an analysis of the impact of survey subjects' country of origin on predictors of a causal definition of mental illness variable.

Educational attainment comparison.

Table 2.7 presents a comparison of educational attainment differences between the survey sample and national Latino population.

Table 2.7

Comparison of Educational Attainment, Survey Sample and National Latino Population (Percent)

Education	Survey Sample	National Latino
Elementary	32.25	23.5
Secondary	36.75	41.7
College	30	34.8

Note: Data on national Latino population are from the PEW Hispanic Center 2008 American Community Survey (2009). The 'college' category includes college graduates and those with some college.

The proportion of survey respondents with an elementary school education is greater than the national Latino population, while there are slightly fewer college educated respondents in the survey sample. One consequence of these sample group characteristics could be a bias in favor of non-scientific causal explanations for emotional problems.

Age comparison.

The median age of the Latino population living in the U.S. is 27 years-of-age (*Statistical profile of Hispanics 2008, 2009*), while the modal age range of survey participants is 25 – 34 years-of-age. Age characteristics of the survey sample suggest a limited potential for bias based on age differences.

Gender comparison.

Table 2.8 shows a comparison of gender proportions between the survey sample and the national Latino population.

Table 2.8

Comparison of Gender Groups, Survey Sample and National Latino Population (Percent)

Gender	Survey Sample	National Latino
Male	48.5	52
Female	51.5	48

Note: Data on national Latino population are from the PEW Hispanic Center 2008 American Community Survey (2009).

While females are slightly overrepresented in the survey sample, a bivariate analysis of these differences using cross tabulation shows there is not a significant difference in the proportion of females, $\chi^2(1, N = 400) = 0.85, p = 0.36$. Therefore, a survey sample bias based on gender is unlikely.

Analytical methods for assessing survey response data.

Principles outlined by Agresti (2007), and Bishop, Fienberg & Holland (2007) guide the selection of analytical methods for categorical data analysis used in this research. I use contingency tables to analyze associations between categorical variables by describing the association and applying inferential methods for those parameters. I use the chi-squared test of independence to

test the significance of the proportions for each set of variables. I also use the phi coefficient to assess the degree of association between variables for each set of variables.

My research examines selected variables using appropriate statistical modeling procedures. The most popular model for statistical modeling of binary response variables is binary logistic regression. Binary logistic regression can have multiple explanatory variables, and these predictors can be categorical rather than quantitative. Multinomial logistic regression analysis can also be employed with categorical data and can model multiple categorical dependent variables. The number of variables selected for inclusion in each logistic regression model depends on the need to be complex enough to fit the data well, but simple enough to interpret (Agresti, 2007).

Scope and Limitations of the Research

This research utilizes data collected in 2004-2005 from interviews conducted with Latino community members residing in the Charlotte urban area of Mecklenburg and Cabarrus Counties, North Carolina. Although survey subjects come from a diverse selection of community organizations, and reside in various geographic areas dispersed throughout Mecklenburg and Cabarrus Counties, they do not constitute a random sample, and results cannot be generalized to the larger Latino population. The results do, however, suggest the degree to which these Latino community members adopt culturally influenced definitions of mental health/illness, and the impact these definitions have on their reporting the experience of emotional problems, seeking care, selecting sources of care, and reporting satisfaction with care.

Referral sources for survey subjects are both secular and religious organizations in Mecklenburg and Cabarrus Counties, North Carolina. It is possible that subjects referred from religious organizations may have different characteristics than the balance of the sample due to their religious orientation. See Chapter 4 for an analysis of these differences.

Survey subjects from a number of different Latin American countries may have cultural differences which influence their responses to the survey questions. While Latino community members from Mexico and Central America comprise the majority of survey subjects (84%), the remaining subjects (16%) may bias the results because of their dissimilar cultural backgrounds. See Chapter 4 for an analysis of these differences.

Differences between the educational attainments of Latino community members participating in the survey compared to the overall Latino population living in the U.S. may bias the results of the survey. About 32% of the participating Latino community members report an elementary school education, while educational attainment data show 24% of Latinos in the U.S. have an elementary school education (*Statistical profile of Hispanics 2008, 2009*).

Although the original study team made every effort to carefully select and train Spanish-speaking interviewers, it is possible that interviewer biases may have influenced interview subjects' responses. The use of a relatively large number of interviewers recruited from a variety of different community groups tends to mitigate potential biases.

The Spanish language has many variants in the diverse zones where it is spoken in Latin America (Ager, 2010). A Latino Advisory Committee made up of

representatives from several different Latin American countries, including Mexico, Venezuela, Columbia, Cuba, Puerto Rico, El Salvador, the Dominican Republic, and Mexican American, carefully reviewed the translation of the survey instrument into Spanish. National and regional differences in Spanish language variants or dialects, however, may have introduced potential biases for survey participants from different regions of Latin America.

The intent of qualitative data from the original research is to provide descriptive information to increase understanding and enhance meaning and context, but not to serve as a source for causal determination or prediction. Focus group members (N=21) and key informants (N=11) are not representative samples and results cannot be generalized.

Because the research reported in this dissertation uses secondary data analyses of survey data from prior research focusing on mental health service needs among Latino community members, several variables that would be helpful in separating the effects of non-Latino factors (socioeconomic status, age and date of immigration, marital status, health insurance coverage, etc.) are not available for analysis.

Terminology Distinctions

I make several distinctions regarding terminology used in this dissertation. The first relates to the designation for the people who are the central focus of the investigation. In the United States, the terms “Hispanic” and “Latino” reflect a cultural identity based on language and geographical provenance; they are not racial definitions, and in fact, they include people from several races.

Latinos are not a homogenous group. They are a highly diverse population with many different designations, some of which are self-imposed. Latino identities comprise an ethnic rainbow—a few of the labels are: Hispanics, Latinos, Hispanos, Latins, Central and/or South Americans, Xicanos, Ricans, Boricuas, Mexican Americans, Chicanos, Tejanos, and Americanos (Comas-Díaz, 2006). I refer to members of this community as Latinos in this dissertation.

Terminology for the dominant, White U.S. population is also problematic, with some authors using White and Caucasian incorrectly because many Latinos are White and Caucasian. Others use European Americans or European Origin which are insufficiently inclusive. The more pejorative Anglo or Gringo are not appropriate. I choose to adopt U.S. Census Bureau terminology of ‘Non-Latino White’ to designate this population group. Although somewhat cumbersome, this terminology accurately delineates the desired population group.

The immigration status of Latino community members is an important concern in this research. Immigration status is referred to as documented or undocumented, authorized or unauthorized, legal or illegal, and within the community itself, with or without papers. In most instances I use the documented/undocumented dichotomy in this dissertation.

To distinguish between conditions community members understand as diagnosable emotional disorders, I use the term ‘emotional/mental problems.’ To identify culturally specific emotional disorders found in Latino communities, often called culture-bound syndromes, I use the term ‘culturally defined emotional problems.’

Human Subjects Full Review Exemption

Since my dissertation research consists exclusively of secondary analysis of existing data, human subjects are protected because all subjects in the original research are anonymous. None of the subjects in the original research are identified in any way in the records of the study. Also, all of the subjects in the original study are adults. Focus group participants are not individually identified in the focus group discussion records or elsewhere in the study's records.

The research reported in this dissertation has been exempted from full IRB review by the Rutgers University Institutional Review Board for the Protection of Human Subjects in Research. The researcher also has successfully completed the Rutgers University Human Subjects Compliance Program (11/23/2008).

Summary of Data and Method

In this chapter, I review research question and methodology used in the original research which created the data analyzed in this dissertation. First, I summarize available data, including population statistics, on the Latino population living in the U.S., North Carolina, and Mecklenburg/Cabarrus Counties. I also discuss Charlotte's changing multicultural population and the social and cultural issues related to the transformation.

I describe methods used in the original study, including information on qualitative data collection (key informant panel and focus groups) and survey research. I also detail objectives and methods for the current research, identify survey questions selected for secondary analyses, and present research

hypotheses predicated on issues identified in the literature review and data from the original research.

In addition, I provide a data summary describing the selected sample, including descriptive statistics on variables of gender, age, education, country of origin, years living in U.S., and referral source. I compare survey sample characteristics to national Latino population statistics and discuss potential biases.

Finally, I outline analytical methods for assessing survey response data, the scope and limitations of the research, terminology distinctions, and human subjects full review exemption.

Chapter 3: Qualitative Data & Results

In this chapter I present qualitative data from key informant panel discussions and survey participant focus group responses. I also link these qualitative data to Latino cultural constructs identified in the Theory & Research Literature Review (Chapter 1) as key considerations in understanding Latino mental health issues.

While my use of cultural constructs and cognitive frameworks may appear incompatible, these approaches are not necessarily mutually exclusive. Cognitive sociologists identify mental structures used by humans to represent and integrate information. I connect concepts drawn from cognitive sociology to facets of Latino culture that impact community members' recognition of, and reaction to, symptoms of mental disorder.

A careful definition of culture as it relates to mental health and illness is necessary in this approach. One such definition is: "Culture refers to socially shared systems of beliefs, values, and meanings. It encompasses, among many other factors, people's ethnic heritage, religious beliefs, and political principles..." (Horwitz, 2010, p. 7).

Culture influences community members at basic levels and has important implications for mental illness. Understanding cultural values can enhance our understanding of Latino emotional disorder experiences and their mental health service utilization (Romero, 2000). Latinos are a heterogeneous group with varying ancestry and geographic influences. Yet many Latinos share similar cultural constructs that powerfully influence their lives, beliefs, and behavior

(Añez, Paris, Bedregal, Davidson, & Grilo, 2005). Comas-Díaz (2006) writes about such shared history and experiences:

Notwithstanding their heterogeneity, most Latinos share a history of Spanish colonization (culture, religion, language, and worldview); experience of uprooting, separation, or immigration; and exposure to oppression (Comas-Díaz, 2006, p. 436).

The following Table 3.1 summarizes a number of important cultural constructs found in Latino cultures.

Table 3.1

Summary of Latino Cultural Constructs Related to Mental Health Issues

Latino Cultural Construct	Description	Source(s)
Familismo (family orientation; extended family)	Family orientation, a ubiquitous context in Latino culture, makes health and sickness family affairs. The family is looked at first in terms of help-seeking; influences mental health utilization. Family beliefs and traditional patterns of behavior are transmitted generationally. Family is broadly defined with grandparents, aunts, uncles, cousins, <i>compadres</i> , (close friends) and <i>padrinos</i> (godparents) of the family's children included.	(Añez, et al., 2005; Comas-Díaz, 2006; Duran, et al., 2001; Guarnaccia & Martinez, 2002; Romero, 2000)
Personalismo (personal rather than institutional relationship)	Emphasis on trust and rapport from warm, friendly, personal relationships. Latinos relate more effectively to people than to institutions; they resist formal, impersonal structures.	(Molina, et al., 1994)
Respeto & Dignidad (respect; mutual and reciprocal deference; dignity)	Dictates appropriate deferential behavior towards others based on age, sex, social position, economic status, and authority. Lack of <i>respeto & dignidad</i> brings stigma.	(Añez, et al., 2005; Duran, et al., 2001)
Confianza (trust and intimacy in a relationship)	Trust results from appropriate <i>respeto & dignidad</i> . When there is <i>confianza</i> , Latinos value time with health care providers and believe them because <i>confianza</i> means the provider has their best interests at heart.	(Duran, et al., 2001; Molina, et al., 1994)
Fatalismo (fatalism; external locus of control)	Fatalism is the belief that individuals have minimal control over their environment. Latinos who accept fatalism believe that events occur only as a result of luck, God's will, or harmful wishes of adversaries.	(Kouyoumdjian, Zamboanga, & Hansen, 2003)

Latino Cultural Construct	Description	Source(s)
Controlarse (self-containment or conscious control of negative affect)	In Latino culture a strong individuals are able to control themselves; it is a character weakness to experience mental illness or to seek professional help. Believing inability to control emotions is a weakness reduces likelihood of seeking professional care and creates stigma.	(Añez, et al., 2005; Comas-Díaz, 2006; Kouyoumdjian, et al., 2003)
Aguantarse (the ability to withstand stressful situations during difficult times)	Being able to withstand stress during bad times. Mental health problems are not necessarily validated, but are viewed as a sign of weakness, and may carry stigma.	(Añez, et al., 2005; Duran, et al., 2001; Romero, 2000)
Sobreponerse (self-suppression)	Construct similar to <i>controlarse</i> , calls for a particular mindset in overcoming challenges. Individual needs to overpower and triumph over his/her adversity.	(Añez, et al., 2005)
Locura (madness)	The label of <i>locura</i> or madness carries strong negative connotations for Latinos. Someone who is <i>loco</i> is seen as severely mentally ill, potentially violent, and incurable. The stigma of mental illness is a barrier to seeking care.	(Guarnaccia & Martinez, 2002)
Tristeza (sadness) and duelo del corazón (mournful heart)	Ubiquitous conditions found among Latino populations and expressed creatively in literature and art. Not considered to be <i>locura</i> , but rather a common experience of Latino community members, especially women, often in response to problems.	(Garrard–Burnett, 2000; Vélez-Ibáñez, 1996)
Curandersimo (Latino folk-healing system)	Many Latinos hold a worldview strongly influenced by spiritual and religious factors that includes beliefs about illness and health. Beliefs are part of complex medicine systems that originated in pre-Columbian cultures. Equilibrium between forces of nature creates health, while the disequilibrium of these forces causes illness.	(Murguía, Peterson, & Zea, 2003; Trotter & Chavira, 1997)
Realismo Mágico (Magical Realism)	Latinos' cognitive style which is highly reactive to imagery and fantasy. A belief in the supernatural, magical realism is expressed through cultural forms. Magical realism can have a spiritual omnipresence in Latino life.	(Abrams, 2004; Comas-Díaz, 2006)
Virgen María (Virgin Mary)	Mother Mary is a powerful cultural figure for Latinos. Mary as the symbol of a nurturing mother keeps women at home and out of politics, while machismo encourages men as strong, dominant and powerful.	(Vélez-Ibáñez, 1996)

In their comprehensive review and analysis of Latino mental health issues, Guarnaccia and Martinez (2002) call attention to the dearth of empirical research

focused on the application of these Latino cultural values in mental health treatment. They acknowledge that:

The literature contains many suggestions about Latino values (such as *respeto*, *personalismo*, *familismo*) that should be incorporated into mental health treatment. Articles also suggest that therapies that are more directive rather than insight oriented and more family rather than individual focused will be more effective with Latinos. However, the research base for these assertions is lacking (Guarnaccia & Martinez, 2002, p. 22).

In this research, I use these cultural constructs to show how cultural beliefs transform Latino community members' understandings of emotional problems they and their family members experience, and how these social constructions influence Latinos' responses to these problems by shaping care-seeking and treatment preference decisions.

I suggest that by using concepts drawn from cognitive sociology, insights emerge about how these cultural constructs impact community members' recognition of and reaction to symptoms of mental illness. To this end, I apply concepts like worldview, schemata, and frames to link Latino cultural constructs to the qualitative data presented in this chapter. Table 3.2 illustrates a model linking concepts from cognitive sociology with Latino cultural constructs. It adopts a hierarchical design illustrating the parallel structure of these ideas².

Table 3.2

Linking Cognitive Sociology with Latino Mental Cultural Constructs and Mental Health Characteristics

Cognitive Sociology	Latinos	Description	Impact(s)
Worldview/Ethos — cognitive aspects of a culture/emotional, evaluative and aesthetic facets.	Group orientation	Latinos define themselves within the context of a relationship to others and to a collective.	Collective orientation; opposite to individualistic orientation of U.S. majority.
	Fatalism	Fatalism is the belief that individuals have minimal control over their environment.	May accept mental disorders as inevitable.
	Spirituality	A respect for and deference to the divine; spirituality permeates Latino life.	Emphasis on spirituality in understanding mental disorder.
	Magical realism	Latinos' cognitive style which is highly reactive to imagery and fantasy.	Acceptance of supernatural explanations and cures.
Schemata—broad structures embodying different types of knowledge (from basic concepts to complex information).	Cultural constructs	Many, including: <i>familismo</i> (family orientation), <i>personalismo</i> (personal rather than institutional relationship), <i>confianza</i> (trust and intimacy in a relationship).	Influence understanding of mental disorder and choices of care.
	Health & illness beliefs	Health is attributed to the equilibrium between forces of nature, and illness is attributed to the disequilibrium of these forces.	Acceptance of non-biological explanations; reliance on alternative sources of care.
	Institutional mistrust and avoidance	<i>La Migra</i> , fear of corrupt authority especially among undocumented groups.	Aversion to institutional sources of care. Barrier to most mental health services.

Cognitive Sociology	Latinos	Description	Impact(s)
Frames—discrete models people use to represent repetitive interactions or circumstances.	Stigma of <i>locura</i>	The label of <i>locura</i> or madness carries strong negative connotations for Latinos.	Discourages seeking care from mental health professionals.
	Extended family lay referral	Family orientation, a ubiquitous context in Latino culture, makes health and sickness family affairs.	Family is first in terms of help-seeking; influences utilization.
	Idioms of distress <i>Ataque de nervios, susto, angustia, mal de ojo</i>	Specific ways in which members of sociocultural groups convey affliction.	Destigmatizing culturally disapproved of conditions. Expressing conditions of disadvantaged groups.
	Alternative care Religious Folk medicine Self-treatment/ <i>Botánica</i>	Reliance on alternative sources of care including <i>curanderos</i> and <i>botánica</i> .	Affects utilization of professional mental health services.

Note: Sources for table content include (Añez, et al., 2005; Cerulo, 2010; Comas-Díaz, 2006; Guarnaccia & Martinez, 2002; Schwartz & Kim, 2002).

At the broadest level, Latino community members' worldview establishes shared general cultural understandings reflected in the more specific cultural constructs (Schwartz & Kim, 2002). A collective orientation predominates for Latinos as contrasted with a more individualistic emphasis for the Non-Latino White majority culture in the U.S. Fatalism may lead Latino community members to accept problems as inevitable, and spirituality may influence their choices regarding solving problems. A cognitive style which is highly reactive to imagery and fantasy may lead Latinos to favor supernatural explanations and cures over biological explanations for mental disorder (Comas-Díaz, 2006).

Schemata—broad structures embodying different types of knowledge—exist for Latino community members in the form of cultural constructs that cover a wide range of social situations and conditions (Cerulo, 2002). They include constructs like *familismo* (family orientation), *personalismo* (personal rather than institutional relationship), and *confianza* (trust and intimacy in a relationship). Other schemata include beliefs about health and illness, and attitudes about the negative aspects of institutions (Comas-Díaz, 2006).

Frames—discrete models people use to represent repetitive interactions or circumstances—include examples from Latino culture like the stigma associated with the label of *locura* (madness) which carries strong negative connotations for Latinos (Cerulo, 2002; Guarnaccia & Martinez, 2002). Other examples of how frames are relevant to understanding Latino community members' perceptions and behaviors related to mental disorder include extended family members' role as a lay referral network, ways in which members of Latino groups convey affliction through idioms of distress, and their reliance on alternative sources of care, including *curanderos* and *botánicas* (Comas-Díaz, 2006).

Previously, in Chapter 2, I present methodological details regarding key informant panel and focus group research. Because of confidentiality concerns, key informant panel members' comments remain anonymous in this chapter. In addition, focus group participants' identity and personal information remain confidential to protect their privacy, especially in regard to their mental illness history and their uncertain documentation status. Because of these

confidentiality concerns, additional information about focus group participants, including several variables that would be helpful in separating the effects of non-Latino factors (socioeconomic status, age and date of immigration, marital status, health insurance coverage, etc.) are not available for analysis.

I organize the qualitative data presented in this chapter in terms of the primary issues that are the focus of this research. First, I consider qualitative results that underscore how Latino community members conceptualize emotional/mental problems in ways that differ from members of the majority Non-Latino White population living in the U.S. Then I address how Latino community members experience emotional/mental disorders. I discuss qualitative data that illustrate how Latino community members' experience culturally defined emotional disorders. These culturally specific conditions are part of Latino culture but not readily understood within definitions of mental illness existing among Non-Latino White groups. In addition, I consider issues related to care-seeking and barriers to care existing for members of the Latino community. I discuss how Latino cultural constructs may play an important role in a pattern of mental health service underutilization among Latino populations living in the U.S. Finally, I present qualitative data regarding violence and its associated trauma which are major health concerns for many in the Latino community. I discuss the linkage of emotional problems to the experience of violence and explore care seeking for these emotional problems.

Causal Definitions of Emotional/Mental Disorders

The primary focus of this research is on how unique Latino cultural constructs influence members of the Latino community by creating

understandings of the emotional problems they and their family members experience that are different from those shared by the majority Non-Latino White population in the U.S. Qualitative data informs this research by providing descriptive information from Latino community members who experience mental/emotional problems and who participate in focus groups. Additional qualitative data describing how Latino community members understand the causes of emotional disorders and react to symptoms of emotional/mental problems come from mental health professionals and community leaders who are members of a Key Informant panel.

The key informant panel and focus groups initiated their meetings with discussions of how Latino community members understand the causes of emotional/mental disorders. In their discussion of Latino community members' beliefs about the causes of emotional/mental problems, key informant panel members emphasize the differences between widespread beliefs existing in the Latino community about behavioral disorders and mental illness constructs commonly accepted in U.S. culture. They stress that, especially in less educated, rural populations, Latino community members tend to accept behavioral disorders as natural, part of nature, caused by evil spirits, or as punishment by God for sinful behavior.

Many segments of the Latino population share a similar worldview encompassing beliefs about illness and health that exhibit powerful influences of spiritual and religious forces. Latino culture typically views health from a synergistic point of view. This view encompasses a continuum of body, mind, and *espíritu* (spirit) (Duran, et al., 2001). Roots of Latinos' cultural explanations

about illness and disease exist in shared historical knowledge as well as in common spiritual experiences and practices (Molina, et al., 1994). Many of these understandings derive from an ancient heritage of complex health-belief systems originating in pre-Columbian civilizations (Murguía, et al., 2003).

Key Informant Panel results.

Quotes from key informant panel members emphasize these themes:

Particularly among rural populations, people do not believe there is something actually wrong with a person who has mental health problems. They believe the problems are related more to an individual's personality or even religion. Also, they believe the person may be under a voodoo curse or spell. This is particularly true among the less educated. The more rural the person is, the more that person is lacking in knowledge of other options. There is still a strong belief in gods and devils.

One panel member remembers her childhood experiences growing up in a rural Venezuelan village where several community members who behaved in deviant and unusual ways received tolerance and support within the community.

She says:

In the small village where I grew up in Venezuela there were always a few people who talked to themselves or to spirits, had strange visions or hallucinations, and were not capable of working or caring for themselves. Their odd and bizarre behavior was generally accepted as natural, part of nature, and people in the village watched out for these people and gave them food and a place to sleep if needed.

Another panel member expands the discussion of Latino community members' alternative conceptions of emotional/mental disorder to include Caribbean and Andean cultures:

In the Caribbean region there is a strong spiritual influence from Africa. In other countries there are similar beliefs. The Andeans in Latin America see these issues as natural (being of nature), so they are not defined as mental health problems. For this reason, there is more tolerance for someone being unusual. When someone is known to see things or hear voices, other Latinos (particularly the less educated or those that may

have grown up in more rural areas) often associate such behavior as a peculiarity or an eccentric/artistic quality of that person. They learn to simply tolerate those differences.

These observations by a key informant panel member focus on Latinos' belief in spirituality—respect for and deference to the divine—which is an important part of their worldview. Called *sanación*, spirituality permeates Latino life, shapes how Latinos socialize their children, and consecrates the family as the center of social life (Añez, et al., 2005; Comas-Díaz, 2006).

Another panel member illustrates acceptance of emotional/mental disorder symptoms as natural or part of nature by describing a client who does not recognize her symptoms of depression:

I have a client who has symptoms of depression she understands as normal sadness. For Latinos, sadness is not connected to mental health. They recognize they are sad but that does not equate to a mental health issue like depression.

Tristeza (sadness) and *duelo del corazón* (mournful heart) are ubiquitous conditions found among Latino populations and expressed creatively in Latino literature and art. Not considered to be *locura* (madness), but rather a common experience of community members, especially among women, these conditions often occur in response to problems of living, including problems of violence and abuse (Garrard–Burnett, 2000; Vélez-Ibáñez, 1996).

Several panel members discuss the role of religion and religious beliefs. One panel member says:

I want to emphasize the weight of religion. This is a very heavy thing in the Latino community—something that can either suffocate or enlighten. The burden is on the individual. One has to worry about how the church will view mental illness and how the family will view it. Is it a sin or a curse? It's a heavy topic that no one wants to talk about.

Another panel member comments on how the Catholic Church in the U.S. is different for Latino community members compared to Non-Latino White church members:

These issues are perpetuated in the American Catholic Church too. The church is very paternalistic—women are told to listen to and serve their husbands. Also, there is a difference between masses. In the American Churches (uptown), 95-98% of the members will go to Communion. In comparison, in the Latin American Churches, only 5-10% go to Communion. Within the American Catholic Church, we may have a more self-righteous attitude. In the Latino community, it's more about, "God is looking at me. I can't lie about that." So, even if I talk about somebody else, I can't go to Communion because I'm not worthy of it.

One panel discussion participant emphasizes the role of women as portrayed by religious beliefs. She states:

The Virgin Mary is the model for women in Latino society. Women are expected to be pure, virginal. They are expected to stay at home, care for the family, and especially their man. Meanwhile the macho men are out carrying on with other women. All of this is changing for the modern, urban Latina, but rural, less educated women still live as before.

For more than five centuries the religious culture of the Virgin Mary, mother of Jesus Christ, has strongly influenced the broader, mainstream Latin American culture and society. Today, Mother Mary continues as a powerful cultural figure for Latinos. Mary as the symbol of a nurturing mother keeps women at home and out of politics, while *machismo* beliefs encourages men as strong, dominant and powerful (Vélez-Ibáñez, 1996).

As a result, heavy social pressures demand that Latinas strive to make motherhood their major objective in life, to protect their virginity before marriage, to act like a lady, and to care for children and elderly family members. Latinas who are socialized into these traditional gender roles often face conflicts,

especially when confronting the gender-role expectations of modern, urban cultures in the U.S. (Canales, 2000).

Focus Group results.

Focus group responses mirror a number of the same issues regarding Latino community members' beliefs about the causes of emotional/mental problems. The first discussion topic in the focus groups is: What are the differences in how Latino community members recognize and understand mental health problems?

A split in opinion exists among participants of one group regarding the importance of 'spirits' versus 'natural causes' for emotional/mental problems. Another group emphasizes 'evil spirits' as the primary cause. Focus groups conclude that how each participant is raised and educated determines their response(s) to emotional/mental problems. One focus group participant says:

We believe these problems are part of life, something from nature. But when people have serious problems, many try to blame evil spirits, the evil eye, or being cursed. We learn these things from our families and our communities.

Overall, focus group participants express varying opinions on the root causes of mental health problems divided among the following: evil spirits, the evil eye, and natural causes. Several participants also mention the notion of being cursed. When asked directly about hallucinations, participants agree evil spirits cause them.

Comas-Diaz (2006) makes a distinction between spirituality and religion in Latino culture. She writes:

Spirituality differs from organized religion because it transcends religious affiliation. As a way of life, spirituality helps many Latinos to deepen their

sense of meaning and purpose. Problems and obstacles are interpreted as trials, where the goal is to fulfill one's life mission. Many Latinos learn spirituality through imitation, participation in rituals, and cultural osmosis (Comas-Díaz, 2006, p. 444).

Focus group participants also mention generational and age differences as important factors for identification and understanding of mental health issues, with younger Latinos having a more modern, scientific viewpoint which helps them to accept mental illness as the cause of emotional problems.

Experience of Emotional/Mental Disorders in the Latino Community

Qualitative data also provides descriptive information on how Latino community members experience emotional/mental disorders. Focus group participants report a number of examples of Latino community members' experience of emotional/mental problems. Most participants admit to experiencing some type of depressive symptoms themselves at one time or another since being in the U.S. A general consensus also exists about knowing someone in their community with serious mental health problems.

Focus Group results.

Group participants identify isolation and loneliness as important factors for Latinos, as are physical and verbal abuse. They also mention homesickness as a common theme when feeling depressed, since many Latino community members suffer family dislocation when they immigrate to the U.S. One participant comments about her family dislocation and the sadness she has experienced:

I feel so much loneliness and sadness. It's worse at the holidays when I miss friends, children, my family. Homesickness is something I feel all of the time. When I'm alone it is all I think about.

The Latino cultural construct of *familismo* reflects the importance of family among Latino community members who look first to the family for help-seeking. Family orientation is ever-present in Latino culture. For this reason, the family serves as an influential lay referral network in the Latino community. One way to understand the impact of *familismo* is by using the concept of frames from cognitive sociology. Making health and sickness a family affair has a powerful influence over how Latino community members make care-seeking decisions and how they decide on preferred sources of care (Guarnaccia & Martinez, 2002; Romero, 2000).

Focus group participants agree that sadness and depression are common among Latino immigrants. There is a consensus that leaving family and friends results in isolation, loneliness and in some cases emotional/mental problems. Health statistics data indicate Latinos in general experience feelings of sadness twice as often as Non-Latino White groups. Latino men experience feelings of sadness 2.1 times as often as Non-Latino White men, and Latino women experience feelings of sadness 2 times as often as Non-Latino White women. For women, the percentage of population with feelings of sadness is 6% for Latino women, compared to 3% for Non-Latino White women ("Summary Health Statistics for U.S. Adults: 2007," 2009).

There is also a consensus among focus group participants that a generalized level of anxiety and fear exists among the more recent Latino arrivals to the U.S., even if they have papers (legal immigration documentation). One participant talks about the constant worry and anxiety:

Yes, I feel frightened, anguished, nervousness. My family is legal, we have papers, but so many of our friends and neighbors are not. We are always looking over our shoulder. Many of our friends are anxious, nervous, especially the ones who have been in the U.S. a short time. They worry about getting sent back and losing everything they have here.

Latinos who migrate to new locations that separate them from their families may increase the risk for emotional problems. Examples include groups such as young immigrant workers or couples newly arrived in the U.S. (Duran, et al., 2001). There is, however, research evidence that indicates lower rates of mental disorder among Latino immigrant populations. Often referred to as the Mexican paradox or Latino paradox, a large body of research indicates that Latino immigrants appear to have lower rates of mental health problems. Members of this group may under-report symptoms used as criteria for a psychiatric diagnosis in epidemiological research on the prevalence of mental disorder among Latino population groups (Alegría, et al., 2008; Ortega, Rosenheck, Alegría, & Desai, 2000). Not all Latino subgroups exhibit this phenomenon. Puerto Ricans, for example, have mental illness rates similar to those reported by U.S. born Latinos and U.S. born Whites (Guarnaccia & Martinez, 2002). See Chapter 4 for a more detailed discussion of the Latino paradox.

Culturally Defined Emotional Problems

The importance of idioms of distress, also called culture-bound syndromes, is a central issue in understanding how Latino cultural beliefs and specific cultural constructs impact Latino community members' experience of culturally defined emotional disorders and how they seek culturally appropriate care. Qualitative data provide descriptive information regarding these conditions

which are part of Latino culture but not readily understood within mental illness definitions of emotional disorder among Non-Latino White groups.

Key Informant Panel results.

Key informant panel members emphasize the importance of culturally defined emotional problems in the Latino community. They note that these beliefs can persist even after the community member migrates to the U.S.

A fundamental aspect of Latino beliefs regarding health and illness involves spirituality (*sanación*), which is a basic part of their worldview and shapes their understanding of mental health and disorder. Many Latinos believe that harmony of mind, body, and spirit creates good health, and illness is an enemy of balance, creating disharmony. A main goal of *sanación* is healing (Comas-Díaz, 2006). Folk healers (*curanderas, espiritistas*) work to restore balance through a harmonious relationship between the natural and supernatural (Trotter & Chavira, 1997). In Latino culture, these understandings of health and illness result in locating the origins of illness in spiritual states, in environmental or natural causes, and in supernatural origins. The family reinforces these health and illness beliefs, and family members are important sources of health information (Molina, et al., 1994).

One panel member comments on folklore and culturally defined emotional problems existing in Charlotte:

We also need to consider issues related to folklore. Here in Charlotte you see amulets on Latino babies to protect them from “the evil eye” (*mal de ojo*). Families still follow supernatural beliefs and go to *curanderas* for spiritual cures.

Focus Group results.

The second discussion topic in the focus groups is: Emotional or mental problems found uniquely in Latino cultures. Among focus group participants, there is a general consensus that culturally defined emotional problems are an important issue for Latino community members living in the U.S. Individual focus group participants in one group describe having personal experiences of *ataque de nervios*, *susto*, *angustia*, and *mal de ojo*. A number of participants report first-hand experience with several of the culturally defined emotional problems, including the following:

Yes, I have those problems. I am frightened, anguished, I have much nervousness.

I have many problems with *mal de ojo*, panic attack, anguish, insomnia.

Yes, for me it is panic attacks, weeping, and anguish. It affects me because I miss my friends, my family. Being here, sometimes, the homesickness gets in my mind when I am alone.

The concept of frames from cognitive sociology is useful in understanding idioms of distress, the term commonly used by social scientists to describe culturally defined emotional problem. Idioms of distress function as frames, discrete models people use to represent repetitive circumstances. In this example, the frames are specific ways in which Latino community members convey affliction. Cultural beliefs shared by Latino community members constitute a frame of shared understandings that influences their perceptions and definitions of mental disorder (Cerulo, 2002; *Mental health: culture, race, and ethnicity--a supplement to mental health: a report of the Surgeon General*, 2001).

There is also a consensus among Focus Group members that prayers and other natural remedies are more effective than professional help in treating culturally defined emotional problems. One group expresses a unanimous agreement that they choose to see a pastor or priest before seeking any type of professional caregiver, and that prayer and natural remedies are more effective than professional help. Participant responses include the following:

The minister at *Iglesia Bautista Camino del Rey* helps me with my problems. He helps my wife too. We pray together and I feel better. God helps me when I pray.

In our neighborhood there is a *curandero* (folk healer) who has many natural things we can use when we have problems. My family uses *té de manzanilla* (chamomile tea) when we are upset. It helps us calm down. The *curandero* has many other things from nature that help us that we can't get from a doctor or drug store.

Latino community members' preference for, and reliance on, personal relationships is an example of *personalismo*—a preference for personal rather than institutional relationships. *Personalismo* emphasizes trust and rapport from warm, personal relationships. Examples of this preference, which can exert an important influence on care-seeking, include seeking care from a minister or *curandero* (Añez, et al., 2005; Duran, et al., 2001).

Care-Seeking and Pathways to Care

Care-seeking among Latino community members is a critical concern of mental health providers because of community members' tendency to underutilize mental health services. Latino cultural constructs may play an important role in this pattern of service underutilization. Qualitative data provides information regarding how Latino culture discourages community members from

using many of the mental health services available to Non-Latino White populations in the U.S.

A consistent theme found in the qualitative data involves a strong preference among Latino community members for non-professional sources of care. Explanations for these care-seeking predispositions include the importance of family support networks, negative beliefs about professional mental health providers, mistrust of institutions, stigma associated with being mentally ill and seeking professional care, acculturation, economic issues, privacy issues, discrimination, and other barriers to professional care.

Institutional mistrust is an important aspect of cultural influence on care-seeking. For example, Latino community members see an ever-present threat from *La Migra* (immigration police) and other government authorities. This fear explains why there is a general avoidance of institutions, including professional mental health services, even among immigrants with papers (documentation) (Molina, et al., 1994).

