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INCREASING THE UTILIZATION OF HEALTH
CARE SERVICES BY MEXICAN AMERICANS:
AN EXPERIMENTAL APPROACH

By

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A DISSERTATION

Submitted to
Michigan State University
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for the degree of

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Department of Psychology

1980

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ABSTRACT

INCREASING THE UTILIZATION OF HEALTH CARE SERVICES BY MEXICAN AMERICANS: AN EXPERIMENTAL APPROACH

By

Miquela C. Rivera

The primary purpose of this study was to experimentally investigate the problem of caregiver-consumer linkages and the provision of culturally relevant health services to Mexican Americans in Lansing, Michigan. It used an informational outreach component to investigate whether the knowledge of the availability of a curandera's (folk medical practitioner's) services in a health center would significantly affect service utilization rates by Mexican Americans. It also investigated attitudinal, perceptual, belief and socioeconomic correlates of Mexican American health care behavior.

Two treatment and one control group comprised the final sample of 101 in this study. One treatment group received outreach visits at home in which they were informed of contemporary medical services available through a neighborhood health program. The second treatment group received the same information as the first treatment group but were also told that the services of a curandera or folk healer were available through the Health Program. The control group received no outreach contacts whatsoever. Four weeks after outreach, all groups were contacted for a follow-up

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survey.

A primary measure determined the effectiveness of the outreach contacts: receipt of a service through the Health Program. There were no significant differences between treatment groups on receiving a service. Significant differences in service use were found when treatment groups were compared with the control group. The outreach contact itself, not the folk medical dimension, resulted in increased service use.

No significant differences were found between treatment groups on the follow-up survey scales. When subjects were grouped according to language spoken during the interview, significant differences were noted in Health Anxiety and Health Locus of Control Scales. Subjects interviewed in Spanish reported greater Health Anxiety and more external Health Locus of Control than those interviewed in English. When grouped according to educational level, subjects with less than an eighth grade education reported poorer health status, greater health anxiety and worse health histories than those with more education. A significant difference in service use was noted when subjects were grouped according to receipt of government assistance. Recipients of government assistance used health program services after outreach contact more than those not receiving government aid.

Pearson correlations between survey variables generally indicated that health status, health histories, health

Miquela C. Rivera

anxiety and attitudes towards health care delivery were related to economic variables such as monthly income or the ability to afford medical payments. Findings were discussed in terms of differential health care received and socioeconomic factors. Implications for health care policy formation, service delivery and future research with Mexican Americans are discussed.

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CHAPTER I

INTRODUCTION

Projections by the United States Bureau of the Census predict that the Hispanic* population will be the largest ethnic group nationally by the turn of the century. Mexican Americans comprise the largest Hispanic subgroup in the United States. Researchers, administrators and health care providers must plan and implement health services to meet the needs of Hispanics based upon reliable data from various segments of the population.

Most of the early research on Mexican American health care behavior were conducted with very low income Mexican Americans in rural areas of the Southwest. Anthropological in nature, these studies were frequently compared to findings of research based on middle-class white populations. As a result, Mexican Americans were viewed as having "primitive, unscientific" attitudes towards health and illness and firm beliefs in traditional Mexican American folk medicine (Curanderismo). Researchers explained these differences in health care behavior in terms of cultural differences. Two

*Hispanics: People whose ancestry stems from Mexico, Puerto Rico, Cuba, Spain, Central and South America (excluding Brazil).

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decades of research and service delivery were subsequently based on these early studies.

The urban Chicano has largely been the focus of Mexican American health care research in the last decade. Researchers critical of the early work in the field note that previous studies promote ethnocentric stereotyping and do not consider health system variables that pose barriers to Mexican Americans attempting to use existing services. The role of attitudinal, socioeconomic and health system variables in Chicano health care behavior have been investigated in recent studies through survey research methods.

No studies to date have experimentally investigated cultural, attitudinal and socioeconomic variables in Mexican American health care. This research was designed to experimentally investigate the problem of caregiver-consumer linkage and the provision of culturally relevant health services to Mexican Americans in Lansing, Michigan. It uses an informational outreach component to investigate whether knowledge of the availability of a curandera's (folk medical practitioner's) services in a health center will significantly affect service utilization rates by Mexican Americans. It also investigates attitudinal, perceptual, belief and socioeconomic correlates of Mexican American health care behavior.

The background for the conceptual framework of this research is discussed in this chapter. First, literature

on health care beliefs and attitudes in the general population are reviewed. Factors affecting health care utilization rates by Mexican Americans are then detailed. Third, the problem of linkage between health services and community members is reviewed. Finally, a brief description of this experimental research is presented. Detailed research methodology is presented in Chapter II, and findings of the project are reported in Chapter III. Conclusions and implications for service delivery and future research are made in the final chapter.

REVIEW OF THE LITERATURE

Beliefs, attitudes and values are "ordering mechanisms" which provide continuity and structure for a person's psychological world. They are cognitive organizations of a person's knowledge and perceptions of previous experience. "Beliefs tell us how things are related to each other, attitudes tell us how we relate to them, while values tell us how to choose from among objects and events." (King, 1962, p. 53.)

Beliefs are the pattern or meaning of things or events. They are comprised of knowledge, opinions and faith about life experiences. Attitudes add an affective component to beliefs, resulting in a readiness to act. Attitudes frequently are seen as either positive or negative, depending upon the emotion attached to the belief. Values are principles by which people establish priorities among

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needs, desires and goals. Beliefs, attitudes and values thus help an individual find meaning in events and answers to various life situations. They assist a person in achieving various goals.

Beliefs and attitudes can be clear and explicit or vague and indistinct. Some may be interwoven in a belief or attitudinal system, while others may be distinct and separate. Beliefs and attitudes that are central to the individual's personality structure are generalized, well organized and based on that person's need for identification with people and groups.

Cultural and social backgrounds are important factors in the development of an individual's beliefs, attitudes and values. Margaret Mead (1953) defined culture as those learned behaviors and traditions in arts, sciences, technologies, religions and philosophies, foods, daily living practices and political systems passed from one group to their children or other immigrant groups that become members of the society. Culture thus serves as a systematic device for perceiving the world (Paul, 1955). As cultures vary, so do world views. Cultural groups will thus vary in the extent to which they perceive circumstances as illness or health, normalcy or abnormalcy, needing remedy or not.

Social class membership is another factor in the individual's development of beliefs, attitudes and values. Level of education, occupation, income, prestige, place of residence and social interactions are frequently used as

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indices of social class. Social class groupings provide frameworks for common values, leisure activities, customs, aspirations and child-rearing practices. They influence one's perception of a situation, including those pertaining to health care.

Ethnic group membership is determined by a common background in language, customs, habits and traditions of racial or national origin. Racial consciousness and pride are of central importance, too. Family structure, marriage patterns, and daily life practices are influenced by ethnicity. Health attitudes, beliefs and values also vary accordingly. The definitions of health and illness, preventive and treatment measures, and expectations of intervention differ between ethnic groups.

One's perception of the world is a dynamic process in which cultural, social class and ethnic factors contribute and interact. Since these perceptions are dynamic, the importance of each factor will vary from situation to situation.

Health, illness and death are biological and social phenomena. They influence the individual's physical well-being and affect roles and social relationships. Beliefs and attitudes toward health and illness are important in understanding how a group will perceive and react towards illness. The meaning, definition, classification, prevention and treatment of health and illness may all be

influenced by beliefs and attitudes as well as culture, social class and ethnicity (King, 1972).

Three general considerations should be recognized in reviewing health belief and attitude systems. Primarily, health beliefs and attitudes will be integrated with other belief and practice systems, such as familial networks, religious beliefs and political and social control. Second, the perception and treatment of health and illness will vary from group to group. Third, the group will hold firm in their assurance of the adequacy of their health belief system.

King (1962) places health attitudes and beliefs into three major categories: scientific medicine, primitive medicine, and folk medicine. Considerable variation occurs within each, yet each type has distinguishing characteristics. An individual or group can ascribe to more than one belief system. One system exists within each individual or group, but an alternative system may be called upon under severe, unpredictable or threatening health situations.

Scientific Medicine

The rational explanation of health and illness in terms of cause and effect is the basic feature of scientific medicine. Cause is viewed as naturally occurring, not supernatural. Facts are determined in this belief system through the scientific method of observation, description and classification. Hypotheses are derived through

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inductive reasoning and predictions tested through experimentation. In turn, findings are compared to basic principles, with the latter being changed as necessary.

Primitive Medicine

Primitive medicine is based on magic. Causal relationships in primitive medicine are viewed as supernatural, not natural. The supernatural laws are unchangeable, so experimentation is not necessary. Tradition is an important support for the powers of the supernatural.

"Primitive" medicine is so named because it was the first health system in existence, is unsophisticated, and found most frequently today among pre-literate, unscientific societies.

Though unsophisticated, primitive medicine may be detailed and complex. Magic may be used in all life areas such as work, war and in family relationships. Objects are tied together through magic, and rituals become mechanistic. Efficiency in health is thus determined by a magical element. Disease may be caused by a number of factors: sorcery, breach of taboo, disease object intrusion, soul loss and spirit intrusion.

Folk Medicine

Traditional nonprofessional beliefs about health care are the key to folk medicine. Folk medical beliefs gain much credence from experience of elders, and case or natural

empirical evidence. Cause and effect are noted in folk medicine, but the mechanism producing illness is not understood scientifically. Since folk medicine is empirical rather than experimental, it is rather disorganized and fraught with contradictions. These deficits, however, are minimized by the adherence to tradition.

Folk medicine is typically characterized by the use of home remedies. Its roots lie in agrarian social practices, involving the group rather than selected professionals. Since the beliefs are shared by everyone and passed through generations, there may be resistance to change as societies develop. It exists in some societies alongside primitive or scientific medicine with little conflict. The role of folk medical beliefs in the health care behavior of Mexicans and Mexican Americans will be elaborated in another section of this chapter.

Prevalent throughout many folk medical belief systems is the idea that health is maintained through the balance of hot and cold forces in the body. When one is overexposed to one or the other, disease results. Foods, liquids, body states, illnesses and the environment are considered inherently hot or cold regardless of their actual thermal quality. The hot-cold dimension of folk medicine is notable in folk medicine of India, Spanish-speaking countries, and Greece or groups influenced by Greek thought.

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Body fluids are often the center of certain folk medical beliefs that have little or no substantiation in scientific medicine. Blood and semen are seen as central agents of strength and resistance to illness. If semen or blood is lost, resistance decreases. In the United States, for example, folk medical beliefs state that blood "thickens" in the winter and must be "thinned" or purified with sulfur and molasses in the Spring.

Health Beliefs and Attitudes in the United States

Talcott Parsons (1979) described health attitudes and values in the United States in terms of the nation's general value system and social structure. He viewed Americans as achievement oriented and concerned primarily with role-performance. Parsons considered education and health the basic essential components for achievement. The maintenance of health itself thus becomes an important value among Americans. Any disturbance in a person's ability to fulfill a role is most likely viewed as illness. Health services provide protection and restoration of the person's capacity for achievement. Instead of passive acceptance of illness, American society promotes the person's mastery over illness and complete cooperation with the health care provider. A person thus works to achieve recovery, as he works to achieve other valued goals. Illness is viewed as an undesirable condition to be recovered from as quickly as

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possible. When medical science sanctions that a person "can't help" his illness, it is generally accepted by society. Where scientific evidence is not readily available, American health attitudes reflect that the person probably could help or avoid the illness. Plans for "free" health care are frequently viewed with suspicion by some because of the readiness of people to claim illness whenever possible.

