CULTURE AND MENTAL HEALTH HELP-SEEKING ATTITUDES IN MEXICO

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This study was designed to investigate 1) the cultural factors involved with Mexican citizens' attitudes toward seeking professional psychological help and 2) Mexican citizens' explanatory models of mental distress. Questionnaire data from 110 Mexican college students indicate that those who report a higher tolerance for stigma report lower endorsement of both the construct of personalismo and the machismo. Respondents who reported more interpersonal openness also reported a lower endorsement of the machismo construct. Participants from a large city reported significantly more stigma tolerance than those from a small city. Regression analyses reveal machismo as a significant predictor of stigma tolerance. Qualitative data was collected to provide additional in-depth information. Study results could be used to provide culturally appropriate mental health services.

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CHAPTER 1

INTRODUCTION

While the study of culture in clinical psychology and psychiatry has been relatively longstanding, not until recently has the importance of culture in the study and treatment of psychopathology been appreciated. Interestingly, while historical review of the history of psychology in North America reveals that cultural issues were integral in the thinking of the discipline's founders, over the past three decades, North American psychology has given culture minimal treatment in research and theory development (Kazarian & Evans, 1998). Clinical psychology in particular in North America has not embraced the study of culture in psychological research and the development of theory; this has led clinical psychology to become socially irresponsible with regard to the service needs of a diverse, multicultural population (Kazarian & Evans, 1998).

The major aim of the present study, therefore, is to contribute to the psychological literature in a way that will help make clinical psychology and other mental health professions be more socially responsible and inclusive of individuals from diverse backgrounds. More specifically, the proposed study is designed to discover how Mexican culture creates a Mexican construction of reality, and how this reality, as it pertains to health and illness beliefs, compares to the reality established by the dominant, Eurocentric mental health care system in the United States.

Mental health help-seeking will then be examined as a result of beliefs about mental health and illness. International data from Mexico will give a broad view of the scope of Mexican culture as it exists today. The sections that follow present information on culture, psychopathology, mental health care disparities, and mental health help-seeking in order to have

an overview of the current scope of the help-seeking disparity problem. In addition, information on the history, social status, and economic condition of Mexicans and Mexican Americans is presented in order to present this population within their broader socioeconomic, political, and historical context.

Culture and Mental Health Research

Thankfully, an increasing amount of research in recent years is being done within the realm of clinical psychology that considers culture and ethnicity as significant factors in assessment, diagnosis, and treatment of mental disorders. Notable in this recognition of the importance of culture in clinical psychology is the American Psychological Association's publication of multicultural guidelines for education, research, and practice (American Psychological Association, 2003). The goals of these guidelines include providing psychologists with 1) the rationale for studying multiculturalism, 2) information, terminology, and data to support the relevance and necessity of the guidelines, 3) references for continued education, research, and informed practice, and 4) paradigms that broaden the scope of psychology (American Psychological Association, 2003). Publications such as these and studies in clinical psychology that address culture and ethnicity have helped to provide more culturally competent mental health services to individuals who have traditionally been marginalized in the mental health system. In addition, cultural studies in clinical psychology aid in the task of better understanding any particular disorder's etiology, giving the study of psychopathology a more holistic and inclusive perspective.

Despite these improvements in mental health research and practice, the Surgeon General's report (U.S. Department of Health and Human Services, 1999), states the United States mental health system is "not well equipped to meet the needs of racial and ethnic minority

populations." Furthermore, many barriers exist that discourage ethnic and racial minority group members from seeking treatment, and if ethnic and racial minority group members succeed in accessing services, their treatment may be inappropriate for their specific needs (U.S. Department of Health and Human Services, 1999). Research demonstrates that many members of minority groups do not feel comfortable with the mental health system (U.S. Department of Health and Human Services, 1999). These groups often experience the mental health system as "the product of white, European culture, shaped by research primarily on white, European populations" (U.S. Department of Health and Human Services, 1999). Furthermore, "they may find only clinicians who represent a white middle-class orientation, with its cultural values and beliefs, as well as its biases, misconceptions, and stereotypes of other cultures" (U.S. Department of Health and Human Services, 1999).

Clearly, this information illustrates the desperate need for more research in clinical psychology, as well as other mental health professions, to have a multicultural and holistic focus. Furthermore, as the United States population becomes increasingly diverse, the need for multicultural research and practice will continue to intensify, as an increasing number of potential new clients will be from different, non-majority cultural and linguistic backgrounds. In addition, the likelihood that a clinician and client will be from different ethnic and cultural backgrounds will also increase.

According to the 2002 United States Census Bureau (Ramirez & de la Cruz, 2002), there were 37.4 million Hispanics/Latinos in the civilian, noninstitutional population of the United States, accounting for 13.3% of the total United States population. Among the Hispanic/Latino population, two-thirds, or 66.9%, were of Mexican origin. Clearly, the overwhelming increase in the Hispanic/Latino population, coupled with the fact that the majority of Hispanics/Latinos

residing within the United States are of Mexican descent, gives substantial practical support for the increasing importance of psychological studies that examine the potential impact of historically and traditionally Mexican cultural factors on mental health and help-seeking. Cross-cultural and international research of this nature will help practitioners and researchers alike in providing better, more informed, and more culturally sensitive mental health services. In addition, multicultural mental health research is beneficial in providing a way of gaining a better understanding of Mexican culture, including experiences with mental health and psychopathology. Furthermore, multicultural psychological research affords the opportunity to gain a deeper, more inclusive understanding of the psychological constructs used in the mental health and helping professions that have too often been tested only with homogenous European populations.

Culture and Psychopathology

While culture plays an important role in an individual's potential to seek psychological services in the United States mental health care system and their likelihood of receiving appropriate and culturally sensitive mental health services, considering culture is also essential to understanding psychopathology. In the past, a biomedical model that does not account for culture has influenced the study and treatment of mental disorders. In this literature, when culture is taken into account, culture is often viewed as an independent variable that influences psychopathology, viewed as the dependent variable (Sam & Moreira, 2002). Sam and Moreira contend that, on the contrary, the concept of mental illness cannot exist without considering culture, meaning that the two concepts are "mutually embedded in each other" (Sam & Moreira, 2002, p. 1) and that culture "does not just influence mental health and illness, but rather it is a constituent of them" (Sam & Moreira, 2002, p. 3).

Using depression as an example, Marsella (1980) concluded that the psychological construct of depression does not have a worldwide form and differs in presentation, such as in reported symptoms, when comparing the Western and non-Western worlds. Marsella adds that, in many cases, "it is only when individuals in non-Western societies become more Westernized that we find similarities in the patterns of depression found in the Western world" (p. 261). According to Marsella, that fact that important aspects of a Western conceptualization of depression (e.g., guilt) are absent in the non-Western world demonstrates that the "epistemic framework of a culture must be considered in evaluating psychiatric disorders" (p. 261). These important findings and conclusions give strong evidence for the idea that the expressions of mental disorders are heavily influenced by the culture in which they exist.

Explanatory Models of Illness and Disease

Kleinman, Eisenberg, and Good (1978) provide a distinction between the concepts of *disease* and *illness*. These authors define a disease as an abnormality occurring in the structure and function of the body's organs and systems. Clearly, this concept of disease is rooted in the biological and physiological domain. Illnesses, however, define the human lived *experience* of sickness, which includes unwelcome changes in a patient's state of being or function in society. Patients, therefore, suffer from illnesses, while modern biomedically-oriented physicians and other health care providers diagnose and treat diseases. Compared to the concept of disease, one can see that the experience of illness is culturally constructed and culturally patterned. Illnesses are "shaped by cultural factors governing perception, labeling, explanation, and valuation of the discomforting experience" (Kleinman et al., 1978, p. 252), and these processes are naturally embedded within one's family, as well as their social and cultural realities. In this way, illnesses are culturally constructed ways of perceiving, experiencing, and coping with sickness.

Furthermore, when confronted with sickness, our culturally constructed rules about health and sickness teach us "approved ways of being ill" (Kleinman at al., 1978, p. 252) that create ways of knowing how to be sick in a particular family, social class, society, and culture. These ways of knowing are different between individuals, families, levels of social class, societies, and cultures. Additionally, since the concept of ethnic identity is intertwined with an individual's culture of origin or culture of identification, an individual's ethnicity will affect their cultural construction of illness. Indeed, different ethnic groups have different ways of knowing about how to be ill and what it means to be ill within their community.

As Adler, Boyce, Chesney, Folkman, and Syme (1997) demonstrate, the intersectionality of race/ethnicity, class, and health results in the creation of new identities when constructs are considered together. These new identities present new ways in which people culturally construct the illness experience in their lives, based on factors like access to resources, beliefs about the nature and severity of symptoms, and culturally appropriate ways of dealing with deviations from normal, healthy functioning.

Intimately tied to the above discussion and to the idea of the important distinction between illness and disease is the concept of the explanatory model. Explanatory models can first be understood as being the result of the way that humans "put their brains to work" to understand and make sense of their worlds. This process of developing ways of knowing or understanding is different for individuals within and between cultures. Helman (1994) mentions Kleinman's definition of an explanatory model within the context of his work on doctor-patient interactions. Explanatory models are "the notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process" (Kleinman, 1980, p. 105). A key part of this definition is the idea that everyone involved in the clinical encounter and clinical

process has an explanatory model. Therefore, both physicians and patients have ways of understanding and making sense of the experience of sickness that they bring to the clinical encounter and the doctor-patient interaction.

Kleinman et al. (1978) remind us that "it is crucial to recognize that patient-doctor interactions are transactions between explanatory models" (p. 254), and these interactions ultimately represent a negotiation of clinical and medical realities that are culturally constructed and, therefore, differ within and between cultures. Explanatory models are also shaped by the current discourse, or the conversation that the society and culture are having about a certain topic, or in the case of health, a certain disease. This discourse is expressed through influential avenues in a society, such as the media, government, and scientific research community.