Key Informant Panel results.

One key informant panel member makes the following comments as part of a discussion of care-seeking in the Latino community:

Seeking care is about going to ministers or priests first, family physician second. Often they've built a relationship with their family doctors and will stay with them for years and travel for miles to see them. They go to Church, priests, healers, and they self medicate (they share/trade medications). If they go to a priest or minister, the clergy member may not recognize the symptoms of mental health problems. The common prescription issued by a member of the clergy is prayer.

The importance of the family physician in treating Latino community members' emotional problems is the focus of a study that explores care-seeking

and treatment of depression by Miranda and Cooper (2004). Results of this research show that even though their primary care providers recommend depression treatments at rates similar to those of Non-Latino White patients, Latinos are less likely than Non-Latino White patients to report that they actually took antidepressant medications or attended specialty care.

Key informant panel members identify the importance of family in the Latino community and the extent to which family members rely on the family support network to deal with problems. Latinos include many people in their extended families, not only parents and siblings, but grandparents, aunts, uncles, cousins, *compadres* (close friends), and *padrinos* (godparents) of the family's children (Duran, et al., 2001). The extended family functions as a lay referral network for family members seeking care for emotional/mental problems. Some Latinos may even feel guilt for seeking help outside of the family (Kouyoumdjian, et al., 2003).

One key informant panel member comments about the importance of families and family support:

Family support is still very strong among poor (low to medium income) families. Family members do not move away—they tend to stay in the same location. It is not unusual for the young to remain at home until their late twenties or until they marry. Even if they are attending college, a majority of young people stay in the same city and live at home. There is a strong family network and support system providing help.

Another panel member comments on the importance of the family to Latinos:

I also want to emphasize the family issue. Most Latinos prefer to handle things within the family. Another stress factor happens when families are split. Men typically come to the U.S. first. When women arrive, sometimes feelings have changed. Sometimes men have found another

woman. Sometimes the stress associated with the numerous life-changes causes the family to fall apart.

Another panel member emphasizes the impact of immigration and disruption of the family support network:

When the Latino families were together and everyone worked together for the welfare of the family, many of the psychological problems were not as prevalent. When they get to the U.S., there is the whole issue of being in a country where everything is different and away from their families without their known support system.

This theme regarding the importance of family network support in Latino mental health and the consequences of the networks' break down when families migrate to the U.S. appears frequently in the literature. For example, one report states:

Latinos tend to have large family networks that are very important sources of social support and problem solving at times of crisis. The centrality of Latino families to social life is captured in the concept of *familismo*. However, it is important to recognize that many recently immigrated Latinos have fractured family systems as a result of the migration process (Guarnaccia & Martinez, 2002, p. 21).

The emphasis on *familismo* among Latino community members and the negative consequences associated with family disruption illustrate the power of this cognitive aspect of Latino culture on the experience of mental disorder and choices of care.

Focus Group results.

The third topic explored by focus group participants is the practices used by community members in seeking help for mental health problems. The following qualitative data explore explanations for care-seeking behaviors discussed by focus group participants.

Focus group participants identify a pastor or priest as the primary source of help for mental health problems. Important sources of help also include family members or very close personal friends. One participant says:

When I suffer fright, anguish, nervousness, I talk to a priest, or somebody at the church. It affects me because I miss my friends, my family. Being here alone, sometimes, the homesickness gets in my mind.

Another focus group member talks about how important the extended family is when they have emotional problems. She says:

At home in my country I have many people to help when things are bad—*la familia*—but here I have no one. With no family I think always about children left abandoned, remembering friends, and missing holidays. Here I feel lonely because nobody cares what the individual is going through and they are indifferent to the person.

Beliefs about Professional Mental Health Providers

The use of alternative sources of care, including folk healers and members of the clergy, indicates that some Latino community members may not seek help from professional mental health providers. Qualitative data collected in this research indicate a largely negative attitude among participants regarding professional mental health providers. These negative attitudes reinforce preferences for non-professional sources of care. Understanding community members' preference for non-professional care requires a clearer picture of how Latino cultural constructs influence care-seeking.

Several Latino cultural constructs can influence care-seeking. *Sanación* (Latino spirituality) proliferates in Latino life. When viewed together with *fatalismo* (fatalism—the belief that individuals have minimal control over their environment), these cultural constructs influence Latinos who suffer

emotional/mental problems to be less inclined to seek professional help for their problems (Comas-Díaz, 2006; Kouyoumdjian, et al., 2003).

The functions of *fatalismo* and *sanación* in Latino culture exemplify how cognitive aspects of a culture can influence the experience of mental disorder and choices of care. Another cultural influence on Latino community members involves culturally specific conditions often called idioms of distress. A commonly reported idiom of distress among Latino community members responding to the survey called *angustia* (anguish) consists of intense or extreme worry, anxiety, and often extreme sadness or depression. Latino community members do not perceive the experience of idioms of distress like *angustia* as mental illness, but rather as a normal part of living, a normal response to stressful living. They also do not usually seek professional care but instead seek help from family members, friends, clergy, or from folk healers and remedies.

Key Informant Panel results.

Comments by Key Informant panel members' on community members' preference for non-professional care include one panel member who says:

There are folk healers here in Charlotte that families will go to before going to a doctor or priest. Often more homeopathic remedies are tried first. We seem to have a tea for everything.

Focus Group results.

Comments from focus group participants stress their negative attitudes toward professional mental health care providers. A consensus emerged among participants regarding mistrust of psychologists and other mental health professionals. They point to several examples of how mental health professionals have not helped participants with emotional problems. They also

describe professional sources of care, including medical doctors, as too expensive and often not helpful. Comments include:

You have to pay \$50 just to go in to the office. No one speaks Spanish. Everyone is cold and unfriendly—they don't even remember my name.

They don't understand when I talk about my problems of *nervios* and *susto*. The doctors are all *Anglos* and they charge big fees that I don't have. My priest and counselors at Our Lady of Guadalupe are much more sympathetic and understanding and they really care about me and help me.

Data from national comorbidity research, however, appears to contradict findings suggested by the qualitative analyses of data from this research. In a recent study, researchers analyze data from the National Comorbidity Survey Replication (NCS-R) to determine attitudes toward treatment-seeking behavior among people of Non-Latino White, African-American, and Hispanic or Latino race-ethnicity. Findings indicate that, contrary to the initial hypothesis, African Americans, and Hispanics or Latinos, may have more positive attitudes toward mental health treatment seeking than Non-Latino Whites. Hispanic or Latino race-ethnicity is associated with an increased likelihood of willingness to seek professional help and lesser embarrassment if others find out, but these differences do not persist after adjustment for the effects of socioeconomic variables (Shim, Compton, Rust, Druss, & Kaslow, 2009).

A number of explanations for these differences between the National Comorbidity research and qualitative data from this research are possible. First, the Charlotte region experienced a rapidly growing Latino population for over twenty years. Growth has come from the influx of many international migrants,

including a substantial number of refugees. These populations are likely to have different needs and attitudes than the broader Latino population (Deaton, 2008).

Charlotte also experienced a number of problems accommodating its nascent multicultural population that may negatively impact Latino community members' attitudes regarding professional mental health care. Data from a University of North Carolina, Charlotte, study of Charlotte's Latino community summarize a number of key sociodemographic challenges faced by new Latino immigrants in Charlotte (Harrison, et al., 2006).

In addition, all participants in the NCS-R research were English-speaking and are interviewed in English. In contrast, all respondents participating in the focus groups reported in this dissertation prefer Spanish, and the focus groups are conducted in Spanish. Language is an important barrier to care, and the care-seeking experience of focus group participants may be substantially different from the NCS-R sample.

Finally, qualitative data in this research provides descriptive information to increase understanding and enhance meaning and context, but these data do not provide causal determination or prediction. Focus groups (N=21) and key informant panel (N=11) are very small and are not intended as representative samples.

Mistrust of Institutions

A factor reinforcing Latino community members' aversion to using professional mental health services may involve a generalized mistrust of institutions. Qualitative data from Key Informants and Focus Group participants provide additional information on Latino cultural constructs that may contribute to Latino community members' viewpoint about institutions and other barriers to care.

The Latino cultural construct of *personalismo* (personal rather than institutional relationship), compounded by some Latino community members' experiences of corruption and institutional bureaucratic ineffectiveness in their native countries, contributes to negative attitudes toward professional health care providers and the institutions that often employ them. A lack of trust is likely to exist regarding attitudes toward institutions, rather than toward treatment itself. Immigrant families with members who might be undocumented may have greater levels of mistrust, and they may be less likely to trust authorities for fear of being reported and of having to face government action such as deportation (Garcia & Rodriguez, 1989).

Key Informant Panel results.

Key informant panel members identify a source of institutional mistrust coming from a longstanding culture of corruption and abuse throughout institutions in many of the immigrant's native countries. One panel member speaks of her experiences of government and institutional corruption in Mexico:

In my homeland of Mexico, corruption and government intimidation are part of life. The practice of *una mordida*—a little bite—involves bribes expected by police, government officials, and even court officers. If you have money you can buy justice. If not, you can expect to be victimized by the institutions that are supposed to help you. You grow up distrusting everything associated with government.

Another key informant panel member comments about the fear often experienced by Latino immigrants:

When you come to the U.S. from another country there is a tendency to hold on to what you have left of your belief system, nationality, and traditions. Some are scared—they wonder if they'll be sent back if something is wrong. Some will be open, but again, others will not be willing to admit problems because of their fear of what will happen to them and to the rest of their family.

A panel member emphasizes the role of distrust toward institutions and the fear of deportation among undocumented immigrants who might otherwise seek professional mental health care:

Knowing they are undocumented keeps many Latinos fearful of being sent back. From their perspectives, Mecklenburg County Area Mental Health is connected to the government, and the government is not to be trusted—they fear that and will not use available services.

Other panel members comment on barriers to care resulting from stigma, language, immigration status, lack of insurance coverage or economic ability to pay, and mistrust of institutions:

Stigma, language, economics, and the intimidation of institutions and government are barriers to care. In Mexico, they have socialized medicine and they don't trust it. These feelings carry over to the U.S.

Youth and Family Services uptown is a good example. You go in and it is very sterile. You are met by a guard, sent to a receptionist/secretary, and connected to no one who speaks Spanish. This is not good for Latinos—they will not go.

They must be legal to get help. If Latinos are undocumented, they are not going to seek help because they are not eligible. Who pays? They have no insurance. For example, at Teen Health there is a \$50 charge just to start. About 95% of people we see (in her two agencies) are undocumented. The ones that need help the most have no insurance or money.

Cultural constructs can function as schemata—broad structures embodying different types of knowledge that influence Latino community members' understanding of mental disorder and choices of care. In this example, the confluence of *personalismo* and fear of *La Migra* work to create barriers to understanding and a lack of trust of institutional sources of mental health services (Cerulo, 2002; Garcia & Rodriguez, 1989).

Focus Group results.

Focus group participants also talk about fear of *La Migra* (immigration police) and explain that even among immigrants with papers (documentation), government authorities are seen as a threat. There is a consensus among participants that fear of *La Migra* is a serious barrier to accessing professional mental health services. One participant says:

My family sees a good doctor who is from our country (El Salvador). He speaks our language—his nurse and receptionist do too—and he understands the things that trouble us. We have to drive all the way to Gastonia to see him, but it is worth it to have someone you can trust.

Another focus group member speaks about avoiding government-run services and seeking help from church and community based services. She says:

We go to places we can trust and that we can afford. Our Lady of Guadalupe has priests that do free counseling and *Centro de Salud Betesda* charges only what you can afford to pay. And they are safe—no government or *La Migra* to have to worry about.

Finally, a woman who struggles with trauma she experienced in her native country comments about another community-based service she and her family use for counseling and support. She says:

Mi Casa Su Casa is a place we go for help. You don't need a Social Security card or need to fill out lots of paper. They all speak Spanish and understand what we need. When I had panic attacks, anguish, insomnia they helped.

Stigma and Care-seeking

Key informant panel members discuss Latino community members' preferences for care and patterns of care-seeking when they experience emotional/mental problems. Focus Group members comment on other barriers

to care, including privacy concerns. The idea of stigma associated with *locura* (madness) is an example of how a cultural construct can function as a frame that discourages community members from seeking professional care. Latino cultural constructs that emphasize self-control and the ability to withstand problems may also be key aspects of mental health care underutilization.

Latino cultural constructs of *controlarse* (self-containment or conscious control of negative affect), *aguantarse* (being able to withstand stress during bad times), and *sobreponerse* (self-suppression), taken together suggest that Latinos who experience mental health problems and seek professional care can attract disapproval in their community. Professional care-seeking is a sign of weakness, and may itself carry stigma (Añez, et al., 2005; Duran, et al., 2001). For many Latino families, experiencing mental illness, or seeking professional mental health help, is a character weakness (Kouyoumdjian, et al., 2003).

Guarnaccia and Martinez (2002) stress the importance of stigma as a barrier to seeking care, and identify the cultural construct of *locura* (madness) as a powerful stigmatizing force among Latinos. The authors also point out that labeling mental illness as a culturally defined condition such as *nervios* instead of *locura* has a destigmatizing effect for the person's experience of emotional problems both in the family and the community.

The existence of stigma associated with *locura* and the destigmatizing result of culturally defined conditions such as *nervios* are examples of how Latino community members frame mental disorder in a culturally accepted form and seek culturally preferred sources of care accepted by their family and community.

Key Informant Panel results.

A key informant panel member identifies the impact of religious beliefs and cultural taboos on willingness to seek professional mental health care:

There are those who will not be open about problems because of religious beliefs and/or cultural taboos.

Another panel member discusses how attitudes in Latin America regarding mental health and the stigma associated with using professional providers impacts care-seeking:

Mental health issues are not a primary concern in Latin America. Several years ago (historically), very few cases of mental health problems were identified. Today, they are on the rise. As the populations have gotten more educated, those with financial means have begun to utilize therapists, but they are still not comfortable with it. Stigma is still an issue.

Latino immigrants coming to the U.S. may have low expectations about the availability of professional care because access to professional care in the community members' country of origin may be a problem. For example, research on treatment access in Mexico for mental health and substance use disorders shows that using professional mental health services is a relatively rare event. Data from The Mexican National Comorbidity Survey show 5% of persons with an active disorder and 24% of persons with severe mental illness received any form of care within the previous 12 months. In rural areas, where obtaining treatment can require more than a day's journey to reach facilities or personnel, rates of service use are even lower (Borges, Wang, Medina-Mora, Lara, & Chiu, 2007).

Privacy Issues

Latinos may feel conflicted when having to disclose what they may perceive to be negative or intimate information about themselves or their families.

As a result, Latinos may be reluctant to share their mental health problems with people outside their family. Cultural constructs of *familismo* (family orientation) which promotes problem-solving within the family, and *respeto* (respect; mutual and reciprocal deference) may influence these attitudes because community members may feel they might lose *respeto* if knowledge of their emotional/mental problems becomes known outside of the family (Añez, et al., 2005; Kouyoumdjian, et al., 2003).

Focus Group results.

Among focus group participants, issues of privacy occur in discussions several times. There is a general concern about confidentiality as well as about gossip surrounding community members seeking mental health assistance.

Participants note the possibility of gossip among friends and/or family members.

Focus group participants make statements like:

I worry about my neighbors gossiping about my problems if they knew I see someone for help. They love to talk about me behind my back all the time.

When I go to *Mi Casa Su Casa* for counseling I tell them I'm going shopping. It's none of their business. I hate it when people know about what goes on in my family—that's only our affair.

I get good advice from my friends but I don't tell them too much. They like to talk about me anyway so I try not to give them things they don't need to know, especially about my problems.

Acculturation and other Barriers to Care

Cultural constructs shared by Latinos, and the reluctance of some Latinos to relinquish their native cultures after immigrating to the U.S., can discourage community members from using professional mental health services. When Latinos seek help for emotional/mental problems, they often encounter services

that are insensitive to their cultural and spiritual orientations. Therapeutic encounters in these somewhat xenophobic settings can lead some Latinos to suspect the techniques and goals of mainstream professional mental health treatment exist primarily to support acculturation goals of the dominant culture (Comas-Díaz, 2006).

Key Informant Panel results.

Key informant panel members discuss attitudes toward acculturation and Latino community members' willingness to assimilate into the dominant U.S. culture. One member speaks of her own experience in delaying U.S. citizenship because she did not want to abandon her culture of origin.

Acculturation can take a long time. It took me fifteen years to become a U.S. citizen just because I didn't want to let go of my cultural background. Also, if you look at those living in the Charlotte Latino community, they do not have to do anything in English. They can live, work, shop, buy car insurance, go to restaurants, etc. – all in Spanish. They do not have to change. Some come here and want to absorb this culture as much as possible so they can erase where they come from (for example, parallel names - Ricardo to Richard). Others are proud of their heritage and want to keep that as part of their lives.

She continues her comments by describing a young Mexican man she observed wearing a tee shirt that loudly proclaims his Mexican nativity:

I saw a young man at the Charlotte airport recently. He wore a tee shirt which had large letters that said "Don't Call Me A [expletive deleted] Hispanic—I'm Mexican." That shows how some immigrants want to hang on to their native culture and how proud they are to be Mexican or any other Latin American origin.

A panel member discusses the importance of language for her. She is fluently bilingual, growing up as a *chicana* (Mexican American) living in the *barrio* (Mexican neighborhood) of East Los Angeles. She says:

I spoke only Spanish at home with my family and in the *barrio*, but I had to speak and write English at school. Today I am very comfortable with both languages, but I notice that while I think in English, I pray in Spanish. *Es el corazón*—it is my heart.

Key informant panel members stress the difficulties faced by Latino community members attempting to access mental health services in Mecklenburg County. One panel member compares the difficulties as similar to solving a complicated maze or labyrinth.

Mecklenburg Area Mental Health is a very bureaucratic and complex agency difficult even for English-speaking American clients to access. My Latino clients, especially the Spanish-speaking ones, find it to be like a maze or labyrinth. So they seek care somewhere else, usually from religious groups or folk healers they feel comfortable with.

Focus Group results.

The fourth topic discussed by the focus groups involves barriers encountered by Latino community members in accessing mental health services. Focus group participants identify language barriers and frustrations associated with being unable to communicate effectively, cultural changes, culture shock, discrimination, and financial problems as barriers in accessing mental health services.

Participants stress economic issues as an important barrier to seeking professional mental health services. Participants also express an overwhelming consensus about financial stressors as the most important factor in seeking any kind of professional help for either medical or mental health assistance. None of the participants say they have any insurance that covers mental health care or that they have the ability to pay fees. One participant says:

We have no insurance. To get Medicaid you have to go to the government and tell them about your life. We don't have papers yet, so we can't get government help.

A number of focus group participants say that discrimination is a serious barrier they encounter. There is a consensus among participants that Latino community members face discrimination and disrespect from professional mental health care providers. One focus group participant talks about how a local hospital emergency room sent her to *Centro de Salud Betesda* to avoid providing uncompensated care:

I took my husband to the emergency room at University Hospital. He was very upset and acting very strange. Once they saw we spoke Spanish and didn't have insurance they said we should go up the street to a clinic for our people. The man even gave us a map with directions in Spanish. He sent us to *Centro de Salud Betesda* because they did not want to help us at the hospital. It was God's will because we got good help at no cost from *Betesda*. But it still makes me mad—it's a kind of discrimination.

Lack of knowledge about mental health services and how service agencies provide care is a common theme among focus group participants. They acknowledge there is no immediate knowledge among participants of where to go for mental health needs in Mecklenburg County. There is also a consensus that the Latino community has a general lack of understanding of how service agencies work. One participant talks about the difference between community-based sources of help and government agencies:

My family goes to *Centro de Salud Betesda* or *Mi Casa Su Casa* when we have problems. Some of our friends find help at Our Lady of Guadalupe Catholic Church. None of us go to the government—it's too complicated. I wouldn't know where to start or who to see. And no one speaks Spanish like at our churches or community places.

Experience of Violence

Violence and its associated trauma are major health concerns for many in the Latino community. People living in the Americas are at risk for earthquakes, volcanic eruptions, hurricanes, floods, mud slides, and other natural disasters.

Some countries in Latin America also have high levels of political violence. Natural disasters and mass violence can affect social adjustment as well as emotional and physical health. These problems are especially prevalent among refugee populations (Norris, 2009).

Tristeza (sadness) and *duelo del corazón* (mournful heart) are ubiquitous conditions found among Latino populations. An example of the importance of these cultural constructions exists among women in conflict-ridden countries like Guatemala. Research shows elevated levels of *tristeza* among women in post-conflict Guatemala. *Tristeza* among the women studied also appears in problems, such as “mournful heart” (*duelo del corazón*), and sleep disturbances from nightmares and other types of compelling dreams. For victims of Mayan ancestry, disturbing dreams have a special significance because dreams are a form of communication with one’s ancestors and are a rich reservoir for cultural interpretation (Garrard–Burnett, 2000).

New research documents a culture of extreme violence affecting trans-border Mexican migrants who often experience direct violence such as beatings, kidnappings, and rape. They also suffer from indirect violence such as poverty, hunger, marginalization, and increased health hazards (Jácome, 2010).

Key Informant Panel results.

Descriptive information from the qualitative data can add clarity to better understand the problems of violence-related trauma and associated emotional problems among Latino community members. A discussion of the problems of violence experience by Latino immigrant populations elicited the following comments from a Key Informant panel member:

Natural disasters are a factor. So are political violence and abuse. I'm currently in touch with a middle class family (refugee status) that is unable to cope with a situation with their son who is experiencing PTSD. They are having difficulties in not only getting over their nervousness, but in finding someone who knows how to deal with all of their issues. This does not apply just to Latinos. There are immigrants from other countries who have experienced all kinds of horrible trauma.

Focus Group results.

The fifth focus group topic is negative consequences of trauma experienced by refugees and other immigrants. Focus group participants comment that some community members live only with the painful memories they have of how difficult and ugly their way was to the U.S. Some say that they prefer to keep this to themselves because they have family members who are willing to come to the U.S. and they don't want them to suffer the way they did.

One common theme is that they left their family in their country of origin, and sold almost all their belongings to pay the *polleros* (**border**-crossing smugglers) to bring them across the Mexican and U.S. borders. Focus group participants say *polleros* often swindle people crossing the border, and they lose most or all of their money on their way to the U.S. Participants also comment on the violence often associated with illegal immigration and the frequent victimization of Latinos attempting to cross the border illegally.

One focus group participant speaks of how she was raped repeatedly by *polleros* as they brought her across the border:

My travel to the U.S. was horrible. The *polleros* raped me over and over again when they brought me from Mexico across the border. Now after many years I still have nightmares, I remember the terrible details, and I have anxiety all the time. My counselor says I have PTSD. It stays with me always.

Summary of Qualitative Data & Results

In this chapter I link qualitative data from key informant panel members and focus group responses to Latino cultural constructs identified as important in understanding Latino mental health issues. I use these cultural constructs to show how cultural beliefs frame Latino community members' understandings of the emotional problems they and their family members experience, and influence their responses to these problems by shaping care-seeking and treatment preference decisions.

I present several examples of Latino cultural constructs and how they function as cognitive aspects of the culture. I suggest that applying concepts from cognitive sociology like worldview, schemata, and frames, can provide insights on how Latino cultural constructs impact community members' recognition of and reaction to symptoms of mental disorder.

Key informants emphasize the differences between modern American concepts of mental illness and widespread beliefs existing in the Latino community about emotional/mental problems. They stress that, especially in less educated, rural populations, Latino community members tend to accept behavioral disorders as part of nature, as caused by evil spirits or as punishment by God for sinful behavior.

Key informant panel members underscore the importance of culturally defined emotional problems in the Latino community, and a consensus exists among focus group participants that culturally defined emotional problems are an important issue for Latino community members living in the U.S. Individual participants in one focus group identify their own personal experiences of *ataque*

de nervios, susto, angustia, and mal de ojo. Most focus group participants also disclose they experienced some type of depressive symptoms themselves since living in the U.S., and most know someone in their community with serious mental health problems.

Qualitative data illustrate a strong preference for non-professional sources of care among Latino community members and indicate a largely negative attitude among participants regarding professional mental health providers. I discuss differences between these results and national comorbidity research data. The qualitative data also identify a generalized mistrust of institutions and a fear of stigma as barriers to care. Other barriers include privacy concerns, acculturation difficulties, language problems, discrimination, and economic constraints (including lack of insurance). Documentation problems exacerbate most of these barriers to care. Undocumented community members are especially anxious and fearful about contact with government officials since such contact might result in arrest or deportation.

Finally, violence-related trauma is a major concern for many in the Latino community, especially among refugee populations. Natural disasters and political violence in their native countries affect Latinos' emotional and physical health. A culture of extreme violence victimizes many Latino migrants crossing the U.S./Mexico border illegally.

Chapter 4: Quantitative Data Analyses: Latino Community Members’ Causal Definition of Emotional/Mental Disorder

In this chapter I consider quantitative analyses of Latino community members’ survey responses related to their causal definitions of emotional/mental disorder. I analyze these quantitative data based on Latino survey subjects’ demographic characteristics, including age, education, time living in U.S., and gender. I also explore the impact of survey subjects’ referral source by comparing subjects referred from religious and non-religious organizations. In addition, I examine the influence of country of origin by comparing responses from subjects with Mexican origins with those from Central America and other Latin American countries in the sample.

First I discuss relevant theory and research identified in the Theory & Research Literature Review (Chapter 1) as important in understanding Latino mental health issues, including the social construction of meaning, selected demographic characteristics and mental health and illness, gender and mental disorder, and Latino demographic trends. I also link quantitative data discussed in this chapter to qualitative findings reported in Chapter 3.

Relevant Theory and Research

Concepts from the sociological discipline of cognitive sociology anchor the basic contention of this dissertation—that Latino community members’ beliefs regarding the cause of emotional/mental problems impact their illness experience, care-seeking behavior, preferred sources for mental health services, and satisfaction with care. Theory and research in the field of medical sociology

is also relevant. In this section I summarize theory and research that are germane to demonstrating this premise.

Sociological theory and the social construction of meaning.

In this dissertation, the social construction of meaning encompasses sociological concepts useful in understanding the differences between Latino community members' causal definitions of emotional/mental disorders and definitions commonly accepted in U.S. culture. The social construction model emerged in early sociological writing. For example, nineteenth century sociologist Emile Durkheim (1966 [1895]) applied the social construction model in his analysis of deviant behavior. He posits the existence of a cultural system of meaning that creates deviance and defines its characteristics.

In medical sociology, one can apply the social construction model to understand the definition and experience of illness. In his essay *Naming and framing: The social construction of diagnosis and illness*, Brown (1995) posits that the social construction of illness focuses primarily on the illness experience. He applies a symbolic interactionist approach to understanding the multiple social forces that come together to create the illness event. Differences in how individuals perceive and understand health problems may vary dramatically based on a number of social factors such as race, class, gender, socioeconomic status, and national origin. Individuals with different cultural backgrounds may possess dramatically dissimilar worldviews regarding the illness experience. These worldviews tend to frame their understanding of the occurrence, including its etiology. The author also emphasizes that lay people may have a direct experience of illness and such experiences are central to a lay initiation process

that identifies conditions which may not be commonly dealt with by health care professionals.

Angel & Williams (2000) elaborate the role of culture and cognition in the illness experience. They point out that illness has individuals meaning that are part of the person's cultural tradition rooted in socially based cognitive models of the disorder's causes and consequences. Culture provides a framing function which forms a milieu within which people interpret their lives and their actions gain meaning. These cultural understandings frame definitions of health and illness, and decisions about appropriate help-seeking actions. The illness experience involves using cognitive schemas and language contained within the individual's cultural heritage to understand the illness episode.

Modern theories of psychopathology typically emphasize biological or psychological dimensions of emotional disorder, with limited attention to the social and cultural environment. To focus exclusively on biological or psychological phenomena, however, ignores the social and cultural context in which they exist—and in which illness is defined by both the individual and society (Angel & Williams, 2000).

The social construction concept is also applicable in understanding the social origins of mental disorder. Mental disorders do not occur in nature—they are defined by human beings. Two aspects of mental disorder are part of the definitional process. One aspect involves the individual's internal functioning. People who experience internal dysfunctions may be incapable of fulfilling the role responsibilities expected of them. Cultural values play a key role in the second aspect of defining mental disorder. Recognizing these aspects lead to

the conclusion that “mental disorders are internal dysfunctions that a particular culture defines as inappropriate” (Horwitz, 2002, p. 12).

Issues persist regarding how underlying biological conditions fit within constructionists' views of mental illness. For constructionists, even disease models of mental illness that involve biological explanations are social constructions because they conform to contemporary versions of social reality (Horwitz, 2002).

Rosenberg (1992) attempts to circumvent some of the criticisms of the social construction model by substituting the metaphor of the frame to discuss culturally influenced explanations of disease. He applies concepts of frame analysis proposed by Erving Goffman (1974a) in *Frame analysis: An essay on the organization of experience*. Rosenberg argues that within a framing model of disease, biology shapes the choices available within a culture to conceptually frame a disease. The process of framing also involves an explanatory element. A familiar and understandable explanation of the cause makes the problem more emotionally manageable for the victim.

Rosenberg (1992) also identifies the importance of the disease definition and the consequences of such definitions in the lives of individuals and in the delivery of health care. Concepts of disease and their causation exist in social and intellectual space which develops over time and varies from one culture to another. He notes that disease definitions can serve as tools of social control, and exaggerate the importance of scientific knowledge, the professions, and social power. He identifies the medicalization of society as one important outcome of a controlling and legitimating ideological system.

Medicalization is a process where non-medical aspects of life are redefined in medical terms, usually as disorders or illnesses, and come under medical authority. Medicalization impacts many different phenomena, including normal life events (birth, death), biological processes (aging, menstruation), common human problems (learning and sexual difficulties), and forms of deviance. The medicalization of deviance involves non-normative or morally condemned appearance (obesity, unattractiveness, shortness), belief (mental disorder, racism), and conduct (drinking, gambling, sexual practices) being redefined as illness. Constructing deviance as illness confers a moral status different from crime or sin. Medicalization has implications for social control, power, knowledge, authority, and personal liberty (Ritzer, 2007).

Cultural differences between Latino and dominant U.S. culture.

Numerous authors have identified cultural differences between Latino populations and the dominant U.S culture which may contribute to a substantial variation in how Latino community members understand the causes of emotional/mental problems (Añez, et al., 2005; Comas-Díaz, 2006; Molina, et al., 1994; Romero, 2000). See Table 3.1 for a summary of cultural constructs that may be involved in Latino conceptions of mental disorder. The impact of these definitional differences can have a substantial influence on Latino community members' understanding, not only of the problem's causes, but also the need for care, and preferences for sources of care.

Cultural influences can play an important role in shaping one's view of mental disorder. Many Latinos hold a worldview that includes beliefs about illness and health strongly influenced by spiritual and religious factors. These

beliefs are often part of complex medicine systems that originated in pre-Columbian cultures. Health exists in the equilibrium between forces of nature, while illness exists in the disequilibrium of these forces. Breaking the equilibrium between the forces of nature, or breaking the balance in community institutions, brings negative effects on the individual, the family, or the community (Murguia, et al., 2003; Trotter & Chavira, 1997).

Specifically, Latinos' perception of mental disorders may play an influential role in their underutilization of community services. For example, Latinos who experience mental disorder and believe in fatalism may be less inclined to seek help for their psychological needs. Latino community members who endorse religious or supernatural causes of mental disorders are less likely to utilize mental health services. Because religion plays an important role in the lives of many Latinos, they often seek help for medical and mental health needs from religious organizations. Some Latinos will seek mental health assistance from folk healers. *Curanderos* are knowledgeable about folk medicine and are thought capable of communicating with the spiritual world. The use of folk healers may be more common among Latinos living in rural environments, those who are Spanish monolinguals, are less acculturated, and come from lower socioeconomic backgrounds. The use of folk healers and religious organizations may limit Latinos' utilization of community mental health programs (Kouyoumdjian, et al., 2003).

In research conducted with an ethnically diverse elderly population who received prescribed antidepressant medication within the past year, Latinos acknowledge fewer biopsychosocial causes of depression than Non-Latino

Whites or Non-Latino Blacks, and Non-Latino Whites believe in fewer spiritual/personal causes than the other two groups. Believing in biopsychosocial causes is a positive predictor of receiving psychotherapy, while believing in spiritual/personal causes is a negative predictor of receiving psychotherapy (Ayalon, Alvidrez, & Arean, Nov, 2005).

There is little additional research on how Latino community members understand the causes of mental/emotional problems and the impact these cultural understandings have on illness recognition, care-seeking, preferred sources of mental health services, and satisfaction with care. The analyses presented in this chapter represent initial steps in filling these gaps.

Mental health and illness in a cross-cultural context.

Every culture identifies deviant behaviors that while viewed negatively, are not seen as antisocial because they are not understandable within that culture's interpretations (Horwitz, 1982). There is, however, great variation across cultures regarding concepts of mental health and mental illness, and distinctions between problems whose origins are biomedical and those caused by other factors. The universal existence of mental disorder as a construct does not result in universal schemes of recognition and classification. The meanings attached to various syndromes by different populations vary extensively, and cross-cultural research identifies unique syndromes found only in specific cultural settings (Lefley, 2010).

Cultural systems of meaning are one of several societal factors contributing to diverse rates of mental disorders measured across different countries. Depression rates vary enormously in cross-cultural research, and

other mental disorders differ dramatically across cultures. A greater prevalence of many categories of mental illness in the U.S. than found in the balance of the world illustrates the impact of social and cultural factors on rates of mental disorder (Horwitz, 2010).

Research on Latino demographic trends in the U.S.

I use demographic variables in this dissertation to analyze variations in Latino community members' survey responses related to their causal definitions of emotional/mental disorders. Demographic trends among Latino populations are important because the Latino community living in the U.S. experienced dramatic changes in recent decades, and I summarize these changes to provide a context for the following discussion.

The large influx of new immigrants from developing countries of Latin America and Asia transformed the ethnic population of the United States since 1970, increasing the numbers of people of foreign birth or parentage and those with undocumented immigration status. Estimates indicate that 45% of the total Latino population of the U.S. is foreign-born, and another 31% consists of second generation children of immigrant parents. The Latino immigrant population tends to be young, have limited or no English language skills, and limited educational attainment. These trends are strongest among undocumented groups (Rumbaut, 2010).

The Latino population age structure accentuates younger age groups with a median age of 27, and a disproportionate number of males in the younger working ages. Almost 40% of the total Latino population of the U.S is under age 20, and 65% is under age 35. Although there is substantial variation among

Latino ethnic groups, immigrant Mexican males are an example of low educational attainment. Among immigrant Mexican males ages 18 to 34, 63% have no high school diploma (Rumbaut, 2010).

Demographic factors and mental disorder in the Latino community.

Data available for analyses in this dissertation include demographic variables of age, education, time living in the U.S., and gender. Although these demographic factors are part of a variety of mental illness prevalence studies, including recent analyses of data from the National Latino and Asian American Study (NLAAS) (Alegría, et al., 2008; Alegría, Shrout, et al., 2007), little analysis has focused on the impact of these variables on how Latino community members define the causes of emotional/mental problems.

Mental disorder prevalence rates for Latinos living in the U.S. are also important as they contribute to the understanding of the impact of demographic factors. I use data from the NLAAS research in this discussion. The NLAAS is a nationally representative community household survey that estimates the prevalence of mental disorders and rates of mental health service utilization by Latinos and Asian Americans in the U.S. (Alegría, et al., 2004).