In a Regionville, New York study by Koos (1967) health care attitudes and behavior were found to vary according to social class. Cost and age were also significant factors, with the former being a deterrent to health care and the latter a promoter. Psychogenic needs, social role, symptom occurrence and class values all affected the perception of health and illness in the sample.

A National Opinion Research Center study sponsored by the Health Information Foundation (King, 1962) surveyed a cross-section of the American public on their health beliefs and attitudes. Data were analyzed in terms of sociological and demographic variable breakdowns.

Positive or preventive health were concepts familiar only among the upper socioeconomic classes. The low income viewed illness as an inevitable part of life. The lower social class also had poorer nutrition and used health services less than those of higher income. Low income respondents displayed much less knowledge about scientific

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medicine, particularly contagion. While inadequate knowledge does not necessarily mean that the person will not use scientific medicine, he may be less inclined to do so if aspects of the health care system pose barriers to the patient. Wary of the doctor and medically naive, some still rely to some extent on folk medicine.

Overall, results of the NORC-HIF survey indicated that most respondents utilized existing health services and had faith in medical personnel. Scientific medicine dominates nationally, with folk medicine occasionally being practiced as an added or alternative approach.

Health Care Utilization

In the past two decades much literature has dealt with differences in the use of mainstream medical facilities. Despite the extent of the literature, McKinlay (1972) concluded that the literature were more substantial than the findings, results were inconsistent, and little had been done to account for the disparities. A number of variables related to health care use have been delineated, however, and investigated in subsequent studies. McKinlay defined six sets of factors evident in health care utilization.

Economic aspects of health care were examined. While cost was a factor, its removal did not significantly affect the rate at which health care services were used. Socio-demographic variables (age, sex, religion, socioeconomic

status, education, race) are related to health care usage, but explain little in terms of causal relationships. Geographic location of services was also considered an important determinant of health care usage. Little evidence exists to show proximity of services to consumers as a significant variable. Social psychological variables such as knowledge of cure, recognition of need, and alienation from health care services have also been studied, but findings remain unclear. Sociocultural variables have been studied as factors in health service usage because groups dictate health beliefs and practices. Cultural differences in health care patterns have been studied by Koos (1967), Denton (1978) and Zola (1966). Organizational variables comprise the sixth set of factors delineated by McKinlay as important to health service utilization. The discrepancies between beliefs and practices of health care providers and those of consumers have been noted as deterrents to service use.

Mexican American Health Care

Accurate demographic data on the Mexican American population nationally have been scarce because government sources traditionally have not regarded "Mexican American" as a distinct ethnic classification in census information. The U. S. Bureau of the Census estimated that the Hispanic or "Spanish origin" population nationally numbered over 9

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million in 1971 (USBC, 1971). Of these, approximately five million persons were of Mexican descent (Forbes, 1970). Available census information and population growth trends have currently placed Mexican Americans as the second largest and fastest growing minority in the United States. An historical overview of Mexican Americans nationally and in the Midwest specifically is elaborated in Appendix A.

Investigations of Mexican American Health Care Behavior

Weaver (1976) noted three historical phases in research and analyses of Mexican American health care behavior. He repeatedly noted the theme that Mexican American health behavior was a consequence of and reinforcement for a community-wide subculture (Weaver, 1978).

Lyle Saunders, the first noted investigator, is noted for his impact upon subsequent analyses of Mexican American health care behavior. In the late 1940's, Saunders (1954) used anthropological and ethnographic investigations in attempting to formulate a cultural perspective of health care behavior. He used Latin American investigations as a background for describing six families in New Mexico. Saunders proposed that four basic sources of health care existed and were utilized by Mexican Americans: (1) folk medical beliefs originating in Spain and modified in Mexico, (2) Native American tribal practices, (3) Anglo folk medicine and (4) scientifically-based contemporary medicine.

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Saunders considered folk medicine the central core of the Mexican American health care system. He also noted that the Hispanic's health beliefs, knowledge and practices were influenced by the person's age and extent of participation in the Anglo culture. Saunders made no regional or social class distinctions among Mexican American groups. Instead, comparisons are made between general Mexican American and Anglo American health belief models (Weaver, 1976). A detailed description of basic beliefs in Curanderismo, Mexican American folk medicine, may be seen in Appendix B.

Saunders noted that Mexican American folk culture looked upon health as a matter of chance, with the individual having little control in prevention of disease. Many illnesses occurred because of supernatural forces. Many diseases could be treated by the afflicted person, an attending family member or a physician. A curandero(a) or folk healer may be seen if the disorder is thought to result from supernatural forces. Saunders noted that because of the family-centered social organization and social interaction aspects of the culture, Mexican Americans avoid hospitalization as much as possible. Their poor (if any) conceptualization of time also results in nonadherence to time schedules or return visits.

The second phase of Mexican American health care studies occurred during the middle and late 1950's. Three of the main investigators during this period developed

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detailed ethnographies of working class rural and village populations. Like Saunders's work, they focused upon folk medicine and cultural interpretations of behavior.

Margaret Clark (1959) investigated a small population of Mexican Americans in Sal si Puedes ("Escape if you can") near San Jose, California. Clark obtained information from fourteen (14) families in the barrio. Clark used Saunders's research as a framework; her findings confirm his health subculture hypothesis. Patients used self-treatment, assistance by family or friends, or consultation with a curandero(a) for medical assistance. Etiologies were similar to those in Saunders's study.

Some of the most detailed descriptive works on Mexican American health behavior were done by Rubel (1966) and Madsen (1964). Rubel's intensive research focused upon the detailed lifestyles of key informants in a small village in the Rio Grande Valley of South Texas. Madsen, alternatively, attempted to draw an overall cultural picture. Both investigators used participant observation, biographies of key informants and familiarization with many aspects of community life in their studies.

Rubel (1966) investigated natural and magical diseases, healing through the use of natural herbs, fatalistic attitudes toward illness, and reliance upon alternate support systems such as family or folk healers for medical care. Rubel noted that not the cost of health care but the fee

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system itself was a barrier to Mexican Americans receiving medical care. Folk healers are paid through gratuities, so some Mexican Americans may view physicians requiring payment as advancing themselves at the expense of the patients instead of serving the common good.

Madsen (1964) stated that reliance upon traditional folk health beliefs varies inversely with social class. Lower social class members may rely heavily upon folk healing techniques in alleviating disorders; middle class individuals would have more contemporary orientations while maintaining some traditional beliefs. Madsen noted that many Mexican Americans may struggle between contemporary medicine and traditional folk beliefs and health practices. He hypothesized that many contemporary Chicanos may actually use folk healing practices while not admitting to it openly. While Madsen contended that adherence to folk beliefs varied according to education, occupation, and social class, he viewed the Mexican American community (excluding the elite) as traditional.

On a different scale, E. Gartly Jaco (1959) conducted a statewide study on the incidence of mental illness among Mexican Americans in Texas. Jaco's data were from records of psychotic patients admitted for the first time to Texas mental institutions during 1951-1952. First-time admission rates for Mexican Americans were 42 per 100,000 population compared to 80 for Anglos and 55 for nonwhites. The Mexican

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American admissions rate to public institutions was about three times greater than their admission rate to private treatment facilities. Jaco recognized but minimized cultural differences in Mexican American health beliefs. He concluded that Mexican Americans have lower psychotic admission rates simply because they are afflicted less often than other groups.

A review of admission rates in Colorado about a decade later (Colorado Commission on Spanish-surnamed Citizens, 1967) found a slightly higher admissions rate for Mexican Americans across all classes of illnesses, not simply psychoses. Psychiatric admission rates alone were lower and alcoholism admission rates higher than those in the general Anglo population. Moustafa and Weiss (1968) found that admissions for Mexican Americans in New Mexico were 41.8 per 100,000 population compared with 53.6 for Anglos. Both studies support Jaco's findings in Texas.

Overall, during the second phase of Mexican American health care behavior research Chicanos were viewed as a fairly homogeneous group who relied upon folk medicine, reflected fatalistic attitudes toward illness and manifested a complex system of health beliefs and practices.

The research on Mexican American health care conducted during and since the 1960's has had more methodological diversity and varied scope than works done in earlier phases. Survey and ethnographic studies on large

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and small populations of varied socioeconomic strata in rural and urban settings were conducted. Politically, chicanismo or the Chicano movement for respect and recognition witnessed an upsurge in research across disciplines. This diversity resulted in new, though frequently contradictory, literature. In general, however, high morbidity, mortality and health service underutilization rates by Mexican Americans were reported.

Bachrach (1972) noted that the occurrence of mental illness among Mexican Americans varies inversely with age, with younger Chicanos showing higher incidence rates (Bachrach, 1972). Cultural and assimilation stresses and conflicts are possible explanations for such a pattern (Castro, 1977; Karno & Edgerton, 1969). Younger Chicanos may experience these difficulties more than those older because the latter may be more sheltered within the family structure.

Ari Kiev (1964; 1968) developed and presented a psychodynamic explanation of Mexican American culture in several works on folk psychiatry. Kiev explained stereotypic Mexican American traits such as male recklessness and machismo and female masochism in terms of Oedipal conflicts, unmet dependency needs and other psychodynamic concepts. He concludes that the basic Mexican American cultural traits of traditionalism, personal dignity (dignidad) and world view orientations were dysfunctional to an individual's sense of

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well-being. Kiev's implication is that intervention by a curandero(a) sensitive to the Mexican American cultural framework deters a more widespread psychoses or other disruptive behavior in the Chicano population. Curanderos(as) treat individuals with symptoms of psychopathology.

The third phase of Mexican American health behavior research included investigations of social, structural and cultural components of service delivery. These differed from the patterns of study followed in the earlier two research phases. Their general findings are reviewed further.

Mexican American Health Needs and Service Utilization

In a Colorado study (Moustafa & Weiss, 1968) infant mortality was three times the rate for Mexican Americans (13.6%) than among Anglos (4.3%). The average age of Mexican Americans at death was 56.7 years as compared to 67.5 for Anglos. Similar patterns were noted in a San Antonio, Texas study. While morbidity and mortality are high among Chicanos, they also underutilize existing health facilities. Among California hospitalization rates, Chicanos ranked lowest per 1,000 persons with 76 compared to 82 for Blacks and 95 for Anglos. Rates of visits to physicians by Mexican Americans were also comparatively low; Chicano enrollment in health insurance plans followed the same pattern.

Researchers attribute low health facility utilization rates among Mexican Americans to: (1) folk medical beliefs

and practices in prevention and treatment (2) negative attitudes toward Anglo American medical treatment, prevention and programs and (3) beliefs toward causation and prevention of illness. Reluctance of some Mexican Americans to seek help or give information to government or other agency investigators or practitioners may cast a different light on research findings (Clark, 1959; Humphrey, 1941; McWilliams, 1933).

The role of the family in health behaviors of Mexican Americans has been considered by some researchers. Some have found the family to be a source of strength and support for Chicanos experiencing mental stress (Woods, 1958), but others have argued that the family is more disruptive than supportive for many Mexican Americans (Heller, 1966; Nall & Spielberg, 1967). The latter contend that the Mexican American family stresses values which hinder mobility and are not conducive to an industrial society. Family ties, honor and present time orientation are antithetical to those values of achievement, independence and delayed gratification essential to success in the majority culture. This psychopathological view of the family has been termed the "Social Science Myth of the Mexican American Family." (Montiel, 1978, p. 56.)

