Assessment of mental health services and needs in Hispanic communities

Raul Gonzalo Guilarte

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ASSESSMENT OF MENTAL HEALTH SERVICES AND NEEDS
IN HISPANIC COMMUNITIES

A Thesis
Presented to the
Faculty of
California State College
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Arts
in
Community Mental Health

by
Rev. Raul Gonzalo Guilarte
August 1982
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Approved by:

Chairperson

Date
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This study investigated the mental health services and needs in selected Hispanic communities in Southern California. The participants in the study were 150 selected Hispanics from various cities within Riverside County and 150 selected Hispanics from various cities within San Bernardino County. The participants were administered a mental health awareness survey and their patterns of response were subsequently analyzed. It was found that there was a low level of awareness of existing mental health services and facilities available to the Hispanic community. Although awareness of available community mental health resources was low, two-thirds of the study participants had at one time or another had an emotional problem for which they had not received help. The main reasons cited for not having received mental health help were: (a) not knowing where to go for help, (b) language communication problems, (c) inability to afford services, and (d) services seemed to unfamiliar or foreign. Only one-fourth of the 300 survey respondents reported ever actually having received mental health services, and of these 42% reported that they were dissatisfied with the services they had received. In response to being asked to identify specific individuals who might serve as consultants when
emotional problems were experienced, a priest or minister, family members, and friends were mentioned in preference to mental health professionals. Resorting to folk healers was not widespread. In overall comparison, the Riverside and San Bernardino County respondents were very similar in their pattern of response to the mental health issues presented in the survey questionnaire. Specific recommendations for improving the delivery of mental health services to Hispanics within the community included, (a) increasing the level of awareness of existing mental health services through local mass media, (b) increasing the number of bilingual mental health personnel, (c) increasing the number of Hispanic mental health professionals and paraprofessionals, (d) taking into account the cultural perspective and socioeconomic conditions of Hispanics when providing mental health services, (3) making use of the extended family concept in mental health treatment plans, (f) adopting the Raza mental health perspective, and (g) continuing research to clarify factors and issues related to the mental health status of Hispanics.
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CHAPTER I

INTRODUCTION

Statement of the Problem

The ability to function successfully in everyday living is highly dependent upon a sound state of mental health. When persons are confronted with mental turmoil, so much energy and attention is focused on the psychological affliction at hand that the quality of personal, social, and occupational activities is adversely affected. Mental well-being is a crucial and indispensable human asset.

Although mental health is a major concern for all persons, it takes on special significance when applied to individuals of minority status. In this instance, social, economic, and environmental factors very often serve as catalysts in precipitating psychological affliction. Thus, particular effort must necessarily be put forth in order to adequately meet the mental health needs of minority group members.

The central focus of the present study is the American Hispanic population. Specifically, concern is with the assessment of mental health services and needs in Hispanic communities, and the subsequent development of recommendations for the implementation of improved community mental
health programs for Chicanos. In order to put the stated problem in more complete perspective, a review of pertinent literature related to this issue is warranted.

Review of Related Literature

Hispanics constitute a significant and rapidly growing segment of the American population; next to the black population, they are the second largest minority population in the United States. According to the 1970 census, there were 9.6 million persons of Spanish origin in the United States (U.S. Bureau of Census, 1973). The 1975 Current Population Reports raised this number to 11.2 million, which can be considered as the most conservative base figure for the Hispanic population (U.S. Bureau of Census, 1976). Other estimates which take into consideration census undercount, increase from births, and legal as well as undocumented immigration suggest that more than 23 million Hispanics live in the United States today (Special Populations Sub-Task Panel on Mental Health of Hispanic Americans, 1978). Moreover, they are the fastest growing ethnic group. Although projections vary widely on the basis of baselines and growth rates, it is expected that by the year 2000 the number of Hispanic Americans will have reached 55 million; even by conservative estimates, they soon will become the largest ethnic minority in the United States (Macias, 1977).
Hispanic Americans are not evenly distributed throughout the United States in terms of national origin or geographic location. Approximately 59% are of Mexican origin (Chicanos or Mexican Americans) and live primarily in the five southwestern states of Arizona, California, Colorado, New Mexico, and Texas. Puerto Ricans live primarily in New York State and constitute 16% of the Hispanic population. Cuban Americans are concentrated in southern Florida and represent 6% of the Hispanic population. Seven percent are of Central/South American origin. Finally, the remaining 12% (identified as "other") includes groups such as the Filipinos (U.S. Bureau of the Census, 1976).

Hispanic Americans are largely urban dwellers: 84% of them reside in metropolitan areas, particularly in the central cities of Los Angeles, New York, and Chicago. One out of two families of Hispanic origin lives in the central city of a metropolitan area, as compared to one out of four families in the general United States population (U.S. Bureau of the Census, 1976).

The United States has the fifth largest Spanish-speaking population in the world. The Spanish language continues to be a significant aspect of Hispanic cultural heritage; over 80% of Hispanic Americans report Spanish as the mother tongue, while 20% report difficulty with English (U.S. Bureau of the Census, 1973). Although situated in American society, Hispanics are found to retain, to varying degrees, their
parent cultural identity.

In comparison to other national groups, Hispanic Americans exist in more stress-producing situations. Persons belonging to ethnic minority populations are likely to encounter serious personal problems when they attempt to adapt to the social mores of an alien culture (Cohen, 1970). The plight of Hispanic Americans has been extensively documented (Padilla & Ruiz, 1973; Padilla, Ruiz, & Alvarez, 1975). They have been found to suffer the full impact of a "culture of poverty" to a much greater extent than the general population. Low income, unemployment, underemployment, undereducation, poor housing, prejudice and discrimination, and cultural/linguistic barriers have been compounded by the low quality and quantity of mental health services available to Hispanics. This situation has perpetuated undue stress on Hispanic Americans and often results in severe deleterious consequences not only for the Hispanic population, but also for American society at large.

A major factor which compounds the predicament of Hispanic Americans is that, as mentioned earlier, they are primarily urban dwellers. The consequences for mental health of growing up amidst the decay, poverty, and crime that characterize the large central cities of the United States cannot be overemphasized.

Another factor which has important implications for the mental health of Hispanics is that almost one-half are
children or adolescents (Special Populations Sub-Task Panel on the Mental Health of Hispanic Americans, 1978). The consensus among social and behavioral scientists is that childhood and adolescence are the most critical periods of human development which determine, to a great extent, the quality of later psychosocial adjustment in adulthood. This means that many Hispanic Americans are suffering the consequences of the "culture of poverty" during their most critical years of development.

A compounding problem is that Hispanic children and adolescents are twice as likely to belong to large families (seven or more persons) than the general population. These large families are the poorest: 37.7% of Hispanic American families with seven or more members are below the poverty level (U.S. Bureau of the Census, 1976).

Concerning the self-image of Mexican Americans, Casavantes (1970) has stressed that the identity of the Mexican American has been clouded by the wide acceptance of Mexican Americans of a broad range of stereotypes which project a false image of what it is that constitutes being Mexican American. In this regard, Aranda (1971) has undertaken an examination of the "Mexican American syndrome." Aranda states that Mexican Americans have been described as dumb, dirty, lazy, and as fatalistic, voodoo practitioners of a criminal mentality.
In linking ethnic identity and psychological stress, Bayard (1978) has referred to "marginal ethnic identity" in connection with Mexican Americans. This concept of marginality refers to a person having a foot in two different cultures, so to speak, yet at the same time not closely connected to either one. Consequently, an identity crisis inevitably arises.

Stoddard (1973) goes a step further and suggests that Mexican Americans are removed from the cultural patterns of both the Mexican and Anglo groups in a distinctive way:

The traditional approach (which has assumed that Mexican Americans are merely transplanted Mexicans, saturated with Mexican values, but subject to Anglo influences) would consider Anglo and Mexican values as opposite poles on a continuum. Mexican American values would lie somewhere between these polar types. Yet, two social scientists reject this model, proclaiming instead that Mexican American values do not merely mix Mexican and Anglo values, but comprise indeed a distinct culture. Nall (1962:37) in comparing Mexican, Mexican American, and Anglo students found that Mexican Americans expressed values with a distinct cultural dimension, often representing a more extreme position along the continuum than those of either the Mexican or the Anglo samples. Another comparison of university students in Mexico City and Austin with Mexican Americans from the borderland zone resulted in similar findings. The American attitude toward respect, for example, was one of detached, self-assured equalitarianism, whereas Mexican students displayed a close-knit, highly emotionalized, reciprocal dependence and dutifulness within a firm, authoritarian framework. Mexican Americans, rather than combining the two attitudes, were further removed from the core-culture pattern of the other two than they were from each other's. (p. 45)

Martinez, Martinez, Olmedo, and Goldman (1976), in their work with the semantic differential and junior high
school students, similarly suggest that Mexican Americans have developed into a culturally distinct group. In the process of acculturation, many Mexican Americans have remained marginally acculturated, attaining a very moderate degree of acculturation. Mexican Americans are different from other groups because they are clinging to their ethnic identity, culture, language and values by refusing to give up their Hispanic culture that remains traditionally Mexican. Mexican Americans have closer ties to the family and these closer ties are reinforced by the Mexican American culture in many ways, and provides a continually reinforced sub-culture in a dominant culture. Spanish remains the official language at home with the family and, therefore, is full of emotion. On the other hand, English is the language of the school, the job and is mostly spoken at the mentioned places.

The process of acculturation (i.e., the acquisition of the values and behaviors of a host society by members of a minority or immigrant group) is of interest to psychologists because it is believed to bring about a certain amount of stress, psychological discomfort, or behavioral disorders to some members of the smaller, weaker group (Berry & Annis, 1974; Child, 1943; Stonequist, 1964). In addition, "level of acculturation" (interpreted broadly as the capacity to function in and interact with the larger society) has been highlighted as a most important variable to be considered in studies dealing with effectiveness of psychotherapy with
Chicanos (Miranda, Andujo, Caballero, Guerrero, & Ramos).