One of the Collaborative Psychiatric Epidemiology Surveys (CPES), the NLAAS employs a questionnaire based largely on the World Health Organization's (WHO) expanded version of the Composite International Diagnostic Interview (CIDI). The CIDI produces diagnoses based on WHO International Classification of Disease (ICD) criteria ("Background: Collaborative Psychiatric Epidemiology Surveys (CPES)," n.d.).

Relationship between demographic variables, qualitative data findings, and Latino mental health and illness research.

Each of the four demographic variables from the survey research data available for analysis in this dissertation has links to qualitative results discussed in Chapter 3 and to research identified in the Theory & Research Literature Review (Chapter 1).

Age and mental disorder in the Latino community.

The survey subject's age is one of the variables available for analysis in this dissertation. Focus group participants note generational and age differences as important factors for identification and understanding of mental health issues. They point out that, in their experience, younger people are more likely to have a modern, scientific viewpoint—which leads them to adopt a mental illness definition as the cause of mental/emotional problems.

In a study of an ethnically diverse elderly population prescribed antidepressant medication, belief in biopsychosocial causes of depression is negatively correlated with age, with younger participants more likely to identify biopsychosocial causes of depression than older participants. Latinos in the study identify more spiritual/personal causes and fewer biopsychosocial causes of depression than Non-Latino Whites or Non-Latino Blacks. Non-Latino Whites identify fewer spiritual/personal causes than the other two groups (Ayalon, et al., Nov, 2005).

Age emerges as a demographic factor in several mental disorder prevalence studies, including those employing data from the NLAAS. (Alegría, et al., 2008; Alegría, Mulvaney-Day, et al., 2007; Alegría, Shrout, et al., 2007). In

one prevalence study, results of lifetime psychiatric disorders by age groupings shows the highest proportion of disorder among the 35-49 year-old group (32.2%), and the lowest among the 18-34 year-old group (26.9%). Past-year disorders, however, are highest among the 18-34 year-old group (16.5%) (Alegría, Mulvaney-Day, et al., 2007).

Education and mental disorder in the Latino community.

Educational level is another variable selected for analysis in this dissertation. In general, qualitative data discussed in Chapter 3 suggests that rural, less educated Latinos are more likely to accept mental disorder as part of nature or attribute its causes to evil spirits or God's punishment for sinful behavior. In contrast, more educated, urban Latinos are more likely to adopt the scientific explanation of mental illness rather than alternative explanations.

Beliefs about biopsychosocial causes of depression are positively correlated with level of education in one study. Among participants in a sample of an ethnically diverse elderly group prescribed antidepressant medication, Latino group members acknowledge fewer biopsychosocial causes of depression than Non-Latino Whites or Non-Latino Blacks—and Non-Latino Whites identify fewer spiritual/personal causes than the other two groups (Ayalon, et al., Nov, 2005).

Education level appears as a demographic factor in several mental disorder prevalence studies, including those employing data from the NLAAS (Alegría, et al., 2008; Alegría, Mulvaney-Day, et al., 2007; Alegría, Shrout, et al., 2007). In one prevalence study, lifetime psychiatric disorders by education shows the highest proportion of disorder among Latinos completing 12 years of education or more (31.4%), and the lowest proportion of disorder among Latinos

completing 11 years or less (27.1%). Past-year disorders are highest among those completing 12 years of education or more (15.8%).

Gender and mental disorder in the Latino community.

Another of the variables available for analysis is the subjects' gender. Gender is an especially salient factor affecting Latino community members because of the importance of traditional gender roles in Latino culture and the linkage of traditional role expectations to religious beliefs. It is also a complex issue because of recent changes in traditional gender role expectations among some Latinos.

Qualitative data from key informants and focus group participants reviewed in Chapter 3 stress the role of religious beliefs among Latinos and the impact of these beliefs on Latina gender roles. Among Latinos, cultural understandings connected to beliefs about *Virgen María* (Virgin Mary) support largely paternalistic schemes in traditional Latino culture by which women are expected to serve husbands and families, and to be the moral nucleus of the family. Not surprisingly, Latinas living in modern, urban settings can face conflicts between traditional gender roles and more contemporary expectations of womanhood which are currently evolving (Hurtado, 1995; Ortiz, 1995).

Recent research emphasizing cultural and economic changes that have occurred challenges traditional portrayals of Latino families as highly patriarchal with inflexible gender role expectations. For example, Mexican Americans and other Latino groups living in the U.S. are primarily urban, with an increasing participation of Latino women in the labor force. Instead of accepting full-time status as a housewife and mother, Latinas justify their need to work based on

economic necessity (Ortiz, 1995). Competing demands from economic concerns motivating Latinas into the work force and traditional norms of appropriate female conduct create tension for contemporary Latino women. Latinas are also likely to be exposed in the workplace to opposing cultural definitions of acceptable gender roles (Hurtado, 1995).

In general, women and men exhibit dissimilar patterns of mental disorder. Women are more likely to experience mood disorders, anxiety, and depression. Men are more likely to suffer from personality disorders and substance abuse. Rates of schizophrenia are similar for both groups. Early analyses of these differences focused on hormonal and personality differences between women and men. More recent analyses emphasize cultural and social contexts in explaining these differences, including gender role socialization (Brown & Scheid, 2010).

Race and ethnicity are also important factors in understanding gender differences in mental health and disorder. Culture and gender work jointly to influence attitudes, feelings, and behaviors. Specific ethnic groups provide a particular cultural context that gives unique meanings to femininity and masculinity. Latino cultures have unique perspectives on the meaning of being a woman or a man. These gender-role norms can have a profound impact on mental health, mental disorder, and care-seeking (Canales, 2000).

Cultural factors shape Latinas' health related beliefs, attitudes, and practices. Specific cultural constructs including *familismo* (family orientation; extended family), *respeto & dignidad* (respect; mutual and reciprocal deference; dignity), and *personalismo* (personal rather than institutional relationship) may be especially relevant in understanding Latina mental health issues (Amaro & Torre, 2002).

Differing rates of the experience of *tristeza* (sadness) in Latino and Non-Latino groups are an example of gender and ethnic variation. Data from *Vital and Health Statistics* published by the U.S. Centers for Disease Control indicate Latinos experience feelings of sadness twice as often as Non-Latino White groups. Latino men experience feelings of sadness 2.1 times more often as Non-Latino White men, and Latino women experience feelings of sadness twice as often as Non-Latino White women ("Summary Health Statistics for U.S. Adults: 2007," 2009).

Elevated suicide rates among adolescent Latinas living in the U.S. are another indicator of gender and racial dissimilarity in mental health and disorder. For over a decade, surveys have reported that among ethnic and racial minority youth in the U. S., Latinas have the highest rates of suicidal behavior. High rates of suicidal behavior by teenage Latinas reported in large-scale surveys may be a cultural phenomenon, a product of specific elements of the history, tradition, ideology, and social norms. The unique situation of adolescent Latinas involves the convergence of cultural and familial factors (i.e., familism, acculturation, relatedness, autonomy, etc.) with the developmental, social, and individual factors frequently associated with suicidal behaviors (Zayas & Pilat, 2008).

Language preferences and mental disorder in the Latino community.

Language preferences are important because research has linked these choices to mental health and disorder outcomes, including access to care. All of the subjects participating in the Latino community survey used in this dissertation elected to take the survey in Spanish, even though an English version was available. Key informant panel members noted that Latinos living in the U.S. do

not necessarily need to adopt English to deal with their daily needs. They can conduct most of their daily lives by communicating in Spanish. Some Latinos living in the U.S. choose not to change their primary language to English, but prefer to continue speaking Spanish.

In research linking language preferences among Latino community members to mental health issues, about half of adult Latinos report having low English proficiency. Poor English fluency in itself is a risk factor for lower use of health care and mental health care services among Latinos in the study (Marin, Escobar, & Vega, 2006, Winter).

Another study specifically examines the effect of English fluency on racial and ethnic disparities in health care utilization. Among insured nonelderly adults in this study, disparities exist in health-care use by race and Latino ethnicity. Differences in English fluency largely explain ethnic disparities in utilization rates based on these data. The health care use pattern of English-speaking Latino patients is not significantly different from Non-Latino White patients. In contrast, Spanish-speaking Latino patients are significantly less likely than Non-Latino White patients to have a physician or mental health visit (Fiscella, Franks, Doescher, & Saver, 2002).

Recent mental disorder prevalence research using data from the NLAAS employs English-language proficiency as a demographic factor. Subjects with excellent/good English-language proficiency have the highest proportion of lifetime psychiatric disorder (35.1%), while those with fair/poor English-language proficiency have the lowest proportion of lifetime psychiatric disorder (21.1%). Past-year psychiatric disorder is highest (19%) among Latino community

members with excellent/good English-language proficiency (Alegría, Mulvaney-Day, et al., 2007).

Time living in the U.S. and mental disorder in the Latino community.

Subjects' time living in the U.S. is another variable from survey data available for analysis. While it is generally accepted that an immigrant's time living in the U.S. is positively associated with acculturation, qualitative data discussed in Chapter 3 suggests that time living in the U.S. might or might not be related to acculturation, with Latino community members having the option to adopt the dominant U.S. culture or remain primarily within their culture of origin. For example, key informant panel members discuss the reluctance of some community members to give up their culture of origin, while others are more strongly motivated to assimilate into U.S. culture.

The demographic variable "years living in the U.S." is used in recent research on psychiatric disorder prevalence using data from the NLAAS. In one study, researchers find that Latino community members with the longest period of time living in the U.S. (21 years or more) have the highest proportion of lifetime psychiatric disorder (29%), while those with the shortest period of time (≤ 5 years) have the lowest proportion of lifetime psychiatric disorder (17.3%). Past-year psychiatric disorder is also lowest (7.2%) among Latino community members with the shortest period of time living in the U.S. (≤ 5 years) (Alegría, Mulvaney-Day, et al., 2007).

Often referred to as the Mexican paradox or the Latino paradox, a phenomenon exists of lower mental disorder prevalence rates among recent Latino immigrants compared to U.S.-born Latinos and Latino community

members with the longest period of time living in the U.S. (Lefley, 2010). Initially this linkage appears to be counter-intuitive, especially considering the stressful life events associated with being an immigrant. In the following section I discuss the Latino paradox. I review empirical data from a number of different research sources and explore several explanations for the phenomenon.

Discussion of the Latino Paradox

Although epidemiological research consistently shows lower rates of diagnosable mental disorders among Latino immigrants than among U.S.-born Latinos of several major subgroups (Marin, et al., 2006, Winter), the phenomenon is not consistent among Latino subgroups. In a recent analysis of data from the NLAAS, the authors conclude:

The immigrant paradox consistently held for Mexican subjects across mood, anxiety, and substance disorders, while it was only evident among Cuban and other Latino subjects for substance disorders. (Alegría, et al., 2008).

Mental disorder prevalence studies show results supporting the existence of a Latino paradox. In a study comparing Mexican immigrants to Mexican Americans, data show lower lifetime prevalence rates of key psychiatric disorders for less acculturated Mexican immigrants compared to more acculturated Mexican Americans. The researchers conclude that Mexican immigrants have mental health advantages over Mexican Americans due to protective buffering created by superior family life, lower divorce rates, more two-parent families, and greater retention of traditional Mexican culture. These findings suggest that the maintenance of Mexican culture anchored by family ties may provide protection against psychiatric disorders (Gamst, et al., 2002).

More recent research confirms similar findings by focusing on mental disorder prevalence rates among the Latino population and sub-groups. These studies use diagnostic interview results from the NLAAS epidemiological research to compare mental disorder prevalence rates. In one analysis of the NLAAS data, nativity is a discriminating factor in differential prevalence rates among Latino subgroups. Significantly higher risk exists among U.S.-born Latinos than among immigrant Latinos for any disorder (37.1% versus 24.9%), major depressive episode (18.6% versus 13.4%), social phobia (8.5% versus 6.0%), posttraumatic stress disorder (5.9% versus 4%), anxiety disorder (18.9% versus 15.2%), and substance disorder (20.4% versus 7%) (Alegría, et al., 2008).

A very different viewpoint regarding the Latino paradox appears in *Migration and health: Latinos in the United States*. In this report, the author suggests that the paradox regarding Latin American immigrants' health indicators can be partly explained by reverse migration which leads to underestimating illness rates in the U.S. for Latin American immigrants. The report points out that those Latino immigrants who suffer from various conditions often return to their original communities for family support and traditional forms of treatment. This is especially true in the Southwestern U.S. where frequent cross-border travel is common. As a result, reverse migration to Mexico masks illness rates among the Mexican-born immigrant population living in the U.S. (Castañeda, 2008).

Another recent report focusing on migration issues from the California Center for Population Research utilizes data from a survey of Latin American migrants living in the U.S. to document the frequency of cross-border travel. The data identify various patterns that show large numbers of Latino migrants moving

across borders, and include patterns of return migration, repeat migration, and circular migration. Nearly two-thirds (65%) of all Latino immigrants have made at least one trip to their native country since moving to the U.S., and 29% have traveled in the past two years. In this study, level of acculturation is negatively associated with cross-border travel (Waldinger, 2006).

Factors that may contribute to Latino community members' underreporting of symptoms used as criteria for psychiatric diagnoses in recent epidemiological studies include a number of cultural characteristics identified in this dissertation. These Latino cultural constructs may contribute to unwillingness on the part of some survey participants to be forthcoming in revealing personal matters like emotional problems. Even though researchers acknowledge the importance of cultural concerns in developing epidemiological studies, a number of potential sources of cultural dissonance remain. For example, in the NLAAS study, issues which may contribute to underreporting among Latino community members include:

- In the initial contact with subjects, researchers describe the topic as an investigation of their "physical and emotional well-being."
- Researchers read a standard informed consent statement, including possible risks to subjects, and ask subjects to consent to it.
- Interviewers give subjects a 'resource card' at the beginning of the interview that contains a list of various organizations that offer mental health support services for substance abuse, domestic violence, and mental health problems.

- The overall length (average of 2.7 hours) and formality of the interview, along with the use of a computer-assisted interview format.

- Researchers record a subset of the interviews (more than 5%) for quality control purposes.

- The interviewer workforce is primarily female (71.4%) even though 51.5% of the interview subjects are male.

- Many of the subjects are initially reluctant to participate in the research as evidenced by the multiple contacts required to complete data collection. An average of 9.2 contacts is necessary to complete the first respondent interview and 11.6 contacts required to complete the second respondent interview.

- The use of a number of refusal conversion strategies, including respondent incentives paid up to \$150 for participation (Pennell, et al., 2004).

Although each of these issues considered individually may represent a relatively small potential to discourage candid responses from recent Latino immigrants, collectively these factors could create an interview environment that some Latino community members (especially recently immigrated and undocumented group members) might view as threatening, and could result in a more reticent response from these participants.

Among participants in the survey research leading to this dissertation, the majority of subjects reported beliefs about the cause of emotional/emotional problems as a cause other than mental illness. A segment of Latino community members participating in the NLAAS epidemiological research may not consider the diagnostic symptoms used in the questionnaire to be caused by an illness. Since the stated purpose of the epidemiological study is investigating

participants' "physical and emotional well-being and areas of their life that could affect their physical and emotional well-being" ("NLAAS Questionnaire," n.d., p. 5), some Latino participants may have under-reported such symptoms.

Several procedural aspects of the NLAAS interview could also have a negative impact on some Latino participants' willingness to be forthcoming. For example, reading a standard informed consent statement to all interview subjects warning them of potential risks and asking them to acknowledge the risks. Furthermore, the overall formality and institutionality of the interview are exacerbated by university-affiliated interviewers giving subjects a 'resource card' at the beginning of the interview that contains a list of various organizations that offer mental health support services. Contact information provided to subjects who can call directly and receive assistance on issues such as substance abuse, domestic violence, and mental health, may be interpreted as threatening by some subjects ("Collaborative Psychiatric Epidemiology Surveys (CPES)," n.d.; Pennell, et al., 2004).

Cultural forces could also discourage candid reporting of symptomology used as criteria for a psychiatric diagnosis among recently immigrated Latino community members. Latino cultural constructs (such as *respeto*, *personalismo*, *familismo*) may influence some Latino survey subjects to be less forthcoming about personal information in a formal interview context. The NLAAS expects subjects to report detailed emotional experiences to an unfamiliar interviewer during a formal (computer assisted) and lengthy (average of 2.7 hours) interview. Reluctant subjects earn up to \$150 in additional compensation to motivate participation in the research. The extra money may also influence them to be

motivated more by the compensation and, as a result, be less forthcoming about personal matters. In addition, recording of a subset of the interviews for quality control purposes (more than 5%) adds to the formality of the interview environment in these instances (Pennell, et al., 2004).

Since Latino communities often reflect a strongly patriarchal culture, and 51.5% of the NLAAS subjects are male, a primarily female (71.4%) interviewer workforce could have a negative effect on male subjects' candidness in discussing intimate emotional issues ("Collaborative Psychiatric Epidemiology Surveys (CPES)," n.d.; Pennell, et al., 2004).

As a result of the collective impact of these issues on recently immigrated and possibly undocumented Latino community members, under-reporting of symptoms used as criteria for a psychiatric diagnosis in research like the NLAAS would not be surprising. Even documented Latino community members fear the disclosure of problems that could cause them to be detained or deported. Comments reported by focus group participants in this dissertation support the contention that a generalized level of anxiety and fear exists among recent Latino arrivals in the U.S., even if they have legal immigration documentation.

Quantitative Analyses of Survey Research Data

To better understand the extent, nature and consequences of cultural differences between Latino community members and the dominant U.S. culture, I explore the results of quantitative analyses of survey response data focusing on how Latino community members define the causes of emotional/mental problems. I also assess the impact of selected demographic characteristics on Latino community members' causal definition of emotional/mental problems.

In this chapter I define variables used in these quantitative analyses, present research hypotheses for each set of variables analyzed, and report results for bivariate and multivariate models. My discussion of the results link to theoretical and research issues important in understanding Latino mental health concerns identified in the Theory & Research Literature Review (see Chapter 1).

It is possible that subjects referred to this study from religious groups may have differing beliefs about causal definitions of emotional/mental problems than subjects who were referred from non-religious organizations. To resolve this potential source of bias, I investigate differences between responses by survey subjects referred to the study by religious organizations and those referred by non-religious organizations.

Many authors have commented about the heterogeneity of Latino cultural groups and the importance of understanding Latino cultural diversity in designing research projects (Alegría, Shrout, et al., 2007; Duran, et al., 2001; Rivera, et al., 2009). Authors of recent research using data from the NLAAS to assess Latino diversity and its consequences for acculturation and mental health conclude that:

. . . researchers need to design studies that take into account the diversity of Latinos and to focus on this diversity in their analytic strategies. It is no longer tenable to treat Latinos as one large, homogeneous group for analyses (Guarnaccia, et al., 2007).

To address this issue, I assess the extent to which survey subjects' country of origin results in significantly different responses by comparing subjects with Mexican origins (59.7% of the responses), Central American origins (El Salvador, Honduras, Costa Rica, Guatemala, and Nicaragua--23% of the responses), and subjects from other Latin American countries (17.3% of the

responses). I group Central American countries together for comparison because they are the second largest sub-group of national origins. Research also suggests a consistency of health beliefs and practices among Central American populations, largely influenced by similar religious and indigenous worldviews, including Mayan historical traditions (Murguia, et al., 2003).

Other countries of origin shown in the research literature to have significantly different mental health and illness characteristics include Puerto Rico, Cuba, and the Dominican Republic (Guarnaccia & Martinez, 2002). In the sample used for the dissertation research, subjects from these countries represent a small proportion of the overall sample (Puerto Rico 2.75%, Cuba 1.5%, and Dominican Republic 2.75%) and I do not analyze them separately.

Variables used in the analyses.

The dependent variable used in the analyses is Latino community members' responses to a survey question on the cause of emotional/mental problems. Multiple answers include: Mental Illness, Devil, Evil Spirits, and Nature.

Independent variables used in the analyses include: subject's age (< 35 years of age/ \geq 35 years of age), subject's educational status (\leq Secondary/ $=$ College), subject's time living in the U.S. (\leq 5 years/ $>$ 5years), and subject's gender (female/male). Additional independent variables in the analyses are: subject's referral source (religious/non-religious), and subject's country of origin (Mexico, Central America, Other).

Since the analyses reported in this dissertation employs secondary data from prior research focusing on mental health service needs among Latino

community members, several variables that would be helpful in separating the effects of non-Latino factors (socioeconomic status, age and date of immigration, marital status, health insurance coverage, etc.) are not available.

Research hypotheses.

The following hypotheses predict relationships between variables selected from survey responses for secondary analyses. See Chapter 2 for a more extensive discussion of hypotheses development.

Hypothesis related to subject's causal definition of mental/emotional problems.

Latino community members responding to the survey are more likely to define the cause of mental/emotional problems as something other than mental illness.

Hypotheses related to subject's demographic characteristics.

Latino community members responding to the survey who are younger (<35 years of age) are more likely to define mental illness as the cause of emotional/mental problems.

College educated Latino community members responding to the survey are more likely to define mental illness as the cause of emotional/mental problems.

Latino community members responding to the survey who have lived in the United States for more than five years are more likely to define mental illness as the cause of emotional/mental problems.

Female Latino community members responding to the survey are more likely to define mental illness as the cause of emotional/mental problems.

Hypotheses related to subject's referral source and country of origin.

Latino community members responding to the survey referred from a religious group are less likely to define mental illness as the cause of emotional problems.

Latino community members responding to the survey who report Mexico as a country of origin are less likely to define mental illness as the cause of emotional problems.

Discussion of Bivariate Results

Although a number of authors comment about Latino community members' contrasting beliefs about the causes of emotional problems, little reported evidence exists regarding the actual proportion of the population sharing specific beliefs. In this section I concentrate on bivariate results of Latino community members' responses to survey questions focusing on their causal definition of emotional/mental problems. My intent is to identify variables suitable for use in logistic models capable of assessing the relative importance of the various predictors.

Survey responses on causal definition of emotional/mental problems.

In this study, a majority of subjects (52.25%) report causal definitions of emotional/mental problems as a cause other than mental illness. Table 4.1 summarizes specific responses. The most frequent response among explanations other than mental illness is "nature" with 35% of the total responses. The devil (10%) and evil spirits (7.25%) are less frequent responses.

Table 4.1

Responses to Survey Question on the Cause of Emotional/Mental Problems

Causal Definition of Emotional/Mental Problems	Frequency	Percentage
Mental Illness	191	47.75
Devil	40	10
Evil Spirits	29	7.25
Nature	140	35

Bivariate analyses of demographic variables.

Table 4.2 summarizes results of analyses using contingency tables constructed to examine associations between each of the independent variables and the key dependent variable, causal definition of emotional/mental problems. Demographic variables analyzed as independent variables include the subject's age, education, time living in the U.S., and gender.

Table 4.2

Survey Response Analyses, Causal Definition of Emotional/Mental Problems by Survey Subject's Demographic Variables

Demographic Variables	χ^2
Age (<35/≥35)	23.75***
Educational Status (≤Secondary/=College)	75.9***
Years Living in U.S. (≤5/>5)	92.84***
Gender (Male/Female)	5.43*

† < 0.10; * $p \leq 0.05$; ** $p \leq 0.01$; *** $p \leq 0.001$

All of the demographic variables analyzed are significantly associated with survey subjects' reported causal definition of emotional/mental problems. Age, education, and time living in the U.S. are significant predictors of a mental illness causal definition at the < 0.001 level, while gender is a significant predictor of a mental illness causal definition at the < 0.05 level.

Among subjects grouped by age, a significantly larger proportion of subjects under 35 years-of-age (58%) report a mental illness causal definition compared to those 35 years-of-age or older (33%), $\chi^2(1, N = 400) = 23.75$, $p < 0.001$. Considering subjects grouped by educational status shows a significantly larger proportion of subjects with a college education (81%), compared to those with a secondary education or less (33%), report a mental illness causal definition, $\chi^2(1, N = 400) = 75.9$, $p < 0.001$. Among subjects grouped by years living in the United States, a significantly larger proportion of subjects living in the United States for more than 5 years (71%), compared to those living in the United States for 5 years or less (23%), report a mental illness causal definition, $\chi^2(1, N = 400) = 92.84$, $p < 0.001$.

For all three of these variables, the Cramer's Phi measure suggests a moderate effect on a mental illness causal definition for subjects under 35 years-of-age ($\Phi = 0.24$), for subjects with a college education ($\Phi = 0.44$), and for subjects living in the United States for more than 5 years ($\Phi = 0.48$).

The effect of gender on the dependent variable of reporting a mental illness causal definition is significant at the < 0.05 level, $\chi^2(1, N = 400) = 5.43$, $p = 0.02$. Among subjects grouped by gender, female subjects are more likely to report a mental illness causal definition (53%) than male subjects (42%). Cramer's Phi measure, however, suggests a very weak effect for gender on a mental illness causal definition, $\Phi = 0.01$.

Bivariate analyses of additional independent variables.

I summarize results in Table 4.3 for two additional independent variables included in the analyses: subject's referral source (religious/non-religious), and

subject's country of origin (Mexico, Central America, Other). First, I examine differences in survey subjects' responses on the key dependent variable of a mental illness causal definition by comparing subjects referred to the study by religious organizations and those referred by non-religious organizations. I also assess the extent to which survey subjects' country of origin results in significantly different responses on the key dependent variable of a mental illness causal definition by comparing subjects with Mexican origins (59.7% of the responses), Central American origins (El Salvador, Honduras, Costa Rica, Guatemala, and Nicaragua--23% of the responses), and subjects from other Latin American countries (17.3% of the responses).

Table 4.3

Survey Response Analyses, Causal Definition of Emotional/Mental Problems by Survey Subjects Referral Source and Country of Origin

Referral Source & Country of Origin	χ^2
Referred from a Religious/Non-Religious Organization	0.11
Country of Origin (Mexico/Central America/Other Latin American)	2.89

† < 0.10; * $p \leq 0.05$; ** $p \leq 0.01$; *** $p \leq 0.001$

Comparing subjects referred from religious and non-religious organizations indicates that the proportion of subjects reporting a causal definition of emotional/mental problems as mental illness does not differ significantly by their referral source, $\chi^2(1, N = 400) = 0.11, p = 0.74$.

When I compare subjects from Mexico with those from Central America and other Latin American countries in the sample, the proportion of subjects reporting a causal definition of emotional/mental problems as mental illness does

not differ significantly by the subject's country of origin, $\chi^2(2, N = 400) = 2.89$, $p = 0.24$.

These results indicate that neither one of the independent variables of referral source or country of origin is significantly associated with the survey subject's reported causal definition of emotional/mental problems. Hypotheses regarding survey subjects' referral source and country of origin as significant predictors of a causal definition of mental illness therefore are not supported.

Discussion of Multivariate Results

I include demographic variables shown in bivariate analyses as significant predictors of the dependent variable of causal definition of emotional/mental problems in logistic regression models. These analyses will further explicate Latino community members' cultural understanding about the cause of mental disorder and the impact of demographic variables on that understanding.

Results of analysis for demographic variables predicting causal definition of emotional/mental problems as mental illness.

Table 4.4 shows results of the binary logistic regression analysis of demographic variables of age, education, time living in U.S., and gender as predictors of the causal definitions of emotional/mental problems as mental illness.

Table 4.4

Summary of Logistic Regression Analysis for Demographic Variables Predicting Causal Definition of Emotional/Mental Problems as Mental Illness

Cause of Emotional/Mental Problem	Log-odds (B)	Odds Ratio (OR)	95% CI for OR
Mental illness			
Intercept	0.23		
Age (< 35)	0.77	2.16 **	[1.23, 3.79]
Education (college)	1.89	6.63 ***	[3.38, 13.03]
Time living in US (≤ 5)	-2.15	0.12 ***	[0.07, 0.214]
Gender (female)	0.39	1.47	[0.86, 2.54]

N = 400 $R^2 = 0.39-0.41$ DF = 4

Difference in -2 Log Likelihood = 183.27

Notes: Difference in -2 log likelihood subtracts -2 log likelihood for full model from -2 log likelihood of model with only intercepts. R^2 reported are Pseudo R^2 Cox and Snell, & Nagelkerke

† < 0.10; * $p \leq 0.05$; ** $p \leq 0.01$; *** $p \leq 0.001$

Variables in the logistic regression model include the dependent variable, causal definition of emotional/mental problems, and independent variables age (< 35), education (college), time living in U.S. (≤ 5 years), and gender (female). Results of the logistic regression analysis for variables predicting the causal definition of emotional/mental problems as mental illness indicate that three of the variables, (age $p \leq 0.01$, education $p \leq 0.001$, and time living in U.S. $p \leq 0.001$) are significant predictors.

Gender (female), however, is not a significant predictor in this model. In the bivariate analysis, Cramer's Phi measure suggests a very weak effect for gender on a mental illness causal definition, $\Phi = 0.01$. In the logistic regression models, the odds ratios for gender are not significant predictors for any of the causal definitions. This is an unexpected result that I will attempt to explain.

According to data from the NLAAS, lifetime psychiatric disorder prevalence estimates are slightly higher for Latinas, with 30.2% for women and 28.1% for men (Alegría, Mulvaney-Day, et al., 2007). Even though Latinas may experience higher rates of specific mental/emotional problems (i.e., depression) (Canales, 2000) and culturally defined emotional problems (i.e., *ataque de nervios*) (Guarnaccia, et al., 2010), they share essentially the same worldview and cultural foundation regarding health and illness as men. The influence of a shared culture may be more important than gender-related factors in developing beliefs regarding the cause of mental/emotional problems, and if so, it would not be surprising that similar proportions of Latinas and male Latinos define mental illness as the cause of mental/emotional problems.

Two of the significant independent variables, age ($B = 0.77$) and education ($B = 1.89$), have a positive effect on the causal definition of emotional/mental problems as mental illness. However, the third independent variable, time living in the U.S. ($B = -2.15$), has a negative effect on the causal definition of emotional/mental problems as mental illness.

These results suggest younger, college educated Latino community members are more likely to define the cause of mental/emotional problems as caused by mental illness. However, recently immigrated Latino community members who have lived in the U.S. for 5 years or less are more likely to report causal definitions other than mental illness.

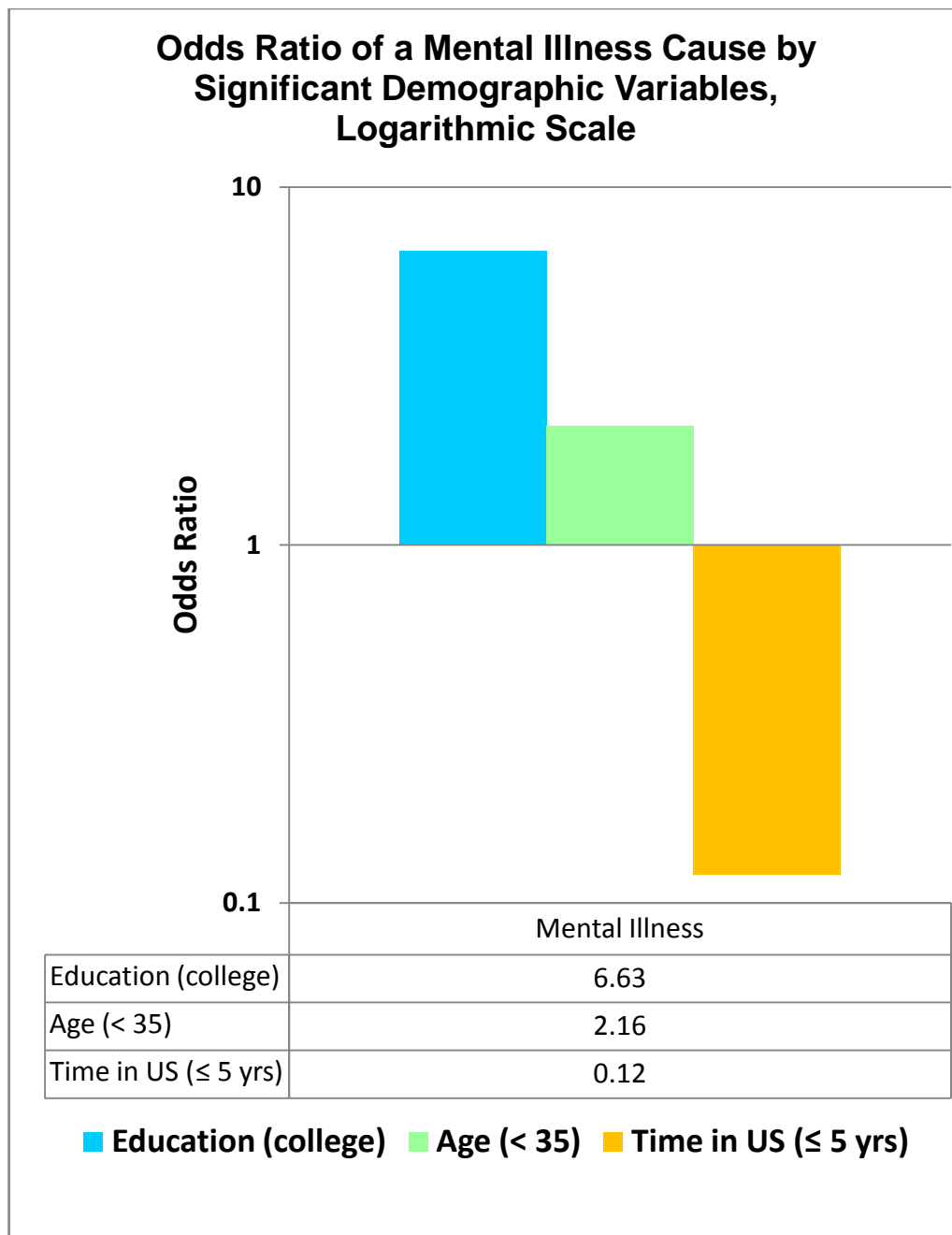
Odds ratios <1 predict a decrease in the dependent variable for a unit increase in the independent variable. In the logistic regression model, odds ratios <1 suggest a decrease in the likelihood of defining the cause of

emotional/mental problems as mental illness by the subjects' living in the U.S. for five years or less ($OR = 0.12$). Odds ratios >1 for the independent variable predict an increase in the likelihood of defining mental illness as the cause of emotional/mental problems. In the logistic regression model, odds ratios >1 suggest that being less than 35 years old ($OR = 2.16$) or having a college education ($OR = 6.63$) increase the likelihood of defining the cause of emotional/mental problems as mental illness.

The following graph (Figure 4.1) illustrates the odds ratios for the demographic variables included in the model predicting the likelihood of a mental illness causal explanation for mental disorder among Latino community members. Education (college) exhibits the greatest predictive strength for an increasing likelihood of a mental illness causal explanation, while age (< 35) exhibits somewhat lesser predictive power for an increasing likelihood of mental illness causal explanation. Time living in the U.S. (≤ 5 yrs), however, shows a correspondingly strong predictive strength for decreasing likelihood of a mental illness causal explanation.

Figure 4.1

Graph of Odds Ratio of a Mental Illness Cause by Significant Demographic Variables, Logarithmic Scale



Results of analysis for demographic variables predicting causal definition of emotional/mental problems as caused by the devil, evil spirits, or nature.

I include demographic variables shown in bivariate analyses to be significant predictors of the dependent variable of causal definition of emotional/mental problems in a multinomial logistic regression model. Table 4.5 shows results of the model. Variables in the multinomial logistic regression model include the dependent variables of the subjects' causal definition of emotional/mental problems as caused by the devil, evil spirits, or nature. I include independent variables age (< 35), education (college), time living in U.S. (≤ 5 years), and gender (female) in the model.