An explanatory model also includes a person's beliefs (and behaviors) in five important domains of an episode of sickness: 1) etiology, 2) symptom onset, 3) pathophysiology, 4) course of illness, and 5) treatment (Kleinman et al., 1978). As can be seen from this extensive definition and description of an explanatory model, there are many opportunities for discrepancies between the explanatory models of physicians (or other health care professionals) and patients during the course of their interactions and time together. Kleinman et al. (1978) note growing problems in health care delivery and accessibility that are no longer appropriately studied by traditional biomedical frameworks of research. These authors call for the elicitation of patient explanatory models as a critical step to improving health care. In this way, the physician or other health care provider can gain knowledge about "the beliefs the patient holds about his illness, the personal and social meaning he attaches to his disorder, his expectations about what will happen to him and what the doctor will do, and his own therapeutic goals" (p. 256). By eliciting patient explanatory models, major discrepancies between the explanatory models of the provider and

patient can be identified. After being identified, negotiations between the two explanatory models (doctor and patient) can begin, and this negotiation is hypothesized to improve patient trust of health care providers and communication between provider and patient. In addition, the identification of patient and provider explanatory models affords the opportunity for each to educate each other on each individual's way of making sense of the experience of illness.

In an attempt to understand the nature of the explanatory model that Mexican immigrants have about latent tuberculosis infection (LBTI), McEwen (2005) conducted an interesting critical ethnographic study of Mexican immigrants diagnosed with LBTI and their spouses living along the U.S/Mexico border region. Results for the Mexican immigrants who participated in this study indicated that their "understanding of LTBI was constructed in the context of multiple and conflicting explanations from the popular and professional health sectors that are historically unique and foundational to the border region" (McEwen, 2005, p. 353). McEwen's results attest both to the localized nature of explanatory models of illness and disease, as well as the necessity for eliciting patient explanatory models when attempting to deliver the highest quality of health care in a particular region.

In a recent study, Sheikh and Furnham (2000) investigated the relationship between cultural beliefs, the potential causes of mental distress, and attitudes toward seeking professional help for psychological problems. These researchers did not find a statistically significant relationship when culture, treated as a variable, was examined along with participants' positive attitudes toward seeking professional psychological help. When examining the relationship between culture and the four causative categories of mental distress proposed by Eisenbruch (1990), however, culture was found to be a statistically significant predictor of all four causative

categories of mental distress: stress, Western physiological, supernatural, and non-Western physiological causes.

Using a multiple regression technique, Sheikh and Furnham (2000) also examined the relationship between positive attitudes toward seeking professional psychological help and the four potential causes of mental distress discussed above. Results from this analysis revealed causal attributions of mental distress acted as significant predictors of a positive attitude toward seeking professional psychological help for the two Asian samples (British Asian and Pakistani) but not for the Western (white European) sample. This interesting finding supports the notion that it is important to understand and assess a person's explanatory model for mental distress and psychological disorder prior to starting treatment, particularly if the individual is from the non-dominant culture in society. As Sheikh and Furnham's work suggests, these findings have important implications for the delivery of more culturally appropriate mental health services.

Mexican Culture and Mental Health Factors

History, Social Status, and Economics

To fully understand the experience of many Mexicans in the United States today, it is important to consider their history in the United States, along with the history of the relationship between the United States and Mexico. There is a longstanding history of war and conflict between the United States and Mexico, and many contend these conflicts and wars are unjust (Martinez, 1993). According to Montejano (as cited in Martinez), this history of conflict between the dominant European American culture of the United States and Mexico has taken many modern forms, including discrimination, immigration restrictions, school segregation, and electoral disenfranchisement. Particularly in the southwest region of the United States, where

there is a high concentration of individuals of Mexican descent, Mexican Americans have faced the most struggles (Martinez, 1993).

Therefore, while individuals of Mexican descent and European Americans (often termed "Anglos" in the United States Southwest) have lived in close proximity for several generations, a palpable amount of distrust can still be found in the relations between these two groups due to many years of conflict (Martinez, 1993). It is not unrealistic to imagine that this existing distrust might be expressed in a mental health care setting. In the southwest region of the United States, Mexican Americans are the largest ethnic and cultural minority group, since there are fewer other ethnic minority groups in substantial numbers; therefore, in the southwest region, racism, discrimination, and other unfair practices have largely been targeted towards people of Mexican origin. Thus, according to Martinez, some individuals of Mexican descent living in the United States feel a "complex ambivalence" toward Anglos because of a longstanding history of war, conflict, racism, and discrimination between the people of Mexico and the United States. Mexicans who have arrived in the United States more recently may not have been raised with this historically derived attitude, yet their experience of growing up in Mexico may be highly influential in their overall attitude towards the United States.

The history of Mexico has undoubtedly influenced Mexican and Mexican American identity, and it has also shaped how those of Mexican descent experience life in the United States. According to Martinez (1993), it is essential to understand the social and cultural conditions in Mexico when trying to understand individuals of Mexican descent residing within the United States. During the time of the Mexican conquest by Cortés and the Spaniards in the 16th century, Mexico had a substantially developed and widespread indigenous population that had its own complex culture. While the Aztec empire was dominant at the time of Spanish

exploration and conquest, Mexico had a history of many other civilizations that had thrived in the past, including the Olmecs, Mayas, and Toltecs. These indigenous populations, taken together, were highly influential in shaping the indigenous population and culture that the Spaniards encountered when exploring Mexico.

The Spaniards, in turn, brought with them their own cultural influences, beliefs, and traditions, including Catholicism. It is important to note that, while the Spaniards were generally successful in their mission to subjugate and convert the indigenous people of Mexico, unlike what happened to the native people living in the United States before European exploration and conquest, the indigenous presence in Mexico was not removed. Instead, the culture, beliefs, and traditions of the indigenous people of Mexico was absorbed and incorporated with the culture of the Spanish settlers (Martinez, 1993). Importantly, this blending of peoples gives Mexicans and Mexican Americans a unique and blended culture that must be taken into account when investigating mental health beliefs and attitudes toward professional psychological help-seeking in this population.

During the colonial period of Spanish influence in Mexico, Spanish settlements, exploration, exploitation, expansion, and intermarriage between Spanish and indigenous people flourished. Spanish colonists came into contact with not only the indigenous people of Mexico, but also with the Native American tribes and with the Anglos recently arrived in the United States from Europe. In the late 18th century, many generations of Mexican born Spaniards began to seek a Mexican identity and subsequently, desired independence from Spain. The independence movement lasted for many years and included the campaign against Texas, war with the United States, occupation by French foreign troops, and an externally imposed emperor.

After the Mexican revolution, the present government system evolved in the 1930s (Martinez, 1993).

Mexico began the 20th century with a largely rural population dominated by the peonage system. The country had some wealthy, European-style cities, and was governed by an authoritarian government supported by a powerful Catholic hierarchy. The Mexican revolution at the beginning of the 20th century disrupted this authoritarian and highly Catholic-influenced system, with major consequences for the United States. These consequences included an almost continuous migration of the Mexican poor, displaced, or frightened who sought to escape economic instability and future wars. As a result of Mexico's turbulent past, the system that evolved in Mexico has not been successful in distributing available land fairly and effectively and has not produced fair economic development. This has resulted in substantial inequality in wealth and opportunity in Mexico that has persisted to modern times, influencing further migration from Mexico to the United States (Martinez, 1993).

The majority of Mexican immigrants to the United States have been from the poorer Mexican states, the northern states, and the rural regions of Mexico. Many come to the United States to seek a better life or for adventure, and are characterized by a work ethic, are law-abiding, and in general, do not depend on government programs. Many return to Mexico for various reasons, such as to be with their families. Since the United States-Mexico border is relatively porous, there is a large amount of movement back and forth across the border; this creates problems with separation and hardship, in addition to being a major way that Mexican and Latin culture infuses the culture of the United States, and vice versa (Martinez, 1993).

Culture and Acculturation

In his retrospective look at the last 25 years of the study of Hispanic psychology, Padilla (2002) states that, more important than specific national origin or preferred ethnic label, what is important when studying those from a Hispanic background are the cultural values and traditions shared by the Hispanic population, and how these shared cultural values and traditions influence behavior. Some of the important shared cultural values and traditions within the Hispanic population include: use of the Spanish language, Catholicism, a strong sense of familism, and traditional male and female roles (Padilla, 2002).

Rogler, Cortes, and Malgady (1991) discuss the linkage between acculturation and mental health status among Hispanics. These authors describe how acculturation is customarily thought of as being an exogenous force that shapes each individual's psychological functioning and distress. In this view, changes in a person's state of acculturation also involve changes in an individual's relationship to his or her environment, which imposes in new and different ways upon an individual's psychological well-being (Rogler et al., 1991). Examples of acculturation's impact on mental health and psychological functioning include the following: a) when acculturation relates negatively and linearly with psychological distress, such as when an immigrant low in acculturation experiences the strains of persistent isolation, unfamiliar and unpredictable environment, and low self-esteem, b) when acculturation relates positively and linearly, such as when an individual becomes more acculturated to U.S. culture, becomes isolated from their traditional support group, and starts to internalize the stereotypes and prejudicial attitudes toward Hispanics, and c) when a curvilinear relationship exists, in which good mental health is the result of an optimal combination of cultures, resulting in a truly bicultural individual (Rogler et al., 1991).

Clearly, this evidence suggests that acculturation is a vital cultural factor that must be considered when assessing mental health status in Hispanic populations. Furthermore, since Mexicans and Mexican Americans do not seek mental health care services with the same frequency as their Anglo or European American counterparts, the number of Mexican immigrants is increasing, and level of acculturation undoubtedly influences an individual's conceptualization of the dominant mental health care system, acculturation and its consequences become factors that should be examined in order to explain help-seeking behavior for individuals of Mexican descent.