Recent research has indicated that Mexican Americans exhibit a wide range of variability in the acculturation continuum (Olmedo, J. Martinez, & S. Martinez, 1978; Olmedo & Padilla, 1978). As sociocultural and geographic characteristics of a subject population vary, so do degrees of acculturation and processes of assimilation.

With regard to incidence of mental illness, B.P. Dohrenwend and B.S. Dohrenwend (1969) have pointed out the consistent indication in the literature of an inverse relationship between social class and reported rate of psychological disorder. Two hypotheses are offered for this finding: 1.) Social causation, the environmental pressures associated with low social status cause psychopathology, and 2.) social selection: pre-existing psychological disorder leads to low social status. Since neither social environmental nor genetically oriented investigators have presented conclusive evidence for the causal factor in psychopathology. Their perspective is based on the problems of ethnic group assimilation in open-class societies, where there is an almost universally shared norm that upward social mobility is desirable.

Gartly (1957), in examining the social and cultural factors involved in the incidence of mental disorders found that: (a) the probability of acquiring a psychosis is not random or equal among subgroups of the population; (b) in-
habitants of different areas exhibit different incidence of psychosis; and, (c) persons with different social attributes of affiliation have different incidences of psychosis. In a later report, Gartly (1959) reports that major mental disorders among the Spanish Americans, Anglo-Americans, and non-white populations of one of the states are compared. The principal hypotheses is that the Spanish Surname population will exhibit significant differences in both form and frequency of major mental disorders from the other groups.

Data on diagnosed psychotic cases for the Spanish American group were obtained from a recent survey dealing with the incidence rate of mental disorders during 1951-1952. Cases were averaged into an annual rate and computed for the 27 economic subregions of the state. Mental disorders rates were adjusted for age, sex, and ethnic composition. From the total number of 11,298 psychotic cases, there were 648 (6%) Spanish Americans, 9,557 (84.6%) Anglo Americans, and 1,057 (9.4%) non-white. The results indicate that: 1.) The incidence rate of total psychoses for the Spanish Surname is considerably lower than for the other groups. Gartly disclosed that education is correlated with incidence rate for only the Spanish American subgroup. These findings generally support the hypotheses that the Spanish Americans exhibit differences in the incidence and types of mental disorders from the other subgroup with a lower rate of incidence for Spanish Americans than for other groups, in-
cluding Anglo Americans, Gartly (1959). The development of neurosis has been investigated by Diaz-Guerrero (1955). Two hundred ninety-four subjects were administered a 46-item questionnaire to measure the degree of mental health problems of the urban Mexican. The questionnaire, distributed in accordance to Cantril's weighted random sample technique, yielded a 57% return.

The data revealed that the general family pattern is favorable to the development of neurosis. Approximately 32% of the male and 44% of the female population over 18 years of age are "neurotic". For example, in the male there are community problems of submission, conflict, and rebellion to authority, preoccupation and anxiety regarding sexual potency, and conflict and ambivalence regarding his double role. At times he must act maternally and tenderly and at other instances sexually and virily. In addition, the male encounters problems before and after marriage, difficulties in superceding the maternal stage, dependent female individuals and the Oedipus complex. Hispanic males tend to play the role of being an authoritarian and at other times very tender and loving. In the female, the main area of stress centers around her variable success in meeting the stiff requirements that culture demands (submission). If she fails to meet her role expectations, self-belittlement and depressive trends are noted. Another area of disturbance
is found in the "old maid" complex. It is suggested that many neurosis-provoking conflicts in Mexicans are "inner" conflicts which are provoked more by clashes in values than by clashes of the individual with reality. The nature and characteristics of the Mexican American family have been discussed by Murillo (1976).

Some evidence exists which supports the point of view that certain aspects of the Hispanic subculture protect members against mental breakdown or provide continued familial support following a breakdown (Jaco, 1959, 1960; Madsen, 1964). Jaco, after finding that Mexican Americans are underrepresented in residential-care facilities for the mentally ill, argues that the social structure of Mexican Americans provides protection against stress for its members. Madsen generally concurs with this "stress resistance" formulation, but adds an elaboration of the protective role of the extended family system. He suggests that Mexican Americans discourage the referral of family members to mental health centers—as they would to any other majority group institution—since these are perceived as alien and hostile.

Some investigators have suggested that although Hispanics receive comparatively less mental health care than the general population, they actually need more (Abad, Ramos, & Boyce, 1974; Kanno, 1966; Kanno & Edgerton, 1969; Torrey, 1972). A major reason given for this is that Hispanics as a group are only partially acculturated and marginally inte-
grated economically and, as a consequence, are subject to a number of "high-stress" indicators. Diaz-Guerrero (1967) examines the different sociocultural neuroses found in American and Hispanic populations. Americans are classified as active endurers of stress and Hispanics as passive endurers of stress.

The two sociocultural premises are that the Hispanics want to avoid stress and Americans want to face stress. In crosscultural research, there is a need to ascertain sociocultural premises of world wide value so as to classify cultures according to them and to find within each culture their relation to local socialcultural values. For example, here in the United States different cultures keep their customs alive by the usage of language, food, music, etc.

It was learned that: 1.) Interactions with a different social system can strongly affect the individuals response. 2.) Hispanics need coping mechanisms for proper adaptation and assistance during the transitional periods of adaptations to the dominate culture. 3.) The need to develop programs in preventive community mental health for Hispanic Americans.

**Utilization of Mental Health Services**

Central to much of the recent research on mental health and the Mexican American population is the question, "Why do Mexican Americans underutilize public mental health servi-
ces?" (Keefe, 1978, 1979). Hispanic Americans as a whole are found to underutilize available mental health services, with utilization rates varying for different groups and geographic locations. These rates, however, rarely exceed 50%—that is, Hispanic representation among recipients of services is one-half (or less) of their representation in the general population (Brandon, 1975; Kruger, 1974; NIMH, 1974; Solis, 1977).

Underutilization has been established by several studies done in the southwestern United States. Early work conducted by Jaco (1959) indicated that Mexican Americans in Texas sought treatment for psychosis from a variety of public and private psychiatric facilities at a much lower rate than Anglo Americans and nonwhite groups. Karno and Edgerton (1969) found that while Mexican Americans represent 10% of California's population, they account for only 2.2% of state mental hygiene clinic admissions, 0.9% of neuropsychiatric institute outpatient admissions, and 2.3% of inpatient admissions to state-local jointly supported facilities. Moreover, Karno and Edgerton reported that only 3.3% of the resident population in California's state hospitals for the mentally ill in 1966 was Mexican American.

In a study of the UCLA Neuropsychiatric Institute (a joint operation of the University of California at Los Angeles and the California State Department of Mental Hygiene),
Karno (1966) found only 1% of the clients during a 52-month period were of Mexican descent, despite the fact that Mexican Americans made up 9.5% and 10.5% respectively of the population in the county and city of Los Angeles. Similarly, Torrey (1972) indicates that 11% of the patients at the East Valley Mental Health Center in San Jose during 1968 were Mexican American while the census tract in which the clinic is located is 25% Mexican American. Keefe, Padilla, and Carlos (1978), in a survey of the Mexican American and Anglo-American populations in three cities in Southern California, have reported significantly fewer Mexican Americans than Anglos have used a public mental health clinic during a two-year period.

Numerous reasons suggested to account for this underutilization include various social, economic, and cultural aspects of the Mexican American population, as well as certain attributes of mental health clinics and the services they provide.

Researchers have established that blue-collar workers and other members of the lower socioeconomic class underutilize health services in general and mental health clinics in particular (Glasser, Duggan, & Hoffman, 1975; Marin, Marin, Padilla, & de la Rocha, & Fay, 1981; Marin, Padilla, & de la Rocha, 1982; Rosenblatt & Suchman, 1964). Therefore, it is reasonable to assume that socioeconomic variables have much
to do with utilization of mental health services by Mexican Americans, who are predominantly lower class, blue collarites.

McLemore (1963) has shown that Mexican Americans' attitudes toward hospitalization are directly associated with level of education. For some uneducated Mexican Americans predominately of low socioeconomic class, the concept of folk illness can be deeply entrenched and resistant to the influence of Anglo culture and its scientific medicine. It is suggested that failure of a physician to recognize the cultural implications of folk medicine can result in faulty diagnosis and inappropriate and costly treatment procedures. The incidence and significance of folk medicine in, as yet, poorly understood and the underlying cultural factors are inadequately studied. Clarifying cultural factors and the conflicts implicit in acculturation will make it possible to provide a better standard of caring for the physically and mentally ill in the Hispanic American subculture. McLemore suggests that socioeconomic factors may be more important than ethnic differences in explaining why Mexican Americans might be more reluctant to use hospitals than Anglo-Americans.

A somewhat different perspective is held by Nall and Speilberg (1967), who maintain that social integration into the ethnic subcommunity is primarily responsible for Mexican Americans' rejection of modern medical treatment. Hence, it
is the combination of low socioeconomic status and the socio-cultural adaptation to economic scarcity (i.e., reliance on the collective support of family and community) which affect health behavior. The authors go on to suggest that this system operates among disadvantaged ethnic minority groups in general and is not restricted to Mexican Americans.

Reliance on alternative resources, other than professional psychiatric care, seems to be a universal-cultural and universal class method of seeking help for psychological problems (Keefe et al., 1978; McKinlay, 1972; Torrey, 1972). However, differences in degree of reliance on alternative sources of help are not clear. Jaco (1957, 1960), and also Madsen (1969), maintain that Mexican Americans are more likely than Anglos to rely on the extended family for emotional support, which subsequently reduces their use of psychiatric services.

More recent data indicate little difference between Anglo-Americans' and Mexican Americans' tendencies to consult with relatives about emotional problems, but ethnic differences are apparent in reliance on friends (Keefe, Padilla, & Carlos, 1979). While Anglos and Mexican Americans both frequently rely on relations, Anglos are more likely than Mexican Americans to turn to friends when they are having emotional difficulties. This reluctance of Mexican Americans to reveal their personal problems to nonfamily
members has also been observed in other studies (Madsen, 1964; Rubel, 1966).