Table 4.5

Summary of Logistic Regression Analysis for Demographic Variables Predicting Causal Definition of Emotional/Mental Problems as a Cause Other than Mental Illness

Cause of Emotional/Mental Problem	Log-odds (B)	Odds Ratio (OR)	95% CI for OR
Devil			
Intercept	-0.44		
Age (< 35)	-1.39	0.25 ***	[0.12, 0.53]
Education (college)	-2.21	0.11 ***	[0.04, 0.33]
Time living in US (≤ 5)	0.8	2.23 *	[1.05, 4.74]
Gender (female)	-0.05	0.95	[0.45, 1.98]
Evil spirits			
Intercept	-1.74		
Age (< 35)	-1.31	0.27 **	[0.11, 0.64]
Education (college)	-1.75	0.17 **	[0.06, 0.54]
Time living in US (≤ 5)	1.69	5.41 ***	[2.21, 13.25]
Gender (female)	0.56	1.75	[0.73, 4.21]
Nature			
Intercept	-0.23		
Age (< 35)	-0.77	0.46 **	[0.26, 0.81]
Education (college)	-1.89	0.15 ***	[0.08, 0.29]
Time living in US (≤ 5)	2.15	8.55 ***	[4.89, 14.98]
Gender (female)	-0.39	0.68	[0.39, 1.17]

N = 400 $R^2 = 0.39 - 0.41$ DF = 12

Difference in -2 Log Likelihood = 183.27

Notes: Difference in -2 log likelihood subtracts -2 log likelihood for full model from -2 log likelihood of model with only intercepts. R^2 reported are Pseudo R^2 Cox and Snell, & Nagelkerke

† < 0.10; * $p \leq 0.05$; ** $p \leq 0.01$; *** $p \leq 0.001$

Results of the multinomial logistic regression analysis for variables predicting the causal definition of emotional/mental problems as a cause other

than mental illness indicate that three of the independent variables (age, education, and time living in U.S.) are significant predictors for all three of the dependent variables. See Table 4.5 for the level of significance for each independent variable. Gender (female) is not a significant predictor in this model for any of the dependent variables.

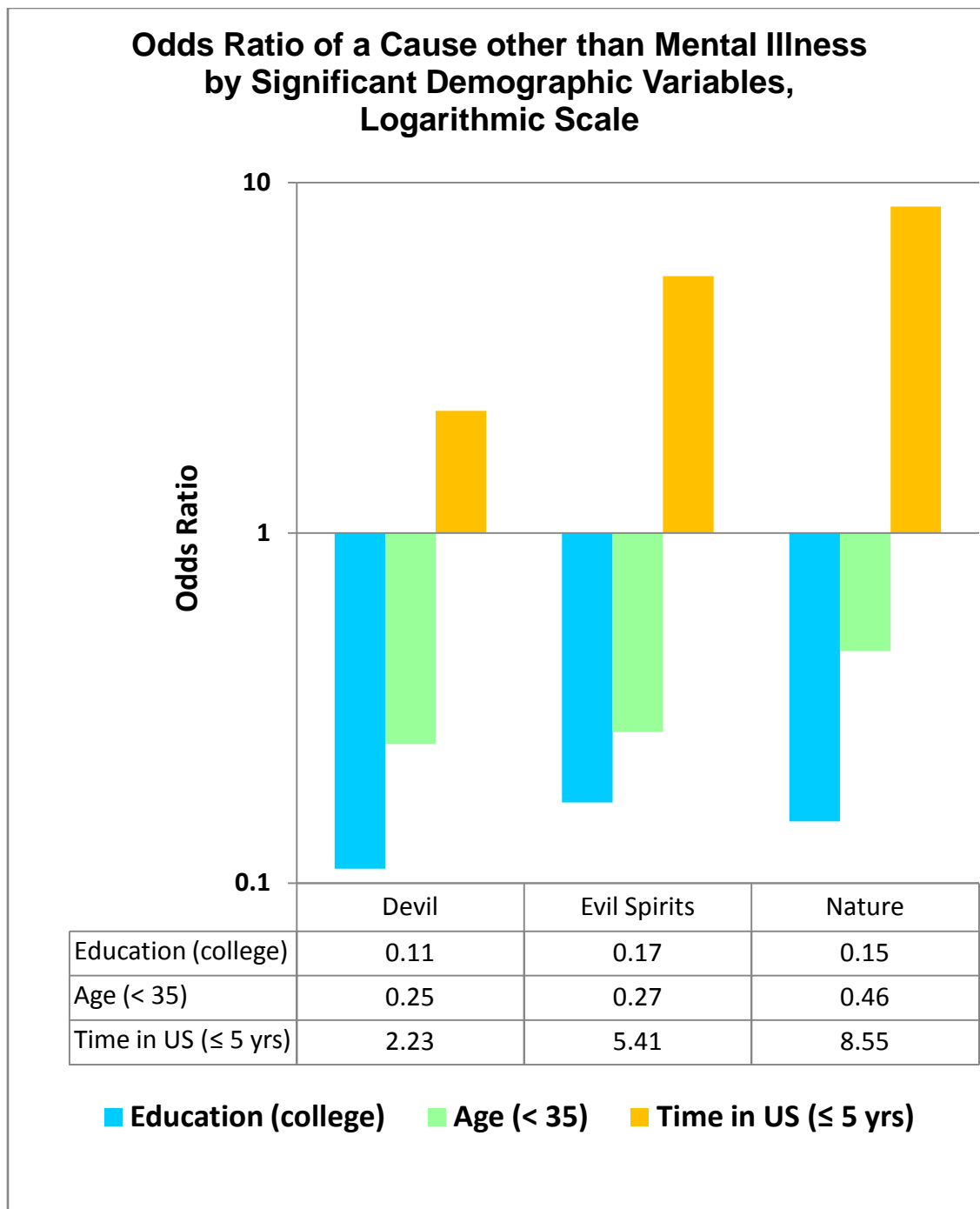
Two of the significant independent variables, age (< 35) and education (college), have a negative effect on the subjects' causal definition of emotional/mental problems as a cause other than mental illness. The third significant independent variable, time living in the U.S. (≤ 5 years), has a positive effect on the causal definition of emotional/mental problems as a cause other than mental illness. These results confirm the suggestion that younger, college educated Latino community members are less likely to define the cause of mental/emotional problems as caused by the devil, evil spirits, or nature. However, recently immigrated Latino community members who have lived in the U.S. for 5 years or less are more likely to report causal definitions other than mental illness.

Odds ratios <1 predict a decrease in the dependent variable for a unit increase in the independent variable. In the multinomial logistic regression model, odds ratios suggest a decrease in the likelihood of defining the cause of emotional/mental problems as a cause other than mental illness by the subjects' being less than 35 years old or by having a college education. Odds ratios >1 for the independent variable of living in the U.S. for five years or less predict an increase in the likelihood of defining a cause other than mental illness as the cause of emotional/mental problems.

The following graph (Figure 4.2) illustrates the odds ratios for the demographic variables included in the model predicting the likelihood of causal explanations for mental disorder as a cause other than mental illness among Latino community members. Education (college) exhibits the greatest predictive strength for a decreasing likelihood of all three alternative causal explanations, while age (< 35) exhibits somewhat lesser predictive power for a decreasing likelihood of all three alternative causal explanations. Time living in the U.S. (≤ 5 yrs), however, shows a correspondingly strong predictive strength for an increasing likelihood of all three alternative causal explanations. Time living in the U.S. also impacts the dependent variables in a pattern opposite to the other independent variables, with the dependent variable of nature showing the strongest influence, and the devil the weakest impact.

Figure 4.2

Graph of Odds Ratio of a Cause other than Mental Illness by Significant Demographic Variables, Logarithmic Scale



Summary of Results: Latino Community Members' Causal Definition of Emotional/Mental Disorder

The majority of Latino community members responding to the survey (52.25%) report a belief in causal definitions of emotional/mental problems as a cause other than mental illness, thus supporting the initial hypothesis. The most frequently reported alternative causal definition is nature (natural, part of nature) (35%), while the devil (10%) and evil spirits (7.25%) are less frequent responses.

Quantitative analyses of survey research data using contingency tables show that three of the demographic variables (age, education, and time living in U.S.) are significant predictors ($p < 0.001$) of the subject's causal definition of emotional/mental problems as a cause other than mental illness, thus supporting each of the three hypotheses related to subject's demographic characteristics. In this model, a fourth demographic variable, gender (female), is not a significant predictor ($p = 0.46$), and the hypothesis related to gender is not supported.

Logistic regression analyses support the bivariate results and calculate odds ratios for the demographic variables included in the model. Odds ratios predict the likelihood of a mental illness causal explanation for mental disorder among Latino community members responding to the survey by demographic characteristics. In the binary model (See Figure 4.1) the independent variable education (college) exhibits the greatest predictive strength for an increasing likelihood of a mental illness causal explanation, while age (< 35) exhibits a somewhat lesser predictive power for an increasing likelihood of mental illness causal explanation. Time living in the U.S. (≤ 5 years), however, shows a

correspondingly strong predictive strength for a decreasing likelihood of a mental illness causal explanation.

These results confirm similar results from contingency table analyses and suggest those Latino community members with a college education or who are age 35 or less are more likely to accept a mental illness causal definition for mental/emotional problems. Community members living in the U.S. for 5 years or less are less likely to adopt a mental illness causal definition.

An interesting pattern appears when I consider survey response data for the three significant predictors of causal definitions of emotional/mental problems along with qualitative results reported in this dissertation together with findings of epidemiological research on psychiatric disorder prevalence from the NLAAS. Age (< 35) predicts a causal definition of emotional/mental problems as mental illness, a finding which confirms similar results from qualitative data. NLAAS data indicate the youngest age group (18-35) has the highest reported rate of last-year disorders (the < 35 age group does not have the highest lifetime mental disorder prevalence rates in the NLAAS data because of their truncated age span.).

A similar pattern emerges for education, with college-level education predicting a mental illness causal definition in the dissertation data. This result also confirms the qualitative finding that more educated Latinos are more likely to adopt a scientific explanation of mental illness. Education is also associated in the NLAAS data with the highest proportion of lifetime mental disorder prevalence rates shown among college-educated Latinos.

Finally, the variable of years living in the U.S. evidences a similar pattern, although the association with a causal definition of mental illness is inverse, with

the shortest period of time living in the U.S. (≤ 5 years) predicting a causal definition of emotional/mental problems other than mental illness. NLAAS data show that Latinos with the shortest period of time living in the U.S. (≤ 5 years) have the lowest proportion of lifetime psychiatric disorder.

One inference suggested as an explanation for this pattern is that Latino community members who believe mental illness is the cause of emotional/mental problems are more likely to frame their experience within the mental illness model. As a result, these Latino community members are more likely to interpret the symptoms they experience as an illness, seek care from mental health professionals, and report symptoms on psychiatric disorder prevalence questions when they participate in epidemiological research. Conversely, Latino community members who define a cause other than mental illness for emotional/mental problems are more likely to frame their experience within culturally accepted models, to seek care from alternative sources, and to be less likely to report symptoms on psychiatric disorder prevalence questions when they participate in epidemiological research.

The research by Ayalon et al. (Nov, 2005) is one of the few studies to address the relationship among beliefs about mental illness causation, race/ethnicity, and demographic variables of age and education. Although limited in its scope, this research confirms an association between subjects' race/ethnicity and beliefs about the causes of mental illness, with Latino participants more likely to report spiritual/personal weakness causes. Variables of age and education predict subjects' beliefs in this study, and beliefs explain lower levels of mental health service use by Latino participants.

These results are consistent with data presented in this dissertation on Latino community members' mental health care-seeking and Latino participants reporting symptoms used as criteria for a psychiatric diagnosis in epidemiological research. Factors that increase the likelihood of defining emotional/mental problems as mental illness by Latinos also increase their rates of reporting symptoms consistent with a psychiatric diagnosis, and increase the likelihood of professional mental health care-seeking. For Latinos living in the U.S. for five years or less, the data show a negative effect on their defining emotional/mental problems as mental illness. This demographic variable is also associated with lower rates of reporting symptoms consistent with a psychiatric diagnosis, and a reduced likelihood of seeking professional mental health care.

In addition, the data discussed in this dissertation suggest an alternative explanation for the Latino paradox. Since some Latino immigrants in the U.S. adopt a cultural understanding about emotional and behavioral disorders as caused by something other than mental illness, and they do not view symptoms of these problems as a disease of mental illness, they may be less likely to report such symptoms when they are used as criteria for a psychiatric diagnosis in epidemiological research. Several cultural forces common among Latino community members may also work to suppress their reporting of symptoms in epidemiological studies. Not the least of these may be a generalized fear among recently arrived Latinos of institutional entities which they believe have the power to directly or indirectly deport them.

Latino culture often incorporates a series of culturally defined emotional disorders, as well as belief in *curanderos*—a Latino folk-healing system. Latino

community members' beliefs about culturally defined disorders creates yet another frame that provides those who experience emotional problems with idioms for expressing their distress, with means for avoiding the stigma associated with being *loco* (crazy), and with guidance for care-seeking from religious, spiritual, or supernatural sources.

In the following Chapter 5, I discuss culturally defined emotional disorders found in the Latino community and analyze quantitative data from participants' survey responses to better understand how these cultural beliefs are linked to Latino's cultural frame of beliefs about emotional and behavioral disorders.

Chapter 5: Quantitative Data Analyses: Latino Community Members’ Experience of Emotional/Mental Problems and Culturally Defined Emotional Problems

In this chapter I consider quantitative analyses of Latino community members’ survey responses pertaining to reported experiences of emotional/mental disorder. I analyze these quantitative data based on Latino survey subjects’ responses concerning their causal definitions of emotional/mental disorder. First I discuss relevant theory and research identified in the Theory & Research Literature Review (Chapter 1) as important in understanding Latino mental health issues, including research about culturally defined emotional problems often called culture-bound syndromes. I also link quantitative data discussed in this chapter to qualitative findings reported in Chapter 3.

The notion of “idioms of distress” is a focus of my discussion of culture-bound syndromes. This concept introduces a way of understanding how different cultures express, experience, and cope with feelings of distress. Cultural beliefs shared by Latino community members constitute a frame of shared understandings that influences their perceptions and definitions of mental disorder (*Mental health: culture, race, and ethnicity--a supplement to mental health: a report of the Surgeon General*, 2001).

By considering the topic of idioms of distress, I use this opportunity to link concepts from the sociology of culture and cognition with findings in regard to culturally defined emotional problems identified among Latino community

members. Focal concerns of my discussion include the meanings associated with these idioms of distress and the utility they provide sufferers in destigmatizing culturally disapproved of conditions. Also important are ways in which idioms of distress provide powerless group members a means of expressing their situation.

The topic of culturally defined emotional problems experienced by Latino community members living in the U.S. is notable because of the clinical consequences for Latino clients. Mental health providers in the U.S. need to treat a growing population of culturally diverse clients. Immigrants often have their own patterns and conceptions of mental illness, some of which exist as culturally defined syndromes. To provide effective treatments, clinicians who serve culturally diverse populations must know more about these syndromes and their cultural contexts (Guarnaccia & Rogler, 1999).

Relevant Theory and Research

Culturally specific conditions found in Latino cultures foster unique ways of defining and responding to mental disorder. Culturally patterned idioms of distress are linguistic and bodily styles of expressing and experiencing illness. Latino cultural definitions of emotional problems typically do not have an exact concurrence with diagnostic categories used by professional mental health clinicians in the U.S., although there may be some overlap. Culturally defined conditions may also be linked to class, poverty, and inequality, and they may be a reflection of the sufferer's experience of powerlessness (*Mental health: culture, race, and ethnicity--a supplement to mental health: a report of the Surgeon General*, 2001).

Cognitive sociology and cultural sociology.

Cognitive sociologists make distinctions between how cognitive science and cultural sociology view thinking, information processing, accumulation, and organizing of thought. Within cognitive science, the emphasis is on thought produced by biochemical processes in the brain, how information processing functions, and universal rules for organizing and storing thought. In contrast, cultural sociology emphasizes how situated interaction creates thought, how social settings specify information processing systems, and how the sociocultural context distinguishes organization and storage management. Importantly, for the current topic of this dissertation, sociocultural context explains why certain cultural constructs, such as those shared by members of the Latino community, function to shape shared definitions of reality and patterns of social action (Cerulo, 2002).

Furthermore, in this dissertation I use two key concepts drawn from cognitive sociology that require careful delineation: schemata and frames. Schemata translate worldviews into everyday thinking, feeling and action (Schwartz & Kim, 2002). Organizing Information, opinion and attitudes into schemata accomplishes this function. Social schemata provide frameworks that help humans interpret new information (DiMaggio, 2002, p. 276). Schemata are abstract, organized networks of relations that must be filled in with specific details. They consist of very general knowledge structures, abstract principles and rules that assist in the human construction of meaning and interpretation of situations (Cerulo, 2002).

In contrast, frames are fixed structures that characterize stereotyped interactions or situations. People use a variety of situational and interactional frames which comprise a set of expectations used to evaluate new situations (Cerulo, 2002). Framing encloses situations, acts, or objects with mental brackets that define them. Frames classify not only different but also separate realms of experience. They also establish segments of our perceptual environment as relevant or irrelevant (Zerubavel, 1991).

Importance of cultural factors.

Kleinman (1989) observes that culture not only shapes illness, but also influences the ways members of the culture envision illness. Even in similar countries, dramatic differences can exist in the way patients present, how physicians interpret medical tests, and the types and forms of treatments provided. Today, culture does not just consist of preset guiding structures that automatically direct behavior, but instead it functions as a set of pliable and changing cognitive options from which individuals and groups select to accomplish specific goals (Angel & Williams, 2000).

The dominant U.S. culture centers on beliefs, norms, and values transmitted from its primarily Non-Latino White, Judeo-Christian origins. While modern America is increasingly more multicultural in character, its societal institutions continue to be shaped by Non-Latino White American culture, and more broadly, Western culture. That cultural legacy has left its imprint on how its members, including mental health professionals, respond to mental and emotional conditions and problems (*Mental health: culture, race, and ethnicity--a supplement to mental health: a report of the Surgeon General*, 2001).

Angel and Thoits (1987) analyze the impact of culture on the cognitive structure of illness. They develop a theoretical framework for understanding the impact of culture on symptom recognition, labeling, and help-seeking. The authors assume that culture constrains the subjective experience of illness. Cognitive and linguistic categories of illness are characteristic of a specific culture, and these categories limit the options available to individuals in responding to symptoms. Further, they theorize learned cognitive structures exist that filter experiences, and these structures influence the interpretation of deviations from culturally-defined physical and mental health norms. They also posit that these processes have a significant impact on responses from different ethnic group members participating in large-scale epidemiological studies.

Angel and Williams (2000) suggest the concept of cognitive schemas as a useful way to understand how culture influences individuals' beliefs about health, illness, and care-seeking. They propose a definition of schemas for this purpose as "culturally based embedded and hierarchical abstractions concerning both categories and processes" (p. 32). They argue that several schemas may be needed in recognizing, identifying, and acting on symptoms and illnesses. One can think of schemas as stored collections of lore, knowledge, and experience. Therefore, in relation to health and illness, schemas influence how we respond to deviations from what we consider normal and what we react to as pathological.

Latinos immigrating to the U.S. bring with them structured cultural syndromes, some of which consist of indigenous patterns and conceptions of mental disorder. These culturally specific syndromes illustrate the influence of

the mind in deciding how a culture connects symptoms and defines a disease (Guarnaccia & Rogler, 1999).

Cultural beliefs shared by Latino community members influence their perceptions and definitions of mental disorder. Culturally specific conditions found in Latino cultures are examples of unique ways of defining mental disorder. Examples include conditions referred to as *mal de ojo*, *ataque de nervios*, *susto*, and *angustia*. Different Latino group members experience these culturally specific disorders in dissimilar ways, reflecting the heterogeneity among Latino groups (See information on specific conditions below.) (Romero, 2000).

Comas-Días (2006), in her discussion of the need to culturally adapt mainstream psychotherapy to Latino populations, points to Latinos' cognitive style as highly reactive to imagery and fantasy. She also notes that research demonstrates that Latinos use more fantasy, magical thinking, and dissociation than their Non-Latino White and African American counterparts. She identifies the popular literary genre "magical realism" as an example found in Latino culture of belief in the supernatural.

Further, the popularity of magical realism as a literary genre in Latin America underscores the prominent role of the supernatural in Latino culture. Magical realism incorporates supernatural explanations of everyday occurrences as seen in the Nobel prize winning novel *One Hundred Years of Solitude* (*Cien años de soledad*) by Colombian author Gabriel García Márquez, and the popular movie *Like Water for Chocolate* (*Como agua para chocolate*) written by Mexican novelist Laura Esquivel. These writers interweave realism together with fantastic

and dreamlike elements, often derived from myths and fairy tales, in representing ordinary events and descriptive details in their works (Abrams, 2004).

Many of the culturally defined emotional problems identified in Latino cultures rely heavily on belief systems that incorporate supernatural explanations of emotional and mental problems. For example, the belief that a victim's soul has left the body because of a frightening event resulting in unhappiness and illness is the basis for *susto*. The evil eye, *mal de ojo*, is a culture-bound syndrome based on a complex and interlinked pattern of beliefs in which excessive admiration or envy causes distress.

Culturally defined problems (culture-bound syndromes).

Culture-bound syndromes are clusters of symptoms that appear more often in some cultures than in others. For example, some Latino patients, especially women from the Caribbean, experience a condition called *ataque de nervios*. This condition often includes symptoms such as screaming uncontrollably, attacks of crying, trembling, and verbal or physical aggression. A number of other culture-bound syndromes appear in the DSM–IV “Glossary of Culture-Bound Syndromes” (*Mental health: culture, race, and ethnicity--a supplement to mental health: a report of the Surgeon General*, 2001).

Research examines the interrelationships between culture-bound syndromes and the diagnostic classifications of DSM–IV. In early research, authors often viewed culture-bound syndromes as variants of DSM diagnoses. Current investigators focus on examining how the social, cultural, and biological contexts interact to shape mental illnesses and reactions to such disorders, instead of assuming that the DSM diagnostic classifications establish the basic

patterns of mental illness (*Mental health: culture, race, and ethnicity--a supplement to mental health: a report of the Surgeon General*, 2001).

The stigma of mental illness is particularly powerful as a barrier to Latino victims' seeking care. The label of *locura* or madness carries strong negative implications. Latino community members see someone who is *loco* as severely mentally ill, probably violent, and most likely incurable. Labeling a family member who experiences mental disorders as suffering from a culture-bound syndrome such as *nervios* serves to destigmatize that person's experience both in the family and the community (Guarnaccia, et al., 2005).

DSM-IV definition of culture-bound syndromes.

The American Psychiatric Association recognizes culture-bound syndromes and states that:

The term culture-bound syndrome denotes recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category. Many of these patterns are indigenously considered to be 'illnesses', or at least afflictions and most have local names. Although presentations conforming to the major DSM-IV categories can be found throughout the world, the particular symptoms, course, and social response are very often influenced by local cultural factors. In contrast, culture-bound syndromes are generally limited to specific societies or culture areas and are localized, folk, diagnostic categories that frame coherent meanings for certain repetitive, patterned, and troubling sets of experiences and observations (*Diagnostic and statistical manual of mental disorders (DSM-IV-TR)*, 2000, p. 898).

From the qualitative data reported in this dissertation, individual focus group participants describe personal experiences of *ataque de nervios*, *susto*, *angustia*, and *mal de ojo*. A number of participants report experiencing several of the culturally defined emotional problems, including *angustia*, and *mal de ojo*.

Information on ataque de nervios.

Defined as an idiom of distress within the *DSM-IV-TR* “Glossary of Culture-Bound Syndromes,” the publication documents the existence of *ataque de nervios* among many Latin American populations. One of the most comprehensively studied of the culture-bound syndromes, symptoms commonly reported include:

...uncontrollable shouting, attacks of crying, trembling, heat in the chest rising into the head, and verbal or physical aggression. Dissociative experiences, seizure-like or fainting episodes, and suicidal gestures are prominent in some attacks but absent in others. A general feature of an *ataque de nervios* is a sense of being out of control (*Diagnostic and statistical manual of mental disorders (DSM-IV-TR)*, 2000, p. 899).

A family-related stressful event often precedes an *ataque de nervios*.

Typically, *ataques de nervios* originate from threats to the Latino community members' social world. Threats can come from breakdown of family relationships, loss of a family member, or from threats to valued relationships, including divorce and conflict with children. A powerful threat involves the death of a family member, especially if it is unexpected. *Ataques de nervios* are cultural idioms that express suffering and indicate an appeal for help (Guarnaccia, 1993; Guarnaccia & Rogler, 1999).

Another aspect of the experience is that victims may have amnesia regarding what happened during the episode, and as a result, they can rapidly assume their normal function level. Although there may be some overlap with *DSM-IV* Panic Attacks, *ataque de nervios* differs because of the presence of a precipitating event and the absence of acute fear or apprehension found in panic

attacks (*Diagnostic and statistical manual of mental disorders (DSM-IV-TR)*, 2000; Guarnaccia, 1993; Guarnaccia & Rogler, 1999).

Ataque de nervios is also described as an “acute, drama-laden clinical syndrome that typically follows stressful events” (p. 2). It typically includes clusters of somatization and dissociative symptoms that appear together. Because of the common occurrence of somatic symptoms, *ataque de nervios* is an example of a phenomenon often encountered in cross-cultural psychiatry. That phenomenon involves a norm in many cultures which involves converting personal or social distress into somatic complaints. These somatic complaints characteristically consist of socially accepted models and conform to common medical paradigms existing in the various societies. Victims tend to develop somatic symptoms that are medically correct—symptoms that physicians expect and understand (Escobar, 2004; Guarnaccia, 1993; Guarnaccia & Martinez, 2002).

NLAAS epidemiological research data show a prevalence of *ataque de nervios* ranging from 7% to 15% based on the specific Latino group, with Puerto Ricans reporting the highest frequency. Women report *ataque de nervios* more often than men, and rates are higher among those women with troubled marital status, and those more acculturated to the U.S. There are higher rates of affective, anxiety and substance abuse disorder symptomology among those reporting *ataque de nervios* (Guarnaccia, et al., 2010).

Information on susto.

Susto (fright or soul loss) appears in the DSM-IV as a folk illness common among Latinos living in the U.S. and throughout Latin America. Victims believe

that a frightening event causes their soul to leave their body, resulting in unhappiness and illness. Typical symptoms include:

...appetite disturbances, inadequate or excessive sleep, troubled sleep or dreams, feelings of sadness, lack of motivation to do anything, and feelings of low self-worth or dirtiness. Somatic symptoms accompanying *susto* include muscle aches and pains, headaches, stomachache, and diarrhea (*Diagnostic and statistical manual of mental disorders (DSM-IV-TR)*, 2000, p. 903).

Folk healers often employ ritual healings as a treatment for cases of *susto*—healings intended to restore the soul to the body and re-establish bodily and spiritual balance. Some of the experiences of *susto* victims may be related to a variety of DSM-IV diagnoses, but the folk illness is unique in its etiology and symptom configurations which exist in a number of different cultures in many parts of the world (*Diagnostic and statistical manual of mental disorders (DSM-IV-TR)*, 2000).

In her research on *susto*, Mysyk (1998) links the folk illness to class position, and documents that the majority of sufferers come from poor, working poor, and downwardly mobile populations. Her evidence suggests that *susto* may serve as a symbolic statement of the victim's disadvantaged class position and negative conditions. She argues that *susto* functions as a statement that its victims have been physically taxed beyond their ability to cope with the socioeconomic conditions in which they live.

In a cross-cultural study of *susto*, researchers find considerable diversity among different Latino ethnicities. Latino populations targeted in the study include Mestizo/ladino populations who participated in interviews in Guatemala, Mexico, and south Texas. Although results document consistency in reports of

what *susto* is, what causes it, its symptoms, and how to treat it, there appears to be substantial regional variations in treatments and a difference between past descriptions and contemporary reports of etiology (Weller, et al., 2002).

Several researchers demonstrate an association between *susto* and another common idiom of distress among Latinos, *nervios*. For example, Baer et al. (2003) conduct a multisite comparative study of *susto* and *nervios* among Puerto Ricans, Mexicans, Mexican Americans, and Guatemalans. While they find agreement among all four samples on a core description of *nervios*, as well as some overlap in aspects of *nervios* and *susto*, they conclude *nervios* is a much broader illness, related to continual stresses, while *susto* seems to be related to a single stressful event.

In more recent research, Weller et al. (2008) explore the relationship of the Latin American folk illnesses of *susto* and *nervios* to mental health. They posit that these folk illnesses are distinct from each other and that there is a stronger association between current levels of stress and depressive symptoms with past experience of *nervios* than with *susto*. They conclude that the cultural constructions of these folk illnesses reflect chronic and acute concepts of distress. Based on data collected from interviews in Guadalajara, Mexico, *susto* and *nervios* are extremely prevalent and occur across sociodemographic subgroups. The authors suggest the role of these folk illnesses may be to signal distress and generate a cultural response that is protective against more serious mental health consequences. It is possible that these resources have a greater buffering effect for short-term or acute conditions, such as *susto*, than they do for chronic conditions like *nervios*.

Information on angustia.

Qualitative data from Key Informant Panel members and Focus Group participants collected in the original research indicate that *angustia* (anguish) is a commonly reported culturally-defined condition among Latino community members living in the Charlotte region. Key Informant Panel members identify *angustia* as a cluster of symptoms similar to the DSM-IV diagnosis of Anxiety Disorder. Latino community members, however, do not classify these problems as mental illness but rather as a normal part of living. They also do not typically seek professional care but instead seek help from family members, friends, clergy, or from folk healers and remedies. One Key Informant panel member comments about *angustia* that:

I see *angustia* usually among my women clients—it consists of intense or extreme worry, anxiety, and often extreme sadness or depression. Recent immigrants have much to worry about, especially the undocumented ones. And those who are living in poverty, have split families, have little in the way of support networks suffer most. Their cure is to go to church or to a *Botánica* for herbs or tea.

Panel members also link the experience of *angustia* to the Latino cultural construct of *fatalismo* (fatalism). Community members who believe in *fatalismo* adopt an external locus of control and accept that individuals have minimal control over their environment. Latinos who accept fatalism believe that events occur only as a result of luck, God's will, or harmful wishes made by their adversaries (Kouyoumdjian, et al., 2003).

Key Informant Panel members suggest that a linkage exists in the Latino community between *fatalismo* and the excessive worry that can lead to *angustia*. One panel member says:

My clients who talk about *angustia* often have very fatalistic beliefs. For them, what happens to them in life is out of their control. They think there is nothing they can do but worry and pray. They say “It’s God’s will.” The church’s teachings don’t discourage this point of view. Counseling at church emphasizes prayer as a solution to most problems including *angustia*. They are supposed to come to church, pray, light a candle, and make an offering.

Focus Group participants in the original research report *angustia* as a commonly experienced culturally defined problem. In one group, for example, all seven of the participants mention *angustia* when they discuss their personal experience of culturally specific problems. One Focus Group participant says, referring to their emotional problems: “It is in God’s hands. All I can do is pray.”

Constant fear and worry about the future are common themes among participants. One participant talks about the constant worry and anxiety:

Yes, I feel frightened, anguished, nervousness. My family is legal, we have papers, but so many of our friends and neighbors are not. We are always looking over our shoulder. Many of our friends are anxious, nervous, especially the ones who have been in the U.S. a short time. They worry about getting sent back and losing everything they have here.

Little published research exists regarding *angustia*. Moreira (2007), who conducts cultural research in Brazil, Chile and the U.S. on meanings associated with anxiety and depression, notes anguish has links to violence, poverty, and inequality among her subjects. She reports that her subjects feel powerless to fight the experience of anxiety and believe that *angustia* is itself an expression of powerlessness.

While there may be a substantial overlap between the symptoms reported for *angustia* and DSM-IV diagnosis of General Anxiety Disorder (GAD), Latino community members may interpret their symptoms quite differently. In one study, Street, et al. (1997) analyze Latino patients served by an anxiety clinic.

They find a majority of the Latino sample served by the anxiety clinic report emotional disturbances that do not fit adequately within the DSM diagnostic system. Nearly one-sixth of patients interviewed report distress and/or symptoms of anxiety or depression that do not fit the criteria for GAD. They also note that Latino clients worry more extensively about a greater number of topics than other clients at the clinic.

Information on mal de ojo.

Evil eye, or *mal de ojo*, is a culturally defined condition that relies extensively on supernatural beliefs as an explanation for the problem. The evil eye is the name for a sickness transmitted, usually without intention, by someone who is envious, jealous, or covetous. Latinos explain *mal de ojo* by evoking a supernatural cause that comes from outside the body. In this explanation, distress comes from excessive admiration. For example, when someone compliments a baby about their beauty, the admiration can cause a *mal de ojo* on the baby that creates general malaise, sleeplessness, or even severe illness. Parents try to protect their babies from *mal de ojo* by having them wear a special charm or amulet made of onyx (Galarraga, 2007).

Latin American and Mediterranean cultures share beliefs in syndromes similar to *mal de ojo*, as do a number of other cultures worldwide. The disorder involves a culturally-based belief system invoked to explain certain disorders. The concept evokes a complex and interlinked pattern of beliefs unfamiliar to Non-Latino White American culture. Children are especially at risk for the effects of *mal de ojo*, and symptoms include: “fitful sleep, crying without apparent cause,

diarrhea, vomiting, and fever in a child or infant” (*Diagnostic and statistical manual of mental disorders (DSM-IV-TR)*, 2000, p. 901).

There are several references to the evil eye or *mal de ojo* in the qualitative data reported in this dissertation. For example, one focus group participant says:

We believe these problems are part of life, something from nature. But when people have serious problems, many try to blame evil spirits, the evil eye, or being cursed. We learn these things from our families and our communities.

One Key Informant panel member comments on folklore and culturally defined emotional problems existing in Charlotte:

We also need to consider issues related to folklore. Here in Charlotte you see amulets on Latino babies to protect them from “the evil eye” (*mal de ojo*).

Quantitative Analyses of Survey Research Data

To better understand the impact of cultural differences between Latino community members and the dominant Non-Latino White U.S. culture, I explore the results of quantitative analyses of survey response data focusing on how Latino community members’ definition of the causes of emotional/mental problems impacts their reports of emotional/mental problems and culturally-defined emotional problems.

In this section I define variables used in these quantitative analyses, present research hypotheses for each set of variables analyzed, and report results for bivariate and multivariate models. I link my discussion of the results to theoretical and research issues important in understanding Latino mental health concerns identified in the Theory & Research Literature Review (see Chapter 1).

Variables used in the analyses.

The independent variable used in the analyses is the Latino community members' responses to a survey question on the cause of emotional/ mental problems. Dependent variables include reporting the experience of an emotional/mental problem, reporting an episode of a specific culturally defined emotional problem, and reporting one or more episodes of the specific culturally defined emotional problems (*ataque de nervios, susto, angustia, mal de ojo*).

Specific wording of questionnaire items.

The following are specific questionnaire items used in the analyses:

If someone in your family started acting very sad (depressed), very strange (anti-social), bizarre (hallucinations) or self-destructive (suicidal), what would you think was causing the problem?

Mental Illness?

Devil/Evil Spirits/Nature/Other?

Family member experience emotional/mental problems?

Yes/No

Family member experience emotional/mental problems found in Hispanic culture?

Ataque de nervios/Susto/Angustia/Mal de ojo/Other?

Research hypotheses.