A culturally-based explanation for health service underutilization by Mexican Americans emerges and gains support with Kiev's suggestion that Chicanos rely upon folk

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rather than contemporary medicine, the hypothesis that the family is the major support system, and Jaco's conclusion that illness is not as widespread in the population. Alternate health beliefs, sensitivity or reluctance to share problems with outsiders and fear of health authorities are also factors which could influence rates of health service use by Chicanos. These have been tested by investigators in the Southwest.

Karno and Edgerton (1969) found differences between East Los Angeles Mexican Americans and Anglo Americans in the perceptions of mental illness. When Chicanos were shown a situation of a person experiencing mental illness, they recommended a visit to a physician more often than Anglos did. Mexican Americans expressed greater confidence in the psychiatrist's ability to help patients and were more optimistic about the individual's recovery or the "curability" of the mental illness.

Karno and Edgerton (1969) found proportionate underrepresentation of Mexican Americans in psychiatric treatment in California. Chicanos comprised 9 to 10 percent of the population statewide but represented on 3.3% of the psychiatric resident population. On the bases of attitudinal data and utilization rates, the authors concluded that a complex of social and cultural factors, not simply traditional folk beliefs, are barriers to Mexican American health service use.

Linguistic differences, accessibility, and bureaucratic procedures are among the primary factors influencing mental health service use by Latinos (Padilla, Ruiz, and Alvarez, 1975). There are not enough mental health services sensitive and in proximity to the Latino community. Bureaucratic procedures at some mental health facilities may be frustrating and discouraging to people seeking assistance. Extensive personal information requested, checking-in procedures, long waiting periods and scheduled appointments appear intimidating, needlessly inquisitive, insensitive or rude to the Latino seeking help (Padilla, Ruiz & Alvarez, 1975). Fees may pose another barrier.

Personnel variables and treatment modalities in the mental health system also influence service utilization by Hispanics. The effects of therapist ethnicity and language have been noted with Latinos (Edgerton & Karno, 1971; Karno & Edgerton, 1969). Relevant service delivery to minorities is not merely one of matching provider and client ethnicity. Cultural sensitivity, understanding and acceptance of the Latino in his personal and social situation by the health provider is essential (Abad, Ramos & Boyce, 1977; Padilla, Ruiz & Alvarez, 1976; Yamamoto, James & Palley, 1968). The provider must also be aware of his own biases towards minorities (Jones & Seagull, 1976) since they may affect the working relationship.

Social class differences in attitudes, values, goals and lifestyles between lower and middle or upper classes are important in service delivery since therapists work most comfortably and successfully with clients of their same social class (Lorion, 1973). Treatment orientations are frequently developed on Anglo assumptions, too. The insight therapies which rely upon client verbalization have not proven to be very useful with minority groups. Perhaps the discrepancy between an individual's anticipation of treatment and the actual treatment received results in disillusionment, dissatisfaction or alienation of the individual from the system of providers. The individual can then either choose to return for treatment, go without any treatment whatsoever, or seek out alternative sources of support. Clergy, family members, friends, physicians and curanderos(as) serve as general or mental health care providers for many Mexican Americans. These sources are perceived as sensitive, understanding, accessible and fairly inexpensive (except physicians, in some cases).

Some attempts have been made to make health facilities more accessible and relevant to Hispanics. La Frontera Mental Health Center in Tucson, Arizona (Burrue1 & Chavez, 1975) is centrally located in the Mexican American community. Its bilingual bicultural staff provides services in an informal way with minimal bureaucratic procedures. Phillipus (1971) also reported successful and unsuccessful approaches

in delivering mental health services to urban Hispanics. A Denver General Hospital Mental Health Team was located in and served Hispanics in westside Denver. The Team was originally located in an old home, intake procedures were simple and scheduling hours flexible. When they later moved into new neighborhood health center facilities and used more bureaucratic procedures, the number of Hispanic clients dropped by over 50 percent within six months. While the overall number of clients increased, Hispanics represented only 35 percent of the total. Changes were introduced again and the number of Spanish-speaking clients increased. The author suggested that accessibility, the use of a bilingual receptionist (the client's first contact with the Center), a crisis orientation in treatment, bilingual staff members, drop-in facilities for clients, community involvement and active relationships with general medical services are important in providing relevant services to Hispanics.

Vivian Garrison (Fields, 1976) investigated the overlap between folk and contemporary psychiatry in order to promote understanding, collaboration, better planning and delivery of mental health services to Puerto Ricans in the South Bronx. Garrison began by investigating natural helping networks or organizational structures in the Puerto Rican community. She lived in the home of an espiritista (folk healer, somewhat similar to Mexican and Mexican American curanderos(as)) who operated her own centro or

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healing center. Garrison also located other centros in the area frequently visited by community members. A centro is similar to a neighborhood crisis center, sometimes located in storefront buildings. People spend time visiting in a reception area while waiting to see the espiritista. No appointments are scheduled. While a detailed account of services provided will not be covered here, Garrison stated important implications for service delivery. Primarily, interventions by doctors might be more acceptable if they resembled spiritist practices in certain aspects. Walk-in services with short-term treatment orientations might best meet the expectations of the Hispanic client. Home visits, combinations of individual, group and family treatment modalities, role playing rather than didactic techniques, structured problem solving rather than long-term personality change, and use of paraprofessionals are some of her recommendations for relevant services for Hispanics.

In summary, research on the health behavior of Mexican Americans has largely been based upon rural villages, subsistence farmers, or urbanized low income barrios. Weaver (1976) noted that methodological and conceptual limits of mental health studies with Mexican Americans make conclusions difficult to draw, and tenuous at best. Results are frequently contradictory to those in which variables vary slightly. These differences in population and systemic variables have not been experimentally manipulated or other-

wise empirically tested in order to determine their significance in health care. Many studies during the third phase of research in Mexican American health care behavior offered some support for the contention that the emphasis upon traditional folk beliefs was overdrawn. These conclusions, however, were typically drawn from educated, employed, middle class urban Mexican Americans. A systematic investigation of cultural and non-cultural client and health system variables and service use by Chicanos has not been conducted.

Weaver (1976) calls for further research in health attitudes, beliefs and practices of Mexican Americans nationally. He notes that "while there are numerous studies of rural and lower-class southwestern and western Mexican Americans, no research has been conducted that incorporates a cross-sectional sample of the population or encompasses Mexican Americans living in Ohio, Illinois or Michigan" (Weaver, 1976, p. 66). The roles of systemic and cultural variables in the underutilization of health services by Mexican Americans must also be studied. Third, he addresses the need to study the effects of Spanish-speaking personnel in health delivery and the role of active citizen participation in health planning efforts.

This study attempted to investigate some of the questions set forth by Weaver and other investigators of Mexican American health care behavior. Unlike other studies detailed in the literature, this project combined an experimental

outreach information component with a traditional folk medical and attitudinal component in studying health service utilization among a group of Midwestern Mexican Americans.

Community Center Health Services for Mexican Americans: Lansing, Michigan

The Mexican American population in Lansing today is estimated at 10,000 (Garza, 1979). While Chicanos reside throughout the city, they are largely concentrated in the northern section of Lansing. Many are native residents of Michigan; others still have close ties with Texas or Mexico. Haney (1978) considered the Mexican American population in Lansing to be fairly "traditional" in orientation. Many Mexican Americans in north Lansing are of low income, frequently employed as unskilled or semi-skilled workers. Work is not always consistent, however, so many individuals are not only faced with low income problems of poor health, limited education and substandard housing, but also with unpredictable means for dealing with daily needs or crises which may arise. With urgent needs of food, shelter, utilities and clothing, health may be low priority. A person in this situation may exercise various options in dealing with health needs: (1) take no treatment or preventive measure whatsoever (2) call upon family members, friends, or clergy for assistance (3) use available public health clinics of which the person has knowledge or (4) consult with a local curandero(a) for assistance.

Cristo Rey Community Center in North Lansing provides many programs and services to the community. These include employment referrals and placements, recreation, counseling and guidance, senior citizens nutrition and miscellaneous activities, substance abuse intervention, direct assistance (emergency food, clothing and shelter), legal assistance and health education and treatment. Cristo Rey is located within walking distance of many north Lansing residents. The staff is predominantly bilingual and bicultural; many are from the area and are familiar with the lifestyles and opportunities the community provides.

The Cristo Rey Health Program provides information and referral, and preventive services of education and consultation. Treatment services by a physician and attending nurses are available through adult and pediatric clinics. The Cristo Rey Health Program is open to all community members regardless of race, income or residence.

The Problem of Culturally Relevant Services

While the Cristo Rey Health Program services are available, their use by community members has been low. Some of the factors noted earlier in this review which contribute to underutilization of health facilities nationally by Mexican Americans may also be operating with the Chicano population in Lansing. Language barriers (some physicians typically only speak English though an interpreter is available), social class and other variables causing distance in

the doctor-patient relationship and requirements of fees for service (based on a sliding scale) may affect an individual's propensity to use the health service. Three other factors may also be instrumental in the decision of service use or non-use: (1) knowledge of services available (2) a sense of personalized treatment and (3) the maintenance of folk medical beliefs.

The Problem of Linkage

Many Chicanos in north Lansing may not be receiving the services which they need, though services are available in their area. One reason might be a lack of information about available services. Another factor might be perceived costs which may be involved and the concern that one might not be able to meet those costs. Accessibility to services is important, too. The person of low income may experience a sense of social isolation which sets them so apart from the mainstream of life that even seeking available known services might be difficult. Many Mexican Americans also face a language barrier. These factors may result in an individual seeking health care only when crises arise.

The Cristo Rey Health Program attempts to overcome many of the barriers typically experienced by Chicanos when they approach public agencies. The bridging of community members with the Health Program is important in reaching and serving the target group. This bond between the client and appropriate services is one of the main objectives of

the Cristo Rey Health Program. The means to facilitate that initial linkage is needed.

Information Outreach

The Cristo Rey Health Program provides services in order to link clients with appropriate services within or outside the Center. The problem with information and referral services, however, is that the individual must initiate the request for assistance (Brumfield, Fox & Goldman, 1968). The factors that keep people from contacting health care providers initially also keep them from contacting the Information and Referral Service. The hypothesized factors which complement those in the Mexican American health care literature include: client unaware of services, denial of a problem's existence, avoidance of outsiders and other contact, general apathy towards service (Gaitz, 1974), misinformation about services and eligibility, or resistance to receiving public assistance.

One difficulty, then, is getting community members to the Center in the first place. The notion of "outreach," a plan by which the information about services is given to clients directly is an attempt at removing some of these obstacles to service use (Kushler, 1977).

Outreach Strategies

Very little, if any, literature exists concerning effective ways of providing information and referral services

to Mexican Americans. In a study with outreach to the elderly, Klippel and Sweeney (1974) found that senior citizens use informal sources of information in decision-making and that product sampling was important in its sale to this group of consumers. It might be best to use peers or other familiar individuals in giving outreach information to Mexican Americans while trying to insure further positive contact with the Center's personnel. Information in persuasive messages should also be specific (Katz & Lazarsfeld, 1955). These findings are important in formulating an outreach contact.

Bergner and Yerby (1968) noted that mass media does not effectively render health service information to low income people. Rush and Kent (1974) noted that mass media instead most frequently reaches young, white middle class individuals who are well educated and socially active. It's probably safe to say that mass media is not the most effective way of reaching low income Mexican Americans, either.

In an experimental study investigating alternative outreach modes to low income elderly, Kushler (1977) found that in-person contacts were most effective in getting people to register for services, place their names on agency newsletter mailing lists or receive a service from the Center. Lower cost mail and telephone contacts were somewhat successful but were surpassed by the personal contact mode. Bergner and Yerby (1968) also advocate personal

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contact in reaching low income groups most effectively.