Other researchers cite Mexican Americans' reliance on doctors (Karno & Edgerton, 1969), ethnic community workers (Grebler, Moore, & Guzman, 1970; Moll, Rueda, Reza, Herrera, & Vasquez, 1976), and folk healers (Creson, McKinley, & Evans, 1969; Kiev, 1968; Madsen, 1964; Torrey, 1972) as reasons for the lower rate of mental health clinic use by Mexican Americans. Still, evidence presented by Keefe et al. (1979) indicates that Anglos and Mexican Americans both rely on doctors with no clear relationship between rate of use and ethnicity. Furthermore, there appears to be no strong tendency for the Mexican Americans surveyed to go to ethnic community leaders for help. In addition, Edgerton, Karno, and Fernandez (1970) report that the use of folk healers by urban Mexican Americans is on the decline.

Several researchers have mentioned aspects of mental health clinics themselves which discourage potential Mexican American clients. These factors include geographic location, middle-class orientation of treatment, language barriers, maintenance of traditional forms of psychotherapy, culture-bound diagnosis and treatment, and discrimination in service delivery (Burruel & Chavez, 1974; Karno, 1966; Padilla & Ruiz, 1973; Torrey, 1972). Geographic location of clinics within the Mexican American community and employment of
bilingual and bicultural staff are widely recognized as basic requirements for provision of mental health services to the Mexican American population. However, other aspects of treatment are less closely tied to utilization rates, and although culture- and class-bound treatment may affect a Mexican American client's continuation of treatment and the treatment's clinical success, it most likely has little bearing on the initial decision to make use of mental health services.

Language and cultural beliefs and attitudes are frequently suggested to account for Mexican Americans' limited utilization of mental health clinics. Language, for instance, is important not only because it is basic to the communication between staff and clients, but also because it is integral to perception and social behavior (Hornby, 1977; Price & Cuellar, 1981). Edgerton and Karna (1971) have demonstrated a relationship between language usage and attitudes toward mental illness among Mexican Americans, adults is explored. The survey administered included 200 questions involving biographic, demographic, and attitudinal information in addition to the mental illness items. Approximately 60% of the Mexican Americans took the household interview in Spanish. Results show that 75% of the responses between Spanish respondents and English respondents are not statistically significant. However, the language
in which the respondent took the interview is by far the best predictor, among all other variables, of response to mental illness questions.

The 260 Mexican-Americans who took the interview in Spanish differed from 184 Mexican Americans who took the interview in English in six response categories: 1.) depression, 2.) juvenile delinquency, 3.) schizophrenia, 4.) the inheritance of mental illness, 5.) the effectiveness of prayer, and 6.) familistic orientation. The differences suggest that Mexican Americans, at least in east Los Angeles, who speak mainly Spanish or only Spanish, reflect the commonly described cultural traits of fatalism, familism, strong attachment to formal religious values, patriarchal authoritarianism, and conservative morality regarding deviant behavior in the perceptions of mental illness. Thus, language usage and attitudes toward mental illness are related and both reflect cultural distinctions with deep psychological involvement. There is a great need for Spanish-speaking mental health professionals who are sensitive and understanding of the Hispanic American culture.

Recourse to psychological services is often complicated by the belief that consulting a psychotherapist is a sign of weakness of character. Newton (1978) has reported that Mexican Americans are likely to underutilize mental health services because of negatively biased perceptions of mental
illness; by an emphasis upon a self-image of pride and strength of character, Mexican Americans attribute to themselves a major reason for their ethnic group's low rate of mental health service use.

Mexican Americans tend to put off seeking professional mental health care even when they recognize the need for it, and for the most part there is little self-referral to therapy (Kline, 1969; Knoll, 1971; Serrano & Gibson, 1973). Often individuals with psychological problems must be taken to a mental health facility by other members of the family. The critical implication of this is that Mexican Americans delay seeking professional help longer than others might. For example, research by Fabrega, Swartz, and Wallace (1968) indicated a greater degree of regression and disorganization among Mexican American schizophrenics as compared to Anglo and Negro American schizophrenics. It can be speculated that for Mexican Americans, then, the first recourse when psychological problems arise remains the support of family and friends (Keefe, Padilla, & Carlos, 1978; Mindel, 1980; Sena-Rivera, 1980).

Attitudes toward majority group institutions in general are often suggested as inhibiting the use of mental health services. The ineffectiveness of mental health services frequently has been attributed to the continued use of the traditional mental health model which interprets behavior in
"intrapsychic terms" (Padilla, 1971). Nonetheless, the concepts of mental health and mental illness prevalent in mental health facilities for Chicanos continue to be implemented in the traditional framework of the dominant Anglo cultural context (Sanchez, 1971). When psychotherapy is provided, it is often based on culturally irrelevant treatment modalities. Under these conditions, it is not surprising that Hispanics tend to terminate treatment prematurely (Padilla, Ruiz, & Alvarez, 1975; Yamamoto, James, & Palley, 1968).

Philippus (1971) criticizes the formal, bureaucratic delivery system in most mental health facilities as a major factor in the underutilization of such facilities by Chicanos. He advocates the use of an informal, personal approach with much reliance on neighborhood personnel who are bilingual. Karno and Morales (1971), in their description of a community mental health service for Chicanos in East Los Angeles, agreed with Philippus in emphasizing the need for Spanish-speaking personnel. They also advocate the need for personnel who are committed to social, personal, and professional involvement in the community. Hispanics are unable to get the help they need from the mental health profession, according to several members of the profession. The problem seems to be the lack of Hispanics in the mental health field and the lack of understanding of the problems of Hispanics by the non-Hispanics who dominate the profession. No real
effort has been made to plan relevant psychiatric services for them. Surveys also reveal that among 800 mental health centers in the United States, only 40 have services designed to meet Hispanic cultural needs. They must make do with what is available and decreed by the majority culture.

Hispanics differ from the dominant culture in several ways. These differences include language, family philosophy and upbringing, family structure, religious roots, and cultural identity. The Hispanic families tend to come into conflict with the dominant society because their value systems contrast sharply. Among Hispanics, closeness and interdependency are encouraged, and family discipline is maintained by compassion rather than by rules and primitive measures. An attitude of concern is far more common than an attitude of minding one's own business.

Langley (1980) found that professionals from the dominant culture often complain that services are underutilized by Hispanics. They say the reason for this is that Hispanics prefer folk medicine and faith healers. Recent studies have proved otherwise. When efficient, professional treatment geared to their culture is offered to Hispanics, it is fully utilized.

Types of Mental Health Services in Hispanic Communities

Padilla (1971) in questioning the value of traditional
mental health philosophy and treatment, has proposed that social learning theory, an explanatory model for disturbed behavior has emerged from psychotherapy, experimental work in learning laboratories, social work, and cultural anthropology. This theory argues that most disturbed behavior consist of learned operant anxiety-avoiding responses. This theory offers a more appropriate model for treatment with minorities and the poor. While this is a step in the right direction, the issue of who will define the kinds of interpersonal skills and social systems most useful in maximizing human potential is not discussed.

Padilla and Ruiz (1973), in examining the reasons behind the underutilization of mental health facilities by Chicanos, indicated that blame can be placed on institutional policies which discourage self-referrals from Chicanos or which discourage continuation in treatment once referred. Variables which are considered influential in this regard are culture-bound values of the therapists and cultural differences.

Studies on acculturation indicate that those individuals who have rejected their traditional values are more susceptible to mental stress and disturbance (Ramirez, 1971). If mental health facilities and personnel are maintaining an assimilative stance, they are a factor in contributing to the stress they propose to treat. Evidence thus far
indicates that cultural democracy, not policy of assimilation, enhances mental health (Ramirez, 1971). It appears that it has been the ethnocentric orientation of modern medicine, psychiatry, and psychology that has been a barrier to Chicano acceptance and use of modern medical facilities and physicians. Anglo professionals have had the political and social power to maintain over-representation of their own world view and to disparage those who differ from their own values and perceptions. Where mental health facilities are sensitive to language and cultural needs of Chicanos, patronage has increased (Karno and Morales, 1971).

Although attitudes toward majority group institutions may contribute to underutilization of mental health clinics by Mexican Americans, recent attempts to set up clinics with the population's sociocultural characteristics in mind demonstrate that indigenous attitudes may change quickly if the services are relevant. There is much evidence that changing a few institutional policies, Hispanic American utilization can increase tremendously. For instance, mental health clinics can hire bilingual-bicultural mental health professionals. It may be that this policy change will increase and attract more Hispanic American clients (Lasora, Burstein, and Martin, 1975; Martinez, 1977).

Another problem related to the quality of mental health services is that Hispanics are served more often by para-
professionals rather than by professionals. While the former are an important part of the mental health team, they obviously do not have the training to provide the quality of service that the professional mental health worker can provide (Casas & Lopez, 1977).

The use of folk medicine and folk healers is another frequently cited reason for the underutilization of more traditional mental health services by Hispanics. Since the 1950s, anthropologists and other researchers have studied the folk health beliefs of Mexican Americans and other Hispanics (Baca, 1969; Clark, 1958; Kiev, 1968; Madsen, 1964; Rubel, 1966; Saunders, 1954; Schulman, 1960). However, since these researchers have often worked in rural areas with isolated populations, their work has had limited generalizability.

Recent research provides mixed evidence concerning folk health beliefs and practices among Hispanics. Scott (1974) found that folk healers in Miami were consulted by various Hispanic groups, and Martinez and Martin (1966) found widespread use of folk healers in a Dallas survey. However, Teller (1978) found little use of folk healers in Texas, and indicated that when they were used the advice of a physician was also sought. Other researchers have found that utilization of services and acceptance of treatment were unrelated to folk health beliefs (Farge, 1975; Keefe, 1981; Nall &
Speilberg, 1967). Furthermore, Weaver (1970) found that people in rural areas were likely to consult successively with kin, the community, the folk healer, and finally the medical or mental professional. Hispanics in urban areas consulted first with kin, and then went to the professional. Data from these studies provide somewhat contradictory evidence, but suggest that the use of folk health is perhaps limited.