The following hypotheses predict relationships between variables selected from survey responses for secondary analyses. See Chapter 2 for a more extensive discussion of hypotheses development.

Hypotheses related to subject's reporting of mental/emotional problems and culturally defined problems.

Latino community members responding to the survey who define mental illness as the cause of emotional problems are more likely to report an episode of an emotional/mental problem.

Latino community members responding to the survey who define the cause of emotional problems as something other than mental illness are more likely to report an episode of a culturally defined emotional problem.

Latino community members responding to the survey who define the cause of emotional problems as something other than mental illness are more likely to report an episode of specific culturally defined emotional problems (*ataque de nervios, susto, angustia, and mal de ojo*).

Discussion of Bivariate Results

The following section reviews results of bivariate analyses of survey research data on the respondents' causal definition of emotional problems and reports of the experience of emotional/mental problems and culturally defined emotional problems.

Survey responses on causal definition of emotional/mental problems.

Table 5.1 below shows frequencies and percentages reported for specific culturally defined emotional problems.

Table 5.1

Survey Response: Reported Experience of Emotional/Mental Problems

Experience Emotional/ Mental Problem	Frequency	Percentage
No	258	64.5
Yes	142	35.5
Experience Culturally Defined Emotional Problem	Frequency	Percentage
No	169	42.25
Yes	231	57.75
Experience Specific Culturally Defined Emotional Problem	Frequency	Percentage
<i>Ataque de nervios</i>	84	21.0
<i>Susto</i>	81	20.2
<i>Angustia</i>	138	34.5
<i>Mal de ojo</i>	72	18.0

A majority of subjects responding to the survey (64.5%) do not report the experience of emotional/mental problems, while 35.5% do report such an experience. However, a majority of subjects (57.8%) report an episode of a specific culturally defined emotional problem. The most frequently reported problem is *angustia*, with 34.5% of subjects reporting an episode, while 21% of subjects report *ataque de nervios*, and 20.2% report *susto*. The least frequently reported culturally defined emotional problem is *Mal de ojo*, with 18% of subjects reporting an episode.

While these results may not be representative of the national Latino population, the data show a majority of Latino community members responding to the survey report an episode of a culturally defined emotional problem. This finding suggests that the experience of culturally defined emotional problems is a widespread phenomenon in this community. I will discuss the clinical

consequences of these findings for mental health providers who serve Latino clients in the summary of results for this chapter.

Associations between causal definition of emotional/mental problems and subjects' reports of experiencing emotional/mental problems.

Table 5.2 summarizes results of survey response data analyses using contingency tables constructed to examine associations between the key independent variable, causal definition of emotional/mental problems, and dependent variables reported emotional/mental problem and reported culturally defined emotional problem. I use the chi-squared test of independence to test the significance of the proportions for each set of variables. I report Cramer's Phi, a chi-square-based measure of nominal association, to estimate the effect size for the data.

Table 5.2

Survey Response Analyses, Reports Problems by Causal Definition of Emotional/Mental Problems

Reported Problems	χ^2
Reports Emotional/Mental Problem	0.34
Reports Culturally Defined Emotional Problem	10.92***

† < 0.10; * $p \leq 0.05$; ** $p \leq 0.01$; *** $p \leq 0.001$

The proportion of subjects reporting an episode of emotional/mental problems does not differ significantly by their causal definition of emotional/mental problems, $\chi^2(1, N = 400) = 0.34, p = 0.56$. Among subjects reporting an episode of culturally defined emotional problems, however, a significantly greater proportion of those who defined the cause of emotional

problems as a cause other than mental illness (66%) reported culturally defined problems compared to those who reported a mental illness cause (49%), $\chi^2(1, N = 400) = 10.92, p < 0.001$ (See Table 5.3). Cramer's Phi measure suggests a small effect for a cause other than mental illness on experiencing culturally defined problems, $\Phi = 0.17$.

Table 5.3

Reports Culturally Defined Emotional Problem by Causal Definition of Emotional/Mental Problems

Reported Culturally Defined Problems	Causal Definition	
	Mental Illness	Other Cause
Reported Culturally Define Problem	94 (49%)	137 (66%)
Did Not Report Culturally Defined Problem	97 (51%)	72 (34%)
N=400	DF = 1	$\chi^2 = 10.92$ $p < 0.001$

These findings support my hypotheses on the association between a causal definition of something other than mental illness and reporting culturally defined emotional problems. However, the data do not support my hypothesis on the association between a causal definition of mental illness and reporting emotional/mental problems.

One way to understand these results is in terms of a cultural threshold that may exist for recognizing and reporting each of the two different types of emotional disorders. Subjects responding to the survey recognize and report episodes of serious emotional/mental problems like those described in the survey's initial question without the need to adopt a mental illness causal definition of such disorders. For subjects to recognize and report culturally

specific conditions, however, they may need to understand and accept these conditions based on one or more of the alternative causal explanations (nature, the devil, evil spirits).

Associations between causal definition of emotional/mental problems and subjects' reports of culturally defined emotional problems.

Table 5.4 summarizes results of analyses using contingency tables constructed to examine associations between the independent variable, causal definition of emotional/mental problems, and subjects' reports of specific culturally defined emotional problems of *ataque de nervios*, *susto*, *angustia*, and *mal de ojo*.

Table 5.4

Reports of Specific Culturally Defined Emotional Problems by Causal Definition of Emotional/Mental Problems

Report of Culturally Defined Problem	χ^2
Report of <i>ataque de nervios</i>	10.38***
Report of <i>susto</i>	0.33
Report of <i>angustia</i>	0.04
Report of <i>mal de ojo</i>	12.15***

† < 0.10; * $p \leq 0.05$; ** $p \leq 0.01$; *** $p \leq 0.001$

Analyses of associations between the key independent variable, causal definition of emotional/mental problems, and subjects' report of specific culturally defined emotional problems (*ataque de nervios*, *susto*, *angustia*, and *mal de ojo*), indicate that proportions for reporting two of the culturally defined problems (*susto* & *angustia*) do not differ significantly by the subjects' causal definition of emotional/mental problems. However, a significantly larger proportion of subjects

who define the cause of emotional/mental problems as a cause other than mental illness report the other two problems (*ataque de nervios* & *mal de ojo*).

The proportion of subjects reporting an episode of *susto* does not differ significantly by the subjects' causal definition of emotional problems, $\chi^2(1, N = 400) = 0.33, p = 0.57$. The proportion of subjects reporting an episode of *angustia* also does not differ significantly by the subjects' causal definition of emotional problems, $\chi^2(1, N = 400) = 0.04, p = 0.85$.

However, a significantly greater proportion of those who define the cause of emotional/mental problems as a cause other than mental illness report culturally defined problems of *ataque de nervios* (27%), $\chi^2(1, N = 400) = 10.38, p = 0.001$ (See Table 5.5), and *mal de ojo* (73%), $\chi^2(1, N = 400) = 12.15, p < 0.001$ (See Table 5.6). Cramer's Phi measure suggests a small effect for the causal definition of emotional/mental problems on subjects' reporting of *ataque de nervios* ($\Phi = 0.16$) and *mal de ojo* ($\Phi = 0.17$).

Table 5.5

Subjects' Report of Culturally Defined Problem ataque de nervios by Causal Definition of Emotional/Mental Problems

Reports Culturally Defined Problem	Causal Definition	
	Mental Illness	Other Cause
Reports <i>ataque de nervios</i>	27 (14%)	57 (27%)
Not Reporting <i>ataque de nervios</i>	164 (86%)	152 (73%)
N=400	DF = 1	$\chi^2 = 10.38$ $p = 0.001$

Table 5.6

Subjects' Report of Culturally Defined Problem mal de ojo by Causal Definition of Emotional/Mental Problems

		Causal Definition	
		Mental Illness	Other Cause
Reports Culturally Defined Problem			
Reports <i>mal de ojo</i>		21 (11%)	51 (24%)
Not Reporting <i>mal de ojo</i>		170 (89%)	158 (76%)
N=400	DF = 1	$\chi^2 = 12.15$	$p < 0.001$

I suggest that different social and cultural conditions exist for the different types of culturally specific problems which may explain why two of them are not significantly associated with the subjects' causal definition of emotional/mental problems. In the case of *angustia*, one explanation for the absence of a significant association with the subjects' causal definition of emotional/mental problems may be the ubiquitous nature of the condition and its acceptance within the Latino community as a natural part of living. *Angustia* is the most commonly reported culturally-defined condition among Latino community members living in the Charlotte region and responding to the survey. Since Latino community members do not classify this problem as mental disorder but rather as a normal part of living related to the victim's social condition, their causal definition of emotional/mental problems may not influence recognition and reporting of *angustia*.

Susto also may also have links to the sufferer's social condition as suggested by Mysyk (1998) in her research. If *susto* serves as a symbolic statement of the victim's disadvantaged class position and the negative conditions existing for primarily poor, working poor, and downwardly mobile

populations as the author suggests, survey subjects' understanding of the cause of mental disorder may not impact their recognition and reporting of *susto*.

Discussion of Multivariate Results

The following section summarizes results of logistic regression analyses of predictive models designed to examine associations between categorical variables created from survey responses.

Logistic regression analyses.

Table 5.7 explores the key independent variable causal definition of emotional/mental problems as mental illness as a predictor of reporting emotional/mental problems, and reporting culturally defined emotional problems.

Table 5.7

Summary of Logistic Regression Analyses for Causal Definition of Emotional/Mental Problems as Mental Illness Predicting Subjects' Reporting Emotional/Mental Problem and Culturally Defined Emotional Problem

Reports Problem	Log-odds (B)	Odds Ratio (OR)	95% CI for OR
emotional/mental problem	-0.123	0.884	[0.587, 1.333]
Intercept	0.662		
R ²	0.001		
Difference in -2 Log Likelihood	0.345		
Degrees of Freedom	1		
culturally defined emotional problem	-0.675	0.509 ***	[0.341, 0.762]
Intercept	0.031		
R ²	0.027—0.036		
Difference in -2 Log Likelihood	10.953		
Degrees of Freedom	1		

Notes: Difference in -2 log likelihood subtracts -2 log likelihood for full model from -2 log likelihood of model with only intercepts. R² reported are Pseudo R² Cox and Snell, & Nagelkerke

† < 0.10; * $p \leq 0.05$; ** $p \leq 0.01$; *** $p \leq 0.001$

I use two logistic regression models to examine associations between subjects' causal definition of emotional/mental problems as mental illness, and subjects' reported emotional/mental problem and reported culturally defined problem. Variables in the first logistic regression model include the dependent variable subjects' reported emotional/mental problem, and independent variable subjects' causal definition of emotional/mental problems as mental illness. The second model includes the dependent variable subjects' reported culturally

defined emotional problem and the independent variable subjects' causal definition of emotional/mental problems as mental illness.

The result of the logistic regression analysis for the variable causal definition of emotional/mental problems as mental illness predicting the subjects reporting emotional/mental problems is not significant ($p = .56$). However, the result of the logistic regression analysis for the variable causal definition of emotional/mental problems as mental illness predicting the subjects reporting culturally defined problem is significant ($p < 0.001$). Defining emotional/mental problems as mental illness has a negative effect ($b = -0.68$) on reporting culturally defined problems.

Odds ratios of <1 ($OR = 0.51$) suggest a decrease in the odds of the dependent variable for a unit increase in the independent variable. The odds of reporting culturally defined problems decrease by a factor of 0.51 by defining mental illness as the cause of emotional/mental problems.

Table 5.8 examines the key independent variable causal definition of emotional/mental problems as mental illness as a predictor of subjects reporting culturally defined problems of *ataque de nervios*, and *mal de ojo*. I do not include culturally defined conditions of *susto* and *angustia* because they did not reach significance in the bivariate analyses.

Table 5.8

*Summary of Logistic Regression Analyses for Causal Definition of Emotional/Mental Problems as Mental Illness Predicting Subjects' Reporting Culturally Defined Problems of *ataque de nervios*, and *mal de ojo*.*

Reports Problem	Log-odds (B)	Odds Ratio (OR)	95% CI for OR
<i>ataque de nervios</i>	-0.823	0.439 **	[0.264, 0.730]
Intercept	1.804		
R ²	0.026—0.041		
Difference in -2 Log Likelihood	10.63		
Degrees of Freedom	1		
<i>mal de ojo</i>	-0.961	0.383 ***	[0.220, 0.665]
Intercept	2.091		
R ²	0.031—0.050		
Difference in -2 Log Likelihood	120.519		
Degrees of Freedom	1		

Notes: Difference in -2 log likelihood subtracts -2 log likelihood for full model from -2 log likelihood of model with only intercepts. R² reported are Pseudo R² Cox and Snell, & Nagelkerke

† < 0.10; * $p \leq 0.05$; ** $p \leq 0.01$; *** $p \leq 0.001$

I use two logistic regression models to examine associations between subjects' causal definition of emotional/mental problems as mental illness, and subjects' reporting specific culturally defined problem of *ataque de nervios*, and *mal de ojo*. In the first model, the result of the logistic regression analysis for the independent variable predicting the subjects' reporting *ataque de nervios* is significant at the < 0.01 level ($p = 0.002$). In the second model, the result of the logistic regression analysis for the independent variable predicting the subjects' reporting *mal de ojo* is significant at the < 0.001 level ($p = 0.001$). Defining

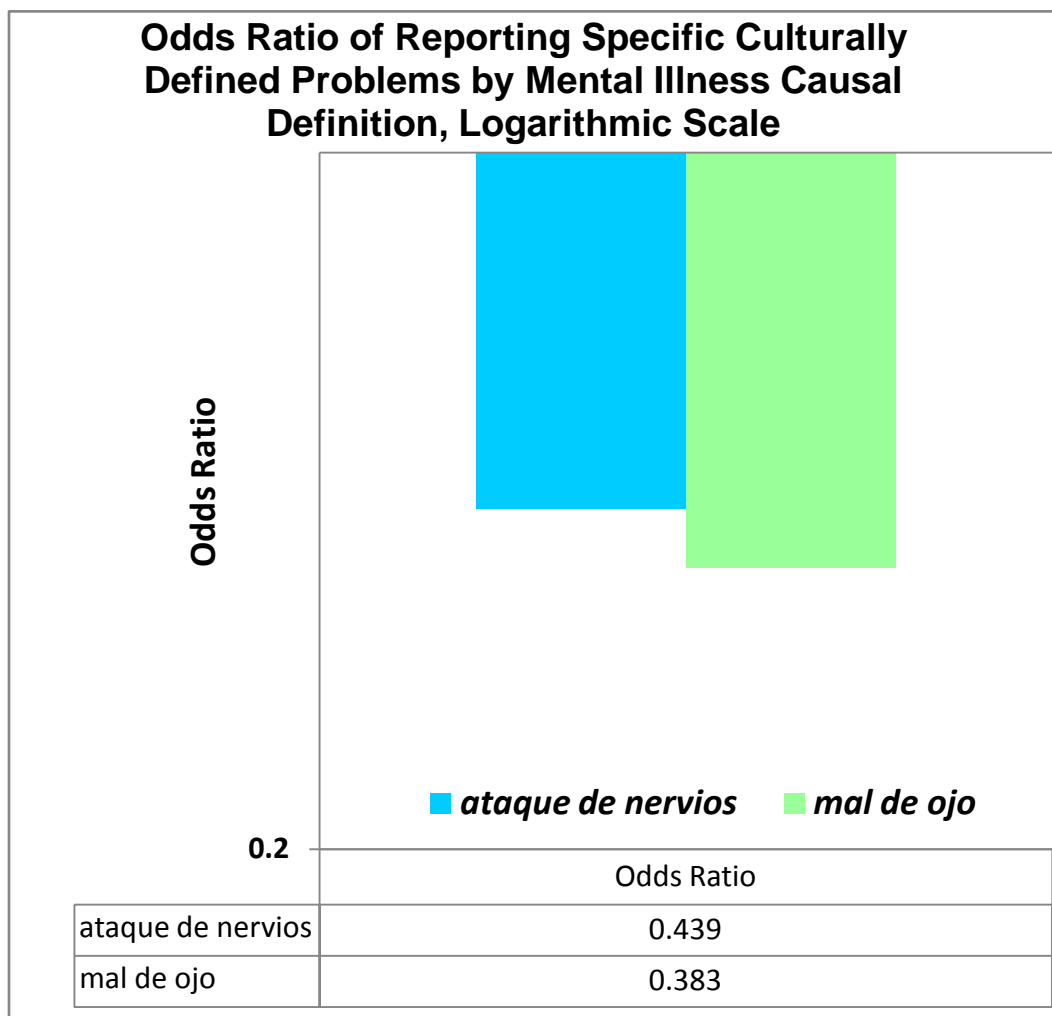
emotional/mental problems as mental illness has a negative effect ($b = -0.823$ and -0.961 respectively) on reporting culturally defined problems of *ataque de nervios*, and *mal de ojo*.

Odds ratios of <1 for both models ($OR = 0.44$ and 0.38) suggest a decrease in the odds of the dependent variable (reporting culturally defined problems of *ataque de nervios*, or *mal de ojo*) for a unit increase in the independent variable (defining mental illness as the cause of emotional/mental problems). The odds of reporting the culturally defined problem of *ataque de nervios* decrease by a factor of 0.44 by defining mental illness as the cause of emotional/mental problems. The odds of reporting the culturally defined problem of *mal de ojo* decrease by a factor of 0.38 by defining mental illness as the cause of emotional/mental problems.

See Figure 5.1 which illustrates the decrease in the odds of reporting the culturally defined problem of *ataque de nervios* and *mal de ojo* by defining mental illness as the cause of emotional/mental problems.

Figure 5.1

Graph of Odds Ratio of Reporting Specific Culturally Defined Problems by Mental Illness Causal Definition, Logarithmic Scale



The results illustrated in Figure 5.1 indicate that Latino community members' causal definition of emotional/mental problems is significantly associated with reporting culturally defined emotional problems of *ataque de nervios* and *mal de ojo*. These results provide partial support the basic premise of this dissertation: that Latino community members' beliefs regarding the cause of mental/emotional problems shape their experience of mental disorder.

Summary of Results: Latino Community Members' Experience of Emotional/Mental Problems and Culturally Defined Emotional Problems

A minority of Latino community members responding to the survey (35.5%) report the experience of emotional/mental problems, while a majority of subjects (57.8%) report an episode of a specific culturally defined emotional problem. The most frequently reported culturally defined condition is *angustia*, with 34.5% of subjects indicating an episode, while 21% of subjects report *ataque de nervios*, and 20.2% report *susto*. The least frequently reported culturally defined emotional problem is *mal de ojo* is, with 18% of subjects reporting an episode.

Qualitative and quantitative data from the original research identify *angustia* (anguish) as an important culturally defined emotional problem among Latino community members living in the Charlotte region and responding to the survey. Key Informant panel members describe clients with *angustia* who report intense or extreme worry, anxiety, and often extreme sadness or depression. Qualitative data link *angustia* with poverty, family disruption, and inadequate support networks. The limited research available supports these characterizations with results from Moreira (2007), for example, linking *angustia* to violence, poverty, and inequality among her subjects.

The prevalence of *angustia* among survey respondents may also reflect the relatively disadvantaged status of Latinos living in the Charlotte region. Demographic data presented in Chapter 2 document high poverty levels in this population. "Compared to other Mecklenburg County residents, Latinos suffer

economic disadvantage at higher rates. For example, 22.5% of Latinos live in poverty and 34.9% live in crowded conditions” (Harrison, et al., 2006, p. vi).

It is important for clinicians serving this population to be aware of the prevalence of culturally defined emotional problems among Latino community members. Knowledge about these idioms of distress and their cultural contexts should be important concerns for mental health providers serving an increasingly culturally diverse population.

Quantitative analyses of survey research data show that the proportion of subjects reporting an episode of emotional/mental problems does not differ significantly by their causal definition of emotional/mental problems failing to support my hypothesis. However, a significantly greater proportion of those who define the cause of emotional problems as a cause other than mental illness report culturally defined problems supporting my hypotheses.

I suggest that an explanation for these somewhat conflicting results in based on cultural thresholds that may exist for recognizing and reporting each of the two different types of emotional disorders. Subjects responding to the survey can recognize and report episodes of serious emotional/mental problems like those described in the survey’s initial question without adopting a mental illness causal definition of such disorders. For subjects to recognize and report culturally specific conditions, however, they need to accept one or more of the alternative causal explanations (nature, the devil, evil spirits).

For specific culturally defined conditions, the proportion of subjects reporting an episode of *susto* or *angustia* does not differ significantly by their causal definition of emotional/mental problems. However, a significantly greater

proportion of those who define the cause of emotional problems as a cause other than mental illness report culturally defined problems of *ataque de nervios* and *mal de ojo* compared to those who report a mental illness cause, thus supporting a portion of my hypothesis.

To explain the partial support for this hypothesis, I consider the different types of culturally specific conditions. In the case of *angustia*, I suggest an explanation for the absence of a significant association with the subject's causal definition of emotional/mental problems based on the ubiquitous nature of the condition among Latino community members living in the Charlotte region. Since Latino community members do not classify this problem as mental disorder but rather as a normal part of living related to the victim's social condition, causal definitions of emotional/mental problems may not influence recognition and reporting of *angustia*.

Susto may have a link to the sufferer's social condition as suggested by Mysyk (1998) in her research. If *susto* affects primarily poor, working poor, and downwardly mobile populations and serves as a symbolic statement of the victim's disadvantaged class position and negative conditions as the author suggests, survey subjects' understanding of the cause of mental disorder may not impact their recognition and reporting of *susto*.

Multivariate analyses indicate a decrease in the odds of the reporting culturally defined problems of *ataque de nervios*, or *mal de ojo* by defining mental illness as the cause of emotional/mental problems. Latino community members who adopt a mental illness causal definition of emotional/mental problems are less likely to report either *ataque de nervios* and *mal de ojo*. These results

provide partial support for the premise that Latino community members' beliefs regarding the cause of mental/emotional problems shape their experience of mental disorder.

Seeking care for emotional/mental disorder is an important concern among Latino populations, especially since these groups tend to underutilize professional mental health services in the U.S. In the following Chapter 6, I discuss care-seeking for emotional/mental conditions among members of the Latino community and analyze quantitative data from participants' survey responses to better understand how their cultural beliefs influence Latino's care-seeking decisions. I also explore data from the survey on Latino community members' experience of trauma, and care-seeking associated with their trauma-related problems.

Chapter 6: Quantitative Data Analyses: Latino Community Members' Seeking of Care, Sources of Care, and Satisfaction with Care

In this chapter I consider quantitative analyses of Latino community members' survey responses related to their seeking care for emotional/mental problems. I analyze these quantitative data based on Latino survey subjects' causal definition of emotional/mental disorder. I explore the extent to which adopting a causal definition of emotional/mental disorder as mental illness or a cause other than mental illness influences the choices Latino community members make about seeking care, identifying appropriate sources of care, and attaining satisfaction with care.

This topic is especially salient because of the tendency for some groups of Latino community members to underutilize professional mental health services in the United States. I discuss this pattern of underutilization and explore explanations for the phenomenon, focusing on the impact of Latino community members' cultural understanding regarding emotional/mental disorder and its cause.

Initially I discuss relevant theory and research identified in the Theory & Research Literature Review (Chapter 1) as important in understanding Latino mental health issues, including a discussion of analytical models developed to describe care-seeking behavior. I also link quantitative data discussed in this chapter to qualitative findings reported in Chapter 3.

Relevant Theory and Research

Medical sociologists have developed a number of theoretical models intended to explicate care-seeking behavior and the social/cultural forces that influence the decision-making processes. In the following section I discuss these models and link them to care-seeking in the Latino community.

Care-seeking theoretical models.

Sociologists typically view illness as a form of deviant behavior. Parsons' (1951) sick role is an early theoretical model that describes how people behave when they feel sick. For Parsons, sickness involves a person deviating from both biological and social norms. This model, based on a functionalist point of view, describes medicine as a form of social control that works to return the sick patient to health. Privileges and exemptions of the sick role motivate the sick person to seek care and recover from his/her deviant status. Designation of sickness as an undesirable and illegitimate condition is, for Parsons, an important feature of his model (Cockerham, 2007).

Suchman (1965) relates utilization of health care services to a person's cultural background. He applies the concept of a lay referral system made up of non-professionals (i.e., family, friends, and neighbors) who assist individuals in coping with their symptoms of illness. Members of the lay referral system advise sick individuals on how to interpret the symptoms they are experiencing and recommend a course of action, including whether or not to seek care, as well as the appropriate source of such care.

Freidson (2000), who originated the lay referral system concept, explains that when cultural definitions of illness contradict professional definitions, the

referral process typically does not result in seeking help from a professional practitioner. His research also demonstrates that residents in lower class neighborhoods with strong ethnic identifications and extended family relationships have the strongest resistance to using professional health care providers. These findings are relevant to data presented in this dissertation regarding the prevalence of culturally defined problems among Latino community members. The degree of support received from a lay referral network can also influence choices about sources of care.

One theory suggests that people with more support from their informal networks are less likely to seek professional help than those with less informal support. Distressed people typically seek help first from members of their informal social networks. This theory is relevant to Latino community members for whom *familismo* is an important cultural construct and the extended family is a primary source of support (Golding & Wells, 1990).

The authors suggest that many functions of informal support and psychotherapy are similar. For example, emotional support and assistance with problem-solving are important aspects of both resources. People may turn to mental health professionals as a last resort when they cannot obtain needed help from informal sources, or when such sources are unavailable. Social resources may also have different relationships concerning mental health service use in specific cultural groups whose attitudes about use differ. Notably, in Latino communities, aversion to institutions and services provided by the government may influence service use (Golding & Wells, 1990).

The Health Belief Model (Becker, 1974) is a prominent example of theoretical approaches designed to describe how healthy people attempt to avoid illness. Based on a social-psychological approach, the health belief model relies on a psychological theory involving a person's desire to avoid negative experiences (illness) and attraction to positive experiences (health). Although limited to describing illness prevention behavior, the health belief model emphasizes the importance of modifying factors (i.e., demographic, sociopsychological, and structural factors) that influence an individual's perceptions of the threat of illness and likelihood of taking preventive action.

Zola (2000) examines the question of why and how a person seeks professional healthcare services. He points out that the presence of symptoms, their seriousness, and the associated discomfort do not reliably predict whether or not a person will seek professional care. Instead, he maintains that delay for seeking care is the norm for almost every condition. Zola's research focuses on the role that changing perceptions of symptoms play in the decision to seek professional care. He identifies several sociocultural triggers that play pivotal roles in the decision-making process. These triggers link specifically to the ethnic groups studied. For example, two of the triggers include "the presence of an interpersonal crisis, and the perceived interference with social or personal relations" (p. 205). These triggers are more frequent among the Italians in Zola's research. Typically, the trigger focuses the person's attention on the symptoms, causes the person to dwell on them, and finally prompts the person to do something about them (i.e., seek professional care).

This pattern of delaying treatment is echoed by a research project that focuses on treatment delay for mental health problems among Latinos living in Mexico. The research identifies failure and delay by Latinos in making initial treatment access after the first onset of a mental or substance use disorder. Delays in obtaining treatment tend to be long: 10 years for substance use disorders, 14 years for mood disorders, and 30 years for anxiety disorders. The research shows that a segment of people with lifetime disorders eventually access treatment, although the proportions vary for mood (69.9%), anxiety (53.2%), and substance use (22.1%) disorders. An important reason for the prevalence of unmet needs regarding mental health care in Mexico involves failure by Latinos to make prompt initial access to treatment (Borges, Wang, Medina-Mora, Lara, & Chiu, 2007).

In an extensive review of theoretical models for care-seeking behavior and the social/cultural forces that influence decision-making processes, Pescosolido (1992) points out that:

... illness careers start with an event that sets into motion a process of attempting to cope with a physical or emotional problem, given an ongoing structured system of social relations. These attempts at coping are created in negotiation with others and constrained by social structure. The use of official medical care practitioners, like any choice, is enmeshed in a wider pattern of help seeking. Sociodemographic contingencies influence health-care decisions by constraining or facilitating network ties (p. 1114).

The author refines her definition of care-seeking behavior (help seeking) to include:

...efforts or actions designed to assist individuals with physical, mental, or emotional behaviors or manifestations somehow noticed as out of the ordinary. Individuals may seek out lay, scientific, or alternative sources of advice or assistance perceived as potentially useful. Further, help-seeking can mean going to a provider of a medical system but, just as

readily, can be applied to using the Internet for information, talking to neighbors about their experience with similar conditions, buying over-the-counter medications, praying, or joining a self-help group (Pescosolido, 2007, p. 2104).

Latino care-seeking and sources of care in the U.S.

Latino immigrants tend to underutilize mental health services in the U.S., with Mexican Americans the least likely to seek care from mental health professionals. Puerto Ricans and Cubans, however, have higher utilization rates, similar to Non-Latino Whites. Immigrants are much less likely to seek help for mental health problems than U.S. born Latinos. When Latinos do seek mental health care, they are most likely to seek care in the general medical sector rather than from mental health professionals (Guarnaccia, Martinez , & Acosta, 2005).

Delgado, et al. (2006) precisely summarize the problem of mental health care services underutilization:

Delivery of adequate mental health care to Hispanics, now the largest and fastest-growing ethnic minority, has been plagued by low utilization rates and inadequate or delayed mental health services (p. 38).

Based on recent research analyzing NLAAS data, however, rates of mental health service use among Latinos demonstrate apparent increases over the past decade relative to rates reported in the 1990s. Cultural factors such as nativity, language, age at migration, years of residence in the U.S., and generational status predict whether or not Latinos use mental health services. But when the researchers consider past-year psychiatric diagnoses, these associations hold only among those who do not fulfill criteria for any of the psychiatric disorders assessed. Rates of mental health service use among those

who do not fulfill diagnostic criteria are higher among Puerto Ricans and US-born Latinos than among Non–Puerto Ricans and foreign-born Latinos (Alegría, et al., 2007).

Explanations for Latino community members' underutilization of mental health care.

Explanations for mental health care underutilization among Latinos typically focus on barriers to obtaining mental health care confronting Latino community members. These barriers include cultural and community factors that discourage care-seeking from professional providers or encourage alternative sources of care. Other barriers involve economic or service system related issues (Guarnaccia, et al., 2005).

I discuss Latino cultural constructs that may play a role in community members' understandings regarding emotional/mental disorders and their responses to such problems in Chapter 3 (See Table 3.1). For example, *familismo* (family orientation) is an important cultural construct which causes health and sickness to be family affairs for Latinos involving extended family members as a lay referral network for emotional/mental problems. Sufferers in the Latino community first look to the extended family in terms of help-seeking decisions, and the family's inputs powerfully influence mental health care utilization choices. Alternative treatments, e.g., folk medicines available from a *botánica* (a dispensary of medicinal herbs and other folk cures) or from sources of care such as a *curandero*, *espiritista*, or *santero* (Latino community folk healers) may emerge as preferred options of respected family members who

provide advice (Gomez-Beloz & Chavez, 2001; Guarnaccia & Martinez, 2002; Murguia, Peterson, & Zea, 2003; Trotter & Chavira, 1997).

Among Latino community members, another group of cultural constructs may discourage care-seeking for emotional/mental disorders from mental health professionals. These include several strongly held Latino beliefs about self-containment or conscious control of negative affect (*controlarse*), the ability to withstand stressful situations during difficult times (*aguantarse*), as well as a more general sense of self-suppression (*sobreponerse*). These cultural constructs may encourage Latino community members to believe that they demonstrate a character weakness if they experience mental illness or seek professional help. Believing that the inability to control emotions is a weakness may reduce the likelihood of seeking professional care and may increase stigma for Latino community members who do seek such care (Añez, Paris, Bedregal, Davidson, & Grilo, 2005; Comas-Díaz, 2006; Kouyoumdjian, Zamboanga, & Hansen, 2003).

The existence of stigma among Latino community members associated with mental illness is a barrier to seeking professional mental health care. The label of *locura* or madness carries strong negative connotations for Latinos. Someone who is *loco* invokes a negative stereotype of being severely mentally ill, potentially violent, and incurable. As an alternative, idioms of distress are culturally-specific disorders Latinos commonly recognize. Idioms of distress tend to destigmatize the victim's experience of emotional distress among family and community members, and they can be dealt with through alternative means (Guarnaccia & Martinez, 2002; Guarnaccia, et al., 2005).

Economic and service system barriers to mental health care also explain underutilization among Latino community members. Key factors include the high cost of professional care, the lack of health insurance coverage, and immigration documentation problems. Qualitative data presented in this dissertation emphasize these issues. For example, one Key Informant panel member says:

Seeking care is about going to ministers or priests first, family physician second. Often they've built a relationship with their family doctors and will stay with them for years and travel for miles to see them. They go to Church, priests, healers, and they self medicate (they share/trade medications). If they go to a priest or minister, the clergy member may not recognize the symptoms of mental health problems. The common prescription issued by a member of the clergy is prayer.

Focus Group members stress the high cost of professional care and their preference for alternative treatment modalities. For example, one member says:

They don't understand when I talk about my problems of *nervios* and *susto*. The doctors are all *Anglos* and they charge big fees that I don't have. My priest and counselors at Our Lady of Guadalupe are much more sympathetic and understanding and they really care about me and help me.

Another issue raised by Key Informant members and Focus Group participants relates to the generalized fear of institutions and institutionalized mental health care, especially among recently arrived Latino immigrants.

Comments from participants include:

In my homeland of Mexico, corruption and government intimidation are part of life. The practice of *una mordida*—a little bite—involves bribes expected by police, government officials, and even court officers. If you have money you can buy justice. If not, you can expect to be victimized by the institutions that are supposed to help you. You grow up distrusting everything associated with government.

Knowing they are undocumented keeps many Latinos fearful of being sent back. From their perspectives, Mecklenburg County Area Mental Health is connected to the government, and the government is not to be trusted—they fear that and will not use available services.

Stigma, language, economics, and the intimidation of institutions and government are barriers to care. In Mexico, they have socialized medicine and they don't trust it. These feelings carry over to the U.S.

The Latino cultural construct of *personalismo* (personal rather than institutional relationship), exacerbated by the ubiquitous corruption and endemic institutional bureaucratic ineffectiveness experienced by some Latino community members in their native countries, could contribute to negative attitudes toward professional health care providers. A lack of trust is likely to exist regarding attitudes toward institutions, rather than toward treatment itself. Immigrant families with undocumented family members may be most likely to experience mistrust and less likely to trust authorities for fear of being reported and having to face government action (Garcia & Rodriguez, 1989).

Other system-related barriers include language problems. A large segment of the Latino population living in the U.S. continues to speak Spanish as their primary language, although there are some variations among specific Latino groups. Some mental health service providers employ bilingual staff members to meet this need, but many others do not. Even among insured Latino community members, language persists as a barrier to accessing care. In one national study of health care utilization by insured adult populations, for example, Spanish-speaking Latino patients showed significantly lower use of health care services, including mental health services, than English-speaking Latinos and Non-Latino White patients. In this study, researchers point to limited English proficiency to explain discrepancies in care (Fiscella, Franks, Doescher, & Saver, 2002).

In another recent study, a longitudinal examination of mental health service use among Spanish-speaking versus English-speaking Latinos and Non-

Latino Whites with serious mental illness shows that for Latinos, preferred language may be more important than ethnicity in decision-making about mental health service use. Results of the study show that Spanish-speaking Latinos differ from English-speaking Latinos on most demographic, clinical, and service use measures, while there are few differences between English-speaking Latinos and Non-Latino Whites (Folsom, et al., 2007).