Mental Health Care Disparities

It is widely understood in the United States that, historically, quality mental health care has depended on a common language and shared beliefs (Dana, 1998). Such a common language and associated shared beliefs could work together to contribute to a mutual understanding process between mental health service providers and their clients (Dana, 1998). Importantly, Dana (1998) summarizes the consequences of a common language and mutual understandings in mental health care delivery when he states that the shared beliefs currently used in our society originate from a "Eurocentric construction of reality" (Dana, 1998, p. 15). This reality in the current mental health care system includes acceptable practices for professional service delivery, the use of standard tests and assessments, frames of reference for the conceptualization and understanding of an individual's personality and psychopathology, as well as a recognized set of interventions and skills for implementing interventions (Dana, 1998). In sum, according to Dana (1998, p. 15), "quality mental health care in the United States has been primarily for Anglo Americans." Individuals of Mexican descent, particularly and especially important for those living in the United States, may not share the common language and beliefs with the dominant,

Eurocentric conceptualization of mental health and mental disorder. Because of this possibility, research on Mexicans' and Mexican Americans' conceptualization of reality surrounding mental health becomes essential for quality mental health care research and practice.

Vega, Kolody, Aguilar-Gaxiola, and Catalano (1999) conducted face-to-face diagnostic interviews with Mexican Americans in order to determine the degree to which Mexican Americans in California underutilized services for mental health problems. Their results indicate that Mexican immigrants are unlikely to access and use mental health services; however, they may utilize general practitioners for their mental health care needs. As the authors of this study note, these results raise questions about the appropriateness, accessibility, and cost-effectiveness of the mental health care system in the United States (Vega et al., 1999).

Mental Health Help-Seeking

According to Leong and Zachar (1999), help-seeking research has a longstanding history in the mental health care professions. In a recent study, Leong and Zachar found that women had more positive attitudes towards seeking psychological help than men. More importantly, however, participants' more positive opinions about mental illness accounted for a significant percentage of positive attitudes towards mental health help-seeking beyond the percentage that was accounted for by gender alone. Since individuals' opinions about mental illness can be shaped largely by their culture and are shown to account for a large part of their attitudes towards seeking psychological help, it is important that researchers and clinicians understand how current and potential clients conceptualize mental disorders in relation to their culture.

In her recent study, Alvidrez (1999) demonstrated strong ethnic differences in the proportion of low-income women making a visit to a mental health care provider in their lifetime, with European American women much more likely to have sought mental health care

services in the past than were African American or Latina women. Importantly, these strong ethnic difference among European American, African American, and Latina women remained despite the women being from similar socioeconomic backgrounds and having similar rates of current mood and anxiety disorders. Alvidrez found that having a self-reported substance abuse problem, having a friend or family member who has made a visit to a mental health professional, and the general belief that mental disorders are caused by an imbalance or lack of moderation in life were all positive predictors of seeking mental health care services. Interestingly, endorsement of religious or supernatural causes of mental disorder was associated with lower rates of use of mental health care services (Alvidrez, 1999).

In a review of the literature on help-seeking attitudes among Hispanic Americans, Leong, Wagner, and Tata (1995) state that, overall, cultural barriers, financial constraints, and institutional barriers are most responsible for the documented underutilization of Western-oriented mental health care among Hispanic Americans. According to Leong, et al. (1995, p. 425), cultural barriers to mental health care suggest that "aspects of Hispanic American culture may conflict with the tenets of Westernized mental health and consequently may serve to limit the utilization of Western mental health services by Hispanics." Specific aspects of Hispanic culture that could act as potential barriers or facilitators for help-seeking, depending on their absence or presence, include: Spanish language proficiency, having mental health professionals who are knowledgeable about the values and beliefs of Hispanic Americans (particularly as they relate to predisposing Hispanic Americans to perceive emotional problems in a way that discourages them from seeking professional mental health services), acculturation, and the availability of resources other than the professional mental health system (e.g., friends, family, clergy, folk healers, and general medical providers) (Leong et al., 1995). Traditional values that

have been linked to help-seeking behavior for Hispanic Americans include trust (*confianza*), trust in the person rather than the institution (*personalismo*), respect of elders (*respeto*), sense of shame (*verguenza*), pride (*orgullo*), familism, fatalism, and a present orientation (Rogler, Malgady, and Rodriguez, 1989).

In addition, these potential cultural barriers can be particularly problematic for Hispanic American males, who might feel their pride in their manliness (*machismo)* is in jeopardy when seeking assistance from a mental health professional (Rogler et al., 1989). These findings suggest gender might play an important role in help-seeking for individuals of Mexican descent. Overall, Leong et al. (1995) suggest that when Hispanic American clients interact with mental health professionals and staff who do not have a cultural understanding of traditional Hispanic values and beliefs, distrust and misunderstanding of mental health services by Hispanic American individuals will likely result, which will ultimately lead to underutilization of services.

Vega, Kolody, and Aguilar-Gaxiola (2001) studied immigrant Mexicans and U.S. born Mexican Americans in their review of data from the Mexican American Prevalence and Services Study (MAPSS), a household survey of individuals living in Fresno County, California. This study, which looked at 507 individuals diagnosed as having one or more *DSM-III-R* disorders, found that immigrant and U.S. born individuals of Mexican descent disproportionately utilized the general medical sector for the treatment of psychological problems. Furthermore, immigrants were much less likely than U.S. born Mexican Americans to use mental health service providers, such as psychiatrists, psychologists, and social workers (Vega et al., 2001).

Overall, Vega et al. (2001) demonstrate that immigrants are marginalized in terms of the mental health care system in the United States, and if and when they seek mental health care, they have the tendency to seek care from medical professionals. These results also suggest that

eligibility for public insurance coverage is necessary, though not sufficient, in potentially increasing mental health care service utilization among immigrants, and that psychoeducation and effective referrals from other professionals would prove useful in increasing the number of Mexicans and Mexican Americans who use specialized mental health care services (Vega et al., 2001). Although this was the largest study of its type ever conducted, Vega et al. (2001, p. 139) note that with the "inclusion of other explanatory factors, other results could obtain." Therefore, these researchers failed to take cultural constructs and potential cultural barriers into account in their analysis of help-seeking among Mexicans and Mexican Americans.

Recently, Dittmann's (2005) article summarized the work of Dr. Andrés Consoli as he attempted to discover what attracts low-income Mexican and Mexican American individuals into treatment for depression by interviewing those who are already seeking help for the disorder. Preliminary findings from his work suggest that the decision for Mexicans and Mexican Americans to seek help for psychological problems is influenced by the mental health professional's evaluation of the impacts of depression on the client's social network. Furthermore, overcoming stigma and language barriers were found to be important (Dittmann, 2005).

With regard to stigma, Consoli is finding that many current clients had past failed attempts to receive mental health services because these individuals "viewed psychological services as being for 'crazy' people and feared they would be perceived as crazy" (Dittmann, 2005, p. 71). With this information, Consoli suggested that psychologists can increase access to mental health care for individuals of Mexican descent with psychoeducation regarding the nature of community mental health services, increasing the number of bilingual psychologists, as well as emphasizing the positive aspects of seeking treatment for psychological problems (Dittmann,

2005). This new data demonstrates the continued importance of the interplay of culture and the decision to seek mental health services in the Mexican and Mexican American community, particularly when two heavily culturally influenced constructs, language and stigma, are involved.

Purpose of the Study

The primary purpose of this study was to 1) better understand the help-seeking attitudes and beliefs that individuals in Mexico have about mental disorders and psychopathology, and 2) investigate how Mexicans' help-seeking attitudes and mental health beliefs work together as potential influences on the act, or lack thereof, of mental health help-seeking. While exploring help-seeking variables, this study additionally investigated the explanatory models that Mexican citizens have about mental health and psychological distress. These explanatory models are evidence of how the Mexican respondents in this study made sense of mental health concerns and psychological distress. Ultimately, respondents' explanatory models reveal how they culturally construct their beliefs about mental health, psychological processes and distress. Furthermore, these explanatory models reveal how, within the context of Mexican culture, one should go about dealing with psychological concerns if they arise. The present international study represents phase I of a larger data collection project being conducted by the researcher. Phase II of this project consists of the researcher collecting data from individuals of Mexican descent living in Texas.

Furthermore, the present study is essential in addressing the paucity of psychological and mental health research on those of Mexican descent. Even more distressing is the apparent lack of psychological and/or mental health research that samples from the interior regions of Mexico, beyond the United States/Mexico borderlands region. Indeed, the above review of the literature

reflects an emphasis on individuals of Mexican descent residing within the United States (often referred to as *Mexican Americans*, or more broadly, as *Latinos* or *Hispanics*) because research on mental health and psychological help-seeking among people of Mexican ethnic and cultural descent who live *in* Mexico is lacking. In addition, research that explores the cultural factors that shape how individuals in Mexico make sense of their mental health experience is noticeably absent or extremely rare. Since Toluca, Mexico is geographically located in the interior of Mexico, the present study was designed to add valuable information and data to the psychological literature regarding the under-researched and underrepresented areas of central and interior Mexico.

While adding important information to the psychological and mental health literature about those living in central Mexico, the present study also has significant implications for those of Mexican descent living in the United States. Since Hispanics/Latinos in the United States are the fastest growing ethnic minority group, with the majority being of Mexican ancestry, it is imperative that mental health care researchers and professionals have substantial knowledge of Mexican culture, including the beliefs many Mexicans have that likely influence their conceptualization of psychopathology and their beliefs and attitudes toward the dominant United States culture's mental health care system. With the improvement of mental health care services that are more culturally sensitive towards individuals of Mexican descent, Mexican immigrants and U.S. born Mexican Americans will be more likely view the United States mental health care system as a place that is worth using in the event that their mental health needs are not being met. In this way, the United States mental health care system will be able to better serve those of Mexican descent and demonstrate that their facilities and professionals are responsive to the needs of the Mexican and Mexican American population. Currently, the mental health care

system in the United States, lacking in cultural sensitivity in several areas, does not always present itself in a way that can reasonably convince individuals of Mexican descent to seek help.

Hypotheses

1. Respondents whose cultural and mental health beliefs are significantly influenced by Mexican cultural constructs and consistent with traditional Mexican culture will have a less favorable attitude toward seeking professional psychological help from the dominant Eurocentric mental health care system than will their more non-traditional counterparts.