To be certain, findings concerning folk health and medicine among the Hispanic population is varied and inconclusive. Such practices have been mentioned by various investigators as alternative solutions for the types of emotional problems for which most majority group members would probably seek more commonplace psychiatric treatment (Creson, McKinley, and Evans, 1969; Edgerton, Karno, and Fernandez, 1970; Garrison, 1971, 1975; Kiev, 1968; Leininger, 1973; Lubchansky, Ergi, and Stokes, 1970).

In recent studies, both Granger (1976) and Graham (1976) have asserted that folk medical beliefs and the use of curanderos (folk curers) are present throughout the Mexican American community, among the rich and poor, the college educated and those with less schooling. Others qualify its importance, maintaining that folk medicine prevails mainly among older, unacculturated, lower-class Mexican Americans (Holland, 1963; Madsen, 1964). Both Torrey (1972) and Kay
(1972) have concluded that folk medicine coexists with modern scientific medicine in the Mexican American community—the utilization of one or the other being dependent upon a number of factors including illness symptoms and self-diagnosis, the degree of belief in the folk medical system, the influence of friends and relatives, the accessibility of healing specialists, and the success of the first-choice specialist's treatment.

Still others conclude that folk healing has all but disappeared (Edgerton, Karno, & Fernandez, 1970). A study by Farge (1977) indicated that belief in folk medicine is not held by the majority of a large random sample of Mexican Americans in Houston.

One reason why many Hispanic subgroups may prefer folk healers to more conventional psychiatric treatment may rest in a conceptual difference between lower-class patients and middle-class therapists as to what constitutes mental health or illness. For instance, Hinsie and Campbell (1970, p. 388) define "mental health" or "psychological well-being" as "adequate adjustment, particularly as community-accepted standards of what human relations should be". This emphasis on adjustment implies a distinction between "mental" and "physical" health which does not exist as a concept among Hispanic subcultures. The ancient tradition of folk healers still thrives among Hispanics to such a degree that some have
called them a hidden health care system. Known as curanderos and espíritistas, they operated on turf staked out by the medical establishment and the Catholic Church. Both the medical and the Catholic Church have found it necessary to co-operate to a degree without formally endorsing the practice. The healers use many symbols of the Church such as crucifixes, icons of the Virgin Mary and incorporate traditional Catholic prayers and holy water into their rituals. They also diagnose illnesses and prescribe treatments.

It is not known how many people seek treatment from these healers, but there have been estimates made that up to 25% of the Hispanic population uses them.

Langley (Hispanic Beat 1980) writes "there is a myth that curanderos are ignorant and old", "there is a belief that it is dying out and that only poor people turn to curanderos. Our research has totally exploded that myth".

Hispanics make use of both orthodox and folk treatment. Educated, professional people may turn to the folk healer for such ailments as the common cold and swear by the potions prescribed by them. Raw eggs are often used. One treatment is to rub the patients body with an unbroken egg to remove the evil, then break the egg in a glass of water and place a crucifix on top of it. Many healers simply pray with the sick person and mostly attribute any cure to the power of
God. In some locations, the medical and psychiatric professions are recognizing the importance of curanderos and espiritistas in Hispanic cultures and are using folk medicine in conjunction with orthodox treatment. For example, in Denver's Southwest Mental Health Center, Diana Velazquez, a curandero born in Mexico, is part of the treatment team along with psychiatrists and psychologist. She serves as a bridge between the two cultures. She learned the ancient folk ways in Sonora, Mexico, from her father-in-law. She expects to complete the requirements for a doctorate in psychology soon.

In the Hispanic community, folk healers may often be the only person consulted outside of the family for emotional, personal or physical problems. Rather than considering folk medicine as an obstacle to be circumvented, the therapist should try to incorporate beliefs of this nature into the treatment program.

Making use of both the old and the new makes it possible for some patients to get help that they might never otherwise receive.

Senter (1947) appears to have been one of the first investigators to report specifically on the nature and characteristics of curanderismo (Mexican American folk psychiatry). With regard to citing certain others not previously mentioned in terms of particular perspective, Hatch (1969)
has examined Mexican American folk medicine from a purely descriptive point of view, Foster (1953) from an historical analytic approach, and O'Neill and Selby (1966) from an epidemiological stance.

Rubel (1960) acknowledges that the persistence of traditional folk beliefs among Mexican Americans is, in part, a phenomenon of trait survival that is reinforced by continual immigration of Mexican nationals into the United States, as well as the proximity of this group to Mexico itself, contribute to the maintenance of Chicano social systems. Rubel argues that mal ojo, susto, and mal puesto function to sustain some of the dominant values of Chicano culture by emphasizing maintenance of the solidarity of a small, bilateral family unit and by prescribing the appropriate role behaviors of males and females and of older and younger individuals.

Rubel's theoretical framework is the most comprehensive one proposed as it encompasses and integrates the assumptions made by other authors reviewed here. His main hypothesis is "that susto illness in societies of Hispanic-Americans may be understood as a product of a complex interaction between an individual's state of health and the role expectations which his society provides, mediated by aspects of that individual's personality" (Rubel, 1964, p.268).
The Community Mental Health Concept

The community mental health concept is aimed at providing mental health care for persons with mental health problems in designated, defined areas referred to as "catchment areas" (Smith, Burlew, Mosley, & Whitney, 1978). These catchment areas are geographical divisions, usually drawn along neighborhood lines, within which mental health services are to be delivered. Although not restricted as such, many of these neighborhoods in these catchment areas are characterized by residents of poor and minority status who generally have extremely low socioeconomic backgrounds.

Community mental health services are provided without regard to ability to pay. Moreover, legislation stipulates that community mental health centers serving populations with substantial proportions of limited English-speaking people must develop plans for providing services in the language and cultural context most appropriate to such people. In addition, a bilingual staff person is to be designated to give guidance to clients and other staff members regarding cultural sensitivities, in order to bridge linguistic and cultural differences and ensure provision of adequate services for those who have limited knowledge of the English language.

In distinguishing community mental health programs from traditional services, Bloom (1973, pp. 1-2) has cited nine
dimensions which distinguish these programs from more traditional clinical activities. These are:

1. Community mental health emphasizes practice in the minority community as opposed to practice in institutional settings.

2. The entire minority community, rather than individual minority patients, is the focus of community mental health.

3. Preventive mental health services for minorities, as opposed to therapeutic services, are emphasized in community mental health.

4. Community mental health emphasizes indirect rather than direct services to its minority community residents.

5. Meeting the mental health needs of larger numbers of minority persons through innovative clinical strategies is a primary objective of the community mental health approach.

6. A rational planning process involving minority community residents in decision making regarding mental health programs is emphasized.

7. The community mental health orientation stresses the use of new sources of manpower--i.e., the minority community residents.

8. "Community control" by members of the designated catchment areas is a major focus of the community mental
health orientation.

9. Sources of stress within the community that contribute to the ills of its minority residents are included in the scope of community mental health.

A very important factor to be considered in regard to mental health treatment is the strong role of religion in Hispanic family life and its potential use as a source for mental and emotional difficulties (Gomez, 1982). Also, striving to replace the aura of professional with a more humanistic approach is essential (Atencio, 1971).

**Future Perspectives**

The shortage of mental health professionals qualified to provide services to Hispanic populations in the United States requires immediate action (Special Populations Sub-Task Panel on Mental Health of Hispanic Americans, 1978). To be effective, psychiatrists, psychologists, psychiatric nurses, and social workers who deliver services to Hispanics must have a thorough understanding of, and sensitivity to, the linguistic and sociocultural characteristics of their clients, as well as a knowledge of their communication and human relational styles.

At the present, there is an alarming absence of mental health policy input on the part of Hispanics, as well as Hispanic contribution regarding the administration and management of mental health resources for research and service.
delivery. This is true for public agencies as well as private institutions and occurs at the local, regional, and national levels (Olmedo & Lopez, 1977).

Recent information indicates that Hispanics continue to be severely underrepresented at all levels of training and employment in psychiatry, psychology, psychiatric nursing, and social work. Professional Hispanic researchers and service providers rarely constitute more than 0.5% of the labor force in the core mental health disciplines. Furthermore examination of trends among PhD and MD recipients, as well as enrollments in medical and graduate schools reveals that no improvements in representation can be expected in the future. Rather, it is suggested that unless pervasive changes take place in national training and manpower policies, the representation of Hispanics in the mental health disciplines will stabilize or even decline in the future (Olmedo & Lopez, 1977).

Also of crucial importance is the need for continued research concerning the mental health of Hispanic Americans. There has been an accelerated growth of research activity in this area. Unfortunately, however, quality has not kept pace the quantity and the research literature has yet to attain the status of an integrated body of scientific knowledge. It remains plagued by stereotypic interpretations, weak methodological and data-analytic techniques, lack of
replicability of findings, and absence of programmatic research (Padilla & Ruiz, 1973; Padilla, Olmedo, Lopez, & Perez, 1978). The review of literature indicates that many of the assumptions stemming from early research in mental health among the Spanish community are being tested empirically by competent professionals. In conclusion, these research findings, do not negate with similar studies that emphasize that Hispanic Americans underutilize mental health services. The need for Hispanic personnel in the mental health profession is crucial before we can ask why Hispanic Americans underutilize mental health services, we must ask ourselves "where they will go".