Attitudinal, Perceptual and Belief Correlates of Health Care

Minimal research has been conducted on the role of Mexican American health care-attitudes, perceptions of health, and medical beliefs in their use of health facilities. Most of the literature originally focused upon the role of traditional medicine in health care; more recent literature has looked at systemic variables as factors influencing utilization rates. Findings about beliefs in folk medicine and utilization rates are inconsistent, with some Mexican Americans very traditional and others very contemporary in their orientation and practice.

Welch, Comer and Steinman (1973) hypothesized that Mexican American social factors and attitudes towards modern medicine would affect their use of health services. They also hypothesized that while negative attitudes toward modern medicine may lead to the avoidance of treatment, social class factors affect the availability of services, the knowledge people have about them, and their attitudes towards health care. The authors found little evidence of folk medical beliefs in their Mexican American sample in Nebraska. Utilization was also related more to social characteristics than health care attitudes.

The use of health care facilities by Mexican Americans may be influenced by the extent to which they believe they

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can actively influence their own health status. Rotter's (1954) Locus of Control concept theorized that a person's experience builds up expectancies about a situation and affects future behavior in that situation. Wallston and Wallston (1975) developed a health locus of control scale on the assumption that the scale would predict the relationship between health behaviors and the extent to which a person feels he has control over his health (internal control). Mexican Americans have frequently been viewed as fatalistic or externally controlled. One would expect, then, that their health locus of control would be related to and influence their health behavior.

An individual's mental health status frequently relates positively to his general physical health (Berkman, 1971). The literature on Mexican American health care behavior has noted that Chicanos use general and alternate sources of health care for mental and physical problems, with clergy, curanderos(as) or general physicians serving as advisors, counselors or other sources of support. An individual's mental health status may thus affect the rate at which that person uses existing health facilities of which he has knowledge.

Another factor which may play an important role in whether or not an individual chooses to use available health services is that individual's perceptions of his or her current health status. Perceptions of prior health status,

future outlook concerning health matters, and perceptions of susceptibility and tolerance of illness may influence a person's need for health care and subsequent decisions in the type he seeks.

The Project

This project was designed to address the problems of linkage and the provision of culturally relevant health services to Mexican Americans in the north Lansing area. It investigated whether knowledge of the availability of a curandera's services in a health center would significantly affect service utilization rates by Mexican Americans. It also investigated attitudinal, perceptual and belief correlates of Mexican American health care behavior.

The results of research investigating the influence of folk medical beliefs upon health service utilization by Mexican Americans are contradictory. Beliefs in and practice of traditional medicine by Mexican Americans vary regionally and according to the rural or urban setting of the population. Chicanos in East Los Angeles seldom utilize curanderos(as) in meeting health needs (Edgerton, Karno & Fernández, 1970), while rural Mexican Americans in the Rio Grande Valley of Texas actively pursue and practice traditional folk medicine as an integral part of overall health care (Rubel, 1966). Many Chicanos in Lansing are originally from or have close ties with South Texas yet currently reside in an urbanized area. This population was

of particular interest in further investigating the influence of folk medical beliefs upon health care among Mexican Americans. To investigate if the availability of traditional folk medical care affects utilization rates, a curandera was available for consultation through the Cristo Rey Health Program. The Health Program thus provided both traditional and contemporary medical care and consultation, aiming to meet the needs of the Mexican American community by responding to possible alternate health beliefs.

Various methods of community outreach have been employed by agencies to bring information about social or health care service to the public. Personal or home visit contacts alone or in combination with telephone outreach have shown to be most effective in reaching target populations (Bergner & Yerby, 1968; Goodrow, 1975; Kushler, 1977). The personal contact-home visit outreach mode was used in this study to experimentally examine whether the availability of traditional folk health care services would affect Mexican American service use. This outreach mode was appropriate in this study because of the subject population. The low income Spanish-speaking individual may feel a sense of isolation and alienation from a predominantly middle class, English-speaking society. This person may not be aware of available health services or may be hesitant to seek health care even if their availability is known. A personal contact-home visit may decrease social isolation

and the sense of depersonalization frequently faced with agency services while encouraging the individual to use the services of the Health Program. Information about the availability of the folk medical dimension was included in one of the outreach formats.

A variety of questions relating to Mexican American health care behavior were investigated in this study. Primarily, it combined an experimental outreach component with a folk medical dimension to investigate whether knowledge of the availability of traditional folk medical services would significantly increase health service utilization among Mexican Americans. It also examined the effectiveness of the in-person outreach contact mode in increasing their health service use. This study was also exploratory; it attempted to identify major determinants and correlates of health care among Mexican Americans. Relationships between health perceptions, health locus of control, attitudes toward traditional and contemporary medicine, mental health status, socioeconomic variables and demographics were examined in order to determine which play the greatest roles in the decision of health service use or non-use by Chicanos.

CHAPTER II

METHOD

Subjects

A population of 308 household addresses of Spanish-surnamed residents in north Lansing was identified through the Lansing City Directory, the Lansing phone book, Bresser's listing of city addresses and phone numbers, the Cristo Rey Community Center newsletter mailing list, El Renacimiento newspaper and publishing office, and a door-to-door survey listing compiled by a neighborhood church. The use of these sources was an attempt to insure that apartment dwellers and people with unpublished phone numbers or no phone at all would be included in the study. Households were included only if they fell in a specified area close to the Cristo Rey Community Center.

Census tract and other types of mailing or membership lists typically have not classified individuals according to Mexican American ethnic background. Winnie (1960) noted that there is no "best" criterion for identifying Hispanics in currently available census tract or population data. Each alternative (use of Spanish language, Spanish or Mexican ancestry and Spanish-surname) has advantages and disadvantages. Winnie noted, however, that the Spanish-surname

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criterion is technically as good as any other general-purpose classifier. It is advantageous in that noncensus records which do not always have language use information can still be reviewed using the surname criterion to identify Hispanics. Winnie's study found that the Spanish-surname criterion underestimated the size of the population by about 10 percent. If classification is done on a subjective basis with knowledgeable raters identifying individuals, a 5 percent rate of underestimation may be expected. If a categorized list of Spanish surnames is strictly followed as a guideline in compiling Hispanic listings, the underestimation rate may be even greater if the guideline list is not exhaustive. In this research, the author subjectively reviewed all source lists using the Spanish-surname criterion. According to Winnie's finding, the total Mexican American population of north Lansing compiled from available lists should be underestimated up to 10 percent.

The compiled list thus consisted of Spanish-surnamed households with the specified north Lansing geographic region. This list was then sent to the Ingham County Health Department, Community Clinic Services Division for removal of names of individuals who had been served by the Cristo Rey Health Program within the six months preceding the outreach project. The Community Clinic Services Division of the Ingham County Health Department maintains central

records for all individuals receiving services at various sites. This list was also reviewed by the Cristo Rey Health Program Coordinator for removal of names of individuals receiving other services from the Program not noted by the Health Department.

After review and revision of the list, 274 Spanish-surnamed north Lansing households were eligible to participate in the outreach project. The experimenter randomly selected and assigned 40 households to each of two treatment groups and the control group, for a total of 120 households. The remaining 154 households were randomly assigned to one of the three groups as replacements for households lost in the study due to noncompliance, bad addresses, non-Latino residents, or incorrect listings. This study thus used random selection of a sample from the target population and random assignment from the sample to treatment conditions. Subjects were identified by outreach workers as an adult from each household responding to the initial outreach contact.

The final sample of 101 was 31% male, 69% female. The "average participant" was 38.5 years old, had an eighth grade education, was married and had 2.5 children. The majority of the sample was unemployed, but the spouse was generally working outside the home. For the majority, a salary or wage was the primary source of income. For those receiving government assistance, most received Aid to

Dependent Children (ADC).

Procedure

Experimental and Control Conditions

The experimental and control conditions in this study are described below.

Control Group. This group served as a control by which to measure the effects of the two treatment categories. The individuals in this group received no personal outreach contact by the Cristo Rey Health Program outreach representatives. Control group subjects were not kept from any incidental exposure to information about the program's services acquired through self-referral, word of mouth, radio announcements, newspaper articles or other media coverage typically used by or given the Community Center. The difference between the control group and experimental group members, then, is the initial personal contact received in the treatment conditions during the first phase of the study.

In-Person Contact Group: Contemporary Medical Services Only. Individuals in this group received a direct personal outreach contact by Cristo Rey Health Program Outreach representatives identifying basic services available through the Program at the Center. These individuals were explained the services and invited to contact the Cristo Rey Health Program by mail, phone, or in person if further information or any services were desired. The contact was

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fairly personalized in nature, with the outreach worker's approach being one of representing a community health program offering a variety of services. Outreach workers adhered to a standardized format as closely as possible while maintaining a personalized and flexible approach. Individuals were also given the pamphlets explaining services available through the Cristo Rey Health Program including phone numbers to call for assistance and a map showing the Center's location. A copy of this outreach informational pamphlet is included in the back of this report. Contacts were made according to predetermined schedules designated by the experimenter.

In-Person Contact Group: Contemporary and Traditional Medical Services. The individuals in this group received a direct personal outreach contact by Cristo Rey Health Program representatives just like the ones in the Contemporary Medical Services Only group. In addition, however, they received information about the availability of curandera or folk healer for consultation at the Center a specified number of hours per week. Along with the pamphlet describing available services, a card indicating the curandera's consultative services at the Center was inserted in the pamphlet to match the information given in the personal contact. As with the Contemporary Medical Services Only group, outreach workers attempted to adhere to a standardized format as closely as possible while maintaining a

personalized and flexible approach. Contacts were made according to a predetermined schedule designated by the experimenter.

The Client Card. When a "successful" outreach contact was made in each group, demographics and some health needs information was reported on the Client Card seen in Appendix C. As with Kushler's (1977) study, if an outreach worker could establish enough rapport with an individual so that the person gave the information requested, a successful outreach was made. In addition to serving as a check on the outreach contact, client cards could also be used as a record-keeping and ongoing needs assessment file.

Employing A Curandera

Many natural helping networks exist between and within groups of people at various levels in any community. In some Mexican American communities, individuals seek the advice of a family member or a local folk healer, a curandero(a), for health-related concerns. These health care givers are typically known through reputation in the barrio. They do not advertise, solicit, or charge a set fee for their services.

In this project, it was necessary to find a curandero(a) who was known in the area where the study was taking place. The experimenter asked staff members of the Community Center and various senior citizens in the Center's Senior Citizens Program if they knew who local curanderos(as)

were and where they resided. A list of names, addresses and phone numbers was compiled; all were women. Later the Health Program Coordinator and the Experimenter individually and together contacted the individuals named and spoke with them about their treatment and consultative activities. Bearing in mind the basics of folk healing, some individuals were not considered further because they had alternate orientations. None of the women were told of the proposed research project.

One woman spoke of her desire to help people through a place like the Community Center's Health Program. In her folk medical practice she used natural herb teas, oils and powders individually or in combination, depending upon the presenting complaint of the consumer. She described each remedio ("cure") to the Health Program Coordinator and Experimenter, relating stories of healing success. She was selected and her name was presented to the Community Center's Director and approved. The entire research plan was then presented in separate meetings to the Center's staff and Board of Directors for their approval. With only two dissenting votes (fear of reprisal from the medical profession), the plan was approved. The curandera was available four hours per week through the Center's Health Program.