2. Respondents' endorsement of non-Eurocentric explanatory models of mental distress and psychological disturbance will be a significant predictor of their help-seeking attitudes with regard to professional Eurocentric psychological help.

3. Respondents' self-reported residency status will be significantly related to their endorsement of traditional Mexican cultural constructs, explanatory models of mental distress, and, ultimately, their attitude toward seeking professional psychological help.

4. Men will report less favorable attitudes toward seeking professional psychological help than women.

In addition to the above hypotheses, exploratory analyses were performed on the data from the ARSMA-II and the qualitative data resulting from the two case scenarios that each participant completed. The goal of the exploratory analyses on the qualitative data was to find common themes in the responses participants wrote to each case scenario and the questions that followed.

CHAPTER 2

METHOD

Participants

Participants for the present study were 110 Mexican college psychology students recruited from la Universidad Autónoma del Estado de México (UAEM), utilizing the University of North Texas' (UNT) joint educational and research venture with UAEM in Toluca, Mexico. Individuals participated completely voluntarily with the knowledge that they were not to receive compensation for their participation. Ages of the participants range from 18 to 46, with a mean age of 22. With regard to gender, 20.6% of the sample is male, and 79.4% of the sample is female. Of the available racial/ethnic groups provided for participants to mark on the demographic questionnaire, 90.7% of participants indicated Mestizo as their racial/ethnic background; none of the other choices totaled more than 5%. With regard to place of residence for the majority of respondents' lives, 30.3% described themselves as living in a large city, 41.3% described themselves as living in a small city, and 28.4% marked town or village for their residential location. Finally, with respect to generational status, 90.9% if the population described themselves as 5th generation Mexican. In addition, 8.2% marked 4th generation Mexican, and 0.9% marked 3rd generation Mexican.

Measures

All participants received a packet with all the measures used in the study, along with a demographic questionnaire, all in Spanish. Because Spanish versions of some measures used are not currently available, translation into Spanish and back translation into English was used to determine whether the Spanish translation used was comparable to the English version/meaning.

Brislin's definition of a back-translation procedure summarizes the method used in the present study (Kazdin, 2000).

Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS; Fischer & Turner, 1970). The ATSPPHS is a 29-item questionnaire that measures attitudes toward seeking psychological help for psychological problems and mental health issues. Respondents are asked to indicate their level of agreement or disagreement with each statement using a 4-point Likert-type scale ranging from "strongly disagree" to "strongly agree." The ATSPPHS consists of 4 subscales or factors; these are: Recognition of Need for Psychotherapeutic Help (e.g., "A person with a strong character can get over mental conflicts by himself, and would have little need of a psychiatrist"), Stigma Tolerance (e.g., "Having been mentally ill carries with it a burden of shame"), Interpersonal Openness (e.g., I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family"), and Confidence in Mental Health Practitioner (e.g., "Although there are clinics for people with mental troubles, I would not have much faith in them"); (Fischer & Turner, 1970).

The ATSPPHS was initially standardized on students in high school through college from various backgrounds and age groups. Internal consistency reliability computed for the scale's standardization sample was .86. Internal consistency reliability estimates for each factor are as follows: Factor I (Need), $r = .67$, Factor II (Stigma), $r = .70$, Factor III (Openness), $r = .62$, and Factor IV (Confidence), $r = .74$. Test-retest reliability was also established with the standardization sample, and attitude scores were shown to remain stable over time (at two months, $r = .84$). Comparable data from a group similar to the one in the present study was not found. Finally, the reading level of the ATSPPHS was altered for the present study in order to

ensure better understanding of questionnaire items across a broader range of individuals with varying reading levels. While the original ATSPPHS has a Flesch-Kincaid readability grade level of 10.2, the measure was revised for the present study to yield a Flesch-Kincaid readability grade level of 9.0.

Mental Distress Explanatory Model Questionnaire (MDEMQ; Eisenbruch, 1990). The MDEMQ is a 45-item questionnaire that has participants rate potential causes of mental distress on a 5-point Likert-type scale ranging from "highly unlikely" to "highly likely." Multidimensional scaling analysis demonstrates four clusters of mental distress: Stress, Western Physiological, Nonwestern Physiological, and Supernatural (Eisenbruch, 1990).

The MDEMQ was initially standardized on a group of students and health professionals from a range of cultural backgrounds, including individuals from Australia, Europe, and Asia. Comparable data from a group similar to the one in the present study was not found. Internal reliabilities of these causative categories, as calculated on groups of British Asians, white Westerners (European), and Pakistanis by Sheikh and Furnham (2000), are satisfactory. These are given below in table format, borrowed from Sheikh and Furnham's (2000) work:

	British Asians	Westerners	Pakistanis
Stress causes	.92	.91	.77
Western physiological causes	.85	.78	.78
Supernatural causes	.95	.95	.91
Non-Western physiological causes	.77	.80	.71

Multiphasic Assessment of Cultural Constructs—Short Form (MACC-SF: Cuéllar, Arnold, & González, 1995). The MACC-SF is a 60-item true/false questionnaire that asks participants to rate as true or false statements assessing for five cultural constructs found with Mexican American populations: Familism, Fatalism, Machismo, Folk Beliefs, and Personalismo. These five cultural constructs have been hypothesized as having the potential to influence Mexican Americans' experience of illness and help-seeking behaviors (Cuéllar et al., 1995). Comparable data from a group similar to the one in the present study was not found. Since the above cultural constructs have been hypothesized to influence the experiences of Mexican Americans, however, they were used with the present study's Mexican population in confidence that the constructs would still be valid. Items used in the MACC-SF were chosen from a larger scale, the Multiphasic Assessment of Cultural Constructs (MACC), developed by Arnold and Cuéllar (1985). Internal consistency data show the five subscales have internal consistency reliabilities ranging from poor to very good, with the folk beliefs and machismo subscales having the best internal consistency scores. These are given below in table format, borrowing from Cuéllar et al., 1995:

	Cultural Construct				
Scale Score Statistic	Familism	Fatalism	Machismo	Folk Beliefs	Personalismo
Spearman-Brown	.67	.59	.77	.82	.53
Guttman (Rulon)	.66	.59	.74	.82	.53
Coefficient Alpha – all items	.65	.63	.78	.75	.47

Acculturation Rating Scale for Mexican Americans-II (ARSMA-II: Cuéllar, Arnold, & Maldonado, 1995). The ARSMA-II consists of two subscales that measure acculturation by measuring cultural orientation and modes of acculturation. The first scale contains 30 items and derives a Mexican orientation subscale (MOS) as well as an Anglo orientation subscale (AOS). The first scale yields the acculturation modes of assimilation and integration. The second scale, the marginality scale, contains 18 items. When combined with the first scale, the marginality scale produces scores that measure marginalization and separation as two modes of acculturation. The ARSMA-II is available in both English and Spanish, and only the Spanish language version was used in the present study. Respondents rate their agreement with each statement on a 5-point Likert-type scale ranging from "not at all" to "extremely often or almost always." The original standardization sample included university students from various socioeconomic backgrounds and from Mexican, Mexican American, and Anglo (non-Hispanic) ethnic backgrounds, representing five generation levels. All scales and subscales of the ARSMA-II (except the Mexican marginality subscale, with an alpha coefficient of .68) have good to excellent reliability, with alpha coefficients ranging from .83 to .91. All scales demonstrate good to excellent test-retest reliability, ranging from .72 to .96. The ARSMA-II demonstrates excellent concurrent validity with a .89 correlation with the ARSMA, which has been demonstrated to be a valid measure of acculturation (Corcoran & Fischer, 2000). Since the ARSMA-II is intended for Mexican Americans and not necessarily Mexicans living in Mexico, the measure was included as a secondary assessment to explore significant acculturation issues, if any, that might exist within the Mexican sample of the present study. The ARSMA-II was therefore not included as an integral part of the above stated hypotheses.

Demographic Questionnaire. A demographic questionnaire asking for each participant's age, gender, race/ethnicity, primary geographic residence, generational status (as reported by parent, grandparent, and great-grandparent data), and parent immigration information, if applicable, was administered to each participant. Participants were asked to report their primary ethnic group affiliation from a given list of ethnic groups.

Case Vignettes. Two hypothetical case vignettes were presented to each participant. The first vignette describes an individual, María, who is suffering from major depressive disorder, a common disorder found in many different populations. According to Areán and Chatav (2003), depressive disorders are some of the most common among all psychiatric disorders. Furthermore, major depressive disorder is also the most serious of the depressive disorders (Areán and Chatav, 2003). Results from the International Consortium of Psychiatric Epidemiology surveys indicate lifetime prevalence of major depressive episodes in Mexico at 8.1% (Andrade, Caraveo-Anduaga, Berglund, Bijl, de Graaf, Vollebergh, Dragomirecka, Kohn, Keller, Kessler, Kawakami, Kiliç, Offord, Ustun, and Wittchen, 2003). Clearly, this data indicates that depression is a problem in Mexico.

The second vignette describes José, who is suffering from susto ("fright" or "soul loss"). Susto is a widely studied folk illness in Latino cultures (Glazer, Baer, Weller, Garcia de Alba, and Liebowitz, 2004). While the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)* attributes soul loss to the description of susto, recent research in both Mexico and Texas suggests that soul loss is becoming less of a central feature of susto. Instead of the soul leaving the body, a "vital force" is believed to have left the body with a diagnosis of susto (Glazer et al., 2004). Nevertheless, susto is still an important diagnosis and can lead to information about ethnopsychological and mental health beliefs among both Mexicans living in Mexico and the

United States. According to the *DSM-IV-TR*, susto results in unhappiness and sickness for the individual (American Psychiatric Association, 2000). Individuals with susto also experience significant strain in their social roles. Typical symptoms of susto include excessive or inadequate sleep, troubled sleep or dreams, appetite disturbance, feeling of sadness, feelings of low self-worth, feelings of dirtiness, and lack of motivation, in addition to somatic symptoms (American Psychiatric Association, 2000). Each case vignette is accompanied by the same four questions that participants are asked to answer. The questions seek to explore each participant's attitude toward help-seeking behavior and explanatory model of the disorder presented.