Overview of the Study

The present study has as its aim the assessment of mental health services and needs of Hispanics residing in Southern California, as well as the development of specific recommendations which will hopefully contribute to the improvement of mental health service delivery.
CHAPTER II

METHOD

Subjects

A total of 300 male and female Hispanic residents of Southern California, ranging in age from 18 to 70 years old, participated in this study. One hundred and fifty of the subjects were residents of Riverside County, while the remaining 150 subjects were residents of San Bernardino County. Using 1980 Census data, the subjects were selected from different areas of different cities within the counties of Riverside and San Bernardino in proportion to the Hispanic population size of each city involved. Information about socioeconomic status was provided in socioeconomic responses to the questionnaire. A breakdown of subjects according to city of residence is given in Table 1.

Riverside County Subjects

Regarding the subjects from Riverside County, 90 were male and 60 were female. Fifty (56%) of the male subjects were in the 18 to 35 years old age, while the remaining 40 (44%) males ranged in age from 36 to 70 years old. Of the

1. While the selection process was not truly random, a conscientious effort was made to select respondents in Hispanic communities in as impartial a way as possible.
Table 1  
Subjects According to City of Residence:  
Riverside County

<table>
<thead>
<tr>
<th>City</th>
<th>Hispanic Population*</th>
<th>Number of Subjects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cathedral City</td>
<td>4,690</td>
<td>10</td>
</tr>
<tr>
<td>Indio</td>
<td>12,152</td>
<td>30</td>
</tr>
<tr>
<td>Coachella Valley</td>
<td>30,148</td>
<td>30</td>
</tr>
<tr>
<td>Corona</td>
<td>13,249</td>
<td>20</td>
</tr>
<tr>
<td>Norco</td>
<td>2,426</td>
<td>10</td>
</tr>
<tr>
<td>Hemet, San Jacinto</td>
<td>6,429</td>
<td>10</td>
</tr>
<tr>
<td>Riverside City</td>
<td>27,510</td>
<td>30</td>
</tr>
<tr>
<td>Perris Valley</td>
<td>5,605</td>
<td>10</td>
</tr>
</tbody>
</table>

*Source of information 1980 Census  
U.S. Census of population, race, housing County of Riverside  
Total 150

Table 2  
Subjects According to City of Residence:  
San Bernardino County

<table>
<thead>
<tr>
<th>City</th>
<th>Hispanic Population*</th>
<th>Number of Subjects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Victorville</td>
<td>5,273</td>
<td>10</td>
</tr>
<tr>
<td>Chino City</td>
<td>10,733</td>
<td>10</td>
</tr>
<tr>
<td>Ontario City</td>
<td>23,410</td>
<td>30</td>
</tr>
<tr>
<td>Rancho Cucamonga</td>
<td>8,835</td>
<td>10</td>
</tr>
<tr>
<td>Upland City</td>
<td>5,741</td>
<td>10</td>
</tr>
<tr>
<td>Colton City</td>
<td>13,492</td>
<td>30</td>
</tr>
<tr>
<td>Redlands City</td>
<td>7,373</td>
<td>20</td>
</tr>
<tr>
<td>San Bernardino</td>
<td>29,930</td>
<td>30</td>
</tr>
</tbody>
</table>

*Source of information 1980 Census  
U.S. Census of population, race, housing County of San Bernardino  
Total 150
female subjects from Riverside County, 25 (41%) were in the 18 to 35 years old range, with the remaining 35 (58%) female subjects being in the 36 to 70 years old range.

Forty-two (47%) of the male subjects were married, 25 (28%) were single, 18 (20%) were divorced and 5 (6%) were widowers. As for the Riverside County female subjects, 25 (41%) were married, 10 (17%) were single, 22 (37%) were divorced and 3 (5%) were widows.

In terms of level of education, 44 (49%) of the males had completed elementary school, 26 (29%) had completed high school, 5 (6%) had graduated from college, and 15 (17%) had received no formal schooling. Thirty-five (58%) of the females had completed elementary school, 15 (25%) had completed high school, 3 (5%) had graduated from college, and 7 (12%) had received no formal schooling.

Seventy-two (80%) of the Riverside County male subjects and 38 (63%) of the Riverside County female subjects were employed, whereas 18 (20%) males and 22 (37%) females were unemployed.

Regarding income, 58 (64%) of the males and 11 (18%) of the females had an annual income in excess of $10,000, while 32 (36%) of the males and 49 (82%) of the females had an annual income of less that $10,000.00.

Concerning the parentage of the Riverside County subjects, 38 (42%) males and 26 (43%) females reported that
their parents were born in Mexico, 12 (13%) males and 10 (17%) females reported that their parents were born in Cuba, 20 (22%) males and 12 (20%) females reported that their parents were born in the United States, 15 (17%) males and 10 (17%) females reported that their parents were born in Puerto Rico, and concerning parentage five (6%) males and two (3%) females indicated "other" (Central American).

Thirty-six (40%) of the Riverside County male subjects and 20 (33%) of the Riverside County female subjects reported their citizenship as being Mexican, eight (9%) males and 10 (17%) females reported their citizenship as being Cuban, 10 (11%) males and 10 (17%) females reported their citizenship as being Puerto Rican, 31 (34%) males and 18 (30%) females reported their citizenship as being American, and five (6%) males and two (3%) females reported their citizenship as being "other".

In terms of historical family presence in the United States, 36 (40%) males and 20 (33%) females indicated first generation Mexican, eight (9%) males and 10 (17%) females indicated first generation Cuban, 10 (11%) males and 10 (17%) females indicated first and third generation Puerto Rican, 31 (34%) males indicated second and fourth generation American while 18 (30%) females indicated more than third generation American, and five (6%) males indicated first and second generation "other" while two (3%) females
indicated first generation "other".

With respect to how the Riverside County subjects actually perceived themselves, 36 (40%) males and 20 (33%) females saw themselves as Mexican, eight (9%) males and 10 (17%) females saw themselves as Cuban, 10 (11%) males and 10 (17%) females saw themselves as acculturated Puerto Rican, 31 (34%) males and 18 (30%) females saw themselves as bicultural Mexican American, and five (6%) males and two (3%) females saw themselves as acculturated Hispanic American.

Regarding religious affiliation, 68 (76%) of the males and 45 (75%) of the females were Catholic, 14 (16%) of the males and 10 (17%) of the females were Protestant, and eight (9%) of the males and five (8%) of the females were "other".

As to what language was used to complete the survey questionnaire, 95 (63%) of the Riverside County subjects completed it in Spanish, whereas 55 (37%) of the subjects completed the survey questionnaire in English.

San Bernardino County Subjects

Eighty-four (56%) of the 150 San Bernardino County subjects were male and 66 (44%) were female. Thirty-eight (45%) of the male subjects were in the 18 to 35 years old range, while 46 (55%) of the males were in the 36 to 70 years old range. As for the female subjects, 42 (64%) fell
in the 18 to 35 years old range, while 24 (36%) of the females fell in the age range of 36 to 70 years.

Thirty-eight (45%) of the San Bernardino male subjects were married, 26 (31%) were single, 18 (21%) were divorced, and two (2%) were widowers. Of the females, 31 (41%) were married, 17 (26%) were single, 13 (20%) were divorced, and five (8%) were widows.

With regard to education, 52 (62%) of the males and 46 (70%) of the females had completed elementary school, 17 (20%) of the males and 10 (15%) of the females had completed high school, 11 (13%) males and eight (12%) females had graduated from college, and four (5%) males and two (3%) females had received no formal schooling.

Fifty-eight (69%) of the San Bernardino male subjects and 22 (33%) of the female subjects were employed, whereas 26 (31%) of the males and 44 (67%) of the females were unemployed.

In terms of income, 26 (31%) of the male subjects and 20 (30%) of the female subjects had an annual income of over $10,000. Fifty-eight (69%) males and 46 (70%) females had an annual income of less than $10,000.

With respect to the parentage of the San Bernardino County subjects, 52 (62%) males and 26 (39%) females had parents who were born in Mexico, six (7%) males and six (9%) females had parents who were born in Cuba, 23 (27%) males
and 30 (45%) females had parents who were born in the United States, two (2%) males and two (3%) females had parents who were born in Puerto Rico, and one (1%) male and two (3%) females reported the birthplace of their parents as being "other" (Central America).

With regard to citizenship, 48 (57%) males and 25 (38%) females were of Mexican citizenship, six (7%) males and six (9%) females were of Cuban citizenship, two (2%) males and two (3%) females were of Puerto Rican citizenship, 27 (32%) males and 31 (47%) females were of American citizenship, and the citizenship of one (1%) male and two (3%) females was "other".

Concerning historical family presence in the United States, 48 (57%) males and 25 (38%) females were first generation Mexican, six (7%) males and six (9%) females were first generation Cuban, two (2%) males and two (3%) females were first and third generation Puerto Rican, 27 (32%) males were more than third generation American while 31 (47%) females were second and fourth generation American, and one (1%) male was first generation "other" while two (3%) females were first and second generation "other".

In terms of how the San Bernardino County subjects actually perceived themselves, 48 (57%) males and 25 (38%) females saw themselves as being Mexican, six (7%) males and six (9%) females saw themselves as being Cuban, two
(2%) males and two (3%) females saw themselves as being acculturated Puerto Rican, 27 (32%) males and 31 (47%) females saw themselves as being bicultural Mexican American, and one (1%) male and two (3%) females saw themselves as being acculturated Hispanic American.

As to religious affiliation, 50 (60%) of the male subjects and 35 (53%) of the female subjects were Catholic, 15 (18%) of the males and 14 (21%) females were Protestant, and 19 (23%) of the males and 17 (26%) of the females were "other".

With regard to language in which the survey questionnaire was completed by the San Bernardino County subjects, 102 (68%) questionnaires were completed in Spanish while 48 (32%) questionnaires were completed in English.

Instrument

The instrument used in this study was a 4-page mental health awareness survey questionnaire comprised of both sociodemographic and mental health-related variables. The first page of the survey questionnaire contained 12 sociodemographic items, while the remaining three pages of the questionnaire consisted of five multi-part, mental health-related questions. The complete versions of the survey questionnaire in both English and Spanish can be found in Appendix A.