Discrimination against Latinos, lack of information about mental health services, and confusion about how and where mental health services are available also present substantial barriers to care. Research documents discrimination against Latinos in the delivery of medical services, especially for Spanish-speaking group members. Similar discrimination likely exists in the mental health services area as well. Although levels of discrimination vary by Latino population group, some groups such as Caribbean Latinos may suffer a twofold bias from being both Black and Latino (Guarnaccia, et al., 2005).

Finally, lack of information and confusion about mental health services delivery in the U.S. is a concern Latino community members identify in the qualitative data discussed in this dissertation. For example, one participant talks about the difference between community-based sources of help and government agencies:

My family goes to *Centro de Salud Betesda* or *Mi Casa Su Casa* when we have problems. Some of our friends find help at Our Lady of Guadalupe Catholic Church. None of us go to the government—it's too complicated. I wouldn't know where to start or who to see. And no one speaks Spanish like at our churches or community places.

Another panel member compares the difficulties accessing mental health services in Mecklenburg County as similar to solving a complicated maze or labyrinth.

Mecklenburg Area Mental Health is a very bureaucratic and complex agency difficult even for English-speaking American clients to access. My Latino clients, especially the Spanish-speaking ones, find it to be like a maze or labyrinth. So they seek care somewhere else, usually from religious groups or folk healers they feel comfortable with.

In a recent study of Latino community members' information, knowledge, and access to health care in the U.S., results show that foreign-born and less-assimilated Latinos, including those who speak mainly Spanish, who lack U.S. citizenship, or who have lived for a short time in the U.S., are less likely than other Latinos to report they have a usual place to go for medical treatment or advice. Almost two-thirds of the respondents report obtaining health information through their social networks, including family, friends, churches, and community groups (Livingston, Minushkin, & Cohn, 2008).

The extended family network, churches in the community, and folk sector sources such as *curanderos* and *espiritualistas* are alternative sources of support for Latino community members in distress. Research suggests that using alternative sources of care does not necessarily deter the use of professional mental health services, but that barriers to professional services are a more important factor (Guarnaccia & Martinez, 2002).

Family Physicians (General Practitioners) and Latino mental health services.

Latino community members' use of multiple providers in different service sectors for mental/emotional disorders is common. For example, not only are

Mexican Americans who have had a psychiatric disorder within the previous year more likely to see a general medical professional (19.9%) than a mental health specialist (9.3%), they also are more likely to see other professionals, including priests, chiropractors, and counselors (11.2%) (Delgado, et al., 2006; Vega & Lopez, 2001).

Latinos are twice as likely to seek help for mental health problems from primary care providers than from mental health professionals, according to research on sources of care. Results of the research show Latinos' use of mental health professionals is significantly lower than that of Non-Latino Whites, even after adjusting for differences in sociodemographic characteristics and rates of psychiatric disorder (Lewis-Fernández, Das, Alfonso, Weissman, & Olfson, 2005).

Trust and cultural sensitivity are key issues for Latino community members in selecting health care providers. One focus group participant comments on her choice of a family physician and the issue of trust. She says:

My family sees a good doctor who is from our country (El Salvador). He speaks our language—his nurse and receptionist do too—and he understands the things that trouble us. We have to drive all the way to Gastonia to see him, but it is worth it to have someone you can trust.

Family physicians, however, may not be professionally competent to diagnose and treat mental/emotional disorders. A study of depression treatment, for example, explores why ethnic minorities, including Latinos, traditionally receive less care for depression than Non-Latino White populations. In one study, Mexican Americans in Fresno County, CA, are twice as likely to seek treatment for mental disorders in general health care settings rather than in mental health specialty settings. Providers in general health care settings,

however, are less likely to detect diagnosable mental disorders in Latino patients as compared to Non-Latino White patients, and less likely to make appropriate mental health care referrals (Miranda & Cooper, 2004).

Latinos and satisfaction with care.

Insurers, providers, and researchers commonly use measures of patient satisfaction with health care to assess consumer preferences. They frequently use surveys to evaluate health care plans and providers. Research involving quality assessment and quality improvement also use satisfaction measurement. In one study, Edlund, et al. (2003) explore the association between client satisfaction and technical quality of care for common mental disorders. They conclude that a significant association exists between appropriate technical quality of care and higher levels of client satisfaction.

However, there is limited research available on satisfaction with care among Latino mental health services clients. Client satisfaction research focusing on Latinos address two primary research topics: comparisons of satisfaction between Latino and non-Latino patients, and comparisons between Spanish-speaking and English-speaking patients. Mixed results from previous studies limit the usefulness of this research. One study, however, shows significantly more dissatisfaction with health care provider communication among Spanish-speaking Latino clients than among English-speaking Latino and Non-Latino White respondents (Morales, Cunningham, Brown, Liu, & Hays, 1999).

Alegría, et al. (2007) use data from the NLAAS to examine ethnic group, immigration status, generational status, and English language proficiency as correlates of service use and satisfaction with services in a national sample of

Latinos. Their satisfaction analysis focuses on two satisfaction variables: level of satisfaction with services received and helpfulness of services received. Results show Mexicans are less likely than those in the other Latino groups to report satisfaction with mental health services received. Immigrants living in the U.S. for 5 years or less report lower levels of satisfaction with mental health services received than those who have lived in the U.S. for more than 20 years. Latino service users show no significant differences in satisfaction based on nativity, language, age at migration, generational status, or insurance status in these data.

Satisfaction data reported in this dissertation focus on the impact of Latino community members' causal definition of emotional/mental disorder and their preferences for professional mental health providers or care-seeking from alternative sources of care. I also examine issues associated with violence-related trauma, resulting emotional problems, and care-seeking for these problems.

Latinos and care-seeking linked to violence-related trauma.

Key Informant panel members stress the importance of violence-related trauma for a segment of Latino immigrants. They identify natural disaster, political violence, and other violent trauma, such as the victimization of trans-border migrants who often experience direct violence (i.e., beatings, kidnappings, and rape). For example, one focus group participant speaks of how she was raped repeatedly by *polleros* (border-crossing smugglers) as they brought her across the Mexican border:

My travel to the U.S. was horrible. The *polleros* raped me over and over again when they brought me from Mexico across the border. Now after many years I still have nightmares, I remember the terrible details, and I have anxiety all the time. My counselor says I have PTSD. It stays with me always.

Violence and its associated trauma are major health concerns for many in the Latino community. People living in the Americas are at risk for earthquakes, volcanic eruptions, hurricanes, floods, mud slides, and other natural disasters. Some countries in Latin America also have high levels of political violence. Natural disasters and mass violence can affect social adjustment as well as emotional and physical health. These problems are especially prevalent among refugee populations (Norris, 2009).

Latino immigrant men are at elevated risk of exposure to political violence in their country of origin. Specific examples of political violence include state-perpetrated armed conflict, repression, genocide, torture, forced disappearance of family members, and massacre. Although most immigrants enter the U.S. primarily for economic reasons, non-refugee immigrants may also experience pre-migration political violence, with exposure ranging from 11% to 69% (Gupta, et al., 2009).

Fortuna, et al. (2008) examine political violence, psychosocial trauma, and the context of mental health service use among immigrant Latinos in the U.S. Using NLAAS data for analyses, they show 11% of all immigrant Latinos report political violence exposure, and 76% describe additional lifetime traumas. Female victims show an increased likelihood of using mental health services, but men and Mexican immigrants are less likely to access mental health services after experiencing political violence. Explanations for mental health service underutilization include barriers to care previously discussed.

However, for victims of political violence, there may be other cultural issues that impact their self-assessed need for services. Shame or hesitancy

about discussing details of the victimization with health professionals may exist, especially when it involves sexual trauma. Stigma associated with sexual trauma may be especially important for men, and may make it less likely for them to seek help for the trauma. The collective nature of political violence may also influence coping strategies that favor the use of family and community supports rather than formal mental health services. Furthermore, because of its frequent occurrence in some regions of Latin America, political violence may become a normative experience, or at least not perceived as something warranting mental health or medical attention (Fortuna, et al., 2008).

New research documents a culture of extreme violence affecting trans-border Mexican migrants who often experience direct violence such as beatings, kidnappings, and rape. These migrants also suffer from indirect violence such as poverty, hunger, marginalization, and increased health hazards. Documentation problems associated with their illegal entry into the U.S., and shame regarding the details of the abuse, may constrain victims' willingness to seek mental health care (Jácome, 2010).

Quantitative Analyses of Survey Research Data

To better understand the extent, nature and consequences of care-seeking behavior among Latino community members, I explore the results of quantitative analyses of survey response data. In this section I focus on the degree to which adopting a causal definition of emotional/mental disorder as mental illness or a cause other than mental illness influences the choices Latino community members make about seeking care, appropriate sources of care, and satisfaction with care.

In this chapter I define variables used in these quantitative analyses, present research hypotheses for each set of variables analyzed, and report results for bivariate and multivariate models. I link my discussion of the results to theoretical and research issues important in understanding Latino mental health concerns identified in the Theory & Research Literature Review (see Chapter 1).

Variables used in the analyses.

The dependent variables used in the analyses include Latino community members' responses to survey questions about seeking care, sources of care (professional/other), and satisfaction with care. The independent variable used in the analyses is Latino community members' response to the survey question on the cause of emotional/mental problems (mental illness/other).

Dependent variables analyzed in the section on violence-related trauma include Latino community members' reports of experiencing violence-associated emotional problems, seeking care for these problems, and satisfaction with care. The independent variable used in the analyses is Latino community members' response to the survey question on the cause of emotional/mental problems (mental illness/other).

Specific wording of questionnaire items.

If someone in your family started acting very sad (depressed), very strange (anti-social), bizarre (hallucinations) or self-destructive (suicidal), what would you think was causing the problem?

Mental Illness? Devil/Evil Spirits/Nature/Other?

Family member experience emotional/mental problems?

Sought help?

Who did they go to for help?

Mental Health Professional? Family Physician/Priest or Minister/Folk Healer/Other?

Get help they wanted?

Family member experience emotional/mental problems found in Hispanic culture?

Ataque de nervios/Susto/Angustia/Mal de ojo/Other?

Sought help?

Who did they go to for help?

Mental Health Professional? Family Physician/Priest or Minister/Folk Healer/Other?

Get help they wanted?

Family member experience trauma?

Political violence/disaster/other abuse?

Result in emotional/mental problems?

Sought help?

Who did they go to for help?

Mental Health Professional? Family Physician/Priest or Minister/Folk Healer/Other?

Get help they wanted?

Research hypotheses.

The following hypotheses predict relationships between variables selected from survey responses for secondary analyses. See Chapter 2 for a more extensive discussion of hypotheses development.

Hypothesis related to subject's causal definition of mental/emotional problems and care seeking.

Latino community members responding to the survey, and who report an emotional/mental problem and define the cause of mental/emotional problems as mental illness, are more likely to seek care.

Hypotheses related to subject's causal definition of mental/emotional problems and sources of care.

Latino community members responding to the survey who report an episode of emotional/mental problems and define the cause of mental/emotional problems as mental illness are more likely to seek care from a mental health professional.

Latino community members responding to the survey who report an episode of emotional/mental problems and define the cause of mental/emotional problems as a cause other than mental illness are less likely to seek care from a mental health professional.

Hypothesis related to subject's causal definition of culturally defined problems and satisfaction with care.

Latino community members responding to the survey who report an episode of culturally defined problems and define the cause of mental/emotional problems as something other than mental illness are more likely to indicate the care provided for culturally defined problems meets the needs of the victim.

Hypothesis related to subject's report of violence-associated emotional problems.

Latino community members responding to the survey who report an episode of violence-related emotional problems and define the cause of

mental/emotional problems as a cause other than mental illness are less likely to seek care and less likely to seek care from mental health professionals.

Descriptive statistics.

Table 6.1 shows descriptive statistics for survey response data regarding seeking care for emotional/mental problem and culturally defined problem.

Table 6.1

Survey Response Descriptive Statistics Reporting Care-Seeking for Emotional/Mental Problem and Culturally Defined Problem

Care Seeking	Frequency	Percentage
Emotional/Mental Problem	142	35.5
Seek Care	119	83.8
Source of Care		
Mental Health Professional	42	35.3
Alternative Source	77	64.7
Satisfied with Care		
No	26	26
Yes	74	74
Culturally Defined Problem	231	57.8
Seek Care	195	84.4
Source of Care		
Mental Health Professional	31	15.9
Alternative Source	164	84.1
Satisfied with Care		
No	28	16.5
Yes	142	83.5

Data presented in Table 6.1 show patterns of care-seeking that differ based on Latino community members who report experiences of emotional/mental problems compared to those who report culturally defined

problems. Although the proportion of respondents who report seeking care is the same for both groups (84%), a smaller proportion of respondents who report culturally defined problems seek care from mental health professionals (16%) than those who report emotional/mental problems (35%). Conversely, a larger proportion of respondents who report culturally defined problems seek care from alternative sources of care (84%) than those who report emotional/mental problems (65%). These results show that alternative sources of care are a popular choice for Latino community members who report emotional/mental problems, as well as those who report culturally defined problems.

Satisfaction with care the victim receives varies by type of problem, with 74% of Latino community members who report emotional/mental problems indicating the care they receive meets the needs of the victim. A higher proportion of Latino community members who report culturally defined problems (84%) indicate the care they obtain meets the needs of the victim. Considered in terms of the sources of care identified by respondents, these results suggest a somewhat higher degree of satisfaction with alternative sources of care among Latino community members than satisfaction with professional mental health care providers.

Table 6.2 shows descriptive statistics for survey response data regarding subjects' reports of experiencing violence, emotional problems associated with these traumatic experiences, care-seeking for violence-related problems, sources of care, and satisfaction with care.

Table 6.2

Survey Response Descriptive Statistics Reporting Experiences of Violence, Emotional Problems, and Care-Seeking

Experienced Violence	Frequency	Percentage
Political Violence		
No	329	82.2
Yes	71	17.8
Natural Disaster		
No	258	64.5
Yes	142	35.5
Other Abuse		
No	313	78.2
Yes	87	21.8
Experienced Emotional Problem Associated with Violence	Frequency	Percentage
Political Violence		
No	4	5.6
Yes	67	94.4
Natural Disaster		
No	25	17.6
Yes	117	82.4
Other Abuse		
No	8	9.2
Yes	79	90.8
Care-Seeking for Violence Related Emotional Problem	Frequency	Percentage
No	263	72.1
Yes	102	27.9
Source of Care	Frequency	Percentage
Mental Health Professional	16	15.7
Alternative Source	86	84.3
Satisfied with Care	Frequency	Percentage
No	18	21.4
Yes	66	78.6

Latino community members responding to the survey's questions regarding violence are most likely to report experiences of natural disaster (36%)

as a source of violence-related trauma. Respondents also report other abuse (22%) as a source of trauma, while political violence is the least reported source of trauma, with 18% of subjects reporting this type of violence.

Political violence, however, is the most likely form of violent trauma to result in emotional problems among Latino community members responding to the survey, with 94% of respondents who report the experience of political violence also reporting emotional problems associated with the political violence victimization. Of those who report violent trauma from other causes, 91% report emotional problems associated with the other abuse. Among respondents who report natural disaster, 82% report experiences of emotional problems associated with the natural disaster.

A minority of Latino community members who report emotional problems associated with violent trauma (28%) seeks care for the violence-related emotional problem. Of those who obtain care, the majority seeks care from alternative sources of care (84%) and reports a relatively high level of satisfaction (79%) with the care received by the victim.

Discussion of Bivariate Results

In this section I focus on bivariate results of Latino community members' responses to survey questions focusing on their care-seeking, source of care, and satisfaction with care. I analyze the impact of respondents' causal definition of emotional/mental problems on care-seeking, source of care, and satisfaction with care. My intent is to identify variables capable of testing in logistic models so that the relative importance of the various predictors can be assessed. I also analyze survey responses regarding violence-related trauma and emotional

problems associated with such trauma, including care-seeking, source of care, and satisfaction with care.

Survey responses on care-seeking by causal definition of emotional/mental problems.

Table 6.3 shows the results of bivariate analysis of care-seeking by causal definition of emotional/mental problems. Latino community members' causal definition of emotional/mental problems is significantly associated with care-seeking for culturally defined emotional problems at the < 0.001 level, while causal definition is also significantly associated with care-seeking for emotional/mental problems at the < 0.10 level. These results support the hypothesis regarding the relationship between care-seeking and causal definition of emotional/mental problems.

Table 6.3

Survey Response Analyses, Care-Seeking for Emotional/Mental Problem and Culturally Defined Problem by Causal Definition of Emotional/Mental Problems

Care-Seeking by Causal Definition	χ^2
Sought Help for Emotional/Mental Problem	3.3 †
Sought Help for Culturally Defined Emotional Problem	28.29 ***

† < 0.10 ; * $p \leq 0.05$; ** $p \leq 0.01$; *** $p \leq 0.001$

Results of contingency table analysis of care-seeking for emotional/mental problems by causal definition of emotional/mental problems show a significant association, $\chi^2(1, N = 231) = 3.3, p < 0.10$ (See Table 6.4). Results of care-seeking for culturally defined emotional problems also show a significant association, $\chi^2(1, N = 231) = 28.29, p < 0.001$ (See Table 6.5).

Cramer's Phi measure suggests a moderate effect of the causal definition of emotional/mental problems on care-seeking for culturally defined problems ($\Phi = 0.36$), while the effect of the causal definition of emotional/mental problems on emotional/mental problems is small ($\Phi = 0.17$).

Table 6.4

Care-Seeking for Emotional/Mental Problems by Causal Definition of Emotional/Mental Problems

Care-Seeking	Causal Definition	
	Mental Illness	Other Cause
Seek Help	50 (77%)	69 (90%)
Do Not Seek Help	15 (23%)	8 (10%)
N=142	DF = 1	$\chi^2 = 3.3$ $p < 0.10$

Table 6.5

Care-Seeking for Culturally Defined Emotional Problems by Causal Definition of Emotional/Mental Problems

Care-Seeking	Causal Definition	
	Mental Illness	Other Cause
Seek Help	63 (67%)	42 (31%)
Do Not Seek Help	31 (33%)	95 (69%)
N=231	DF = 1	$\chi^2 = 28.29$ $p < 0.001$

These results suggest that Latino community members' cultural understanding about the cause of emotional/mental problems also influence decisions about seeking care for the problem. For community members responding to the survey, those who define mental illness as the cause of emotional problems are less likely to report seeking help for emotional/mental problems (77%) than those who define a cause other than mental illness (90%).

For those who report experiencing a culturally defined emotional problem, a greater proportion (67%) who define mental illness as the cause of emotional problems report seeking help than those who define a cause other than mental illness (31%).

This somewhat counterintuitive result suggests an explanation linked to the choices Latino community members make about sources of care and their preference for non-professional care which I discuss in the next section.

Survey responses on source of care by causal definition of emotional/mental problems.

Latino community members' causal definition of emotional/mental problems plays a significant role in making choices of sources of care. See Table 6.6 for a summary of bivariate analyses of these relationships.

Table 6.6

Survey Response Analyses, Seek Mental Health Professional Help for Emotional/Mental Problem and Culturally Defined Problem by Causal Definition of Emotional/Mental Problems

Source of Care by Causal Definition	χ^2
Seek Mental Health Professional Help for Emotional/Mental Problem	59.53 ***
Seek Mental Health Professional Help for Culturally Defined Emotional Problem	49.38 ***

† < 0.10; * $p \leq 0.05$; ** $p \leq 0.01$; *** $p \leq 0.001$

Among those who report care-seeking for emotional/mental problems, a significantly smaller proportion of subjects who define the cause of emotional/mental problems as a cause other than mental illness (6%) report seeking care from mental health professionals compared to those who report a mental illness cause (76%), $\chi^2(1, N = 119) = 59.53, p < 0.001$ (See Table 6.7 for

a summary of bivariate analyses of this association.) Cramer's Phi measure suggests a strong effect for a mental illness cause of emotional/mental problems on seeking care from mental health professionals, $\Phi = 0.73$.

Table 6.7

Source of Help for Emotional/Mental Problems by Causal Definition of Emotional/Mental Problems

Source of Help		Causal Definition	
		Mental Illness	Other Cause
Mental Health Professional		38 (76%)	4 (6%)
Other Source of Help		12 (24%)	65 (94%)
N=119	DF = 1	$\chi^2 = 59.53$	$p < 0.001$

Among those who report care-seeking for culturally defined problems, none of the subjects who define the cause of emotional/mental problems as a cause other than mental illness (0%) report seeking care from mental health professionals, compared to those who report a mental illness cause (33%), $\chi^2(1, N = 231) = 49.38, p < 0.001$ (See Table 6.8). Cramer's Phi measure suggests a moderate effect for the mental illness cause on seeking care from mental health professionals for cultural emotional problems, $\Phi = 0.48$.

Table 6.8

Source of Help for Culturally Defined Emotional Problems by Causal Definition of Emotional/Mental Problems

Source of Help		Causal Definition	
		Mental Illness	Other Cause
Mental Health Professional		31 (33%)	0 (0%)
Other Source of Help		63 (67%)	137 (100%)
N=231	DF = 1	$\chi^2 = 49.38$	$p < 0.001$

Latino community members' choices of professional mental health providers or alternative sources of care are strongly associated with their causal definition of mental/emotional problems. A very small proportion of respondents who define the cause of emotional/mental problems as something other than mental illness report seeking care from mental health professionals for either emotional/mental problems (6%) or culturally defined problems (0%). Conversely, a large proportion of respondents who define the cause of emotional/mental problems as something other than mental illness report seeking care from alternative sources of care for either emotional/mental problems (94%) or culturally defined problems (100%). These findings support hypotheses concerning the relationship between respondents' causal definition of emotional/mental problems and their selection of sources of care for emotional/mental problems and culturally defined problems.

Survey responses on satisfaction with care by causal definition of emotional/mental problems and source of care.

I show frequencies and percentages for reports of satisfaction with care received by the victim in Table 6.9 below. I include subjects who report satisfaction with care for emotional/mental problems as well as subjects who report satisfaction with care for culturally defined emotional problems. In general, satisfaction with care the victim received is substantial, with 74% of Latino community members reporting satisfaction with care for emotional/mental problems, and 84% reporting satisfaction with care for culturally defined problems.

Table 6.9

Survey Response Descriptive Statistics for Subject's Satisfaction with Care for Emotional/Mental Problems and Culturally Defined Emotional Problems

Satisfaction with Care		
Emotional/Mental Problems	Frequency	Percentage
No	26	26
Yes	74	74
Culturally Defined Emotional Problem	Frequency	Percentage
No	28	16.5
Yes	142	83.5

Table 6.10 shows the results of bivariate analysis of satisfaction with care the victim received by causal definition of emotional/mental problems. While a significant association does not exist between Latino community members' causal definition of emotional/mental problems and satisfaction with care for emotional/mental problems, a significant association does exist between their causal definition of emotional/mental problems and satisfaction with care for culturally defined emotional problems at the < 0.001 level.

Table 6.10

Survey Response Analyses, Satisfaction with Care for Emotional/Mental Problem and Culturally Defined Problem by Causal Definition of Emotional/Mental Problems (Mental Illness/Other Cause)

Satisfaction with Care by Causal Definition	χ^2
Satisfaction with Care for Emotional/Mental Problem	1.98
Satisfaction with Care for Culturally Defined Emotional	31.35 ***

† < 0.10 ; * $p \leq 0.05$; ** $p \leq 0.01$; *** $p \leq 0.001$

Among those reporting care-seeking for emotional/mental problems, the proportion of subjects who report satisfaction with care the victim received does not differ significantly by their definition of a mental illness cause $\chi^2(1, N = 100) =$

1.98, $p = 0.16$. For those subjects who report care-seeking for culturally defined emotional problems, however, a significantly smaller proportion of subjects who define the cause of emotional/mental problems as mental illness (59%) report satisfaction with the care the victim received compared to subjects who define the cause of emotional/mental problems as a cause other than mental illness (95%), $\chi^2(1, N = 170) = 31.35, p < 0.001$ (See Table 6.11). Cramer's Phi measure suggests a moderate effect for a mental illness cause regarding satisfaction with care for culturally defined emotional problems, $\Phi = 0.45$.

Table 6.11

Satisfaction with Care for Culturally Defined Emotional Problems by Causal Definition of Emotional/Mental Problems

Satisfaction with Care	Causal Definition	
	Mental Illness	Other Cause
Satisfied	32 (59%)	110 (95%)
Not Satisfied	22 (41%)	6 (5%)
N=170	DF = 1	$\chi^2 = 31.35$ $p < 0.001$

While satisfaction with care the victim received is not significantly associated with the respondents' causal definition for emotional/mental problems, there is a significant association between satisfaction with care for culturally defined problems and the respondents' causal definition. A significantly smaller proportion of subjects who define the cause of emotional/mental problems as mental illness (59%) report satisfaction with the care the victim received compared to subjects who define the cause of emotional/mental problems as a cause other than mental illness (95%).

These results show consistency with previous findings regarding Latino community members' preference for alternative sources of care. In both instances, respondents' causal definition of emotional/mental problems has a significant impact on preferences and satisfaction.

Survey responses related to satisfaction with care for violence-related trauma by causal definition of emotional/mental problems and source of trauma.

I include data on survey responses to questions pertaining to violence-related trauma in this dissertation because qualitative data from the original research suggest emotional problems arising from these sources are an important issue for Latino immigrants. Results of the survey research data show large proportions (82% to 94%) of Latino community members who report the experience of violence-related trauma also report emotional problems associated with the trauma. A relatively small minority of those victims (28%) seeks care for the violence-related trauma, and an even smaller proportion (16%) seeks care from mental health professionals. The following bivariate analyses explore these relationships. Table 6.12 summarizes the results of contingency table analyses of these variables.

Table 6.12

Survey Response Analyses, Care-Seeking, Source of Care, and Satisfaction with Care for Violence-Related Emotional Problems by Causal Definition of Emotional/Mental Problems

Care-Seeking, Source of Care, & Satisfaction with Care by Causal Definition	χ^2
Care-Seeking for Violence-Related Emotional Problems	28.29 ***
Mental Health Professional Source of Care for Violence-Related Emotional Problems	15.82 ***
Satisfaction with Care for Violence-Related Emotional Problems	0.44

† < 0.10; * $p \leq 0.05$; ** $p \leq 0.01$; *** $p \leq 0.001$

Results of contingency table analysis of care-seeking for emotional problems associated with violence-related trauma show a significant association between care-seeking and causal definitions of emotional/mental problems, $\chi^2(1, N = 365) = 28.29, p < 0.001$ (See Table 6.13). Cramer's Phi measure suggests a weak effect for a mental illness cause in regard to care-seeking for violence-related emotional problems, $\Phi = 0.24$.

Table 6.13

Care-Seeking for Violence-Related Emotional Problems by Causal Definition of Emotional/Mental Problems

Care-Seeking	Causal Definition	
	Mental Illness	Other Cause
Seek Help	26 (16%)	76 (38%)
Do Not Seek Help	137 (84%)	126 (62%)
N=365	DF = 1	$\chi^2 = 28.29$ $p < 0.001$

Contingency table analysis (See Table 6.14) also shows a significant association between mental health professional source of care for violence-related trauma and causal definitions of emotional/mental problems, $\chi^2(1, N =$

161) = 15.82, $p < 0.001$. Cramer's Phi measure suggests a moderate effect for a mental illness cause regarding professional source of care for violence-related emotional problems, $\Phi = 0.33$.

Table 6.14

Mental Health Professional Source of Care for Violence-Related Emotional Problems by Causal Definition of Emotional/Mental Problems

Source of Care	Causal Definition	
	Mental Illness	Other Cause
Mental Health Professional	22 (33%)	2 (0%)
Other Source of Care	62 (67%)	75 (100%)
N=161	DF = 1	$\chi^2 = 15.82$ $p < 0.001$

Finally, Table 6.15 shows that there is not a significant association between satisfaction with care for violence-related emotional trauma and causal definitions of emotional/mental problems, $\chi^2(1, N = 84) = 0.44$, $p = 0$. This negative result suggests a possible influence of the relatively small proportion of Latino community members who respond to the question.

Table 6.15

Satisfaction with Care for Violence-Related Emotional Problems by Causal Definition of Emotional/Mental Problems

Satisfaction with Care	Causal Definition	
	Mental Illness	Other Cause
Satisfied	18 (59%)	48 (95%)
Not Satisfied	7 (41%)	11 (5%)
N=84	DF = 1	$\chi^2 = 0.44$ $p = 0.51$

The relatively small proportion of Latino community members who report seeking care for violence-related traumas, notwithstanding the high percentages of victims of violence who report emotional problems, illustrate the impact cultural understandings can have on care-seeking. Qualitative data reported in this dissertation and published research discussed above suggest several explanations for this phenomenon. Stigma associated with care-seeking for these types of problems is one primary barrier to care. It is also possible that respondents' causal definition of emotional/mental problems as mental illness discourages both care-seeking and professional sources of care. Latino cultural constructs like *controlarse*, *aguantarse*, and *sobreponerse* may foster the belief that an inability to control emotions is a weakness. These cultural understandings may reduce the likelihood of seeking professional care and contribute to stigma for Latino community members who do seek such care.

Discussion of Multivariate Results

The following section summarizes results of logistic regression analyses of predictive models designed to examine associations between categorical variables created from survey responses. Unfortunately, because of the data configuration from the original research, it is not possible to utilize multivariate analysis with the results of violence-related care-seeking and satisfaction with care.

Logistic regression analyses of causal definition of emotional/mental problems as a predictor of care-seeking and sources of care.

Table 6.16 explores the key independent variable causal definition of emotional/mental problems as mental illness as a predictor of care-seeking from mental health professionals for emotional/mental problems. Because of the

division in the original data between subjects seeking care in Mecklenburg County and those seeking care outside the county, this table shows a combination of two models. Unfortunately, this division makes it impractical to combine the data for logistic regression analysis.

Table 6.16

Summary of Logistic Regression Analyses for A Causal Definition of Emotional/Mental Problems as Mental Illness Predicting Subjects Reporting Care Seeking from Mental Health Professionals for Emotional/Mental Problems

Care-Seeking for Emotional/Mental Problems	Log-odds (B)	Odds Ratio (OR)	95% CI for OR
Mental Health Professionals in Mecklenburg County	3.87	47.73 ***	[9.77, 233.1]
Intercept	-4.69		
R ²	41 - 56		
Difference in -2 Log Likelihood	0.16		
Degrees of Freedom	1		
Mental Health Professional outside Mecklenburg County	5.01	149.5 ***	[12.33, 1812.1]
Intercept	-7.57		
R ²	56 - 74		
Difference in -2 Log Likelihood	0.19		
Degrees of Freedom	1		

Notes: Difference in -2 log likelihood subtracts -2 log likelihood for full model from -2 log likelihood of model with only intercepts. R² reported are Pseudo R² Cox and Snell, & Nagelkerke

† < 0.10; **p* ≤ 0.05; ***p* ≤ 0.01; ****p* ≤ 0.001

I use two logistic regression models to examine associations between the causal definition of emotional/mental problems as mental illness, and subjects' reporting of care-seeking from mental health professionals rather than alternative sources of care. Variables in the logistic regression model include the dependent variable of subjects reporting care-seeking from mental health professionals, and independent variable subjects' causal definition of emotional/mental problems as mental illness. I analyze data in two models and report results in two categories because the original data has divisions between care-seeking within and outside of Mecklenburg County. Results of the logistic regression analysis for variables predicting the subjects' reporting care-seeking from a mental health professional indicate that variables from both geographic categories are significantly associated ($p < 0.001$).

Both models show a positive effect of subjects' causal definition of emotional/mental problems as mental illness on care-seeking from mental health professionals ($b = 3.87$ and 5.01 respectively). The odds ratios ($OR = 47.73$ and 149.5 respectively) predict an increase in odds for a unit increase in the independent variable. The odds of seeking care from a mental health professional compared to seeking care from another source increase by a factor of 47.7 by defining mental illness as the cause of emotional/mental problems for care-seeking in Mecklenburg County, and by a factor of 149.5 for seeking care outside of Mecklenburg County.

Table 6.17 explores the key independent variable of causal definition of emotional/mental problems as mental illness as a predictor of care-seeking from mental health professionals for culturally defined emotional problems. I also

divide this table into two models because of the divisions in the original data between subjects seeking care in Mecklenburg County and those seeking care outside the county.

Table 6.17

Summary of Logistic Regression Analyses for A Causal Definition of Emotional/Mental Problems as Mental Illness Predicting Subjects Reporting Care Seeking from Mental Health Professionals for Culturally Defined Emotional Problems

Care-Seeking for Culturally Defined Problems	Log-odds (B)	Odds Ratio (OR)	95% CI for OR
Care-seeking from Mental Health Professionals in Mecklenburg County	-1.17	0.31 ***	[0.59, 1.33]
Intercept	-4.0		
R ²	32 - 41		
Difference in -2 Log Likelihood	.345		
Degrees of Freedom	1		
Care-seeking from Mental Health Professional outside Mecklenburg County	-1.41	0.25 *	[0.34, 0.76]
Intercept	0.53		
R ²	37 - 45		
Difference in -2 Log Likelihood	0.953		
Degrees of Freedom	1		

Notes: Difference in -2 log likelihood subtracts -2 log likelihood for full model from -2 log likelihood of model with only intercepts. R² reported are Pseudo R² Cox and Snell, & Nagelkerke

† < 0.10; * $p \leq 0.05$; ** $p \leq 0.01$; *** $p \leq 0.001$

I use two logistic regression models to examine associations between subjects' causal definition of emotional/mental problems as mental illness, and subjects' report of care-seeking for culturally defined problems. One model analyzes data for care-seeking in Mecklenburg County, while the second model analyzes data for care-seeking outside of Mecklenburg County. Variables in both logistic regression models include the dependent variable of subjects' report of care-seeking for culturally defined problems, and the independent variable subjects' causal definition of emotional/mental problems as mental illness.

The result of the logistic regression analysis for the variable causal definition of emotional/mental problems as mental illness predicting the subjects report of care-seeking in Mecklenburg County is significant ($p = 0.001$). The result of the logistic regression analysis for care-seeking outside Mecklenburg County is also significant ($p < 0.05$). Defining emotional/mental problems as mental illness has a negative effect ($b = -1.17$) on care-seeking in Mecklenburg County, and also on care-seeking outside Mecklenburg County ($b = -1.41$).

Odds ratios of <1 for both models (OR = 0.31 and 0.25 respectively) suggest a decrease in the odds of the dependent variable, for a unit increase in the independent variable. The odds of reporting care-seeking for culturally defined emotional problems in Mecklenburg County decrease by a factor of 0.31 by defining mental illness as the cause of emotional/mental problems. The odds of reporting care-seeking for culturally defined emotional problems outside Mecklenburg County decrease by a factor of 0.25 by defining mental illness as the cause of emotional/mental problems.