Procedure

Each participant was given an envelope packet including all materials required for participation in the present study. Within the study packet, participants were first given a copy of the informed consent form to read and review. Each participant's voluntary participation in the study and successful completion of the questionnaires signified implied consent to participate in the study. Participants were instructed to keep the copy of the consent form for their records. Therefore, the consent form also served as an information page that briefly describes the nature and purpose of the study.

After consenting to participate in the study, participants were instructed to completely fill out each questionnaire and read each case vignette in the packet and answer each question as honestly as possible. For data entry purposes, packet envelopes and each page of the study materials inside were marked with a number, and this number was not tied to the participant in any way, as participants' names do not appear on any consent form or questionnaire completed.

Researchers from UAEM distributed questionnaire packets to individuals who participated on a strictly volunteer basis. Identifying information was not collected from

participants. The questionnaire packets were mailed to UAEM, completed by participants at UAEM, and then subsequently mailed back to the researcher at UNT.

CHAPTER 3

RESULTS

Descriptive Analyses

Frequencies, means, standard deviations, skewness, kurtosis, and observed minimum/maximum values, as appropriate, were calculated for each demographic, independent, and dependent variable (see Tables 1 and 2). Tests of normality on demographic variables using skewness, kurtosis, and histograms revealed a positively skewed distribution for age (M = 21.65), a significantly larger number of women (79.4%) than men (20.6%), a majority who identified as Mestizo with respect to race/ethnicity (90.7%), a negatively skewed distribution for generational status (with 90.9% being 5th generation), and a normal distribution for residence (with 30.3% from a large city, 41.3% from a small city, 28.4% from a town or village, and 0% from a rural farm). Analyses of the independent and dependent variables revealed normal distributions.

Correlations between Demographic and Independent Variables

A series of correlations was calculated to determine the relationships between demographic variables and independent variables. Independent variables in the present study include the five subscales of the MACC-SF and four subscales of the MDEMQ. Several correlations were found.

Utilizing a point-biserial correlation method, gender (coded 1 = men, 2 = women) demonstrated significant associations with four of the five subscales on the MACC-SF. Men reported higher endorsement of the familism scale (r = -.20, p = .04), revealing a small to

medium effect size. An independent samples t-test confirmed that men (M = 5.09, SD = 1.95) reported higher endorsement of the familism scale than did women (M = 4.22, SD = 1.72), t (105) = 2.05, p = .04 (two-tailed). Men also reported a higher endorsement of the machismo scale (r = -.28, p = .003), revealing a medium effect size. An independent samples t-test confirmed that men (M = 3.22, SD = 2.84) endorsed more machismo than did women (M = 1.96, SD = 1.33). Since Levene's Test for Equality of Variances indicated that variances for men and women do differ significantly from each other, t-test information was used with equal variances not assumed, revealing significant results, t (23.43) = 2.03, p = .05 (two-tailed).

Women reported a greater endorsement of folk illness beliefs (r = .20, p = .04), indicating a small to medium effect size. Results from an independent samples t-test confirmed that women (M = 4.74, SD = 2.54) reported a higher endorsement of folk illness beliefs than did men (M = 3.50, SD = 2.24), t (105) = -2.09, p = .04 (two-tailed).

Finally, with respect to age, results indicate that older participants report less endorsement of fatalistic beliefs (r = -.29, p = .002). This correlation demonstrates a medium effect size. No correlations were found between the demographic variables and the four subscales of the MDEMQ.

Correlations between Demographic and Dependent Variables

A series of correlations was calculated to determine relationships between demographic variables and dependent variables. Dependent variables in the present study include the four subscales of the ATSPPHS. Only two correlations were found among demographic and dependent variables: those of a higher generational status in Mexico (those with five generations of family in Mexico) endorsed a stronger recognition of a need for psychotherapeutic help (r =

.25, p = .008) and more confidence in mental health practitioners (r = .30, p = .002) than did those of a lower generational status. These associations demonstrate medium effect sizes.

Correlations among Independent Variables

A series of correlations was computed in order to determine whether the independent variables in the present study were related. Correlation coefficients among subscales are presented in Table 3. Correlations ranged from .13 to .47 among the subscales of the MACC-SF, indicating a range of small to large effect sizes; among the four subscales of the MDEMQ, correlations ranged from .43 to .73, indicating large effect sizes. All four subscales of the MDEMQ were shown to have significant relationships with each other in the present study.

Table 3 also depicts correlation coefficients between the MACC-SF and the MDEMQ subscales. Correlations ranged from -.06 to .40, with significant positive correlations found among several of the subscales. Significant positive correlations ranged from .22 to .40, yielding approximately medium effect sizes. First, the MACC-SF Familism scale was positively related to the MDEMQ supernatural scale. The MACC-SF Fatalism scale was found to be positively related to the MDEMQ Stress and Supernatural scales. Next, the MACC-SF Personalismo scale was positively correlated with the MDEMQ Supernatural scale. Furthermore, the MACC-SF Folk Illness Beliefs scale was positively correlated with the MDEMQ Stress, Non-Western Physiology, and Supernatural scales. Lastly, the MACC-SF Machismo scale was positively related to the MDEMQ Supernatural scale.

Correlations among Dependent Variables

Dependent variables in the present study include the four subscales of the ATSPPHS. A series of correlations was performed in order to determine whether these dependent variables were related. Results indicate that the subscales were all significantly interrelated which shows

an overall generalized attitude toward seeking professional psychological help. Correlations ranged from .35 to .51, indicating medium to large effect sizes. These correlation coefficients are depicted in Table 4.

Hypothesis Testing

Hypothesis 1

The first hypothesis states that respondents whose cultural and mental health beliefs are significantly influenced by Mexican cultural constructs and that are consistent with traditional Mexican culture will have a less favorable attitude toward seeking professional psychological help from the dominant Eurocentric mental health care system than will those whose cultural and mental health beliefs are less influenced by traditional Mexican culture.

Correlations among the subscales of the MACC-SF and the ATSPPHS reveal important relationships regarding this first hypothesis. Three significant relationships were found among the subscales of the MACC-SF and of the ATSPPHS. More specifically, Stigma Tolerance was negatively related to the scales of Personalismo (r = -.19, p = .05) and Machismo (r = -.22, p = .02), with small effect sizes. Participants who report a higher tolerance for stigma report lower endorsement of both the construct of personalismo and the machismo. Additionally, Machismo was also negatively related to Interpersonal Openness (r = -.27, p = .01), revealing a small to medium effect size. This finding reveals that respondents who reported more interpersonal openness also reported a lower endorsement of the machismo construct.

Hypothesis 2

The second hypothesis examines the relationship between respondents' endorsement of non-Eurocentric explanatory models of mental distress and psychological disturbance and their help-seeking attitudes with regard to professional Eurocentric psychological help. Only one

significant correlation was found with regard to this hypothesis. The Western Physiological scale on the MDEMQ was found to be positively related to the Interpersonal Openness scale on the ATSPPHS ($r = .29$, $p = .002$). This positive relationship has a medium effect size. Respondents who reported greater endorsement of the Western Physiological scale of the MDEMQ also reported more interpersonal openness.

Hypothesis 3

For hypothesis three, respondents' self-reported residency (1 = large city, 2 = small city, 3 = town or village, 4 = rural farm) was examined as it relates to participants' endorsement of traditional Mexican cultural constructs, explanatory models of mental distress, and, ultimately, their attitude toward seeking professional psychological help.

One-way analyses of variance were computed in order to test the hypothesized relationships. No significant differences were found between self-reported location of residency and the endorsement of traditional Mexican cultural constructs or explanations of the cause of mental distress; however, a significant difference with regard to residency and stigma tolerance was found. Those living in a large city for most of their lives reported significantly more tolerance of stigma than did those living primarily in a small city, $F(2, 106) = 4.01$, $p = .02$.

Hypothesis 4

This last hypothesis explores the relationship between gender and help-seeking attitudes within the Mexican population. More specifically, it was hypothesized that men would report less favorable attitudes toward seeking professional psychological help than would comparable women. No significant associations were found for gender and attitudes toward seeking professional psychological help.

Exploratory Analyses

Acculturation Rating Scale for Mexican Americans-II (ARSMA-II)

In order for the present study (Phase I) to be identical to Phase II of the broader project being conducted by the researcher, the ARSMA-II was administered to all participants. Results from the ARSMA-II were not incorporated into the hypotheses of the present study because the ARSMA-II was developed for use with Mexican Americans and not Mexicans living in Mexico.

Overall, participants reported a mean on the Anglo orientation scale of 2.01 (*SD* = .43), a mean on the Mexican orientation subscale of 4.56 (*SD* = .24), and mean on the overall acculturation score of -2.56 (*SD* = .50). According to the guidelines established by Cuéllar et al. (1995), these results indicate that, overall, the participants in the present study are considered Very Mexican oriented.

A series of correlations was calculated in order to test for any possible relationships among participants' overall acculturation score and the demographic, dependent, and independent variables. Results indicate that participants' overall acculturation score is negatively related to their residency location (1 = large city, 2 = small city, 3 = town or village, 4 = rural farm) (r = -.27, p = .005) and to the Interpersonal Openness scale of the ATSPPHS (r = -.22, p = .03). Respondents who considered themselves to be more Mexican oriented also reported relatively higher endorsement of the ATSPPHS Interpersonal Openness scale. Both of these negative correlations have small to medium effect sizes.

With respect to residency status, a one-way analysis of variance was performed to further investigate the nature of the relationship between residency and overall acculturation score. As expected, results indicated a significant relationship, F (2, 101) = 4.97, p = .009. Post-hoc analyses reveal that residents of a town or village were significantly more Mexican oriented than were those who reported living in either a small or large city.

Regression Models

Exploratory hierarchical regression models were tested to find variables that were possible significant predictors of Stigma Tolerance, a key indicator of a person's attitude toward seeking professional psychological help. Since hypothesis testing revealed residence location differences in Stigma Tolerance and significant positive correlations among the Personalismo and Machismo scales of the MACC-SF and Stigma Tolerance, these variables were used in the exploratory regression analysis.