The first two mental health-related questions on the
survey questionnaire were directed at discovering the degree of awareness of existing mental health services to which the Hispanic community has access. The third mental health-related question inquired as to what specific help resource persons might tend to resort to when experiencing mental and physical problems. The fourth and fifth mental health-related questions on the survey questionnaire asked whether or not the respondents had ever received mental health help, the identification of the help resource, if any, degree of satisfaction with the help resource, and reasons for not receiving needed mental health help if a problem had occurred and no help had been received.

**Procedure**

Each respondent filled out the survey questionnaire in the presence of the researcher to ensure that all questionnaire items were carefully answered. An introductory statement (see Appendix B) to each respondent identified the researcher and the researcher's institutional affiliation, and described the nature of the study. Each respondent was given the option of participating or not participating in the study, as well as the option of choosing a more convenient time to participate if so desired.

Debriefing (see Appendix B) included an explanation of how the information obtained through the study might be used, offered each respondent a summary of the study results
if desired, and encouraged questions and comments regarding the study. Also, each respondent was thanked for participating in the study.

Data collection took place in the latter part of 1981 and the early part of 1982.
CHAPTER III

RESULTS

Riverside County

The first mental health-related question on the survey questionnaire inquired, "Do you know about any of the places in this area where people can go to get help for their emotional problems?". The level of awareness of available mental health facilities was low, with the psychiatric ward of Riverside General Hospital (indicated by 24% of the respondents) and Al-Anon Alcoholism Rehabilitation Center (indicated by 10% of the respondents) being the most known of existing facilities. Table 3 indicates the facilities which the Riverside County respondents acknowledged knowing.

Regarding the survey question related to patterns of seeking help for specific problems, the results are presented in Table 4. Family-related problems were defined as problems with children, parents, marital conflict, divorce, and widowhood. The main tendency here was to seek out a minister or priest rather than a mental health specialist, with 40% of the respondents choosing this recourse.

Personal problems were defined as feelings of sadness, depression, nervousness, anxiety, or job/school/friendship
Table 3
Percentage of Respondents Familiar with Various Mental Health Resources: Riverside County

<table>
<thead>
<tr>
<th>Resource</th>
<th>Percentage of Respondents Familiar with Resource</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knollwood Center</td>
<td>4</td>
</tr>
<tr>
<td>Chapman General Hospital</td>
<td>0</td>
</tr>
<tr>
<td>Psychiatric Ward, Riverside General Hospital</td>
<td>24</td>
</tr>
<tr>
<td>Private Psychologists/Psychiatrists</td>
<td>2</td>
</tr>
<tr>
<td>Kellogg Psychiatric Hospital</td>
<td>3</td>
</tr>
<tr>
<td>Stress Center</td>
<td>0</td>
</tr>
<tr>
<td>Community Counseling Center</td>
<td>2</td>
</tr>
<tr>
<td>Gardena Parkwood Community Hospital</td>
<td>0</td>
</tr>
<tr>
<td>Al-Anon Alcoholism Rehabilitation Center</td>
<td>10</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
</tr>
</tbody>
</table>

Note: Respondents gave a higher response to Riverside General Hospital because they associate it with the County Hospital and not necessarily the psychiatric unit.
Table 4
Percentage of Respondents Identifying Specific Resources for Help with Three Types of Problems: Riverside County

<table>
<thead>
<tr>
<th>Resource Sought</th>
<th>Family-Related</th>
<th>Personal</th>
<th>Physically-related</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counselor</td>
<td>5</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Psychiatrist, MD</td>
<td>3</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Minister/Priest</td>
<td>40</td>
<td>25</td>
<td>30</td>
</tr>
<tr>
<td>Physician</td>
<td>2</td>
<td>15</td>
<td>40</td>
</tr>
<tr>
<td>Mental Health Worker</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Community Leader</td>
<td>9</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Social Worker</td>
<td>2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Police</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Special Interpreter</td>
<td>22</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Psychologist</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Chaplain</td>
<td>5</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Family</td>
<td>15</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Teacher</td>
<td>6</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Friend</td>
<td>20</td>
<td>17</td>
<td>1</td>
</tr>
<tr>
<td>Self</td>
<td>15</td>
<td>35</td>
<td>25</td>
</tr>
<tr>
<td>Folk Healer</td>
<td>18</td>
<td>10</td>
<td>15</td>
</tr>
</tbody>
</table>

Note: Columns total more than 100% because respondents could give more than one response.
difficulties. The main tendency here was to rely on oneself; 35% of the respondents reported doing so. The second most frequent course of action was to consult a minister or priest (25% of the respondents).

Physically-related problems were defined as difficulty with sleeping, weight control, smoking, having sexual problems, and overuse of alcohol or drugs. The first resource of choice here was a physician (40% of the respondents), followed by a minister or priest (30% of the respondents) and reliance on oneself (25% of the respondents).

Concerning the number of Riverside County respondents who had ever received help for emotional problems, exactly 30% (27 respondents) of the males and 30% (18 respondents) of the females indicated that they had received help. Of the 27 males who had received mental health help, six (23%) were very satisfied with the services they had received, 10 (38.5%) were somewhat satisfied with the services they had received, and 10 (38.5%) were dissatisfied with the services they had received. Of the 18 females who had received mental health help, 10 (56%) were very satisfied with the services they had received, 4 (22%) were somewhat satisfied with the services they had received, and 4 (22%) were dissatisfied with the services they had received. A chi-square test revealed that the service satisfaction differences between males and females were not statistically significant, $\chi^2 (2) = 4.85, p > .05$. 
With regard to having an emotional problem for which help was not received, 44% (40 respondents) of the male and 80% (48 respondents) of the female Riverside County respondents reported having a problem for which they did not receive help. The most frequently cited reasons by both males and females for not receiving help were inability to afford services, language communication problems, and not knowing where to go for help. Complete results concerning this matter are given in Table 5.

Table 5

<table>
<thead>
<tr>
<th>% Males</th>
<th>% Females</th>
<th>Reason for not Receiving Help</th>
</tr>
</thead>
<tbody>
<tr>
<td>44</td>
<td>77</td>
<td>Language communication problems</td>
</tr>
<tr>
<td>36</td>
<td>60</td>
<td>Did not know where to go for help</td>
</tr>
<tr>
<td>31</td>
<td>32</td>
<td>Felt uncomfortable, afraid or ashamed</td>
</tr>
<tr>
<td>23</td>
<td>48</td>
<td>Services seemed too unfamiliar or foreign</td>
</tr>
<tr>
<td>7</td>
<td>18</td>
<td>Unable to get transportation</td>
</tr>
<tr>
<td>43</td>
<td>80</td>
<td>Couldn't afford it</td>
</tr>
<tr>
<td>10</td>
<td>13</td>
<td>Resistance from family members or friends</td>
</tr>
</tbody>
</table>

Note: The women give more reasons, the percentage relate to 90 males and 60 females sample size not just ones with problems or not getting help. Males 40, females 48.

San Bernardino County

As was the case with the Riverside County respondents,
the San Bernardino County respondents also indicated a low level of awareness of available mental health resources. The resource facility receiving the most acknowledgement was Ward B (psychiatric ward), San Bernardino County Hospital (indicated by 26% of the respondents). Table 6 indicates the available mental health resources and the degree to which the San Bernardino respondents were aware of them.

Concerning the patterns of seeking help for specific problems, the results are presented in Table 7. Once again, the results for the San Bernardino County respondents were very similar to those for the Riverside County respondents. The main tendency when dealing with family-related problems was to consult a minister or priest, when dealing with personal problems to rely on oneself, and when dealing with physically-related problems to resort to a physician.

With respect to the number of San Bernardino County respondents who had ever received help for emotional problems 22% (33 respondents) had received help. In terms of sex of the respondent, 26% (22 respondents) of the males and 20% (11 respondents) of the females had received help for emotional problems. Regarding the number of respondents who had or had not ever received help for emotional problems, chi-square tests revealed that there were no statistically significant differences between the respondents of the counties of Riverside and San Bernardino as a whole, between male and female respondents of these two counties across and with-
Table 6
Percentage of Respondents Familiar with Various Mental Health Resources:
San Bernardino County

<table>
<thead>
<tr>
<th>Resource</th>
<th>Percentage of Respondents Familiar with Resource</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loma Linda University</td>
<td>15</td>
</tr>
<tr>
<td>Al-Anon Alcoholism Rehabilitation Center</td>
<td>8</td>
</tr>
<tr>
<td>Alana Club-We Care</td>
<td>3</td>
</tr>
<tr>
<td>La Vista Alcoholism Center</td>
<td>3</td>
</tr>
<tr>
<td>Nueva Vida</td>
<td>13</td>
</tr>
<tr>
<td>Casa Ramona</td>
<td>18</td>
</tr>
<tr>
<td>ALCO</td>
<td>1</td>
</tr>
<tr>
<td>Patton State Hospital</td>
<td>8</td>
</tr>
<tr>
<td>Ward &quot;B&quot;, San Bernardino County Hospital</td>
<td>26</td>
</tr>
<tr>
<td>Family Service Association</td>
<td>5</td>
</tr>
</tbody>
</table>

Note: Respondents gave a high response to San Bernardino General Hospital because they associate it with the General Hospital and not necessarily with the psychiatric unit.
Table 7

Percentage of Respondents Identifying Specific Resources for Help with Three Types of Problems:
San Bernardino County

<table>
<thead>
<tr>
<th>Resource Sought</th>
<th>Family-Related</th>
<th>Personal</th>
<th>Physically-Related</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counselor</td>
<td>2</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Psychiatrist, MD</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Minister/Priest</td>
<td>48</td>
<td>30</td>
<td>36</td>
</tr>
<tr>
<td>Physician</td>
<td>1</td>
<td>12</td>
<td>44</td>
</tr>
<tr>
<td>Mental Health Worker</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Community Leader</td>
<td>15</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Social Worker</td>
<td>5</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Police</td>
<td>3</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Special Interpreter</td>
<td>26</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Psychologist</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Chaplain</td>
<td>8</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td>Family</td>
<td>21</td>
<td>13</td>
<td>6</td>
</tr>
<tr>
<td>Teacher</td>
<td>4</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Friend</td>
<td>30</td>
<td>21</td>
<td>8</td>
</tr>
<tr>
<td>Self</td>
<td>25</td>
<td>42</td>
<td>38</td>
</tr>
<tr>
<td>Folk Healer</td>
<td>12</td>
<td>16</td>
<td>20</td>
</tr>
</tbody>
</table>

Note: Columns total more than 100% because respondents could give more than one response.
in gender, nor between male and female respondents within each county.