Selection, Training and Supervision of the Health Program Outreach Representatives

Upper division undergraduates in the university were recruited to serve as Health Program Outreach Representatives.

First a listing of Chicano students enrolled in the University was obtained. Letters were mailed to 40 eligible students soliciting their participation in the project; seven (7) responded affirmatively. Three (3) Puerto Rican students heard about the project, asked if they could participate, and were also included in the project. Six (6) females and four (4) males comprised the Outreach Team. Each member was bilingual in English and Spanish.

Training sessions were held to teach and clarify outreach procedures to the Outreach Representatives. The first training phase dealt with outreach procedures, the second with those for follow-up. In each phase the Experimenter first demonstrated appropriate procedures, then representatives role-played and practiced among themselves. Representatives formed groups of three: one played the role of the community member, one was the outreach representative and the third was an observer and recorder. Percent agreement reliabilities for training sessions was 96% for the outreach phase and 94% for the follow-up. To determine inter-rater reliability during the actual outreach or follow-up, one representative accompanied another during a contact and recorded data on a separate sheet. Percent agreement reliability was derived by dividing the total number of matching coded responses by the number of total responses on an interview schedule. Percent agreement was 95%.

To avoid possible biasing effects of time, weather or other factors, contacts were distributed across four weeks for each phase. During the four week outreach phase, ten households in each of the two treatment groups were contacted. Four weeks after outreach, follow-up interviews were conducted, following the same schedule used during outreach and adding control group names. Ten control households were also interviewed weekly on the follow-up. Outreach and follow-up schedules are in the Project Outline in Table 1.

Weekly supervisory meetings were held where the project researcher monitored outreach and follow-up activities. The project researcher was also available for telephone consultation as needed.

Measurement of Dependent Variables

Primary Dependent Variable. The primary dependent variable used to test for effects of the experimental manipulation in this study is described below.

Number of People Receiving Services. Since the prime purpose in providing client-service linkage through outreach is to increase the utilization of services by community members, the dependent variable was the number of people receiving services. This was noted as either the individual or a family member receiving a service from the Health Program. This measure determined any effect which the two treatment modes had upon the number of people in the sample

Table 1

Project Outline

I.	<u>Lists Compiled.</u>	Lists of Spanish-surnamed households within specified area compiled. Previously served names removed.		
II.	<u>Randomization.</u>	Random assignment of names to conditions.		
III.	<u>Outreach</u>			
		<u>Control</u>	<u>Contemporary Medical Services Only</u>	<u>Traditional & Contemporary Medical Services</u>
Week 1			1-10	1-10
Week 2			11-20	11-20
Week 3			21-30	21-30
Week 4			31-40	31-40
IV.	<u>Record Outcome Measures</u>	up to 30 days from date of contact.		
V.	<u>Follow-Up Phase</u>			
		<u>Control</u>	<u>Contemporary Medical Services Only</u>	<u>Traditional & Contemporary Medical Services</u>
Week 5		1-10	1-10	1-10
Week 6		11-20	11-20	11-20
Week 7		21-30	21-30	21-30
Week 8		31-40	31-40	31-40
VI.	<u>Data Analyses</u>	1. Response to outreach 2. Services received 3. Demographics 4. Survey Data		
VII.	<u>Final Operations</u>	Provide entire list to Center. Results reported and explained.		

receiving health services. All services were recorded daily by Health Program personnel. Services included consultations, requests for educational materials, attendance at special health classes, referrals, visits to the physician, visits to the curandera, immunizations, blood pressure checks, weight measurement or other services received through the Health Program.

Follow-Up Survey Attitudinal Variables

The Follow-Up Survey. Approximately one month after the outreach contact was made all subjects in the two experimental groups and those in the control group were interviewed in their homes by an outreach representative. The interview was conducted in a fairly standardized procedure, with interview schedules available in both English and Spanish. Interviewers identified themselves as representatives from the Cristo Rey Health Program. They informed individuals that they were talking with community members about attitudes, needs and opinions concerning health care. Subjects were informed that the information provided by the respondent was confidential and could be used by the Center in program planning. If the respondent agreed, the representative obtained their signature on a form giving the consent to participate (see Appendix D). The questionnaire in Appendix E was then administered by the representative.

The data from the follow-up Interview were used to help interpret the findings of the experimental manipulation.

They also provided a description of the project participants and a measure of their health beliefs, perceptions and attitudes.

Construction and Use of Scales

The survey questionnaire is comprised of various established scales and some survey items designed to measure a variety of areas. These include health locus of control, attitudes toward contemporary and traditional folk medicine, general mental health status, general physical health status, knowledge of services provided by the Center, willingness to use the Center's services, and general demographic information.

With previously developed scales reliability coefficients were initially calculated on all scale items. If an item did not correlate significantly with the scale, it was removed and scale reliability was recalculated until an acceptable level was reached.

When the survey questionnaire was originally developed, a number of items were included to examine areas of interest to the study for which there were no previously constructed scales. After the data were collected, items were grouped logically and empirically. Item intercorrelations were noted and scales were tentatively formed. Reliability coefficients were determined and items which did not correlate with the scale were removed or others which correlated well were added. Reliabilities were recalculated

and the process repeated until an acceptable level was reached.

The Health Locus of Control Scale (HLC). The HLC was originally developed and validated in order to provide a health-related locus of control scale over the more generalized Rotter I-E Scale (Wallston & Wallston, 1975). Items such as "Good health is largely a matter of luck," and "If I take care of myself, I can avoid illness" constitute the 11-item scale. Items are scored on a 6-point Likert scale ranging from "Strongly Disagree" to "Strongly Agree." Scores ranged from 11 to 66. Reported alpha reliability was .72. The scale is comprised of items 38 to 48 in the follow-up questionnaire.

Coefficient alpha for the HLC in this study was .49. Reliability was considerably lower when all items were used. Items which did not correlate with the scale were removed; five items formed the final HLC. The HLC is intended to measure the extent to which a person has a sense of control over his health status. The higher the score on the HLC the greater the extent of external control.

The Index of Psychological Well-Being (IPWB). The Index of Psychological Well-Being is intended to measure the general mental health status of project participants. It is an 8-item index which asks participants to indicate how often they experience certain feelings such as "Depressed or very unhappy" or "Bored." When IPWB was used as a

dependent variable, findings paralleled those of the Midtown Manhattan Study. Berkman's (1971) findings indicate that the IPWB correlates positively with physical health status. It also correlates with ethnicity, education, occupation, employment and marital status.

The IPWB is comprised of items 49 through 56 of the follow-up questionnaire. All items were retained in analyses; coefficient alpha was .65.

Perceptions Regarding Health Scale (PRHS). Ware, Wright and Snyder (1974) developed the Perceptions Regarding Health Scale (PRHS) as a series of indices measuring an individual's perceptions about his/her health status. Subscales were constructed on six dimensions: Current Health Status, Prior Health Status, Health Outlook Index, Health Status Anxiety and Resistance-Susceptibility to Illness. Items such as "I'm as healthy as anybody I know," or "I never worry about my health" form the 32-item scale. Each item is rated on a 5-point Likert scale ranging from "Definitely True" to "Definitely False." Items are summed to obtain total scale scores. Reported test-retest reliability coefficients for the six subscales were: Current Health, .81; Prior Health, .70; Resistance to Illness, .60; Health Anxiety, .52; and Acceptance of Illness, .70.

The PRHS in this study consists of 18 items drawn from the six subscales. Reliabilities calculated on the six subscales in this study were low, so items were examined

as a whole, then regrouped according to their intercorrelations. Items which did not correlate were removed and the testing procedure was repeated. Three subscales measuring health perceptions and their alphas resulted: Current Health and Possible Illness ($r=.63$); Illness Anxiety and Acceptance ($r=.58$); and Prior Health and Future Resistance ($r=.50$). Items 20 through 37 comprise these subscales in the follow-up questionnaire.

Needs Scale. The Needs Scale was used by Kushler (1977) in an experimental outreach project to the elderly. It is intended to assess the participants' self-rating of needs in nine areas: housing, employment, health care, income, crime, education, nutrition, transportation and loneliness. All items were retained in this study; alpha was .87. They comprise item 19 in the follow-up survey.

Clarity of Outreach Scale. Items 5 through 8 were included in the follow-up questionnaire to check for the clarity of the initial outreach contact. Three of the items which intercorrelated formed a scale to provide an index of Outreach Clarity. Alpha was .87.

Attitudes Towards Folk Medicine Scale. Since a thoroughly-tested instrument measuring health attitudes of Mexican Americans has not been developed, the experimenter used various questions from other investigations and some newly-created items to measure health attitudes in this study. Items measuring "Hostility towards Doctors" and

"Traditional Attitudes Toward Medicine" were taken from Welch's (1973) study of sociocultural factors and health care utilization by Mexican Americans. Items from a study of health attitudes and behaviors of Houston Chicanos (Farge, 1975) were also employed. These items comprise questions 57 through 69 of the follow-up questionnaire. Items 64, 65, 67, 68 and 69 formed a scale intended to measure attitudes toward folk medicine. Alpha for the scale is .61.

Fluency Scale. Items 96, 97 and 98 form a scale which measures the participants' fluency in the language opposite that in which they were interviewed. If a person was interviewed in Spanish, the fluency scale measures how well that person can speak and understand written and spoken English. The scale measures Spanish fluency for those interviewed in English. Alpha for the scale was .87.

Demographic Information. Items eliciting demographic information such as respondent's age, education, marital status, employment, number of persons in household, place of origin, length of current residence and other areas are included in the follow-up survey. This information provides a general description of the sample while allowing one to examine relationships between demographics, outcome measures and the basic issue of seeking or not seeking services. Some items are taken from Teske and Nelson (1973); others were created by the experimenter for use in this study.

Other Areas of Interest. In addition to the scales and demographic information described, questions in the follow-up survey sought to explain service use or non-use by Mexican Americans. Questions asked opinions about medical services and government assistance, reactions to being contacted by Health Program representatives, reasons for current use or non-use of services, possibility of future service use, and sources of community information.

Concluding Operations

The original unrevised list of Spanish-surnamed residents was provided to the Center and the Health Program upon completion of the outreach and follow-up phases. Informational booklets explaining health services available at the Center which were used in the study were distributed to the general public through clinics, public health offices and at the Center. All community members were thus able to learn of the Health Program services. Copies of project findings were also given to the Center's Director and the Health Program Coordinator, followed by consultation to explain and discuss findings.

CHAPTER III

RESULTS

The Sample

Subject Mortality. The final sample size deviated slightly from the number originally designated per treatment group. Both selection and assignment of names were randomized, maintaining the experimental design. The subject mortality at each phase of the project is shown in Table 2.

Mortality in the outreach phase for the treatment groups and in the follow-up phase for the control group was high because of bad addresses, nonLatinos residing at the address, no one home, abandoned house, etc. Mortality in the follow-up phase for treatment groups occurred because the subject could not be located or was uncooperative.