For the regression analysis, residence location was used as a control and entered in step 1, followed by the Personalismo scale in step 2 and the Machismo scale in step 3. These scales were entered separately in order to test for the unique contribution of each scale to Stigma Tolerance. As Table 5 depicts, the overall model proved to be significant, F (3, 105) = 2.95, p = .04 and accounted for 5.1% of the variance. The Machismo scale (β = -.20, p = .04) proved to be a significant predictor of Stigma Tolerance. Residence and the Personalismo scale were not significant predictors of stigma tolerance. This exploratory hierarchical regression analysis was performed in multiple ordering of variables to ensure accuracy of the above results.

Qualitative Data Analysis

Four semi-structured questions were presented after each of two case studies for respondents to answer. The original responses to each question for both case studies were hand-written in Spanish by each participant, and the researcher first typed each Spanish response into electronic form. Next, the researcher enlisted the help of a colleague who arranged to have each typed response translated and typed into English and checked for accuracy of meaning after being translated from Spanish to English. The researcher was therefore left with the case study question responses translated into English in electronic form for the final analysis.

After reading through each response, the researcher placed each response into an appropriate category or categories based on a particular theme. Themes were developed by the researcher after reading through all participant responses to each case scenario. Case 1 and Case 2 were kept separate in this analysis, resulting in categories and themes created separately for each case. Separation of the cases was important, since Case 1 reflects the symptoms of a commonly known and scientifically recognized psychological disorder (major depressive disorder), while Case 2 reflects the symptoms of a culture bound syndrome (susto).

Finally, since each case contained four semi-structured questions that asked for different information from each participant, categories and themes were developed by the researcher for each individual question within each case. The final result was eight different categories and themes, reflecting the four different questions with each of the two case studies.

Case 1 Question 1

This item posed the question "What is wrong with Maria?" Fifty-six responses noted that Maria is suffering from some sort of depression. Overall, there were ninety-nine responses that acknowledged a psychological or emotional cause for Maria's problems. Fifteen responses also noted work as the source of Maria's problems, and twelve responses stated that her problems could also be attributed to menopause, hormones, and her age. When these twelve responses are examined together with those that mentioned a general physical problem, results indicate that twenty-three participant responses stated that Maria was suffering from a physical problem. The complete listing of participant responses in each theme and category developed by the researcher for this item can be found in Table 6.

Case 1 Question 2

This item asked participants "What should Maria do about her problems?" Forty-three responses noted some personal responsibility for Maria to seek a solution on her own. Sixty-two responses stated that Maria should seek some kind of professional help. Fifteen other responses stated that Maria should seek help from the non-professional sector. These responses can be found in Table 7.

Case 1 Question 3

This item stated the following: "Should Maria go to someone or go somewhere for help? If so, who and where? If not, why?" Overall, one-hundred eighty-one responses were given that demonstrated participants' belief that Maria should seek help from the professional or formal sector. Ten responses noted Maria should look for help from the non-professional or informal sector, and one participant stated that Maria does not need to seek help. These responses are listed in Table 8.

Case 1 Question 4

This item asked the question "What kind of help should Maria expect to receive?" Twenty-four responses stated that Maria should expect to receive emotional support. Eighty-seven responses noted some form of help that is found within the professional sector. Additionally, five responses specifically stated that Maria should expect to receive help from the non-professional sector. Seventeen responses mentioned support and/or guidance for Maria, and twenty-seven responses stated that Maria should expect help that is focused on problem-solving about her current issues. Responses for this item are presented in Table 9.

Case 2 Question 1

This first question asked participants "What is wrong with Jose?" A total of ninety-eight responses stated that Jose is suffering from a psychological and/or an emotional problem. Also

notable are twenty-two responses that stated Jose is suffering from a physical problem, thirteen responses noting that his work was the problem, and eleven responses stating his problems with his family are what are "wrong" with Jose. Frequencies of these responses are given in Table 10.

Case 2 Question 2

This item asked participants "What should Jose do about his problems?" Forty-seven responses stated that Jose should seek a solution to his problems on his own. Fifty-three responses expressed that Jose should seek help from the professional or formal sector. Fifteen responses stated that Jose should seek help from the non-professional or informal sector, and twenty responses mentioned that Jose should seek help but did not specify whether from the professional or non-professional sector. Table 11 shows the responses for this item.

Case 2 Question 3

This question asked "Should Jose go to someone or go somewhere for help? If so, who and where? If not, why?" One-hundred forty-seven responses stated that Jose should seek help from the professional sector. Two responses stated that Jose should seek help from the non-professional sector. Finally, five responses stated that Jose should seek help but did not specify whether from the professional or non-professional sector, and four responses stated that it was not necessary for Jose to seek help. Table 12 presents the responses for this item.

Case 2 Question 4

This final question asked participants "What kind of help should Jose expect to receive?" Twenty-two responses mentioned that Jose should receive some form of emotional help for his problems. Ninety-one responses stated that Jose should expect to receive professional help. Seven responses stated that Jose should expect to receive non-professional help. Finally, eleven responses mentioned that Jose should receive some form of support, six mentioned problem-

solving strategies, and one mentioned Jose participating in activities to improve his condition. Table 13 itemizes the findings for this item.

CHAPTER 4

DISCUSSION

The purposes of the present multi-method study were to 1) better understand the help-seeking attitudes and beliefs that individuals living in Mexico have about mental disorders and psychopathology, and 2) investigate how Mexicans' help-seeking attitudes and mental health beliefs work together as potential influences on mental health help-seeking. While exploring help-seeking variables, this study also investigated the culturally influenced explanatory models held by Mexican citizens who participated in this study regarding mental health and psychological distress. Results from the present study indicate that, of the four original hypotheses proposed by the researcher, three revealed significant findings. Additionally, an exploratory hierarchical regression model revealed an interesting finding that further elaborated on results from hypothesis testing. To enrich these quantitative findings, qualitative data collected in the present study provided in-depth information on the nature of the mental health help-seeking decision making process. Furthermore, the qualitative data collected in the present study revealed how participants make sense of the experience of mental distress and psychological distress. Taken together, the quantitative and qualitative data collected in the present study can be used to inform theoretical models of the experience of mental distress and psychological disorders in Mexico. Furthermore, results form the present study can be used to inform clinical practice in Mexico by informing mental health practitioners about the nature of an individual's help-seeking decision-making process.

The first hypothesis proposed by the researcher investigated the relationships among participants' endorsement of traditionally Mexican cultural constructs and their attitudes about seeking professional psychological help for mental health issues and concerns. Three significant relationships were found. Stigma tolerance was found to be significant in its negative relationship to the constructs of personalismo and machismo. Cuéllar et al. (1995) contend that personalismo "may help determine pathways to service or figure in the selection of a therapist or other form of assistance" (p. 342). Importantly, in the present study, those who reported a higher tolerance for the stigma that is often associated with mental illness also demonstrated a lower endorsement of the personalismo construct. This relationship has important implications for mental health practitioners because it suggests that those who value close and personal relationships may not seek mental health services because they also do not have a high tolerance for stigma. Since stigma has important social ramifications, personal distance expressed by a patient or client toward a mental health professional could be seen as a buffer against the negative consequences of stigma, particularly with respect to close personal relationships with others.

As stated above, those who rated the machismo construct higher rated stigma tolerance lower. Cuéllar et al. (1995) state that machismo "has the potential of influencing the need for services, the presenting problem itself, the type of services accepted, and other help-seeking behavior" (p. 340). Since results from the present study found that those who endorse the construct of machismo less can tolerate more stigma, this suggests that those who identify more with the machismo construct likely have less tolerance for stigma, and therefore will be less likely to desire seeking help for psychological concerns.

With respect to machismo, the third interesting finding from the first hypothesis was that respondents who reported more interpersonal openness also had a lower endorsement of the machismo construct. Clearly, interpersonal openness is a significant aspect of the traditional psychotherapeutic methods employed by a wide array of mental health practitioners. This finding suggests that those who value machismo will be less likely to be interpersonally open, which could severely hinder progress in a psychotherapeutic relationship.

The second hypothesis examined the relationship between respondents' explanatory models of mental distress and their attitudes toward seeking professional psychological help. The only significant finding with regard to this hypothesis was a positive correlation between interpersonal openness and a Western physiological way of attributing cause to mental distress. Perhaps those who adhere more to a Western biomedical way of making sense of the experience of mental distress have an easier time talking about personal problems and distress. These individuals could feel that talking about the cause of their psychological problems in a non-personal biomedical way makes it easier for them to share difficult experiences and problems. Of course, this is only speculation, and future researchers should investigate the role that mental distress language and semantics has in the personal expression of psychological problems.

The third hypothesis explored the relationship of participants' self-reported residence location and the endorsement of Mexican cultural constructs, explanatory models of mental distress, and attitudes toward seeking professional psychological help. Only one significant relationship emerged from this hypothesis. Those participants who reported living in a large city for the majority of their lives also reported having significantly more tolerance for stigma than their counterparts who reported living in a small city for the majority of their lifetime. Perhaps this finding reveals a significant influence that living in an urban environment has on the way

people understand the cause and nature of psychological disorders. Those living in urban environments likely have a better chance of being exposed to a greater variety of people from different backgrounds, including those with psychological disorders. In this way, exposure and knowledge about mental illness could lead to a reduced level of stigma about mental disorders. Clinical practice would benefit from the work of future researchers in this area. Future research could make the relationship between residency and stigma clearer, in addition to suggesting ways that those who do not live in urban environments can be targeted for education and awareness campaigns to reduce stigma if it is found to be higher in less-developed parts of Mexico.

The fourth and final hypothesis explored the relationship between gender and attitudes toward seeking help for mental health problems. More specifically, men were hypothesized to report less favorable attitudes toward help-seeking than women. No significant relationships were found between gender and attitudes toward seeking help for psychological problems. A major limitation of this study, however, is the small number of men who participated relative to women. The present study's skewed sample likely played a significant part in the lack of significance of this fourth hypothesis. Future research should strive for a more balanced sample of men and women when investigating attitudes toward seeking help for mental distress and psychological problems.