Of the 22 males who had received mental health help, 5 (22.7%) were very satisfied with the services they had received, 3 (13.65%) were somewhat satisfied with the services they had received, and 14 (63.65%) were dissatisfied with the services they had received. Of the 11 females who had received mental health help, 4 (36.36%) were very satisfied with the services they had received, 2 (18.18%) were somewhat satisfied with the services they had received, and 5 (45.56%) were dissatisfied with the services they had received. In terms of service satisfaction, chi-square tests revealed no statistically significant differences between the male and female respondents of San Bernardino County, nor between the respondents of San Bernardino and Riverside Counties taken as a whole as well as according to the sex of the respondent.

With regard to San Bernardino County respondents having an emotional problem for which help was not received, 74% (62 respondents) of the male and 79% (52 respondents) of the female respondents reported having a problem for which help was not received. The most frequently cited reasons for not receiving help were for both male and female respondents: (a) language communication problems; (b) not knowing where to go for help; (c) services seemed too unfamiliar or foreign; and (d) inability to afford services. Complete re-
suits regarding this matter are given in Table 8.

Table 8
Percentage of Respondents Giving Reasons for Not Receiving Help for an Emotional Problem: San Bernardino County

<table>
<thead>
<tr>
<th>% Males</th>
<th>% Females</th>
<th>Reason for not Receiving Help</th>
</tr>
</thead>
<tbody>
<tr>
<td>63</td>
<td>74</td>
<td>Language communication problems</td>
</tr>
<tr>
<td>74</td>
<td>61</td>
<td>Did not know where to go for help</td>
</tr>
<tr>
<td>49</td>
<td>33</td>
<td>Felt uncomfortable, afraid or ashamed</td>
</tr>
<tr>
<td>69</td>
<td>59</td>
<td>Services seemed too unfamiliar or foreign</td>
</tr>
<tr>
<td>19</td>
<td>27</td>
<td>Unable to get transportation</td>
</tr>
<tr>
<td>50</td>
<td>79</td>
<td>Couldn't afford it</td>
</tr>
<tr>
<td>18</td>
<td>12</td>
<td>Resistance from family members or friends</td>
</tr>
</tbody>
</table>

Concerning the reasons why respondents had not received help for an existing emotional problem, the response pattern was similar for the Riverside and San Bernardino County respondents, except for the fact that the percentage (74%) of San Bernardino County male respondents who had reported not receiving help for a problem was much higher than the percentage (44%) of Riverside County male respondents who had reported having a problem for which help was not received. This difference, however, can be attributed largely to the fact that the San Bernardino County male respondents had mentioned physically-related problems for which help had not been received in addition to only family and personal problems reported by the Riverside County male respondents.
CHAPTER IV

SUMMARY OF FINDINGS

The results of this study showed a low level of awareness of available community mental health resources on the part of the survey respondents. Only one-fourth of the 300 study participants were able to acknowledge familiarity with at least one community mental health resource, and even then the acknowledgement was in connection with the mental health units of Riverside and San Bernardino County Hospitals. Consequently, responses in this case were dictated largely by a familiarity with the image of the county hospital, with its high visibility to the community at large.

Although the level of awareness of existing mental health facilities was low, two-thirds of the study participants reported having had an emotional problem for which help had not been received. Thus, even though the need exists, there are several possible explanations.

1.) Lack of awareness was a significant problem, with more than one-half of the survey respondents reporting that they did not know where to go for help.

2.) Communication was also shown to be a major obstacle

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to receiving mental health services, with almost two-thirds of the survey respondents citing language communication problems as a reason for not receiving help for an emotional problem. This points out the significance of the language barrier factor between the Spanish and English-speaking sectors.

3.) The economic plight of Hispanics continues to be evident, with 60% of the study participants citing inability to afford services as a reason for not having utilized mental health services when needed. Sixty-two percent of the survey respondents reported an annual income of less than $10,000, and three-fourths of the female respondents were.

4.) The issue of cultural differences could be seen in that one-half of the survey respondents reported that mental health services seemed too unfamiliar or foreign. The organizational rigidity of mental health institutions which tends to hamper the development of appropriate services culturally are relevant to Hispanic populations.

Only one-fourth of the survey respondents had ever actually received mental health services at one time or another, and of these 42% reported that they were dissatisfied with the services they had received. This is an important statistic, because satisfaction with services provided is crucial in terms of having persons continue to make use of existing services.
In asking the survey respondents to identify specific individuals who might be consulted to help with various problems, the importance of religion in the lives of Hispanics was disclosed. When experiencing family problems, almost one-half of the study participants indicated the tendency to consult a priest or minister. Professional mental health individuals were rarely mentioned, but friends and family were mentioned quite frequently. Along with religion, both friends and family play an important role in the lives of Hispanics.

In terms of personal problems, 39% of the study participants indicated a reliance on oneself. This is in line with the fact that 37% of those who had reported not receiving mental health help for an existing emotional problem cited feeling uncomfortable, afraid, or ashamed as a reason. This was especially so for the male respondents; receiving help for males might be seen as a violation of the preconceived Hispanic male image which emphasizes self-strength.

Next to relying on oneself for resolution for personal problems, the survey respondents indicated the tendency to consult a priest, minister, or a friend, rather than consulting a mental health professional. In both the case of family-related and personal problems, the indication is that Hispanics tend to resort to informal, everyday life sources of help rather than seeking out formal, professional, mental health help.
With regard to physically-related problems, however, the main tendency was to first consult a physician (42% of the respondents), followed by consulting a priest or minister (33% of the respondents) and reliance on oneself (32% of the respondents).

For family-related, personal, and physically-related problems pooled together, only 15% of the study participants indicated a tendency to consult folk healers. This is consistent with the disclosure in the literature that folk medicine use by urban Hispanics is not widespread.

In overall comparison, the Riverside and San Bernardino County respondents were very similar in their pattern of response to the mental health issues presented in the survey questionnaire, with no major nor significant differences being evident. This points to the continuity of the unique and particular mental health situation across two large counties (broad sector) of the Hispanic population in California.

Recommendations

In view of the low level of awareness of available mental health facilities, special effort should be made to increase awareness within the Hispanic community. One obvious way to do this would be through the local mass media instruments of radio, television, and news and entertainment periodicals. Also, bulletins could be posted at such high volume establishments as grocery markets. In addition, taking into consideration the important factor of religion in the
lives of Hispanics, priests and ministers could be encouraged to be affiliated with mental health facilities and services in the community, thereby serving as significant agents of referral. Finally, there is the possibility of making use of volunteer workers from the community, and having them spread awareness of existing mental health facilities and programs.

It was seen that language communication problems contributed to the underutilization of mental health services by Hispanics. Consequently, it is important to have bilingual mental health personnel who are able to communicate adequately with the Hispanic client. Also, the number of Hispanics in the mental health profession needs to be increased. In this respect, continued funding such as minority fellowships from the National Institute of Mental Health for graduate students in the professions of psychology, psychiatry, and social work is crucial. Another alternative of immediate consequence is to increase the number of Hispanic mental health paraprofessionals.

Since many Hispanics see mental health services as unfamiliar or foreign, mental health facilities should strive to provide services by fully taking into account the Hispanic cultural perspective. In addition, service delivery to Hispanic clients should take place on more of a collegial rather than bureaucratic level. Also, the existing socio-
economic conditions of Hispanic clients should be given particular attention. This includes an attempt to meet the immediate external needs of the Hispanic client which may constitute a stressful or crisis situation, such as helping to work or housing, or meeting basic family needs.

In view of the tendency to rely on family and friends, Hispanics most of the time rely on their families for emotional support, and is a form of cultural obligation for the family to help any member who may need emotional support. It is important to consider that this type of extended family support system is offered to immediate family members or relatives. When family tie does not exist according to (Keefe, Padilla, Carlos, 1978) its absence or malfunction must be that much more distressing. Thus, with respect to the relationship of the family and mental health, rather than accentuating the strength of the Hispanic American family, we might better emphasize the intensified isolation and stress experienced by those Hispanic Americans who lack supportive families. The importance of the extended family concept should be recognized and incorporated into the mental health treatment plan when possible in dealing with the mental health problems of Hispanics. For it is the totality of cultural experience which must be considered in developing treatment modalities.

The California Raza health plan is an action guide for the promotion of Raza Health in California takes the
positive and effective approach of dealing with the problems of Hispanics directly according to their social, cultural, and economic condition and orientation. The Raza Mental Health perspective goals is to insure the provision of an adequate level of mental health inpatient and out patient and prevention services to Raza communities. To insure that such services support and strengthen the psycho-cultural development of individual self-esteem and community well being it is necessary to design the essential elements of mental health programs within a cultural context including:

1.) intake procedures
2.) staffing and scheduling patterns
3.) innovative treatment modalities
4.) community outreach

The accomplishment of the preceding goals will lay the ground work for the development of an effective Raza Mental Health Delivery System. Thus, this approach is relevantly cognizant of the total array of needs of the Hispanic population.

Ongoing research pertaining to the various factors related to the mental health status of Hispanics needs to be continued. Clarification of relevant issues and factors through research can serve to improve the quality and effectiveness of mental health service delivery to Hispanics within the community.