There was no significant difference in mortality between groups when total initial attempts (Groups I and II at Outreach, Control at Follow-Up), total unsuccessful attempts (Groups I and II at both Outreach and Follow-Up; Control at Follow-Up) and final confirmed sample for each group were compared ($\chi^2 = 1.98$, $df = 2$, $p < .38$). The final sample size was large and fairly evenly distributed

Table 2

Final Sample Composition: Subject Mortality by Condition and Project Phase

	Outreach Phase			Follow-Up Phase			Totals			GRAND TOTAL
	C*	I	II	C	I	II	O	F-U		
Total Contacts Completed	0	36	35	37	32	32	71	101 ^a	172	
Unsuccessful Contacts:										
NonLatinos	0	19	20	18	0	0	39	18	57	
No such address	0	2	1	1	0	0	3	1	4	
Noncompliance	0	3	2	2	2	2	5	6	11	
Unable to Locate Residents	0	6	7	4	2	1	13	7	20	
Total Unsuccessful Contacts										
	0	30	30	25	4	3	60	32	92	
Contacts Attempted										
Unused Replacement Households	0	66	65	62	36	35	131	133	264	
	0	25	26	30	0	0	51	30	81	
Replacements Assigned										
Initial Households Assigned	0	51	51	52	0	0	102	52	154	
	0	40	40	40	0	0	80	40	120	
TOTAL ASSIGNMENTS										
	0	91	91	92	0	0	182	92	274 ^b	

*C = Control; I = Contemporary Medical Services Only; II = Contemporary Medical Services & Folk Medical Information

^aFinal Confirmed Sample

^bTotal households eligible to participate in study, $\chi^2 = 1.98$, $df = 2$ $p < .38$
 when: total initial attempts (Groups I & II Outreach, Control: Follow-Up),
 total unsuccessful attempts (all groups) and final confirmed sample by group
 are compared.

across conditions. The sample was thus acceptable.

Effectiveness of Randomization

Before testing for treatment effects, it is important that the groups be checked for equivalency on all other variables. To determine whether groups were equivalent, 25 demographic and descriptive variables were tested for significant differences between groups. One variable varied significantly between groups: educational level. All three groups had participants with no formal education, but two of the groups had a combined total of five people with some college, bachelor's, graduate or professional degrees. The mean number of years of schooling for each group varied accordingly. With only one significant difference noted between groups, randomization resulted in functionally equivalent groups in the study.

Treatment Effects

Primary Outcome Measure

After an outreach representative explained the Health Program informational booklet to a subject but before an attempt was made to complete the client card outreach check, the subject was asked to sign a consent form for participation in the study. Subjects were retained for follow-up and subsequent analyses only if the subjects consented to participate and completed the client card outreach check.

No significant differences in service use were noted between groups for type of information given in the contact. A significant difference in service use is seen for outreach contact in general ($p < .05$). The number of participants in each group who either personally used or had a family member who used the services since the outreach contact is shown in Table 3.

Table 3
Receiving a Service by Type of Contact

	<u>Control</u>	<u>Contemporary Medical Ser- vices Only</u>	<u>Traditional & Contemporary Medical Services</u>	<u>Total</u>
Received Service	0	5	5	10
Did Not Receive Service	37	27	27	91
Total	37	32	32	101
$\chi^2 = 6.42 \quad df = 2$				
$p < .05$				

To determine whether the three groups varied along attitudinal and belief dimensions, certain follow-up survey variables were examined. Oneway analyses of variance revealed no significant differences on measures of Health Perception (PRHS), Health Locus of Control (HLC), Needs, Psychological Well-Being (IPWB), or Attitudes toward Traditional Folk Medicine.

Other Differences in Primary Outcome Measure
and Attitudinal Variables

While no significant differences were noted for type of contact across the primary outcome measure and attitudinal variables, differences were seen when subjects were classified along different dimensions. These dimensions were chosen in an attempt to distinguish between cultural and socioeconomic factors in Mexican American health care.

When subjects were grouped according to language spoken during the interview, significant differences were noted in the Illness Anxiety and Acceptance and Health Locus of Control Scales. Oneway analyses of variance indicated that subjects who were interviewed in Spanish experience greater health anxiety than their English-speaking counterparts. They were also more external in perceived control over their health. These comparisons are shown in Table 4.

A marginal significant difference in Use of Service is noted when subjects are grouped according to whether or not they receive government assistance (SSI, SSDI, ADC, Welfare, etc.). A oneway analysis of variance indicated that those receiving government assistance used Health Program services more than those not receiving government assistance (Use is designated by a low score; nonuse by a high score). Results are shown in Table 5.

Table 4

Attitudinal Variables According to Language of Interview

<u>Illness Anxiety and Acceptance</u>						
<u>Source</u>	<u>DF</u>	<u>Sum of Squares</u>	<u>Mean Squares</u>	<u>F</u>	<u>Signif- icant</u>	<u>Omega²</u>
Between Groups	1	304.2743	304.2743	14.329	.0003	.0003
Within Groups	98	2081.0857	21.2356			
Total	99	2385.3600				
Group 1 (Spanish)		N	Mean	Standard Deviation		
		35	17.4571	5.69		
Group 2 (English)		65	13.8000	3.91		
Total		100	15.0800			
<u>Health Locus of Control</u>						
<u>Source</u>	<u>DF</u>	<u>Sum of Squares</u>	<u>Mean Squares</u>	<u>F</u>	<u>Signif- icant</u>	<u>Omega²</u>
Between Groups	1	66.3184	66.3184	2.769	.09	.0172
Within Groups	99	2371.4440	23.9540			
Total	100	2437.7624				
Group 1 (Spanish)		N	Mean	Standard Deviation		
		36	15.8611	4.70		
Group 2 (English)		65	14.1692	4.99		
Total		101	14.7723			

Table 5

Receiving a Service by
Receipt of Government Assistance

<u>Source</u>	<u>DF</u>	<u>Sum of Squares</u>	<u>Mean Squares</u>	<u>F</u>	<u>Signif- icant</u>	<u>Omega²</u>
Between Groups	1	.5224	.5224	3.048	.08	.0205
Within Groups	96	16.4571	.1714			
Total	97	16.9775				

	<u>N</u>	<u>Mean</u>	<u>Standard Deviation</u>
Group 1 (No Assistant)	63	3.9524	.2799
Group 2 (Assistance)	35	3.8000	.5841
Total	98	3.8980	

Significant differences are noted on various attitudinal variables when subjects are grouped according to educational level. Significant differences are noted on all three subscales measuring health perceptions. Oneway analyses of variance indicated that more educated subjects (ninth grade and above) reported significantly better prior health histories and perceived resistance to future illness and better current health status than those with an eighth grade education or less. Less educated subjects reported significantly more anxiety about their future health than those with more education.

On the health locus of control dimension, less educated subjects showed significantly greater externality in the extent to which they felt they had control over their

health; more educated subjects showed greater internality. Results of these analyses based on educational level groupings of subjects are reported in Table 6.

Table 6
Attitudinal Variables by Educational Level

<u>Current Health & Possible Illness Scale</u>						
<u>Source</u>	<u>DF</u>	<u>Sum of Squares</u>	<u>Mean Squares</u>	<u>F</u>	<u>Significant</u>	<u>Omega²</u>
Between Groups	1	201.9127	201.9127	6.240	.01	.0497
Within Groups	98	3171.1273	32.3584			
Total	99	3373.0400				
<u>Groups</u>	<u>N</u>	<u>Mean</u>	<u>Standard Deviation</u>			
Group 1*	47	24.85	5.5560			
Group 2	53	27.69	5.8031			
Total	100					
<u>Illness Anxiety & Acceptance Scale</u>						
<u>Source</u>	<u>DF</u>	<u>Sum of Squares</u>	<u>Mean Squares</u>	<u>F</u>	<u>Significant</u>	<u>Omega²</u>
Between Groups	1	118.1043	118.1043	5.105	.02	.0394
Within Groups	98	2267.2557	23.1353			
	99	2385.3600				
<u>Groups</u>	<u>N</u>	<u>Mean</u>	<u>Standard Deviation</u>			
Group 1	47	16.2340	5.0356			
Group 2	53	14.0566	4.6011			
Total	100	15.0800				
<u>Prior Health & Future Resistance Scale</u>						
<u>Source</u>	<u>DF</u>	<u>Sum of Squares</u>	<u>Mean Squares</u>	<u>F</u>	<u>Significant</u>	<u>Omega²</u>
Between Groups	1	71.6603	71.6603	4.671	.03	.0351
Within Groups	99	1518.6961	15.3404			
Total	100	1590.3564				
<u>Groups</u>	<u>N</u>	<u>Mean</u>	<u>Standard Deviation</u>			
Group 1	48	17.5208	4.3662			
Group 2	53	19.2075	3.4605			
Total	101	18.4059				

Table 6 (cont'd.)

Health Locus of Control Scale

<u>Source</u>	<u>DF</u>	<u>Sum of Squares</u>	<u>Mean Squares</u>	<u>F</u>	<u>Significant</u>	<u>Omega²</u>
Between Groups	1	137.8756	137.8756	5.935	.01	.0466
Within Groups	99	2299.8868	23.2312			
Total	100	2437.7624				

<u>Groups</u>	<u>N</u>	<u>Mean</u>	<u>Standard Deviation</u>
Group 1	48	16.0000	4.6402
Group 2	53	13.6604	4.9767
Total	101	14.7723	

*Group 1 = 8th grade education or less
 Group 2 = 9th grade education or more

Correlational Analyses

To investigate further the question of health service use by Mexican Americans the remaining analyses in this study delineated the relationships between the primary outcome, attitudinal measures and other survey variables. Pearson correlations of all variables are shown in Table 7.

Pearson correlations indicate that three demographic variables were significantly related to service use: age, sex and receipt of Medicaid assistance. Younger people, females and Medicaid recipients tended to use the Health Program services more often. Since few demographic variables significantly related to service use, they contribute little towards explaining Mexican American service utilization patterns.

A person's perception or opinion of the outreach contact might also be related to service use. Pearson correlations indicated that a person's reaction to the outreach

Table 7
Pearson Correlations*

	CLARITY	REACT	NEEDS	CURHLTH	ILLANX	PRHLTH	HLCS	IPWB	FLUENCY
Clarity	-								
Reaction	.2191	-							
Needs	.2070	.0994 ^c	-						
Current Health	-.0786	.1759 ^c	-.1194	-					
Illness Anx.	.1005	-.1187	.0496						
Prior Health	-.1787	.0162	-.0893						
HLCS	.0885	.0192	.0665	-.3155 ^c	-.1045				
IPWB	.0278	-.0137	.1473	-.1263 ^b	-.0124	-.0653 ^c			
Fluency	.4720 ^a	.1247 ^c	.0202	-.3840 ^b	.1254 ^b	-.3319 ^c			
Use	-.2913 ^b	.1884 ^c	-.0473	-.0496	.2653 ^b	-.1130	.0930 ^c		
Folk Medicine	-.4380 ^c	.0719 ^c	-.0991	-.0049 ^b	.1152	-.0453	.2075 ^c	-.0998	
Embarrassment	-.2361 ^c	-.1794 ^c	-.1084 ^b	.5590 ^c	.1928	.2560 ^c	.1826	-.0805	-.0441
Afford Drs.	-.1784	-.0513	-.2191 ^c	.1659 ^c	-.0309	.1620 ^c	.1389	.2769 ^a	-.1824 ^a
Free Services	-.0924	.0648 ^c	-.1681 ^c	.0561	-.0346	-.0066	-.0707	-.3446 ^a	-.3373 ^a
Food Import.	-.0944	-.1635 ^c	-.0771 ^c	-.0357	-.0202	-.0074 ^c	-.1395	-.1250	-.1674 ^c
Medicine	-.0302	-.0246	-.1937 ^c	.0123	.0398 ^c	.1737 ^c	.0143	-.1387	-.0403
Doubts Drs.	-.0236	-.0116	-.1961	.0006 ^c	.1659 ^c	.1276	-.0483	.0020	.1125
Curan. Knowl.	-.0568 ^c	.0580	-.0188	-.1833 ^c	.1095	-.0846	.2981 ^a	-.0645	.0082
Curan. Find	.3457 ^c	-.1709	.1551	.0989	.0613	.0301	.0718	-.0861	.1074 ^c
Marital Stat.	.2291 ^c	.0289	.0605	.2253 ^c	-.1254	.1026	-.2343 ^c	.0564	.1893 ^c
Age	-.2895 ^b	.0101	-.0201	-.0147 ^b	-.0246	-.1037	-.0718	-.0501	.0728
Total Resid.	.2589 ^c	.0924	.0977	-.2352 ^b	.0451 ^c	-.0748	.1193 ^b	.0981 ^b	.0106
Kids Resid.	.2685 ^c	.0945	.0851	.2226 ^c	-.1794 ^c	.0938	.2078 ^b	-.2617 ^b	-.1551 ^b
School	-.1722 ^b	-.1826 ^c	-.1110	.2024 ^c	-.1736 ^c	.1539	.3039 ^a	-.0050	.2367 ^b
Military	.3537 ^b	-.0213	.1033	.4097 ^a	-.1542 ^c	.2802 ^c	-.2998 ^a	.0912	.2155 ^b
				-.1400 ^c	.1624 ^c	-.0747	-.0828	-.0205 ^b	-.3956 ^a
				-.1400 ^c	.1624 ^c	-.0747	-.0828	.2880 ^b	.2213 ^b

^a $p < .001$ ^b $p < .01$ ^c $p < .05$

* Corrected for attenuation

Table 7 (cont'd.)