Figure 6.1

Graph of Odds Ratio of Care-Seeking from Mental Health Professionals for Emotional/Mental Problems and Culturally Defined Problems by Mental Illness Causal Definition, Logarithmic Scale

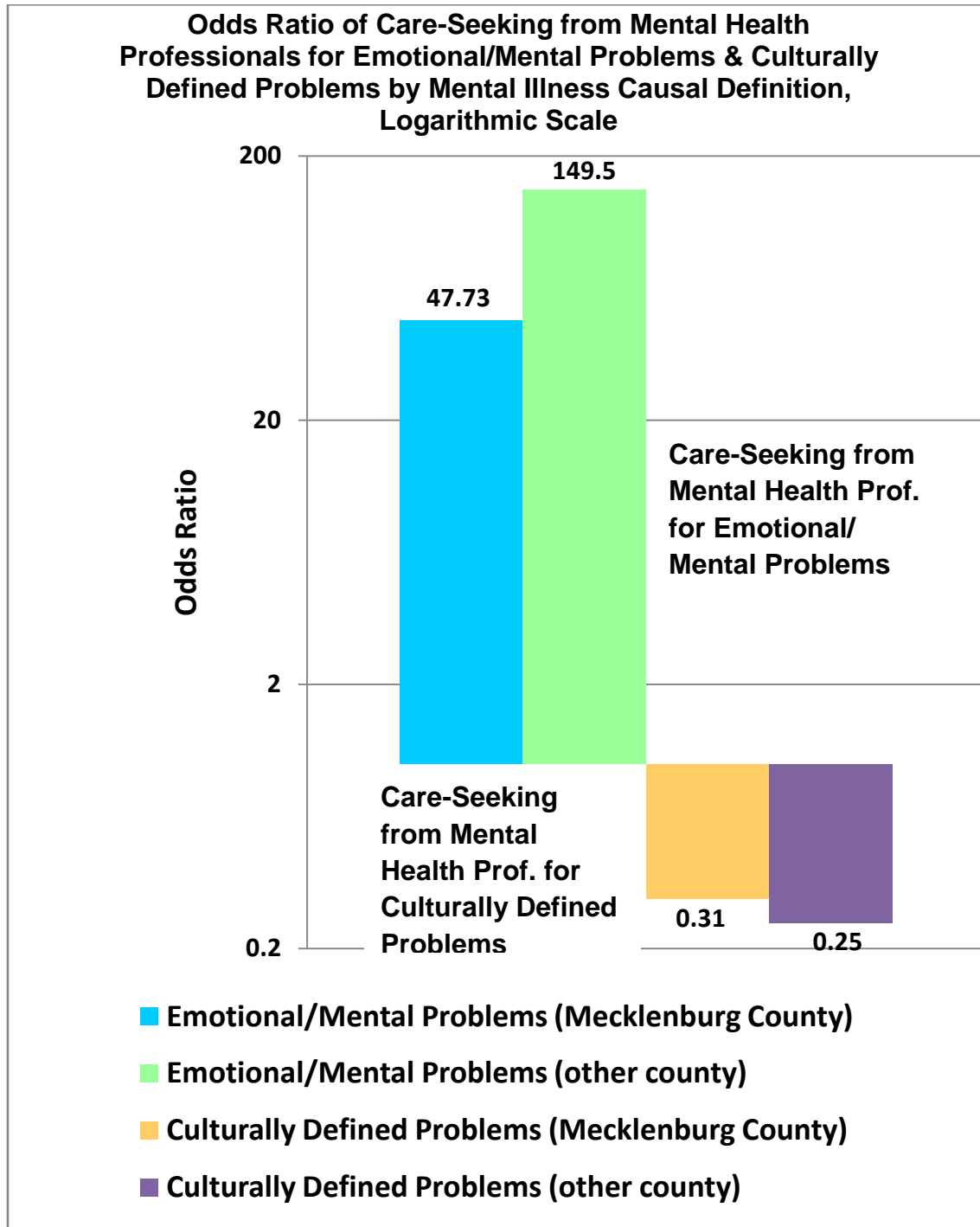


Figure 6.1 provides an illustration of the impact of a mental health causal definition on care-seeking from mental health professionals for emotional/mental problems and culturally defined problems. The odds ratios displayed in this graph show that a mental illness causal definition increases the odds of seeking care from a mental health professional for emotional/mental problems in both geographical locations, and decreases the odds of seeking care from a mental health professional for culturally defined problems in both locations. These relationships persist in Mecklenburg County and other counties where Latino community members seek care. The consistently significant relationships between causal definition and seeking care from mental health professionals illustrate the impact of cultural understandings on care-seeking behavior.

Logistic regression analyses of causal definition of emotional/mental problems as a predictor of satisfaction with care.

I use a logistic regression model to analyze the independent variable of a causal definition of emotional/mental problems as something other than mental illness as a predictor of satisfaction with care among subjects who report care-seeking for culturally defined emotional problems (See Table 6.18).

Table 6.18

Summary of Logistic Regression Analyses for a Causal Definition of Emotional/Mental Problems as a Cause other than Mental Illness Predicting Subjects Reporting Satisfaction with Care for Culturally Defined Emotional Problems

Satisfaction with Care	Log-odds (B)	Odds Ratio (OR)	95% CI for OR
Satisfaction with care for culturally defined problems	2.52	12.38 ***	[4.62, 33.14]
Intercept	0.38		
R ²	0.17 – 0.29		
Difference in -2 Log Likelihood	0.12		
Degrees of Freedom	1		

Notes: Difference in -2 log likelihood subtracts -2 log likelihood for full model from -2 log likelihood of model with only intercepts. R² reported are Pseudo R² Cox and Snell, & Nagelkerke

† < 0.10; * $p \leq 0.05$; ** $p \leq 0.01$; *** $p \leq 0.001$

Data in Table 6.18 show the results of logistic regression analysis for the variable of causal definition of emotional/mental problems as a cause other than mental illness significantly predicting the subjects' report of satisfaction with care for culturally defined problems ($p = 0.001$). An odds ratios of >1 suggests an increase in the odds of the dependent variable for a unit increase in the independent variable. The odds of reporting satisfaction with care for culturally defined emotional problems increase by a factor of 12.38 by defining a cause other than mental illness as the cause of emotional/mental problems.

Summary of Results: Latino Community Members' Seeking Care, Sources of Care, and Satisfaction with Care

In this chapter I analyze Latino community members' survey response data regarding the topics of care-seeking, sources of care, and satisfaction with care. I also present the results of survey response data related to community members' reports of violence-related trauma, emotional problems associated with the trauma, care-seeking for these emotional problems, and satisfaction with the care received.

Latino community members' seeking care.

A significant association exists in these data for Latino community members' causal definition of emotional/mental problems with care-seeking for emotional/mental problems at the < 0.10 level, and with care-seeking for culturally defined emotional problems at the < 0.001 level. These results support the hypothesis about the relationship between respondents' causal definition of mental/emotional problems and care-seeking. These findings also are consistent with the sociological literature on care-seeking patterns and the importance of cultural and structural factors in care-seeking behavior.

Latino community members' sources of care.

Causal definitions of emotional/mental problems appear to play a significant role in Latino community members' care-seeking choices, thus supporting hypotheses related to care-seeking selection. For example, a significantly smaller proportion of subjects who define the cause of emotional/mental problems as a cause other than mental illness (6%) report

seeking care from mental health professionals for emotional/mental problems compared to those who report a mental illness cause (76%), $p = < 0.001$.

Results for seeking professional mental health care for culturally defined problems show an even more dramatic finding. None of the subjects who define the cause of emotional/mental problems as something other than mental illness (0%) report seeking care from mental health professionals compared to those who report a mental illness cause (33%), $p = < 0.001$. These findings support research hypotheses regarding the relationship between causal definition of mental/emotional problems and sources of care.

Survey response data indicate that the proportion of Latino community members who report emotional/mental problems and culturally defined problems and who also report seeking care for the problem are the same (84%). However, a smaller proportion of respondents who report culturally defined problems seek care from a mental health professional. Instead, a larger proportion of these community members seek help from alternative sources of care (84%), suggesting a degree of concurrence between their social construction of the problem as an idiom of distress and the type of care they prefer.

Multivariate analyses provide additional insights regarding Latino community members care-seeking from mental health professionals. Results show that a mental illness causal definition increases the odds of seeking care from a mental health professional for emotional/mental problems and decreases the odds of seeking care from a mental health professional for culturally defined problems in both locations (See Figure 6.1).

Latino community members' satisfaction with care.

A greater proportion of Latino community members who report culturally defined problems (84%) indicate the care provided meets the needs of the victim. Considered in terms of the preference for alternative sources of care identified by the majority of respondents (84%), these results suggest a somewhat higher degree of satisfaction with alternative sources of care among Latino community members.

Logistic regression analysis shows a causal definition of emotional/mental problems as a cause other than mental illness significantly predicts ($p = 0.001$) the subjects' report of satisfaction with care for culturally defined problems. An odds ratios of >1 suggests an increase in the odds of the dependent variable (satisfaction) for a unit increase in the independent variable (causal definition).

These findings support the research hypotheses regarding the relationship between causal definition and satisfaction with care. They also support the basic premise of this dissertation—that Latino community members' cultural understandings regarding emotional/mental disorder have a significant impact on their behavior when they experience such disorder.

Latino community members' experience of violence-related trauma.

I include data on survey responses linked to violence-related trauma in this dissertation because qualitative data from the original research suggest emotional problems arising from these sources are an important issue for Latino immigrants. The research literature also supports the importance of these occurrences among Latino immigrants, especially among refugees from Central American countries.

Latino community members responding to the survey's questions regarding violence-related trauma report natural disaster (36%), other abuse (22%) and political violence (18%) as important sources of trauma. Political violence is the most likely type of trauma to result in emotional problems among Latino community members, with 94% of respondents who experience political violence reporting emotional problems. Of those who report violent trauma from other causes, 91% report emotional problems, while 82% of those reporting trauma from natural disaster also report experiences of emotional problems.

A small proportion of Latino community members who report emotional problems associated with violent trauma (28%) seek care for the violence-related emotional problem. Of those who obtain care, the majority seeks care from alternative sources of care (84%), and report a relatively high level of satisfaction (79%) with the care received by the victim.

The relatively low levels of care-seeking reported by these Latino community members and their reliance on alternative sources of care for emotional problems arising from the violence-related trauma support the previous research reported in the sociological literature. They also confirm the basic premise of this dissertation regarding Latino community members' cultural understandings and the impact of these understandings on their behavior.

Following this discussion, in Chapter 7, I discuss the overall findings of the research presented in this dissertation and relate the results to my original premise about the importance of cultural understandings among Latino community members and the impact of those understandings on behavior. I also

present recommendations about the application of these findings and the need for additional research on the topic.

Chapter 7: Discussion, Conclusions and Recommendations

A consensus exists in the literature concerning the presence of culturally unique ways of understanding mental disorder among Latino community members (Guarnaccia & Martinez, 2002; Guarnaccia, et al., 2005; Guarnaccia & Rodriguez, 1996; Horwitz, 1987; Horwitz, 2002a; Lara, et al., 2005; Romero, 2000; Suárez, 2001). Despite widespread knowledge about these cultural differences, little research focuses on how Latinos' cultural understandings about mental disorder impact their experience of emotional distress and their seeking care for these problems. In addition, there is a dearth of information on linkages between Latino community members' demographic characteristics and relevant Latino cultural constructs.

My research reported in this dissertation investigates the impact of cultural definitions of emotional/mental problems among Latino community members living in the U.S. on their experience of such problems, care-seeking, sources of care, and satisfaction with care. Specifically, this investigation compares differences between community members who identify 'mental illness' as the cause of emotional/mental problems with those who identify other causes, such as 'the devil,' 'evil spirits,' or 'nature.' I also assess the impact of selected demographic characteristics on community members' causal definition of emotional/mental problems (i.e., gender, age, education, time living in the U.S.).

Furthermore, this research examines the influence of cultural definitions of emotional/mental problems on the selection of care providers by contrasting community members who report seeking help from mental health professionals

with those who elect to seek care from family physicians, religious sources, or folk healers. I also explore factors influencing care-seeking behavior, including causal definitions of mental disorder and the occurrence of culturally-specific conditions. Finally, I analyze a related mental health topic involving Latino community members' experience of violence-related trauma, emotional problems resulting from the trauma, trauma-related care-seeking, sources of care, and satisfaction with care.

Notably, these research topics have grown in critical importance during the 21st century due to the continuing rapid growth of Latino populations in the U.S. and the well-documented difficulties often faced by community members in obtaining appropriate care for emotional and behavioral disorders (Aguilera & López, 2008; Molina, et al., 1994). Further, this research addresses challenges confronting mental health service providers created by an increasingly diverse U.S. population who require appropriate cross-cultural approaches to meet their mental health service needs (Guarnaccia & Rogler, 1999).

The presence of approximately nine million (2008 estimate) undocumented Latinos in the U.S. (Passel, 2006), makes accurate projections of Latino population size and growth in the U.S. difficult. I estimate the total Latino population, including undocumented groups, at approximately 55.9 million, or 18.4% of the total U.S. population in 2008. Dramatic growth exists in the number of Latinos in North Carolina and in the Charlotte region, the site of the original research analyzed in this dissertation. Estimated increases for the 2000 to 2008 period are: North Carolina +80%, and Charlotte +110% (Kochhar, et al., 2005).

Research documents a number of problems associated with the rapidly growing Latino community in the Charlotte region. Among the areas of greatest concern are the following: Most Charlotte Latinos are foreign born (68.2%) and not U.S. citizens (57.9%), and 57% do not speak English well, or do not speak it at all. Most Latinos in Charlotte have less than a high school diploma and work in low-wage jobs. A high proportion of Charlotte's adult Latino population has limited formal education and is functionally illiterate in their native language. Compared to other Charlotte residents, Latinos suffer economic disadvantage at higher rates; for example, 22.5% of Latinos live in poverty and 34.9% live in crowded conditions (Harrison, et al., 2006, p. vi).

Discussion of Results

In this chapter I discuss results of my secondary data analyses of prior research focusing on mental health service needs among Latino community members living in Mecklenburg and Cabarrus Counties, North Carolina. My discussion explores salient concerns identified in qualitative data collected as part of the earlier research from Key Informant panel members and Focus Group participants. I also discuss quantitative analyses of data from survey research focusing on results showing significant associations between key variables. In each section, I state conclusions supported by the research data. Finally, I make recommendations regarding mental health issues affecting Latino community members and the need for additional research to explore topics raised by results of this research.

Qualitative data.

Qualitative data presented in this dissertation illuminate several key concerns regarding the Latino community and community members' recognition of, and reaction to, symptoms of mental disorder. Although sample sizes are small and not necessarily representative of the larger Latino population living in the U.S., Key Informant panel members and Focus Group participants do address a number of crucial areas.

Qualitative results underscore how Latino community members conceptualize emotional/mental problems in ways that differ from members of the majority Non-Latino White population living in the U.S. Qualitative data also illustrate Latino community members' experience of culturally defined emotional disorders which are part of Latino culture but not readily understood within definitions of mental illness existing among Non-Latino White groups.

These results are consistent with Latino mental health services research such as information reported on culture-bound syndromes by Guarnaccia and Rogler (1999) and Guarnaccia and Martinez (2002). These authors point out that cultural syndromes, such as *ataques de nervios* among Puerto Ricans and *susto* among Mexican Americans, have complex relationships to psychiatric diagnoses. They also stress there are no simple translations of these idioms of distress into psychiatric diagnoses because they cut across a range of distress and disorders.

Qualitative results also focus on issues related to care-seeking and barriers to care that confront members of the Latino community. Key Informant panel members discuss how cultural constructs play an important role in a pattern of service underutilization among Latino populations living in the U.S. They also

stress the importance of how a lack of information and understanding among Latino community members about the delivery of mental health care in the U.S. creates barriers to accessing care. Mistrust and fear of institutions also create barriers to accessing care, especially if it is provided in institutional settings.

The research literature confirms the importance of these barriers to care among Latino community members. Guarnaccia and Martinez (2002), for example, note that “Lack of knowledge about what mental health services are and where to get services are other major barriers for Latinos” (p. 5). The authors also report that “the extended family system, Catholic and Protestant churches active in the community, and folk sector resources such as *curanderos* and *espiritualistas* all provide alternative sources of support” (p. 11) for Latino community members.

Finally, participating Latino community members provide qualitative data regarding violence and its associated trauma which are major health concerns for many in the Latino community. These data also identify the linkage of emotional problems to the experience of violence.

Quantitative data.

In the following section I discuss the results of survey research data analyses. The results generally support basic hypotheses tested in this research. I suggest explanations for negative results in instances where findings do not support hypotheses.

In the original study, both secular and religious organizations refer survey subjects. To establish if subjects referred from religious organizations respond differently than the balance of the sample, due to their religious orientation, I

examine differences in survey subjects' responses on the key dependent variable by comparing subjects referred to the study by religious organizations with those referred by non-religious organizations. Since results do not show a significant difference by referral source, I reject the hypothesis that Latino community members responding to the survey referred from a religious group are less likely to define mental illness as the cause of emotional problems

I also assess the extent to which survey subjects' country of origin results in significantly different responses on the key dependent variable by comparing subjects with Mexican origins (59.7% of the responses), with Central American origins (El Salvador, Honduras, Costa Rica, Guatemala, and Nicaragua--23% of the responses), and with origins from other Latin American countries (17.3% of the responses). Since results do not show a significant association by country of origin, I reject the hypothesis that Latino community members responding to the survey who report Mexico as a country of origin are less likely to define mental illness as the cause of emotional problems.

Latino community members' causal definition of emotional/mental disorder.

Qualitative data reported in this dissertation identify a number of Latino cultural constructs and show how cultural beliefs influence Latino community members' understandings of emotional problems that they and their family members experience. These cultural constructs also influence Latino community members' responses to emotional problems by shaping care-seeking and treatment preference decisions. Key informants emphasize the differences between modern concepts of mental illness held by Non-Latino White majority

populations in the U.S. and widespread beliefs existing in the Latino community. Especially in less educated, rural populations, Latino community members tend to accept behavioral disorders as part of nature, as caused by evil spirits or as punishment from God for sinful behavior.

A belief in alternative explanations for the cause of emotional/mental problems exists among the majority (52%) of Latino community members responding to the survey. This result supports the initial hypothesis of the research that Latino community members responding to the survey are more likely to define the cause of mental/emotional problems as something other than mental illness. Alternative causal explanations identified by respondents include nature (natural, part of nature), the devil, and evil spirits.

These findings are consistent with reports from a number of authors who identify alternative causal explanations for emotional/mental problems among Latino community members (Añez, et al., 2005; Comas-Díaz, 2006; Guarnaccia & Martinez, 2002). However, previous research does not investigate how social and demographic variables influence Latino community members' adoption of these alternative explanations.

I assess the impact of four variables on Latino community members' reports of alternative beliefs about the causes of emotional/mental problems. Three of the demographic variables (age, education, and time living in U.S.) are significant predictors ($p < 0.001$) of subjects' alternative explanations for the cause of emotional/mental problems, supporting each of the three hypotheses related to subjects' demographic characteristics. These hypotheses are the following:

1) Latino community members responding to the survey who are younger (<35 years of age) are more likely to define mental illness as the cause of emotional/mental problems;

2) Latino community members responding to the survey who are college educated are more likely to define mental illness as the cause of emotional/mental problems; and

3) Latino community members responding to the survey who have lived in the United States for more than five years are more likely to define mental illness as the cause of emotional/mental problems.

Results based on the fourth independent variable of gender (female), however, show that gender is not a significant predictor of the subjects' causal definition of emotional/mental problems. This is a surprising result because a number of cultural factors as well as epidemiological data suggest greater vulnerability to mental disorder and higher levels of reporting specific mental/emotional problems among females.

For example, gender differences in care-seeking reflect cultural conceptions of appropriate gender-related behaviors. Very low mental health service utilization rates for men are consistent with cultural norms that depict men as strong and capable of independently controlling their emotions. Other contrasting cultural norms portray women as weaker and more appropriate victims of illness, and consequently, women are more likely to report mental-illness symptoms and are more likely to utilize mental health services (Romero, 2000).

However, even though Latinas (female Latinos) may experience higher rates of specific mental/emotional problems (i.e., depression) (Canales, 2000)

and culturally defined emotional problems (i.e., *ataque de nervios*) (Guarnaccia, et al., 2010), they share essentially the same worldview and cultural foundation as men. Since the influence of a shared culture among women and men may be more important than gender-related factors, these shared cultural beliefs may result in similar proportions of Latinas and Latinos who define mental illness as the cause of mental/emotional problems.

Findings from epidemiological research on psychiatric disorder prevalence among Latinos (NLAAS Survey) regarding the three significant predictors of causal definitions of emotional/mental problems show a pattern consistent with the results of this research. Age (< 35) predicts a causal definition of emotional/mental problems of mental illness, a finding which confirms similar results from qualitative data. NLAAS data indicate the youngest age group (18-35) has the highest reported rate of last-year disorders (The < 35 age group does not have the highest lifetime mental disorder prevalence rates in the NLAAS data because of their truncated age span.) (Alegría, Mulvaney-Day, et al., 2007).

A similar pattern emerges for education, with college-level education predicting a mental illness causal definition of emotional/mental problems in the dissertation data. This result also confirms the qualitative finding that more educated Latinos are more likely to adopt a scientific explanation of mental illness. In the NLAAS data, the highest proportion of lifetime mental disorder prevalence rates exists among college-educated Latinos (Alegría, Mulvaney-Day, et al., 2007).

Finally, the variable of years living in the U.S. evidences a similar pattern, although there is an inverse association with the causal definition of mental illness.

The group of Latino community members with the shortest period of time living in the U.S. (≤ 5 years) is more likely to report a causal definition of emotional/mental problems other than mental illness. NLAAS data show that Latinos with the shortest period of time living in the U.S. (≤ 5 years) have the lowest proportion of lifetime psychiatric disorder (Alegría, Mulvaney-Day, et al., 2007).

Logistic regression results presented in this dissertation are consistent with other findings. They include odds ratios that predict a significant effect for all three demographic variables on the subject's causal definition of emotional/mental problems. Notably, the variables of education (college), and time living in the U.S. (> 5 years), have a significant and positive effect on the subjects' causal definition of emotional/mental problems as mental illness. Age (> 35) has a significant but negative effect on the subjects' causal definition of emotional/mental problems as mental illness. A logarithmic scale shows that the relative strength of the effect on the subjects' causal definition of emotional/mental problems as mental illness is strongest for education, while time living in the U.S. is slightly weaker. Furthermore, the variable of age has a substantially weaker negative effect.

Interpretation of these results is relatively straightforward. College-educated Latino community members are more likely to adopt a mental illness definition because of their enhanced understanding of this model acquired in their educational endeavors. Latino community members living in the U.S. for a longer period of time are more likely to acculturate and adopt beliefs about a mental illness cause held by the Non-Latino White majority population. Older Latino community members are more likely to maintain traditional cultural

understandings regarding the causes of emotional/mental problems and are therefore more likely to adopt an alternative cause other than mental illness.

These results also are consistent with data presented in this dissertation on Latino population's mental health care-seeking, and with Latino participants reporting symptoms used as criteria for a psychiatric diagnosis in epidemiological research. Factors that increase the likelihood of defining emotional/mental problems as mental illness and that increase the likelihood of professional mental health care-seeking may also increase Latino community members' rates of reporting symptoms consistent with a psychiatric diagnosis in epidemiological research.

For Latinos living in the U.S. for five years or less, the data in this dissertation show a negative effect on their defining emotional/mental problems as mental illness. This demographic variable also predicts a reduced likelihood of Latino community members seeking professional mental health care. In epidemiological research, Latinos living in the U.S. for five years or less report lower rates of symptoms consistent with a psychiatric diagnosis. When viewed together, these results suggest a different interpretation of the 'Latino Paradox.'

Discussion of the 'Latino Paradox.'

A surprising pattern of less frequent reports of psychiatric symptomology exists among more recently arrived Latino immigrants. Known as the 'Latino Paradox,' this phenomenon focuses on the many stressors encountered by new immigrants that should contribute to higher levels of mental disorder contrasted with lower levels of symptomology actually reported by recent Latino immigrants. Explanations offered for the Latino Paradox include theories ranging

from the hardiness of newly immigrated populations, to the extended family support network available to Latino community members (Alegría, Sribney, Woo, Torres, & Guarnaccia, 2007; Lefley, 2010).

I propose an alternative explanation for this counterintuitive pattern. My proposed explanation posits that Latino community members who believe mental illness is the cause of emotional/mental problems are more likely to frame their experience of mental disorder within the mental illness model. As a result, these Latino community members are more likely to interpret the symptoms they experience as an illness, seek care from mental health professionals, and report symptoms on psychiatric disorder prevalence questions when they participate in epidemiological research. Conversely, Latino community members who define the cause of emotional/mental problems as something other than mental illness are more likely to frame their experience within culturally accepted models, and to seek care from alternative sources, but they are less likely to report symptoms on psychiatric disorder prevalence questions when they participate in epidemiological research. Research reported in this dissertation supports my proposed explanation because recently-arrived immigrants living in the U.S. for less than 5 years are more likely to define the cause of emotional/mental problems as an alternative other than mental illness.

Overall results of my survey results analysis support the basic premise of this dissertation: that a majority of Latino community members living in the U.S. define the cause of emotional/mental problems differently from the Non-Latino White population of the U.S. Further, alternative causal definitions have an

impact on Latino community members' perceptions and behaviors related to mental disorder.

Latino community members' experience of emotional/mental problems and culturally defined emotional problems.

Horwitz (2002b) emphasizes the importance of mental disorder symptomology functioning as 'idioms of distress' for normal people who face stressful life conditions. Furthermore, he calls attention to the critical relationship between symptoms and disorders, and to the consequences that arise from stressful structural conditions. In pointing out that culture works to structure symptoms of mental disorder, Horwitz writes that "symptoms of mental disorder are symbolic representations of underlying vulnerabilities that are structured to fit dominant cultural models of 'appropriate' disorders in particular times and places" (p. 268). Further, he suggests that this model calls attention to consequences normal people experience as the result of dealing with stressful structural conditions, such as socioeconomic inequality and racial/ethnic discrimination.

Latino community members living in the U.S. suffer from culturally defined emotional problems, and individual focus group participants analyzed in this dissertation identify their own personal experiences of *ataque de nervios*, *susto*, *angustia*, and *mal de ojo*. Known as 'idioms of distress,' these culturally specific conditions provide important benefits for sufferers within the Latino community. Idioms of distress offer a culturally acceptable way for community members to convey suffering, especially for disadvantaged population groups. Latino community members avoid the stigma often associated with victims of mental illness by conceptualizing their problem in these alternative forms. Research

strongly supports the role of idioms of distress in providing alternative forms for expressing emotional problems by Latino community members while avoiding the stigma associated with *locura* (madness) (Guarnaccia & Martinez, 2002; Lewis-Fernández, et al., 2010).

In summary, the use of idioms of distress by Latino community members illustrates how broad structures that embody complex information (schemata) exist in the form of cultural constructs, and how these cultural constructs can work through discrete models (frames) that community members use to interpret and react to symptoms of mental disorder. This example demonstrates how Latino community members gain certain benefits, such as avoiding stigma and adopting culturally accepted ways of expressing and coping with distress. However, for Latino groups experiencing their native cultures in their countries of origin, these benefits may be more advantageous than for groups when they immigrate to the U.S. This cultural phenomenon occurs because, within the dominant U.S. culture, framing mental disorder in culturally-defined ways may actually be a barrier to care.

Furthermore, a majority of survey subjects (58%) analyzed in this dissertation reports an episode of a specific culturally defined emotional problem, while a minority (36%) reports the experience of emotional/mental problems. *Angustia* is the most frequent culturally defined condition, with 34.5% of subjects indicating an episode, while 21% of subjects report *ataque de nervios*, and 20.2% report *susto*. The least frequently reported culturally defined emotional problem is *mal de ojo*, with 18% of subjects reporting an episode.

In addition, qualitative and quantitative data identify *angustia* (anguish) as an important culturally defined emotional problem among Latino community members living in the Charlotte region. Although *angustia* is not one of the culture-bound syndromes included in DSM-IV-TR, Key Informant panel members describe clients with *angustia* who report intense or extreme worry, anxiety, and often extreme sadness or depression. Qualitative data link *angustia* with poverty, family disruption, and inadequate support networks. The limited research available supports these characterizations, with results from Moreira (2007), for example, linking *angustia* to violence, poverty, and inequality among her subjects. The prevalence of *angustia* among survey respondents may also reflect the relatively disadvantaged status of Latinos living in the Charlotte region.

Quantitative analyses of survey research data which show a significantly greater proportion of those who define the cause of emotional problems as something other than mental illness also report culturally defined problems. However, the proportion of subjects reporting an episode of emotional/mental problems does not differ significantly by their causal definition of emotional/mental problems.

Results of the analysis do not support the hypothesis that Latino community members responding to the survey who define mental illness as the cause of emotional problems are more likely to report an episode of an emotional/mental problem. I suggest an explanation for these somewhat conflicting results in terms of a cognitive precondition that may exist for recognizing and reporting culturally defined emotional disorders. Subjects responding to the survey can recognize and report episodes of serious

emotional/mental problems, like those described in the survey's initial question, without adopting a mental illness causal definition of such disorders. For subjects to recognize and report culturally specific conditions, however, they may need to accept one or more of the alternative causal explanations (nature, the devil, evil spirits).

Regarding specific culturally defined emotional problems, a significantly greater proportion of those who define the cause of emotional problems as something other than mental illness report culturally defined problems of *ataque de nervios* and *mal de ojo* compared to those who report a mental illness cause. Reports of either *susto* or *angustia*, however, do not show a significant association with a causal definition of something other than mental illness.

An explanation for the absence of an association between *angustia* and subjects' causal definition of emotional/mental problems may involve the ubiquitous nature of the condition. *Angustia* ranks as the most often reported culturally-defined condition among Latino community members responding to the survey. Since Latino community members tend to accept this problem as part of normal life related to the victim's social and economic condition, they may not classify this problem as mental disorder. Therefore, their causal definitions of emotional/mental problems may not influence their reporting of *angustia*.

In addition, a linkage may also exist between *susto* and the sufferer's social condition. If *susto* affects primarily poor, working poor, and downwardly mobile populations and serves as a symbolic statement of the victim's disadvantaged class position and negative life conditions, survey subjects' understanding of the cause of mental disorder may not impact their recognition

and reporting of *susto*. This explanation is consistent with the research on *susto* by Mysyk (1998) and Weller et al (2008).

On the other hand, Latino community members who adopt a causal definition of mental illness are less likely to report culturally defined conditions of *ataque de nervios* or *mal de ojo*. Multivariate analyses indicate a decrease in the odds of reporting culturally defined problems of *ataque de nervios* or *mal de ojo* by defining mental illness as the cause of emotional/mental problems. These data support the premise that a link exists between community members' beliefs about causes of mental disorder and their perception and experience of culturally defined conditions. In research on *ataque de nervios* among Puerto Ricans, for example, Guarnaccia (1993) and Guarnaccia and Rogler (1999) find widespread acceptance of the condition among community members.

These research findings support the hypothesis that Latino community members responding to the survey who define a cause of emotional problems other than mental illness are more likely to report an episode of a culturally defined emotional problem.

Latino community members seeking of care, selecting a source of care, and reporting satisfaction with care.

Many factors account for variations in mental health services utilization among mentally disordered members of different ethnic groups. Sociologists identify differences in the cultural definitions of personal problems, such as emotional and behavioral disorders, as important contributors to service utilization patterns. Horwitz (1987; 2002a), for example, notes that members of ethnic groups who are not conversant with psychiatric culture, including some

Latinos, are less likely to seek help from professional mental health service providers. Mexican community members comprise one cultural group that tends to underutilize mental health services.

From the perspective of qualitative data analyzed in this dissertation, results illustrate a strong preference for non-professional sources of care among Latino community members. Data also indicate a largely negative attitude among participants regarding professional mental health providers. Indeed, a generalized mistrust of institutions exists among Focus Group participants, and they identify fear of institutions as an obstacle to seeking care from providers located in institutional settings. Focus Group participants report other barriers to care-seeking and provider selection, including privacy concerns, stigma, acculturation difficulties, language problems, discrimination, and economic constraints (including lack of insurance). In addition, documentation problems exacerbate most of these barriers to care. Undocumented community members are especially anxious and fearful about initiating any contact with government officials, an activity which they believe carries a high risk arrest of deportation.

My findings are consistent with the literature on Latino community members' access to professional mental health care exemplified by data from Ojeda (2008) who documents perceptions and attitudes of avoidance and mistrust of the mental health care system among Latino community members. Further, my results confirm reports published by Guarnaccia and Martinez (2002) regarding barriers to care found in the Latino community as well as reliance among community members on alternative sources of care.

Regarding the topics of care-seeking, sources of care, and satisfaction with care, I analyze Latino community members' survey response data separately. I also analyze survey response data related to community members' reports of violence-related trauma, emotional problems associated with the trauma, care-seeking for these emotional problems, and satisfaction with the care received.

Latino community members' seeking care.

Results of my analysis support the hypothesis concerning the relationship between respondents' causal definition of mental/emotional problems and care-seeking. These findings also are consistent with the sociological literature on care-seeking patterns and the importance of cultural and structural factors in care-seeking behavior.

For example, a significant association exists for Latino community members' causal definition of emotional/mental problems with care-seeking for emotional/mental problems at the $p < 0.10$ level, and with care-seeking for culturally defined emotional problems at the $p < 0.001$ level. I conclude that community members' cultural understandings about the causes of mental/emotional problems influence care-seeking for both categories of disorders.

These findings are consistent with research on Latino community members' beliefs about mental disorder and their care-seeking patterns. For example, Guarnaccia and Martinez (2002) report that a number of cultural factors commonly identified among Latino groups create barriers to accessing mental health services in the U.S. Among these are the stigma associated with *locura* (madness) in the Latino community, and beliefs in a self-reliant attitude known as

ponerse de su parte (contributing one's part). In general, the literature reflects the importance of culturally unique ways Latinos may adopt in understanding mental disorder, and the impact of these beliefs on care-seeking.

Latino community members' sources of care.

Causal definitions of emotional/mental problems appear to play a significant role in Latino community members' care-seeking choices, thus supporting hypotheses related to sources of care. For example, a significantly smaller proportion of subjects who define the cause of emotional/mental problems as something other than mental illness (6%) report seeking care from mental health professionals for emotional/mental problems compared to those who report a mental illness cause (76%), $p = < 0.001$.

Results pertaining to seeking professional mental health care for culturally defined problems show an even more dramatic association. None of the subjects who define the cause of emotional/mental problems as something other than mental illness report seeking care from mental health professionals compared to those who report a mental illness cause (33%), $p = < 0.001$.

Survey response data indicate that the proportion of Latino community members who report emotional/mental problems or culturally defined problems, and who also report seeking care for the problem, are the same (84%). However, a smaller proportion of respondents who report culturally defined problems seek care from a mental health professional. Instead, a larger proportion of these community members seek help from alternative sources of care (84%), suggesting a degree of concurrence between their social construction of the problem as an idiom of distress and the type of care they prefer.

Multivariate analyses provide additional insights regarding Latino community members care-seeking from mental health professionals. Odds ratios show that a mental illness causal definition increases the odds of seeking care from a mental health professional for emotional/mental problems and decreases the odds of seeking care from a mental health professional for culturally defined problems. These relationships persist in Mecklenburg County and other counties where Latino community members seek care.

These results strongly support the premise that the Latino community members' cultural understandings about the causes of emotional/mental problems influence decisions they make about appropriate sources of care for problems of emotional disorder. Congruence exists between beliefs about alternative causes of mental/emotional problems and seeking care from alternative sources. Results support the following specific hypotheses about care-seeking and selecting sources of care:

- 1) Latino community members responding to the survey who report an episode of emotional/mental problems and define the cause of mental/emotional problems as mental illness are more likely to seek care from a mental health professional.

- 2) Latino community members responding to the survey who report an episode of emotional/mental problems and define the cause of mental/emotional problems as a cause other than mental illness are less likely to seek care from a mental health professional.