Considering the rapid and continual increase in the
growth of the Hispanic population in California and also in other areas of the United States, the issue of mental health within Hispanic communities takes on a special significance. This is a fact that is particularly recognized and appreciated by the author, having worked for 14 years as a minister in Hispanic communities and also being Commissioner of Community Relations for the City of Riverside, California.
APPENDIX A
HISPANIC COMMUNITY
MENTAL HEALTH AWARENESS SURVEY
COUNSELING, CRISIS INTERVENTION IN
RIVERSIDE COUNTY AND SAN BERNARDINO COUNTY

BACKGROUND

Sex: Male____ Female____
Age: ______
Marital Status: Married___ Single___ Divorced___ Widow/er___
Years of schooling completed: Elementary___ High School___
College___ Other___
Employed___ Unemployed___
Annual Income:_____________ Under $5,000___________
$5,000 to $10,000__________ Over $10,000___________
Where were your parents born? (Both father and mother)___________
______________________________
Your citizenship________________
Your history (e.g. first, second and third generation in this country)
______________________________

Do you see yourself primarily as:
   a. Mexican (or other Hispanic: Specify e.g. Cuban)____
   b. Bicultural____
   c. Acculturated American____
Religious affiliation: Catholic____ Protestant____ Other____
Form completed in _____English ____Spanish

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2. Do you know about any of the places in this area where people can go to get help for their emotional problems? Yes______No______

____ALCO
____Family Service Association
____Loma Linda University
____Teen Challenge Center
____Christian Counseling Center
____Stresscenter
____Al-Anon Alcoholism
____Rehabilitation Center
____Alana Club-We Care
____La Vista Alcoholism Center
____Nueva Vida
____Knollwood Center
____Casa Ramona
____Patton State Hospital
____Chapman General Hospital
____Psychiatric Ward Riverside
____General Hospital or Ward "B"
____San Bernardino
____Community Counseling Center
____Private Psychologists/
____Psychiatrists
____Kellogg Psychiatric Hospital
____Gardena Parkwood Community
____Hospital
____Others (specify)

3. Do you know about any of the crisis-hotlines in this area?

Yes______No______

If yes, which?______ _______ Don't know exact name or number.

4. If you wanted help for any of the following problems, who do you think you would see or talk to?
<table>
<thead>
<tr>
<th><strong>(A)</strong></th>
<th><strong>(B)</strong></th>
<th><strong>(C)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Family related problems w/ children, parents, marital, divorce, widowhood</td>
<td>Personal problems (such as feelings of sadness, depression, anxiety, nervousness, job/school/friendship difficulties)</td>
<td>Physically related problems such as difficulty sleeping, weight control, smoking, having sexual problems over-use of alcohol/drugs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Counselor</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrist, M.D.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minister - Priest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Worker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Leader</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Worker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Police</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Special Interpreter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chaplain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teacher</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friend</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Folk Healer</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5. Can you tell me if you have ever received help for emotional problems, and if so, how do you feel about the services you received.

___YES, I received help ___NO, I have not received help

If yes (above) specify service (agency of type of help) and satisfaction.

a. How satisfied___ Very satisfied ___ Somewhat Satisfied___ Dissatisfied___

6. Have you ever had an emotional problem for which you did not receive help?

Yes____ No____

If yes, what type of problem?

Why did you not receive help? (Check as many as apply)

___Language communication problems
___Did not know where to go for help
___Felt uncomfortable, afraid or ashamed
___The services seemed too unfamiliar or foreign
___Unable to get transportation
___Couldn't afford it
___Resistance from family members or friends

DEBRIEFING QUESTIONS OR COMMENTS:
INTRODUCTION AND DEBRIEFING COMMENTS

Introduction to Respondents:

My name is Raul G. Guilarte and I am a graduate student from the State College in San Bernardino.

I am doing a study on how the Spanish people get help for their emotional problems and I wonder if you would like to take a little time to help out with the study.

I also want to tell you that, if at any time you like to pass on any of the questions, please feel free to do so.

Are there any questions you feel you should ask or comments you would like to make? We hope that the results of this study will be useful in improving the services available to our Hispanic community. If you are interested in receiving a summary of the results, we will be happy to send it to you.

If you think you will have some time to help us, please mark on the place prepared for it. Thank you.

Yes, I will be happy to help ______________________

No, I am sorry, but I won't be able to help____________

If there is another time more convenient for you to help, please state it____________________________________

Thank you very much for participating in this important study.

Sincerely,

Raul G. Guilarte
APENDICE B
COMUNIDAD HISPANA
ENCUESTA DE CONOCIMIENTO DE SALUD MENTAL
ORIENTACION SOBRE INTERVENCION EN CRISIS
de los
CONDADOS DE RIVERSIDE Y SAN BERNARDINO

ANTECEDENTES:
Sexo: Femenino _____ Masculino_____  
Edad: _____
Estado marital: Casado___ Soltero____ Divorciado____ Viudo/a____
Educación: Años completados: Elemental___ Escuela Superior____
           Colegio_____ Otro_____  
Empleado____ Desempleado______
Entrada anual _______ Menos de $5,000________  
$5,000 a $10,000_____ Sobre $10,000_______  
?Dónde nacieron sus padres? (Ambos, padre y madre)____________
__________________________  
Usted es ciudadano/a de ____________________  
Su historia (por ej. primera, segunda y tercera generación en este país)
______________________________  
?Usted se considera primordialmente como
   a. Mexicano/a (u otro país Hispano: Especifique si es Cubano)
   __________________  
   b. Bicultural_______  
   c. Aculturación Americana ____________  
Afiliación Religiosa: Católica____Protestante_____Otra_____  
Forma completada en ______________________ Inglés______________  
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2. ¿Sabe usted de alguno de los lugares en esta área donde la gente puede ir en busca de ayuda para sus problemas emocionales?

Sí_____ No_____

___ALCO
___Family Service Association
___Loma Linda University
___Teen Challenge Center
___Christian Counseling Center
___Stresscenter
___Al-Anon Alcoholism
___Rehabilitation Center
___Alana Club-We Care
___La Vista Alcoholism Center
___Nueva Vida

___Knollwood Center
___Casa Ramona
___Patton State Hospital
___Chapman General Hospital
___Psychiatric Ward Riverside General Hospital or Ward "B" San Bernardino
___Community Counseling Center
___Private Psychologist/
___Psychiatrics
___Kellogg Psychiatric Hospital
___Gardena Parkwood Community Hospital

___Otros (Especifique)

3. ¿Sabe usted de alguna de las líneas de emergencia en esta área?

Sí_____ No_____

Si su respuesta es "sí" diga cuál____________________

No sé el nombre o el número de teléfono exacto__________

4. Si usted quisiera recibir ayuda para cualquiera de los siguientes problemas, quién cree usted que iría a ver o a consultar?
<table>
<thead>
<tr>
<th>Consejero</th>
<th>Psiquiatra</th>
<th>Ministro-Sacerdote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Médico</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trabajador de Salud Mental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Líder de la Comunidad</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trabajador Social</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policía</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intérprete</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psicólogo</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capellán</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Familia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meistro</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amigo</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sí mismo</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Curandero</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Problemas de familia relacionados con hijos, padres, divorcio y viudez.

Prob. personales (como tristeza, depresión, ansiedad, nerviosismo, dificultades con la escuela, amistades) etc.

Prob. físicos, como dificultades para dormir, control de peso, fumar, problemas sexuales, exceso de alcohol y droga.
5. ¿Puede usted decirme si ha recibido alguna vez ayuda para problemas emocionales? y si es así, ¿cómo se siente usted en cuanto a los servicios que recibió?
   ___ Sí, recibí ayuda  ____ No, yo no he recibido ayuda
Si su respuesta anterior fue "sí" especifique qué clase de servicio, (agencia o tipo de ayuda) y satisfacción.
   a. Cuán satisfecho/a_______ Muy satisfecho/a_______
       Un poco satisfecho/a_______ Insatisfecho_______

6. ¿Ha tenido usted un problema emocional alguna vez para el cual usted no recibió ayuda?  
   ___ Sí ___ No_______
Si su respuesta es "sí" ¿qué tipo de problema fue? ______

¿Por qué no recibió usted ayuda? (Marque tantas como sean aplicables)

   ______ Problemas de comunicación por el idioma
   ______ No sabía a dónde ir en busca de ayuda
   ______ Me sentí incómodo/a, con miedo, avergonzado/a
   ______ Los servicios parecían muy poco familiares o extraños
   ______ No pude conseguir transportación
   ______ No pude pagar lo
   ______ Resistencia de la familia o de amigos

PREGUNTAS DE INTERROGATORIO O COMENTARIOS:

Raul G. Guilarte
INTRODUCCION Y PRESENTACION DE COMENTARIOS

Introducción a las respuestas:

Mi nombre es Raul G. Guilarte y soy un estudiante graduado del State College de San Bernardino.

Estoy haciendo un estudio acerca de cómo pueden los Hispanos hallar ayuda para sus problemas emocionales y yo me pregunto si a usted le sería posible usar un poquito de tiempo para ayudarnos con este estudio.

Yo quisiera decirle también que si en cualquier momento usted desea pasar a otros cualquiera de estas preguntas, síntase libre de hacerlo.

Hay algunas preguntas que usted piensa que debería hacer, o comentarios que a usted le gustaría hacer? Esperamos que los resultados de este estudio sean útiles en mejorar los servicios disponibles para nuestra comunidad Hispana. Si usted tiene interés en recibir un sumario de los resultados, estaremos más que gustosos de enviárselo.

Si usted piensa que podrá tener un poquito de tiempo para ayudarnos, por favor, marque en el lugar indicado y preparado para hacerlo. Muchas gracias.

Sí, tendré mucho gusto en ayudar

No, lo siento, pero no podré ayudar

Si hubiera otro tiempo más conveniente para usted ayudarnos, díganos cuál es

Muchas gracias por su participación en este importante estudio.

Sinceramente,

Raul G. Guilarte
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