	CLARITY	REACT	NEEDS	CURILTH	ILLANX	PRIHLTH	HLCS	IPWB	FLUENCY
Ind. Employed	.2029 ^c	.0241	-.0008	.2622 ^b	.0677	-.1569 ^c	.1314 ^c	-.0504	.2265 ^b
Ind. Occup.	-.2171 ^c	.0794	-.0046	.2762 ^b	-.0568	.1732 ^c	-.2010	-.1055 ^b	-.2989 ^b
Monthly Income	-.0471	.0402	-.0325	.1142	-.1218 ^c	.1846 ^c	-.0175	-.2854 ^b	-.2562 ^c
Medicaid	-.2007 ^b	-.0140	-.0283	.0858 ^c	-.1580 ^c	.0573	-.0746	-.0863	-.1631 ^c
Medicare	.3167 ^b	.0044	.0319	.1594 ^c	-.2167 ^b	.0918	.0420	.1189	.0535 ^c
Walks	-.1954	-.1522	-.1507	-.1082	.1328	.0042	.0267	.0422	.1818 ^c
Drives	.1876	.1005	-.0067	-.1192	-.0057	-.1366	.1497	-.0189	.1440
Uses Bus	-.1074 ^c	.0107	.0255	-.0822	.1090	.1046	.0905	-.1122	.0147
Other Drives	-.2614 ^c	-.1357	-.1302	.0672	.1287	.1018 ^c	-.1397	.0333 ^a	-.0439 ^b
Sex	.2999 ^b	.0966	.1060	-.1372	.0685 ^a	-.1700 ^c	.1221 ^c	.3315 ^a	.2611 ^a
Interview Lang.	-.2840 ^b	.0171	-.0572	.1183	-.3720 ^a	.0587	-.2095 ^c	-.0779	-.4849 ^a
Second Lang.	.1534	-.0377	.0533	-.1069	.3572	-.0345	.1649 ^c	-.0277	.3833 ^a

^a_p < .001 ^b_p < .01 ^c_p < .05

Table 7 (cont'd.)

	USE	FOLKMED	EMBARR	AFFORD	FREESERV	FOODIMP	MEDICINE	DOUBTS	CURKNOWL
Use	-								
Folk Medicine	-.0411	-							
Embarrassment	-.0244	.1156	-						
Afford Drs.	.0681	-.0783 ^c	.0202 ^b	-.1901 ^c					
Free Services	.0909	-.2156 ^c	.2484						
Food Import.	-.1265	.0216	-.0598	-.1178	.0032				
Medicine	.0472	.1098	.0945	.1242	.0320				
Doubts Drs.	.0899 ^c	.1259	-.0028 ^c	.0126	.0014				
Curan. Knowl.	.1579 ^c	.0646	-.1733 ^c	.0052	-.0953				
Curan. Find	-.1604	-.1319	.0048	.0765	.0519				
Marital Stat.	.0164	.0928	-.0789 ^b	-.1135	-.0281 ^c				
Age	.1508	.0571	.2435 ^b	.1324	.1980 ^c				
Total Resid.	-.1032	.0238	-.0645	-.1955 ^c	-.1052				
Kids Resid.	-.0850	.1837	-.1233 ^b	-.2195 ^b	-.1282				
School	-.1263	.1964	.2854 ^a	.0328 ^c	.0628				
Military	-.0808	-.1020	-.2972 ^a	-.1700 ^c	-.1072				
Ind. Employed	-.0990	-.0661	-.1149	-.0089	.1187				
Ind. Occup.	.0956	.0169	.1481 ^c	.0734 ^b	-.0685				
Monthly Income	.1155	-.2682 ^c	.1696 ^c	.2248 ^b	.1573				
Medicaid	.2039 ^c	-.2976 ^b	-.0335 ^c	.0318	.0240 ^c				
Medicare	-.0853	-.1561	-.1855 ^c	-.0644	-.1952 ^c				
Walks	.1393	-.0388	-.1327 ^c	.0217	.0946				
Drives	-.0108	.0261	-.0475 ^c	-.0348	-.1084				
Uses Bus	.1131	.0487	-.1648 ^c	.0703	.0006				
Other Drives	-.0195 ^c	.0661	.0598 ^a	.1577	-.0032				
Sex	-.1626 ^c	-.0735	-.3374 ^a	-.0482	-.0185				
Interview Lang.	.0102	.0562	.1013	.0129	-.0507				
Second Lang.	.0303	-.0157	-.0815	.0164	.0269				

^a $p < .001$ ^b $p < .01$ ^c $p < .05$

Table 7 (cont'd.)

	MARSTAT	AGE	TOTRESID	KIDRESID	SCHOOL	MILITARY	INDEMP	INDOCCUP	MONTHINC
Marital Stat.	-								
Age	-.1654 ^c	-							
Total Resid.	-.1546	-.4025 ^a	-						
Kids Resid.	-.1131	-.3752 ^a	.8207 ^a						
School	.0308	-.3907 ^a	.0085	-					
Military	.1332	-.2755 ^b	.0771 ^b	.1165 ^c	-.3188 ^a	-			
Ind. Employed	.0279	-.0269	.1883 ^b	.1920 ^c	-.1746 ^b	.2060 ^c			
Ind. Occup.	-.0707	.0290	-.2468 ^b	-.2200 ^b	.3227 ^a	-.3443 ^a	-.6978 ^a		
Monthly Income	-.1601 ^c	.1814 ^c	-.1807 ^c	-.1359 ^c	.0638	-.3108 ^a	-.4642 ^a	-.5623 ^a	-
Medicaid	-.2010 ^c	.0779 ^a	-.1163 ^c	-.2014 ^c	.0531	-.1329	-.4488 ^a	.3280 ^a	.4354 ^a
Medicare	.0722	-.5900 ^a	.1889 ^c	.2300 ^b	.1310 ^c	.0969	-.1563	.0755	.0934
Walks	-.0122	.1582	-.2600 ^b	-.2334 ^b	-.2115 ^b	.1146 ^c	-.0628	.0327 ^b	.0090 ^b
Drives	-.0051	.0272	.2088 ^c	.1510	-.2563 ^b	.2107 ^c	.3349 ^a	-.2819 ^b	-.2557 ^b
Uses Bus	-.0396	.1401	-.0867	.0392 ^c	-.1818 ^c	-.0065 ^c	-.0657	.1514 ^b	.2505 ^b
Other Drives	-.0438	.0708 ^a	-.2853 ^b	-.1668 ^b	.0256	-.1628 ^a	-.1537	.2347 ^b	.1947 ^b
Sex	.0757	-.3482 ^a	.1813 ^b	.2449 ^b	-.1459 ^a	.4981 ^a	.3829 ^a	-.3573	.0038 ^a
Interview Lang.	.0792	-.1863 ^c	-.1235	-.0825	.4071 ^a	-.0621	-.0735	.0523	-.3683 ^a
Second Lang.	-.1495	.3301 ^a	.0180	.0181	-.4141 ^a	.1083	.1800 ^c	-.1266	.0287

^ap < .001^bp < .01^cp < .05

Table 7 (cont'd.)

	MEDICAID	MEDICARE	WALKS	DRIVES	USES BUS	OTHR DRV	SEX	INTLANG	SCND LANG
Medicaid	-								
Medicare	.2368 ^b	-							
Walks	.2371 ^b	-.0473	-						
Drives	-.2915 ^b	-.0591	-.1036 ^a	-.2680 ^b					
Uses Bus	.1339	-.0225	.3578 ^c	-.4046 ^b	-.2726 ^b				
Other Drives	.0495	-.1270	.1887 ^c	.2800 ^b	.0293	-.1673 ^c			
Sex	-.1438	.3185 ^a	-.0198 ^c	.1853 ^c	-.1525 ^b	.0255	-.1744 ^c	-	
Interview Lang.	.0437	.0450 ^b	-.1658 ^c	.1217	.2285 ^b	.1081	.0919	-.7707 ^a	-
Second Lang.	.0314	-.2707 ^b	.1802						

^a p < .001^b p < .01^c p < .05

contact and the perceived clarity of the contact and service use were significantly related. The more positive the reaction to the outreach contact, the greater the tendency to use services; also, the clearer the contact, the greater the use.

Finally, Pearson correlations were computed to investigate relationships between service use and the attitudinal measures. Service Use and Health Locus of Control Scale were significantly related, with persons manifesting internal control tending to use services more often than those externally-oriented.

Relationships Between Attitudinal Variables

Pearson correlations were computed between attitudinal variables to determine whether attitudes toward traditional folk medicine, health perceptions, needs, and psychological well-being were significantly related, possibly forming a schema through which Mexican Americans view health care.

The Current Health and Illness Anxiety subscales correlated significantly as did Current Health with Prior Health Perceptions subscales. Individuals who report good health status tend to experience less health-related anxiety and report a better health history than individuals reporting poorer health status.

A person's Current Health and Prior Health Perceptions are significantly related to psychological well-being.

One reporting good current health status tends to report better mental health as well; a report of good prior health history is also related to better mental health.

A significant relationship is also noted between Perceived Current Health Status and Attitudes toward Folk Medicine. A Mexican American in this study reporting good current health also tended to express negative attitudes toward traditional folk medicine. Alternatively, one who perceived his health status as poorer viewed folk medicine more positively.

Relationships Between Other Survey Variables

To help explain patterns of health service use by Mexican Americans, relationships between survey variables tapping opinions of contemporary and/or free medical care and other survey variables were also examined through Pearson correlations. The Free Health Services opinion variable correlated significantly with the Ability to Afford Doctors variable. One with the opinion that free health services are no good may also feel that he cannot afford doctors. The Free Services variable also correlated positively with the variable tapping one's sense of embarrassment at visiting a doctor. A person who has a negative opinion of free health services may also be embarrassed to go to a doctor. The Needs Scale and Attitudes toward Folk Medicine variables had inverse relationships with the Free Health Services variable. An individual with high needs

may tend to also feel that free health services are no good. A person holding a positive attitude towards folk medicine will also react positively to free health services.