An interesting finding surfaced when an exploratory hierarchical regression was performed. Since results from the previous hypotheses revealed residency differences in the tolerance of stigma and significant relationships among stigma tolerance, personalismo, and machismo, these variables were used in a regression analyses with stigma tolerance as the dependent variable. Results indicated that only machismo proved to be a significant predictor of stigma tolerance, above and beyond both residency and personalismo. This key finding suggests

that those who have a higher endorsement of the attitudes and beliefs of machismo will likely report less tolerance for the stigma associated with mental disorders and psychological concerns. Ultimately, this suggests that those with a more traditional machismo-oriented worldview will be less likely to seek help for psychological problems. Future research should explore this important topic further with a larger sample of men than was used in the present study. Furthermore, the importance of machismo in the tolerance of mental illness stigma may be underestimated by the current sample, due to its skewed distribution of gender and exclusively college student sample.

Qualitative data was gathered from each participant in order to add depth and complexity to the data found from the quantitative measures used in the present study. Since the participants in the present study were university students studying psychology, they could be expected to note that either Maria or Jose should seek professional help for their problems. Therefore, it was not surprising to find that the majority of respondents suggested that Maria and Jose should receive help from the professional sector, noting specific mental health professionals and formal locations where help can be obtained from the dominant mental health sector, such as in a clinic or a hospital.

Given this information, however, the results from the qualitative case studies reveal interesting information about the help-seeking beliefs of participants and their explanatory models of mental distress. One might hypothesize that since the participants in this study are college students studying psychology, all would note that Maria and Jose should seek psychological help from a psychologist. This was, however, not the case. An examination of Tables 6-13 reveals that participants gave a variety of responses for each question of each case study, and these responses included different forms of professional help (e.g. medical,

psychological, nutritional) as well as the suggestion to seek non-professional help from family or friends.

Interestingly, 23 responses noted that Maria was suffering from a physical problem, and 22 responses stated that Jose was suffering from a physical problem. For Maria, 12 of these 23 responses attributed Maria's problems directly to the effects of menopause, hormones, and/or age. When discussing the problems with Jose, some participants mentioned problems or possible complications with diabetes. Both menopause and diabetes are distinguishably physical human experiences.

Other researchers have found significant differences among those of Mexican descent when compared to other groups with regard to somatization. In a study of the grief response among Mexican American and Anglo college students, Oltjenbruns (1998) found that Mexican American participants scored significantly higher than Anglo participants on the somatization scale of the Grief Experience Inventory. In 2000, Salgado de Snyder, Diaz-Perez, and Ojeda published work that examined data on *nervios*, an idiom of distress found in many parts of Latin America, and somatization among males and females in rural Mexican communities. Their data was collected as part of a broader project that sought to examine the prevalence of psychological problems, utilization of mental health services, and social and cultural influences on the expression of psychological distress. Salgado de Snyder et al. found that all the psychological and somatic symptoms of *nervios* were higher in women than in men. These two studies corroborate the findings of the present study, in which physical symptoms were mentioned as key components of both Maria's and Jose's distress. The present researcher has also collected data from individuals of Mexican descent in the United States (Texas) as part II of this two-part

study, and it will be interesting to discover what differences arise upon examination of the qualitative data from respondents in both Mexico and the United States.

The explanatory models assessed in the present study give evidence of how the Mexican respondents in this study make sense of mental health concerns and psychological distress. Ultimately, explanatory models indicate how the respondents 1) might culturally construct their beliefs about mental health, psychological processes, and distress, and 2) believe one should go about dealing with psychological concerns if they arise and if they exist. Importantly, this study does not seek to compare the present sample with other samples from different ethnic or cultural groups. The present study seeks an emic approach to data analysis, in which local construction of reality with regard to mental health and psychological help-seeking is emphasized.

With regard to explanatory models of mental illness and mental distress, an interesting finding resulted when correlations were performed among all four subscales of the MDEMQ. Results from this analysis revealed that all subscales of the MDEMQ were significantly correlated with each other, indicating one large underlying factor. These results could be interpreted in many ways. For example, intercorrelations among the MDEMQ subscales could be viewed as evidence of high overlap among the subscales, meaning that each subscale is actually identifying a single underlying construct of the cause of mental distress. In this view, the high intercorrelations among subscales are interpreted as evidence of the ineffectiveness of the MDEMQ as a tool to parcel out hypothesized differences in how people explain the causes of mental distress.

Another interpretation of the intercorrelations among the subscales of the MDEMQ is directly related to the idea of a “cause” for mental distress. Perhaps the intercorrelations among subscales of the MDEMQ are evidence that these respondents do not view mental distress and

mental disorders as being "caused" by anything. This would mean that respondents do not have a clear belief in what they feel may "cause" a person to experience psychological distress and psychological disorders.

Finally, the intercorrelations of the MDEMQ subscales could also be interpreted as evidence that respondents in the present study felt that all of the four causal possibilities provided by the MDEMQ (Western Physiological, Non-Western Physiological, Stress, Supernatural) are realistic and true potential causes of mental distress and psychological disorder. In this view, the respondents agreed that mental distress can potentially be caused by any of the four categories listed above. This interpretive view means that the respondents have a broad and diverse sense of what causes a person to experience psychological distress and disorder, including causes from the physical and non-physical world.

A potential client's or patient's explanatory model is important to understand when a mental health professional is beginning treatment. Understanding a client's or patient's explanatory model for mental distress and psychological disorder is especially important when the client or patient and the mental health professional are from two different ethnic and cultural backgrounds. As the United States becomes increasingly diverse due to immigration and globalization, the possibility that a patient and provider will be from two distinctly different backgrounds will certainly increase. Therefore, it is essential that future researchers continue to build upon the existing sparse research in patient explanatory models of mental distress and psychological disorders. In the present study, the researcher's inclusion of a qualitative data collection technique represents such an attempt. Results from the present study suggest that individuals in Mexico make sense of mental distress in different ways, including both psychological and physical explanations for why people experience mental health problems.

Kleinman et al. (1978) suggest that eliciting explanatory models from patients is a critical step to improving healthcare. While Kleinman et al. claim that a patient's explanatory model can be accomplished "systematically and quickly" (p. 256) with the utilization of a "few simple, direct questions" (p. 256), the reality is that this is likely not the case. Since explanatory models are complex, they are not likely elicited quickly with a few semi-structured questions at the beginning of treatment. True and in-depth elicitation of patient explanatory models will most certainly require an extensive and lengthy conversation between patient and provider that will likely need to take place on multiple occasions. Given the fast-paced nature of mental health care delivery that is currently valued within the health care system in the United States and other countries, such in-depth exploration of explanatory models is probably not feasible or practical.

Kleinman et al.'s (1978) discussion of the negotiation between the provider and patient also alludes to the fact that, in practice, the role of the physician is to "educate" the patient, or convince the patient of the provider's model. This interpretation of Kleinman et al.'s suggestions means the negotiation process will need to be reevaluated and reframed in a way so as not to appear as a method of imposing the provider's beliefs onto the patient, concealed within the guise of a simple negotiation between provider and patient.

These ideas about client or patient explanatory models suggest that more research is needed on the issue, particularly with respect to explanatory models of psychological disorders and mental illness. Given the highly individualized nature of explanatory models, future researchers would be wise to employ qualitative methodology, as was done in the present study, when investigating the nature and role of client or patient explanatory models of psychological distress. Ethnographic and in-depth analysis would be particularly well-suited to this type of investigation, in which significant time would be spent with study participants and multiple

methods of data collection (both quantitative and qualitative) would be employed. Ethnographic research allows for a more holistic view of the constructs being studied and reveals how individual participants make sense of their experience within the context of their broader social, cultural, historical, political, economic, and physical environments. Ethnography is a hallmark of anthropological research. Therefore, collaboration between anthropologists and psychologists would likely prove beneficial for gaining a better understanding of the nature of client or patient explanatory models of mental and psychological distress and disorder.

Limitations and Future Research

Limitations to the present study exist and must be addressed in order to fully understand the implications of the present study and to guide future researchers working within a cultural psychology framework. First, all of the participants in the present study are college students attending a large university in Toluca, Mexico. Given the vast heterogeneity and regional differences found among the people and cultures of Mexico, it is important not to interpret the results of the present study as a generalization of the help-seeking attitudes and cultural beliefs of all Mexican people. Furthermore, because of the nature of the relationship between researchers at UAEM and UNT, psychology students were the most accessible student population to be sampled at UAEM. Clearly, psychology students do not fully represent the broader Mexican population, and they likely have biases in their attitudes toward psychology and mental health that reflects their education and training in a formal academic setting at UAEM. Lastly, the present study's skewed gender distribution in favor of women likely limits the appropriateness of the present findings with regard to hypothesis that can accurately be made about both genders. Studies in the future should aim for an equal number of men and women when studying

psychological help-seeking and Mexican culture, particularly if machismo is a construct of particular interest.

Future researchers should strive to sample a more heterogeneous population of Mexican citizens with regard to their attitudes toward seeking professional psychological help and their explanatory models and epistemology of mental distress and mental health. A heterogeneous sample would include both college and non-college students, and within college students, those studying psychology and those studying other disciplines. Additionally, future researchers should strive to collect a sample that is diverse with regard to socioeconomic background. Samples from diverse geographic areas of Mexico would also certainly prove useful for relating data to the broader population, because as has been mentioned before, Mexico is a widely diverse country with many different cultural influences, beliefs, and traditions. These diverse cultural influences, beliefs, and traditions are in part due to the cultural interplay between indigenous native peoples and the influence of those from Europe, which has continued since the time of Spanish contact with Mexico. While the resource limitations of the present researcher did not allow for a study with the characteristics mentioned above, the present study should be viewed as a source of inspiration and impetus toward more inclusive and holistic international research in psychology in the future.