These findings are consistent with mental health care utilization research such as the data reviewed by Cabassa, Zayas, and Hansen (2006) which show

that a complex interplay of structural, economic, psychiatric, and cultural factors influence Latinos' access to mental health services. They specifically comment on the role of informal sectors (e.g., religious institutions, folk healers) as preferred sources of care for Latino group members. Research by Kouyoumdjian, Zamboanga, and Hansen, (2003) also document how Latino community members' perceptions of mental disorder impact mental health services use and result in a pattern of underutilization.

Latino community members' satisfaction with care.

A greater proportion of Latino community members who report culturally defined problems (84%) indicate the care provided meets the needs of the victim. Considered in terms of the preponderance of alternative sources of care identified by the majority of respondents (84%), these results suggest a somewhat higher degree of satisfaction with alternative sources of care among Latino community members.

Logistic regression analysis shows a causal definition of emotional/mental problems as a cause other than mental illness significantly predicts ($p = 0.001$) the subjects' report of satisfaction with care for culturally defined problems. An odds ratios of >1 suggests an increase in the odds of the dependent variable (satisfaction) for a unit increase in the independent variable (causal definition).

These findings support the research hypotheses regarding the relationship between causal definition and satisfaction with care. The hypothesis is that Latino community members responding to the survey who report an episode of culturally defined problems and define the cause of mental/emotional problems

as something other than mental illness are more likely to indicate the care provided for culturally defined problems meets the needs of the victim.

Latino community members' satisfaction with care provided by alternative sources is consistent with results documented in the literature by Cabassa, Zayas, and Hansen (2006) and by Suárez (2001). A well-documented preference for non-professional sources exists even though community members tend to use more than one source of care for emotional problems,. Guarnaccia and Martinez (2002) clarify this utilization pattern by pointing out that while the preference for alternative treatments among Latinos does not necessarily deter formal mental health services use, structural barriers exist that deter access to professional services and contribute to underutilization.

The research findings also support the basic premise of this dissertation—that Latino community members' cultural understanding regarding emotional/mental disorder has a significant impact on their behavior when they experience such disorder, including care-seeking, selection of sources of care, and satisfaction with the care received.

Latino community members' experience of violence-related trauma.

Qualitative data reported in this dissertation identify violence-related trauma as a major concern for many in the Latino community, especially among members of refugee populations. Natural disasters and political violence in their native countries affect the emotional and physical health of Latinos. Other violence is also a concern, including a culture of extreme violence for many Latino migrants who engage in illegally crossing the U.S./Mexico border.

Problems associated with trans-border migration are consistent with information reported in the literature regarding immigrant groups and the stressors they may encounter. For example, Guarnaccia and Martinez (2002) point out that major stressors associated with cross-border migration include the burden of its cost, having to deal with unprincipled *coyotes* (smugglers), coping with potentially exploitative Mexican border police, and worrying about possible apprehension by the U.S. border patrol.

Qualitative data suggest that emotional problems arising from violence-related trauma are an important issue for Latino immigrants. Findings published in the research literature also support the importance of these occurrences among Latino immigrants, especially among refugees from Central American countries (Fortuna, Porche, & Alegría, 2008; Gupta, et al., 2009).

Specifically, Latino community members' reports analyzed in this dissertation indicate natural disaster (36%), other abuse (22%) and political violence (18%) as important sources of trauma. Political violence is the most likely type of trauma to result in emotional problems among Latino community members, with 94% of respondents who experience political violence also reporting emotional problems. Of those who report violent trauma from other causes, 91% report emotional problems, while 82% of those reporting trauma from natural disaster also report experiences of emotional problems.

These findings are consistent with data analyzed from the NLAAS research which show 11% of all immigrant Latinos report political violence exposure, and 76% describe additional lifetime traumas (Fortuna, et al., 2008).

A small proportion of Latino community members who report emotional problems associated with violent trauma (28%) seek care for the violence-related emotional problem. Of those who obtain care, the majority seeks care from alternative sources of care (84%), and reports a relatively high level of satisfaction (79%) with the care received.

The relatively low levels of care-seeking reported by these Latino community members, and their reliance on alternative sources of care for emotional problems arising from violence-related trauma, are consistent with previous research reported in the sociological literature (Fortuna, et al., 2008; Gupta, et al., 2009; Jácome, 2010). They also confirm the basic premise of this dissertation regarding Latino community members' cultural understanding and the impact of these understandings on their behavior.

Limitations of this Research

This research utilizes data collected in 2004-2005 from interviews conducted with Latino community members residing in the Charlotte urban area, including Mecklenburg and Cabarrus Counties, North Carolina. Although a diverse selection of community organizations serves as the source of interview subjects, and the subjects come from various geographic areas dispersed throughout Mecklenburg and Cabarrus Counties, they do not constitute a random sample, and results cannot be generalized to the larger Latino population. The results do, however, suggest the degree to which these Latino community members adopt culturally influenced definitions of mental health/illness, and the impact these definitions have on their reporting of the experience of emotional problems, seeking care, and their satisfaction with care.

Furthermore, the Charlotte region is home to a rapidly growing Latino population. Growth comes from the influx of many international migrants, including a substantial number of refugees. Consequently, this population may be atypical compared to the national Latino population. Charlotte also has substantial difficulties accommodating its nascent multicultural population, and these difficult issues may negatively impact Latino community members' attitudes regarding professional mental health care. Finally, research data identifies a number of key sociodemographic challenges faced by new Latino immigrants in Charlotte that may create biased results.

Qualitative data from the original research seeks to provide descriptive information for the purpose of increased understanding and enhanced meaning and context, but not for causal determination or prediction. Focus groups (N=21) and key informants (N=11) are not representative samples and results cannot be generalized.

Although the original study team made every effort to carefully select and train Spanish-speaking interviewers, it is also possible that interviewer biases may have influenced interview subjects' responses. The use of a relatively large number of interviewers recruited from a variety of different community groups tends to mitigate potential biases.

In addition, the Spanish language itself has many variants used in the diverse zones across Latin America (Ager, 2010). Translation of the survey instrument into Spanish underwent careful review by a Latino Advisory Committee made up of Mexican Americans and representatives from several different Latin American countries, including Venezuela, Columbia, Cuba, Puerto Rico, El

Salvador, the Dominican Republic, and Mexico. National and regional differences in Spanish language variants or dialects, however, may have introduced potential biases for survey participants from different regions of Latin America.

Because the research reported in this dissertation uses secondary data analyses of survey data from prior research focusing on mental health service needs among Latino community members, several variables that would be helpful in separating the effects of non-Latino factors (socioeconomic status, age and date of immigration, marital status, health insurance coverage, etc.) are not available.

Recommendations for Mental Health Services and Additional Research

In this section I make recommendations based on the results of this research. One group of recommendations relates to mental health service improvements for Latino community members, while the second group addresses important additional research topics identified by the findings of this dissertation.

Recommendations related to mental health services.

The following suggestions point to needed improvements in mental health services for Latino community members:

Increase the availability of community-based, culturally sensitive mental health services that avoid negative stereotypes of institutional providers and employ staff who are not just Spanish-speaking, but who also share an in-depth cultural understanding of their Latino clients. This recommendation aligns with Comas-Diaz (2006), among a number of other authors, who argues for the need to culturally adapt mainstream psychotherapy to Latino populations. She emphasizes the clinical effectiveness of Latino healing as the result of integrating ethnic psychology into mainstream psychotherapy.

Create community outreach and education directed to the Latino community with the objective of educating community members about the need for mental health care and the availability of services in culturally appropriate settings. Qualitative data presented in this dissertation call attention to Latino community members' aversion to institutional settings and preference for community-based, culturally sensitive sources of care like the *Mi Casa, Su Casa* and *Centro de Salud Betesda* programs in Charlotte, NC. Further, authors including Guarnaccia and Martinez (2002) emphasize how the lack of knowledge about what mental health services are, and where to access them, serve as major barriers for Latinos seeking care.

Create provider outreach and education designed to make mental health service providers more aware of the barriers faced by Latino community members and the need to offer culturally-appropriate services. I discuss a number of barriers to care in this dissertation, and authors such as Guarnaccia and Martinez (2002) also detail a number of obstacles Latino community members face in accessing mental health services. Principal impediments include language difficulties and the lack of insurance.

Publicize the need for mental health services intended for victims of violence-related trauma, and provide outreach among Latino community members regarding the need for, and availability of, such services. Refugees from Central American countries and immigrants using a Mexican trans-border entry point should be the primary focus of this outreach effort. Documentation problems and shame associated with abuse create barriers to seeking care and should be the focus of outreach efforts (Jácome, 2010).

Recommendations related to additional research.

The following suggestions pertain to additional research which builds on information developed by this dissertation:

Conduct research that elaborates on Latino community members' beliefs in Latino cultural constructs and the impact of those beliefs on care-seeking and satisfaction with care. While there is an ample number of authors who describe the cultural differences between Latinos and Non-Latino White populations living in the U.S. (Guarnaccia & Martinez, 2002; Guarnaccia, et al., 2005; Guarnaccia & Rodriguez, 1996; Horwitz, 1987; Horwitz, 2002a; Lara, et al., 2005; Romero, 2000; Suárez, 2001), hardly any research focuses on impacts of these cultural differences.

Conduct research that links Latino cultural constructs to culturally sensitive treatment models and to the effectiveness of such treatment. As Guarnaccia and Martinez (2002) point out, although the literature contains many references to Latino cultural constructs (such as *respeto*, *personalismo*, *familismo*) and recommends their inclusion as a part of mental health treatment, there is little research support for these opinions.

Conduct research that develops more data on socioeconomic status and the experience of culturally defined conditions, including Latino community members' reliance on alternative treatment sources and the effectiveness of such treatment. While the literature on idioms of distress links culturally defined conditions to socioeconomic status (Guarnaccia, 1993; Guarnaccia & Rogler, 1999), there is a paucity of research that assesses linkages among socioeconomic status, idioms of distress, and alternative treatments.

Investigate the potential for integrating alternative care models with existing mental health treatment modalities. Guarnaccia and Martinez (2002) point out that using alternative sources of care, including clergy, does not appear to prevent the use of medical/mental health services, but instead seems to be complementary to that use. Comas-Diaz (2006) also discusses the complementary aspects of alternative care models and professional mental health treatment. The potential for improving treatment outcomes by combining these treatment modalities should be explored.

Final Remarks

Growing up and living in San Diego, California, close to the Mexican border, I have experienced substantial life-changing exposure to Latino culture and people. My appreciation and respect for them has deepened through the relationships I developed with Latino community leaders and mental health professionals during the original research project. My hope is that research findings such as those reported in this dissertation will contribute to an improved understanding of the rich and varied Latino culture and its impact on health, illness, and care-seeking. I am also optimistic that mental health service providers will take advantage of the many therapeutic enhancement opportunities available to them which can emerge from an enriched awareness of their Latino clients and their clients' cultural backgrounds.

The Mental Health Association of the Central Carolinas utilizes data from the original research to spearhead efforts to improve understanding and access to mental health services in the Latino community through advocacy and outreach efforts in the Charlotte region. Efforts like these should be undertaken

in other communities where Latinos suffer from lack of access to mental health services and providers, and where policy makers need more complete and accurate information regarding Latino community members' cultural foundations and current requirements.

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Footnotes

¹Language describing deviant behavior is, of course, culturally relative. The Spanish-language description used in the questionnaire is *muy extraño* which translates to ‘very weird, odd, or strange.’ The term *alucinaciones*, also used in the questionnaire, translates to ‘hallucinations.’

²Comparisons in Table 3.2 between Latino cultural constructs and concepts from cognitive sociology are intended to elaborate how cultural constructs impact community members’ recognition of and reaction to symptoms of mental illness while recognizing the essential differences that exist between the sociology of culture and cognitive science.

Appendices

Appendix A: List of Members of the Latino Advisory Committee, Key Informants,
and List of Participating Community Organizations/Interviewers.

Appendix B: English-language Questionnaire.

Appendix C: Spanish-language Questionnaire.

Appendix D: Survey Sample Geographic Distribution by ZIP Code Areas.

Appendix A: List of Members of the Latino Advisory Committee, Key Informants, and List of Participating Community Organizations/Interviewers.

Mental Health Association of Central Carolinas, Inc.
Hispanic/Latino Mental Health Service Needs Assessment

Latino Advisory Committee/Key Informants

Carlos Beteta, Mi Casa Su Casa
Haydee Garcia, Our Lady of Guadalupe Catholic Church
Barbara Guilds, Central Avenue Bilingual Preschool Program
Carlos Hernandez, Mecklenburg County Area Mental Health
Gunda Knese, Mental Health Association
Liz Jordak, Mental Health Association
Helen Leak, Piedmont Behavioral Healthcare
Angeles Ortega, Latin American Coalition
Eliseo Pascual, Centro de Salud Betesda
Rev. Rusty Price, Iglesia Bautista Camino del Rey
Diana Torres, Community Volunteer
Luis Tellez, Mental Health Association
Teresa Villamarin, Programa Esperanza

Interviewers, Focus Group Leaders, and Recorders

Becky Allman, Cabarrus County Community Care Plan
Haydee Garcia, Our Lady of Guadalupe Catholic Church
Carlos Hernandez, Mecklenburg County Area Mental Health
Helen Leak, Piedmont Behavioral Healthcare
Magbis Love, Community Volunteer
Carlos Martinez, Mecklenburg County Area Mental Health
Felipe Pardo, Our Lady of Guadalupe Catholic Church
Diana Torres, Community Volunteer
Ricardo Torres, Community Volunteer
Rosalyn Vargas, Cooperative Christian Ministries

Other Assistance

Lissette Garcia, Latin American Coalition
Jessica George, Latin American Coalition
Sonia Hatfield, Rowan-Cabarrus Community College
Sylvia McGill, NorthEast Medical Center, St. Joseph's Catholic Church of Kannapolis
Melody McGinnis, Rowan-Cabarrus Community College

Research Consultant

Fred Rasmussen

Appendix B: English-language Questionnaire

Organization _____ **Interviewer** _____ **Date** _____ [**Code** _____]

We are looking for information to help improve health services for your community. Could we please ask you a few questions about your family and their health? The interview does not have your name in it and everything you say is private. It will take about 10 minutes. Would you like to talk in Spanish or English?

First, please think about the physical health of your family:

1) Has anyone in your family had a serious health problem in the last five years? Y_____ N_____

If NO: Skip to #9

(If more than one episode, use the most recent one.)

If YES: 2) Was that person? Your Spouse_____ Your Child_____ Yourself_____ Other Family Member (Specify)_____

3) Did your family member try to get help for the health problem from someone outside your family here in Mecklenburg County? Y_____ N_____

If YES: 4) Who did they go to for help (type of provider)? _____

If NO: 5) Did they try to get help somewhere else outside Mecklenburg County? Y_____ N_____

If YES: 6) Where (Geographical location)? _____

7) Were they able to get the help they wanted? Y_____ N_____

If NO: 8) Why weren't they able to get the help they wanted? _____

Second, please think about the emotional and mental health of your family:

9) If someone in your family started acting very sad (depressed), very strange (anti-social), bizarre (hallucinations) or self-destructive (suicidal), what would you think was causing the problem?

Mental illness_____ The devil_____ Evil spirits_____ Nature_____ Other (Specify) _____

10) Has anyone in your family had an emotional or mental problem in the last five years? Y_____ N_____

If NO: Skip to #20

(If more than one episode, use the most recent one.)

If YES: 11) Was that person? Your Spouse_____ Your Child_____ Yourself_____ Other Family Member (Specify)_____

12) Did your family member try to get help for the emotional or mental problem from someone outside your family here in Mecklenburg County? Y_____ N_____

If YES: 13) Who did they go to for help (type of provider)? Mental health services_____ Family physician_____ Priest/Minister_____ Folk healer_____ Other (Specify)_____

If Mental Health Services: 14) Where were the mental health services located? Neighborhood center_____ Hospital/clinic_____ Catholic Social Services_____

Other (Specify) _____

If NO: 15) Did they try to get help somewhere else outside Mecklenburg County? Y_____ N_____

If NO: Skip to #18 **If YES:** 16) Where (Geographical location)? _____

17) Who did they go to for help (type of provider)? Mental health services _____
Family physician _____ Priest/Minister _____ Folk healer _____ Other (Specify) _____

18) Were they able to get the help they wanted? Y_____ N_____

If NO: 19) Why weren't they able to get the help they wanted? _____

20) Has anyone in your family had emotional or mental problems commonly found in Hispanic cultures?
Ataque de nervios Yes _____ No _____ Susto Yes _____ No _____ Angustia Yes _____ No _____
Mal de ojo Yes _____ No _____ Any other (Name) _____

If NO: Skip to #30 *(If more than one episode, use the most recent one.)*

If YES: 21) Was that person? Your Spouse _____ Your Child _____ Yourself _____
Other Family Member (Specify) _____

22) Did your family member try to get help for the emotional or mental problem from someone outside your family here in Mecklenburg County? Y_____ N_____

If YES: 23) Who did they go to for help (type of provider)? Mental health services _____
Family physician _____ Priest/Minister _____ Folk healer _____ Other (Specify) _____

If Mental Health Services: 24) Where were the mental health services located? Neighborhood center _____
Hospital/clinic _____ Catholic Social Services _____
Other (Specify) _____

If NO: 25) Did they try to get help somewhere else outside Mecklenburg County? Y_____ N_____

If NO: Skip to #28 **If YES:** 26) Where (Geographical location)? _____

27) Who did they go to for help (type of provider)? Mental health services _____
Family physician _____ Priest/Minister _____ Folk healer _____ Other (Specify) _____

28) Were they able to get the help they wanted? Y_____ N_____

If NO: 29) Why weren't they able to get the help they wanted? _____

30) Has a family member of yours lived in a country where they suffered political violence and abuse?
Yes _____ No _____

31) Has anyone in your family suffered from a natural disaster like an earthquake, hurricane, or flood?
Yes _____ No _____

32) Has anyone in your family suffered from other abuse or emotional trauma? Yes _____ No _____

If NO TO ALL THREE: Skip to #42 *(If more than one episode, use the most recent one.)*

33) **If YES TO ANY:** Does your family member have emotional or mental problems because of violence and abuse? Yes _____ No _____ or because of natural disaster? Yes _____ No _____
or because of other abuse or emotional trauma? Yes _____ No _____

34) **If YES TO ANY:** Did your family member try to get help for the emotional or mental problem from someone outside your family here in Mecklenburg County? Y _____ N _____

If YES: 35) Who did they go to for help (type of provider)? Mental health services _____
Family physician _____ Priest/Minister _____ Folk healer _____ Other (Specify) _____

If Mental Health Services: 36) Where were the mental health services located? Neighborhood center _____
Hospital/clinic _____ Catholic Social Services _____
Other (Specify) _____

If NO: 37) Did they try to get help somewhere else outside Mecklenburg County? Y _____ N _____

If NO: Skip to # 40 **If YES:** 38) Where (Geographical location)? _____

39) Who did they go to for help (type of provider)? Mental health services _____
Family physician _____ Priest/Minister _____ Folk healer _____ Other (Specify) _____

40) Were they able to get the help they wanted? Y _____ N _____

If NO: 41) Why weren't they able to get the help they wanted? _____

Just a few more questions about your family:

42) Has your family been divided (disrupted) by moving to the US? Y _____ N _____

If NO: Skip to #44

If YES: 43) Has a family member had emotional or mental problems because of the family being divided (disrupted) by moving to the US? Y _____ N _____

44) Do your children have problems because they disagree with you about how they should behave because your ideas are different from their friends' ideas here in the U.S.? Y _____ N _____

45) What is your family's country of origin? Mexico _____ Puerto Rico _____ Cuba _____
Other (Specify) _____

46) How long have you lived in the US? _____ years _____ months

47) Current family residence ZIP Code: _____

48) What is the highest grade you finished in school?

(Enter one number): Elementary (1-8) _____ Secondary (9-12) _____ College (13-16+) _____

49) What is your age group? Under 18 ____ 18-24 ____ 25-34 ____ 35-44 ____ 45-54 ____ 55+ ____

50) Do you worry about any of your family members living in the US because of documentation problems?
Yes _____ No _____

51) Is the subject? (Mark one): male _____ female _____

Thank you very much for your help. None of these answers have your name with them and your answers are private so no one will ever know what you said.

Comments (If any):

If subject answered YES to any of the mental illness questions (9, 10, 20, 30, 31, 32, 33, 43 or 44) please put the completed questionnaire aside and ask them to register separately for a follow-up meeting of community members on family health issues at this organization (see attached for information).

Appendix C: Spanish-language Questionnaire

Organización _____ **Entrevistador** _____ **Fecha** _____ [Código _____]
 Buscamos información para mejorar los servicios de salud para su comunidad. ¿Podríamos hacerle algunas preguntas sobre su familia y su salud? Este cuestionario no tiene su nombre y todo lo que Usted nos diga es confidencial. Va a tomar aproximadamente 10 minutos. ¿Prefiere hablar en español o inglés?

Primero, piense por favor en la salud física de su familia:

1) ¿Sufrió alguien en su familia de un problema serio de la salud en los últimos 5 años? Sí ___ No ___

En caso negativo: Siga con #9 (Si hay más de un incidente, use el más reciente.)

En caso afirmativo: 2) ¿Quién fue esta persona? Su esposo/a ___ Su hijo ___ Usted mismo ___ Otro miembro de su familia (¿quién?) _____

3) ¿Trató esta persona de obtener ayuda para su problema de salud de alguien fuera de su familia aquí en el condado de Mecklenburg? Sí ___ No ___

En caso afirmativo: 4) ¿A quién solicitó ayuda (tipo de proveedor)? _____

En caso negativo: 5) ¿Esta persona trató de obtener ayuda fuera del condado de Mecklenburg? Sí ___ No ___

En caso afirmativo: 6) ¿Dónde (ubicación geográfica)? _____

7) ¿Pudo obtener la ayuda que requería? Sí ___ No ___

En caso negativo: 8) ¿Por qué no pudo obtener la ayuda que requería? _____

Segundo, piense por favor en la salud emocional y mental de su familia:

9) En caso de que alguien de su familia empezó a actuar muy triste (depresivo), muy extraño (antisocial), grotesco (alucinaciones) o destructivo a su mismo (suicida), ¿que piensa UD. causó el problema?

(Escoge uno): Enfermedad mental ___ El diablo ___ Espíritus malignos ___ Causas Naturales ___ Otro (que?) _____

10) ¿Sufrió un miembro de su familia de algún problema emocional o mental durante los últimos 5 años? Sí ___ No ___

En caso negativo: Siga con #20 (Si hay más de un incidente, use el más reciente).

En caso afirmativo: 11) ¿Quién fue esta persona? Su esposo/a ___ Su hijo ___ Usted mismo ___ Otro miembro de su familia (¿quién?) _____

12) ¿Trató la persona de obtener ayuda para su problema emocional o mental de alguien fuera de su familia aquí en el condado de Mecklenburg? Sí ___ No ___

En caso afirmativo: 13) ¿A quién solicitó ayuda (tipo de proveedor)? Servicios de salud mental ___ Médico de la familia ___ Sacerdote/Pastor ___ Curandero ___ Otro (¿cuál?) _____

Si solicitó servicios de salud mental: 14) ¿Dónde están localizados? Centro Vecindario ___ Hospital/Clinica ___ Servicio Sociales de la Iglesia Católica ___ Otro (¿cuál?) _____

En caso negativo: 15) ¿Trató de obtener ayuda de alguien fuera del condado de Mecklenburg? Sí ___ No ___

En caso negativo: Siga con #18 **En caso afirmativo: 16) ¿Dónde (ubicación geográfica)?**

↓
17) ¿A quién solicitó ayuda (tipo de proveedor)? Servicios de salud mental _____
Médico de la familia _____ Sacerdote/Pastor _____ Curandero _____ Otro (¿cuál?) _____

↓
18) ¿Pudo obtener la ayuda que requería? Sí _____ No _____

En caso negativo: 19) ¿Por qué no pudo obtener la ayuda que requería?

20) ¿Sufrió alguien en su familia de problemas emocionales o mentales que se encuentra con frecuencia en personas de origen hispanico? ¿Ataque de nervios? Sí _____ No _____ ¿Susto? Sí _____ No _____ ¿Mal de ojo? Sí _____ No _____ ¿Otros (nombre)? _____

En caso negativo: Siga con #30 *(Si hay más de un incidente, use el más reciente).*

↓
En caso afirmativo: 21) ¿Quién fue la persona? Su esposo/a _____ Su hijo _____ Usted mismo _____ Otro miembro de su familia (¿quién?) _____

22) ¿Trató este miembro de su familia de obtener ayuda para su problema emocional o mental de alguien fuera de su familia aquí en el condado de Mecklenburg? Sí _____ No _____

En caso afirmativo: 23) ¿A quién solicitó ayuda (tipo de proveedor)? Servicios de salud mental _____ Médico de la familia _____ Sacerdote/Pastor _____ Curandero _____ Otro (¿cuál?) _____

Si solicitó servicios de salud mental: 24) ¿Dónde están localizados? Centro Vecindario _____ Hospital/Clínica _____ Servicios Sociales de la Iglesia Católica _____ Otro (¿cuál?) _____

En caso negativo: 25) ¿Se obtuvo ayuda de alguien fuera del condado de Mecklenburg? Sí _____ No _____

En caso negativo: Siga con #28 **En caso afirmativo: 26) ¿Dónde (ubicación geográfica)?**

↓
27) ¿A quien solicitó ayuda (tipo de proveedor)? Servicios de salud mental _____ Médico de la familia _____ Sacerdote/Pastor _____ Curandero _____ Otro (¿cuál?) _____

↓
28) ¿Pudo obtener la ayuda que requería? Sí _____ No _____

En caso negativo: 29) ¿Por qué no pudo obtener la ayuda que requería?

30) ¿Vivió alguien de su familia en un país donde sufrió de violencia política y abuso? Si _____ No _____

31) ¿Sufrió alguien de su familia de una catástrofe natural como, por ejemplo, un terremoto, un huracán o una inundación? Sí _____ No _____

Si NO en ambos casos: Siga con #41 *(Si hay más de un incidente, use el más reciente)*

↓
32) **En caso que SI en uno de los casos:** ¿Esta miembro de la familia sufre de problemas emocionales o mentales a causa de violencia y abuso? Sí _____ No _____ o a causa de una catástrofe natural? Sí _____ No _____

33) **En caso que SI en uno de los casos:** ¿Trató este miembro de la familia de obtener ayuda para su problema emocional o mental fuera de su familia aquí en el condado de Mecklenburg? Sí _____ No _____

En caso afirmativo: 34) ¿A quién solicitó ayuda (tipo de proveedor) Servicios de salud mental _____ Médico de la familia _____ Sacerdote/Pastor _____ Curandero _____ Otro (¿cuál?) _____

Si solicitó servicios de salud mental: 35) ¿Dónde están localizados? Centro vecindario _____ Hospital/Clínica _____ Servicios Sociales de la Iglesia Católica _____ Otro (cuál?) _____

En caso negativo: 36) ¿Trató de obtener ayuda de alguien fuera del condado de Mecklenburg? Sí _____ No _____

En caso negativo: Siga con # 39 **En caso afirmativo:** 37) ¿Dónde (ubicación geográfica)? _____

38) ¿A quién solicitó ayuda (tipo de proveedor)? Servicios de salud mental _____ Médico de la familia _____ Sacerdote/Pastor _____ Curandero _____ Otro (¿cuál?) _____

39) ¿Pudo obtener la ayuda que requería? Sí _____ No _____

En caso negativo: 40) ¿Por qué no pudo obtener la ayuda que requería? _____

Solamente unas pocas preguntas más sobre su familia:

41) ¿Estuvo su familia separada por su traslado a los EEUU? Sí _____ No _____

En caso negativo: Siga con #43

En caso afirmativo: 42) ¿Sufrió alguien en su familia de problemas emocionales o mentales a causa de la separación de la familia por el traslado a los EEUU? Sí _____ No _____

43) ¿Tiene usted problemas con sus hijos porque disienten en como deberían comportarse porque usted tiene ideas diferentes que sus amigos aquí en los EEUU? Sí _____ No _____

44) ¿Cuál es su país de origen? México _____ Puerto Rico _____ Cuba _____ Otro (cuál?) _____

45) ¿Cuanto tiempo reside usted en los EEUU?? _____ años _____ meses

46) ¿Código postal de su residencia presente: _____

47) ¿Cuál es el nivel mas alto de la educación que completó?

(Entre un número): Escuela de enseñanza primaria (1-8) _____ Instituto de enseñanza secundaria (9-12) _____ Universidad (13-16+) _____

48) ¿Cuál es su grupo de edad? 18-24 _____ 25-34 _____ 35-44 _____ 45-54 _____ 55+ _____

49) ¿Esta usted preocupado por alguien en su familia que vive en los EEUU debido a problemas documentarios de emigración? Sí _____ No _____

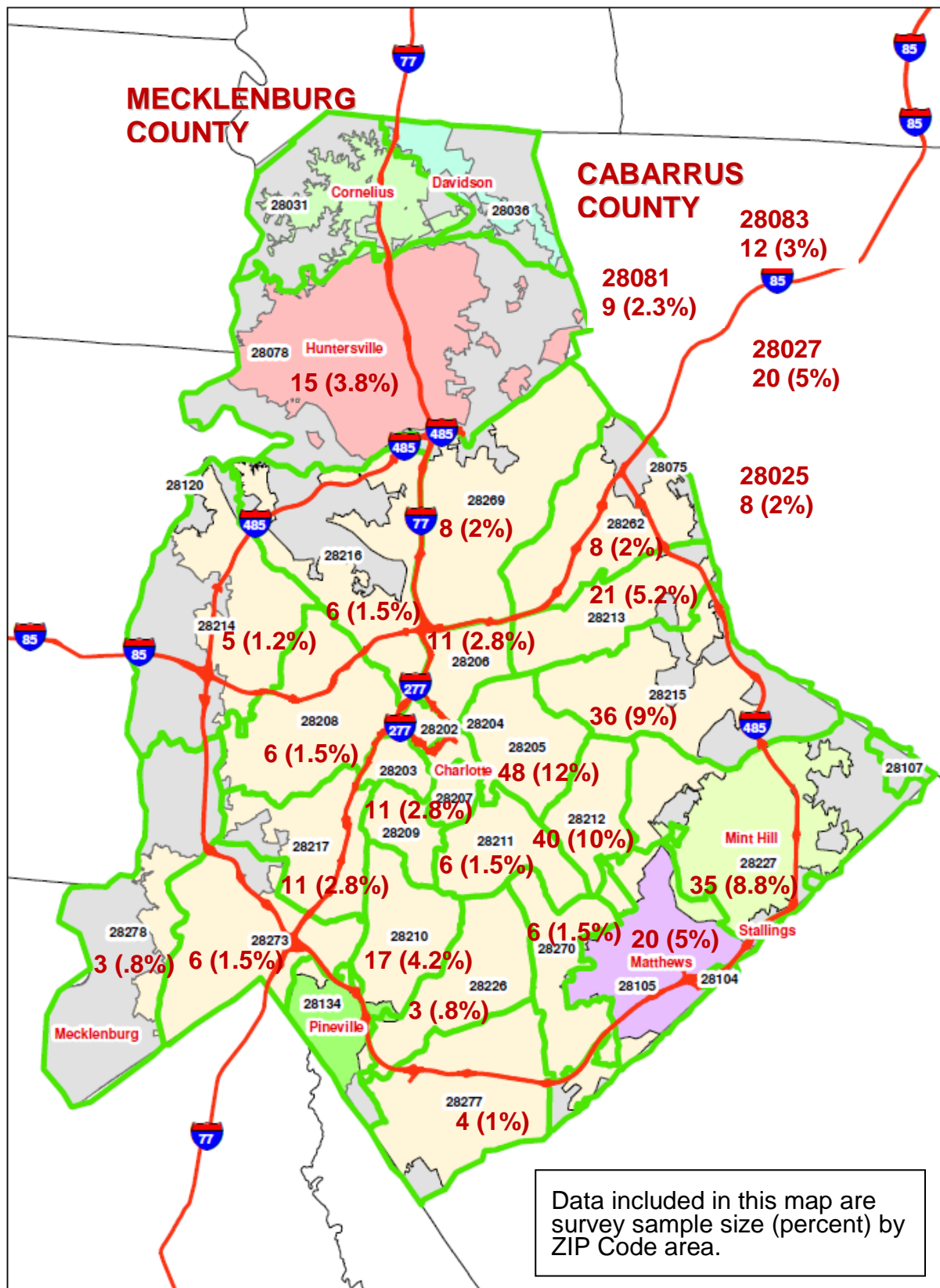
50) Esta persona es (marque uno): varón _____ hembra _____

Muchas gracias por su ayuda. Ninguna de sus respuestas tiene su nombre, y todas sus respuestas son confidenciales así que nadie puede enterarse de lo que usted dijo.

Comentarios (Si hay):

Si la persona entrevistada respondió afirmativamente a una de las preguntas relacionadas con la salud mental (9, 10, 20, 32, 42 o 43), recomiende a esta persona que se inscriba para una sesión de seguimiento con miembros de la comunidad sobre aspectos de salud mental de la familia en la oficina de esta organización (Ver la información adjunta).

Appendix D: Survey Sample Geographic Distribution by ZIP Code Areas



Curriculum Vita

Frederick O. Rasmussen

Education:

- 2011 Ph.D. Sociology, Rutgers University, New Brunswick, NJ
- 1991 M.A. Sociology, High Pass, Rutgers University, New Brunswick, NJ
- 1989 B.A. Sociology, with Department Honors, University of California, San Diego, San Diego, CA

Professional Experience:

- 1999 – Present Instructor, Department of Sociology, Queens University of Charlotte, Charlotte, NC
- 2000 – 2006 Research Consultant, Mental Health Association of the Central Carolinas, Charlotte, NC
- 1999 – 2003 Evaluation Research Manager, Mecklenburg Partnership for Children, Charlotte, NC
- 1996 – 1999 Director of Evaluation Research, Human Services Programs, Urban Institute, University of North Carolina, Charlotte, NC
- 1994 – 2003 Instructor, Department of Sociology, Anthropology, and Social Work, University of North Carolina, Charlotte, NC
- 1993 – 1994 Research Fellow, Institute for Health, Health Care Policy, and Aging Research, Rutgers University, New Brunswick, NJ
- 1991 – 1994 Research Assistant, Perth Amboy Community Partnership for Youth, Center of Alcohol Studies, Rutgers University, Piscataway, NJ
- 1991 – 1994 Instructor, Department of Sociology, Rider University, Lawrenceville, NJ
- 1991 – 1993 Research Assistant, Working Group on Adolescent Mental Illness; Institute for Health, Health Care Policy, and Aging Research; Rutgers University, New Brunswick, NJ
- 1990 – 1991 Research Assistant, Department of Consumer Health Education, Robert Wood Johnson Medical School-UMDNJ, Piscataway, NJ
- 1989 – 1994 Instructor, Department of Sociology, Rutgers University, New Brunswick, NJ
- 1989 – 1990 Research Associate, FIPSE Student Life Research Project, Center of Alcohol Studies, Rutgers University, Piscataway, NJ

Publications:

- Rasmussen, Fred O. (1997). "Preventing Adolescent Problem Behavior with Deviance Theory," In Dan Rea & Robert Warkentin, *Investing In our Youth: Pooling Community Resources*. New York: McGraw-Hill.
- Rasmussen, Fred O. (1995). "Evidence of Multiple Problems of Youth," in Paul Lerman and Kathleen J. Pottick. *The Parents' Perspective: Delinquency, Aggression and Mental Health*. New Brunswick, NJ: Rutgers University Press.