Table 1

Frequencies for Demographic Variables

Demographic Variables	*n*	Percentage
Gender		
Male	22	20.6%
Female	85	79.4%
Race/Ethnicity		
Mestizo	97	90.7%
American Indian/Indigenous Indian	3	2.8%
Spanish	4	3.7%
White, Caucasian, European American, or Anglo	2	1.9%
Mixed	0	0%
Other	1	0.9%
Residence		
Large City	33	30.3%
Small City	45	41.3%
Town or Village	31	28.4%
Rural Farm	0	0%
Generational Status		
1st Generation	0	0%

(table continues)

Table 1 (*continued*).

Demographic Variables	*n*	Percentage
2nd Generation	0	0%
3rd Generation	1	0.9%
4th Generation	9	8.2%
5th Generation	100	90.9%

Table 2

Descriptive Statistics

Variables	*M*	*SD*	Range
Age	21.65	4.52	18-46
MACC-SF Familism Scale	4.40	1.79	1.00-9.00
MACC-SF Fatalism Scale	3.51	1.52	1.00-7.00
MACC-SF Personalismo Scale	5.56	1.83	2.00-11.00
MACC-SF Folk Illness Beliefs Scale	4.44	2.52	0.00-11.00
MACC-SF Machismo Scale	2.19	1.79	0.00-10.00
MDEMQ Stress Scale	4.04	.67	1.17-5.00
MDEMQ Western Physiological Scale	3.81	.71	1.00-5.00
MDEMQ Non-western Physiological Scale	2.61	.73	1.00-4.20
MDEMQ Supernatural Scale	2.17	.67	1.10-3.79
ATSPPHS Recognition of Need for Psychotherapeutic Help Scale	3.34	.37	2.38-4.00
ATSPPHS Stigma Tolerance Scale	3.46	.44	2.40-4.00

(table continues)

Table 2 (*continued*).

Descriptive Statistics

Variables	*M*	*SD*	Range
ATSPPHS Interpersonal Openness Scale	3.11	.43	2.00-4.00
ATSPPHS Confidence in Mental Health Practitioner Scale	3.41	.36	2.44-4.00
ARSMA-II Anglo Orientation Scale	2.01	.43	1.23-3.69
ARSMA-II Mexican Orientation Scale	4.56	.24	3.59-5.00
ARSMA-II Overall Acculturation Score	-2.56	.50	-3.62 - -1.01

Note: MACC-SF = Multiphasic Assessment of Cultural Constructs – Short Form, MDEMQ = Mental Distress Explanatory Model Questionnaire, ATSPPHS = Attitudes Toward Seeking Professional Psychological Help Scale, ARSMA-II = Acculturation Rating Scale for Mexican Americans-II.

Table 3

Intercorrelations among Independent Variables

Variable	1	2	3	4	5	6	7	8	9
1. MACC-SF Familism Scale	(.47)								
2. MACC-SF Fatalism Scale	.24*	(.50)							
3. MACC-SF Personalismo Scale	.31**	.37**	(.42)	.					
4. MACC-SF Folk Illness Beliefs Scale	.18	.14	.21*	(.65)					
5. MACC-SF Machismo Scale	.47**	.16	.16	.13	(.55)				
6. MDEMQ Stress Scale	-.05	.23*	.16	.26**	.05	(.87)			
7. MDEMQ Western Physiological Scale	-.02	.11	.09	.06	-.06	.73**	(.85)		
8. MDEMQ Non-western Physiological Scale	.042	.12	.10	.24*	.09	.51**	.56**	(.63)	
9. MDEMQ Supernatural Scale	.23*	.24*	.22*	.40**	.29**	.51**	.43**	.67**	(.90)

* = p <.05, ** = p <.01

Note. Values on the major diagonal in parentheses are alpha internal consistency reliabilities of scales.

Table 4

Intercorrelations among Dependent Variables

Variable	1	2	3	4
1. ATSPPHS Recognition of Need for Psychotherapeutic Help Scale	(.51)			
2. ATSPPHS Stigma Tolerance Scale	.40**	(.51)		
3. ATSPPHS Interpersonal Openness Scale	.49**	.45**	(.49)	
4. ATSPPHS Confidence in Mental Health Practitioner Scale	.51**	.50**	.35**	(.57)

* = p <.05, ** = p < .01

Note. Values on the major diagonal in parentheses are alpha internal consistency reliabilities of scales.

Table 5

Summary of Exploratory Hierarchical Regression Analysis for Variables Predicting Stigma Tolerance

		Block 1			Block 2			Block 3		
	r	*B*	*SE B*	β	*B*	*SE B*	β	*B*	*SE B*	β
Residency	-.06	-.03	.06	-.06	-.04	.05	-.07	-.05	.05	-.09
Personalismo	-.19				-.05	.02	-.19	-.04	.02	-.16
Machismo	-.22							-.05	.02	-.20*
Adjusted R^2				.006			.021			.051
R^2 change				.003			.035			.039
F (1, 107)				.370						
F (2, 106)							2.15			
F (3, 105)										2.95*

* = $p < .05$

Table 6

Frequencies for Case 1 Question 1 Responses

Response Category	Number of Responses
Psychological/Emotional not elsewhere classified	35
Depression	56
Low Self-Esteem/Low Self-Worth	8
Family	6
Support	2
Work	15
Routine	7
Physical not elsewhere classified	11
Menopause/Hormones/Age	12
Nothing	4
Does Not Know (Maria does not know what is wrong with herself)	5

Note. All responses given by a participant were coded.

Table 7

Frequencies for Case 1 Question 2 Responses

Response Category	Number of Responses
Seek Solutions on Own	43
Seek Professional Help not elsewhere classified	15
Physician	9
Health Professional	1
Psychologist/Psychological	24
Psychoanalyst	1
Therapist	4
Specialist	6
Informational Talk/Information	2
Seek Non-professional Help not elsewhere classified	0
Family/Relative	7
Friend	2
Talk (general talking about problems)	6
Seek Help (unspecified)	10
Activities (activities Maria can do to make herself feel better)	11

Note. All responses given by a participant were coded.

Table 8

Frequencies for Case 1 Question 3 Responses

Response Category	Number of Responses
Seek Professional Help not elsewhere classified	2
Physician	36
Health Professional	2
Psychologist/Psychological	93
Psychiatrist	2
Psychoanalyst	1
Therapist	7
Counselor	1
Social Worker	1
Nutritionist	3
Specialist	3
Religious Leader	2
Clinic/Center	9
Office	6

(table continues)

Table 8 *(continued).*

Response Category	Number of Responses
Health Center	8
Institution	5
Seek Non-professional Help not elsewhere classified	0
Family/Relative	4
Friend	2
Coworker	1
Group	3
Not Necessary	1

Note. All responses given by a participant were coded.

Table 9

Frequencies for Case 1 Question 4 Responses

Response Category	Number of Responses
Emotional not elsewhere classified	16
Listen (being heard or having someone listen to Maria)	6
Talk (being able to talk with someone about her problems)	2
Professional not elsewhere classified	8
Psychologist/Psychological	43
Physician/Medical/Physical	22
Specialist/Specialized	3
Therapy	7
Treatment	1
Clinical	1
Information (educational material or information about her problems)	2
Non-professional not elsewhere classified	0
Family/Relative	4
Friend	1
Support	9
Guidance	8
Problem-Solving	27

Note. All responses given by a participant were coded.

Table 10

Frequencies for Case 2 Question 1 Responses

Response Category	Number of Responses
Incident (mention only of the near accident)	4
Lack of Treatment	4
Psychological/Emotional not elsewhere classified	11
Trauma/Shock/Crisis	21
Lack of Insight	6
Conflict/Frustration/Insecurity/Instability	6
Motivation	9
Fear/Scared	16
Depression/Sadness	18
Anxiety	2
Posttraumatic Stress	7
Psychosomatic	2
Unbalanced	2
Quality of Life	1
Physical	22
Illness	4

(table continues)

Table 10 *(continued).*

Response Category	Number of Responses
Problem (unspecified)	6
Work	13
Family	11
Health (not specified)	1
Nothing	2

Note. All responses given by a participant were coded.

Table 11

Frequencies for Case 2 Question 2 Responses

Response Category	Number of Responses
Seek Solutions on Own	47
Seek Professional Help not elsewhere classified	11
Physician	10
Health Professional	1
Medical	1
Psychologist/Psychological	14
Therapist	1
Therapy	2
Specialist/Expert	12
Institution	1
Seek Non-professional Help not elsewhere classified	0
Family/Relative	6
Coworker	1
Talk (being able to talk with someone About his problems)	8
Seek Help (unspecified)	20

Note. All responses given by a participant were coded.

Table 12

Frequencies for Case 2 Question 3 Responses

Response Category	Number of Responses
Seek Professional Help not elsewhere classified	1
Physician	29
Psychologist/Psychological	75
Psychiatrist	1
Therapist	8
Social Worker	2
Masseuse	1
Faith Healer	1
Specialist	4
Clinic/Center	7
Office	5
Health Center	4
Hospital	4
Institution	5
Seek Non-professional Help	0
Family/Relative	1
Friend	1

(table continues)

Table 12 *(continued).*

Response Category	Number of Responses
Seek Help (unspecified)	5
Not Necessary	4

Note. All responses given by a participant were coded.

Table 13

Frequencies for Case 2 Question 4 Responses

Response Category	Number of Responses
Emotional not elsewhere classified	15
Listen (being heard or having someone listen to Jose)	6
Talk (being able to talk with someone about his problems)	1
Professional not elsewhere classified	9
Psychologist/Psychological	41
Physical	21
Psychiatric	1
Specialist/Specialized	2
Therapy	12
Counseling	1
Treatment	3
Clinical	1
Non-professional not elsewhere classified	1
Family/Relative	4
Friend	2

(table continues)

Table 13 *(continued).*

Response Category	Number of Responses
Support	9
Guidance	2
Problem-Solving	6
Activities (activities Jose can do to make himself feel better)	1

Note. All responses given by a participant were coded.

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