The Embarrassment variable is also related to three follow-up scales. The Current Health Scale and Embarrassment correlate positively; one with good health currently will not be embarrassed at visiting a physician. Similarly, the Prior Health Scale and Embarrassment variable are positively correlated. One with good prior health history will not be embarrassed at visiting a doctor. Finally, a person with good mental health will not experience embarrassment at visiting a doctor, either, as indicated by the correlation between Psychological Well-Being Scale and Embarrassment.

The Ability to Afford doctors is negatively correlated with one's score on the Needs Scale. The higher the person's needs, the less he can afford to pay a doctor.

Monthly income was significantly related to various survey variables. Monthly income is positively related to the Prior Health Scale, with people of lesser income reporting poorer health histories. Lower income people also report lesser psychological well-being and lower second language fluency. These subjects also reported more positive attitudes towards Folk Medicine and greater Embarrassment at visiting, a doctor. Finally, lower income subjects significantly agree that free health services are inferior, while also reporting an inability to afford doctors.

Reasons Given by Subjects for Response
or Non-Response to the Outreach Contact

A series of questions were included in the follow-up questionnaire to determine reasons why subjects did or did not use Health Program services after the outreach contact. Other related items were also included.

Among the individuals who reported receiving an outreach contact, 87.5% reacted positively towards a personal home visit by a Health Program representative, 8.9% were neutral, and 3.6% were negative (see Item 4 of questionnaire).

Responses to Item 10 indicated that 83.5% of the ten individuals who reported personal or family use of the health program did so because of the services available. The social activities at the Health Program (special classes or groups, etc.) was the reason why 16.5% of those who used the services did so.

Among the individuals who received the outreach contact but did not use the Health Program services, 53.6% reported that they had had no need, 3.5% said they were not sure about the outreach information, 3.5% said that the Center did not seem friendly, and 16.7% said they simply never got around to it. The remaining 23.2% of the non-users gave "other" reasons for non-use a medical coverage through insurance elsewhere, negative attitudes towards the Center in general, etc. (see Item 13 of the questionnaire).

Frequencies showing the percentages of the individuals in the sample who personally received or had family members who received services from health professionals elsewhere in the last year are shown in Appendix F.

When asked if they would consider using the Health Program services in the future (Item 15), 96.4% of the respondents said they would; 3.6% said they wouldn't.

Two other items related to possible service use were included in the questionnaire and asked of the entire sample. When asked if they felt others looked unfavorably upon those who received government assistance, 58.4% of the sample said yes, 31.7% said no, and 9.9% did not know.

When asked for their preference in a physician's ethnicity, 22.7% always or usually preferred a Mexican American physician when possible, 11.9% always or usually preferred an Anglo physician, and 65.3% stated that the physician's ethnicity really didn't matter.

CHAPTER IV

DISCUSSION

The primary purpose of this study was to experimentally investigate the problem of caregiver-consumer linkages and the provision of culturally relevant health services to Mexican Americans in Lansing, Michigan. It used an informational outreach component to investigate whether the knowledge of the availability of a curandera's (folk medical practitioner's) services in a health center would significantly affect service utilization rates by Mexican Americans. It also investigated attitudinal, perceptual, belief and socioeconomic correlates of Mexican American health care behavior.

Two treatment and one control group comprised the sample in this study. One treatment group received outreach visits at home in which they were informed of Contemporary Medical Services available through a neighborhood health program. The second treatment group received the same information as the first treatment group but were also told that the services of a curandera or folk healer were available through the Health Program. The control group received no outreach contacts whatsoever. Four weeks after outreach, all groups were contacted for a follow-up survey.

Primary Outcome

A primary measure determined the effectiveness of the outreach contacts: receipt of a service through the Health Program. There was no significant difference between treatment groups on receiving a service. The knowledge of available folk medical services was not a strong enough factor to result in greater service use by the second treatment group. This finding supports other studies in which the role of curanderismo or folk medical beliefs was fairly small in health service utilization (Edgerton, Karno & Fernández, 1970; Welch, Comer & Steinman, 1973). Another explanation might be that people do not admit to practicing curanderismo openly (Madsen, 1964). While traditional folk medical beliefs might play a role in how Mexican Americans view certain illnesses or health care, they appear not to be a significant factor in health service utilization in this study. Other variables were examined in an attempt to explain views of health care in this sample.

In this study the contact itself, not the folk medical dimension, resulted in increased service use. The in-person contact mode showed the same effectiveness in studies by Kushler (1977) and Bergner and Yerby (1968). Approaching someone in their home with service information is most effective in increasing service use.

Follow-Up Survey Scales

A number of health attitude, belief and perception measures were included in a follow-up interview which was conducted on the entire sample one month after outreach. The data indicate that there were no significant differences between treatment groups on these survey scales. The outreach contact provided health service information, but it was not powerful or relevant enough to result in deeper changes in health attitudes, beliefs or perceptions. Kushler (1977) reported similar findings in his outreach experiment with the elderly.

To investigate whether cultural or socioeconomic factors affected the correlates of Mexican American health care, subjects were grouped according to language spoken during the interview, source of financial support or educational level. Differences in follow-up survey scales were noted. Those interviewed in Spanish scored higher on the Health Anxiety scale than subjects interviewed in English. Individuals interviewed in Spanish also had greater externality on the Health Locus of Control scale than those interviewed in English. If one considers those who were interviewed in English as more acculturated into the Anglo culture, these findings are similar to the differences between Blacks and Whites found on the Health Anxiety Scale (Ware, 1974), and in Health Locus of Control (Wallston, 1975). Blacks expressed greater anxiety and health

externality than whites. While cultural influences could be credited for these differences, it is important to note that these were the only health scale dimensions in which significant differences were seen; perhaps socioeconomic factors play a major role. The Spanish-speaking Latino, like the Black, is frequently of low income and limited in social mobility. With continuous socioeconomic struggles, health becomes just one more concern for which little can be done. As a result, the individual expresses higher health anxiety and greater externality in health locus of control than the English-speaking Latino who may be more active in society's mainstream.

When subjects are grouped according to educational level, a similar pattern emerges. On Current Health, Prior Health and Health Anxiety subscales, people with less than an eighth grade education indicated poorer health status, more health anxiety and worse health histories than those with more education. These findings parallel those of Ware (1975). These differences bespeak more than differences in years of schooling; they represent its impact on economic conditions, social mobility and health. With poor living conditions and little hope of relief, current health will be worse and health anxiety greater.

A significant difference in receipt of a service is seen when subjects are grouped according to source of support or receipt of government assistance. Recipients of government

assistance received services from the Health Program after outreach more often than those not receiving government assistance. This may be expected since the Center where the Health Program is located most frequently serves individuals on government aid.

Correlates with Service Use

To further examine the question of what best determines health service use among Mexican Americans, correlations were computed between the Service Use variable and various demographic and survey variables. Of 25 variables investigated, only three demographic variables and the Health Locus of Control Scale correlated significantly with service use. Most contribute little to explaining Mexican American health care patterns and point further to the possible role of socioeconomic factors in service use. Age and sex correlated significantly, with women and younger individuals using the Health Program services more often. Bachrach (1972) noted similar patterns in his investigation of mental health service use by Chicanos. These findings may be expected in this study since young housewives most frequently take their children to the Pediatric Clinic at the Health Program. Most hours of operation at the Health Program are also during working hours, so one would expect mainly young women and children to use the services.

The significant relationship between health locus of control and service use is supported in the literature

(Wallston & Wallston, 1975). An individual who perceives that he has control over his health status will take steps at maintaining or improving it.

Relationships Between Follow-Up Survey Scales

Relationships between follow-up survey scales were examined in order to determine whether or not certain concepts were interrelated and formed a conceptual health schema for Mexican Americans. The Current Health and Health Anxiety subscales were significantly related as were Current Health and Prior Health subscales. One would expect these findings since prior and current health status would influence the anxiety one experiences over matters of health. The literature on the development of the scale supports this finding (Ware, 1974).

The Scale of Psychological Well-Being was significantly related to the Current and Prior Health Subscales. There was also a significant correlation between monthly income and prior health and psychological well-being. Berkman (1971) also reported a significant association between physical health status and mental health; good prior and current health status are related to good mental health. In this study, too, psychic and somatic health and illness are related. The literature has reported that Chicanos with psychological difficulties most frequently express somatic complaints. Previous research and the findings of this study are congruent. The relationships of prior health and

psychological well-being to monthly income also indicate the economic determinants of these health variables. A person with greater financial strength will have had better living conditions and greater access to better health care, resulting in a better health history and sense of psychological well-being.

The relationship between the Current Health Scale and Attitudes toward Folk Medicine indicates that a Mexican American in this study in good physical health tends to report negative attitudes toward folk medicine more frequently. This may be explained by the fact that a person with better health is more mobile and able to draw actively from community resources. It may also reflect good experiences with health care that people with good health have had. For the person with poorer health who is more restricted or has had bad experiences with health care, folk medicine is an accessible, reasonable alternative.

In terms of the questions posed in this study, the relationships between these follow-up survey scales reveal a complex of perceptual and attitudinal correlates that may be more easily explained in socioeconomic rather than cultural terms. Good current physical health, sound health history and good mental health may be most affected by economics--the access a person has to good health care and adequate living conditions--not solely by ethnic group membership. A study by Welch et al. (1973) also indicated that

socioeconomic components determine Mexican American attitudes toward health care and patterns of service use.

Relationships Between Other Survey Variables

Correlations between items asking opinions of contemporary and/or free health services and other survey variables were computed in order to explain patterns of health care use among the Mexican Americans in this sample.

The items which asked the subject's agreement with the statement "Free health services are no good" correlated significantly with five other survey variables: the Ability to Afford Doctors variable, the Embarrassment Variable, the Needs Scale, the Attitudes toward Traditional Folk Medicine Scale and Monthly Income. An individual who feels that free health services are no good typically has a lower income, cannot afford doctors, is embarrassed to go to a doctor, and reports many unmet needs. If one feels that free health services are good, he also has positive attitudes toward folk medicine.

A possible explanation for these findings is that a person who can't afford doctors and has many unmet needs may have had poor treatment or a bad experience with free health services previously. Consequently, he may have many needs and feel he cannot afford a doctor, but the free health services available and the type of treatment received are not good, either. With a history of bad experiences and an element of pride, a person may also be embarrassed to

go to a doctor, especially if the services are free. A person who believes free health services are good will tend to have a positive attitude towards folk medicine. This is congruent since the services of a curandera are free unless the patient wishes to pay a gratuity.

The Embarrassment variable related with four other variables: Current Health, Prior Health, Monthly Income and Psychological Well-Being. A person who has a good income, sound health history and good current physical and mental health will not be embarrassed to visit a doctor. For one who is not wholly healthy or has little money, however, going to a doctor may be frightening, embarrassing or intimidating. It might reflect prior bad experiences with doctors, a sense of stigma attached with ill health, or embarrassment at having limited resources to cover health care expenses.

Reasons Given by Subjects for Response
or Non-Response to the Outreach Contact

The primary outcome analyses in this study determined the effectiveness of the outreach treatment. The correlational analyses tried to determine relationships between the various health attitude, perception and belief scales, other survey variables and service use. The final question in this investigation entails reasons for use or non-use of health program services after outreach contact.

Service recipients most frequently used the health program because of the services available. Those who did not use the services typically reported no need. There are three possible explanations for this finding: (1) either the outcome period was too short and no need would arise within one month (assuming most people would come for treatment rather than prevention services) (2) their health needs are being met elsewhere or (3) they don't actually have many health needs. The follow-up survey revealed that in the past year 69.3% of the respondents indicated that they or someone in their household received the services of a medical doctor; 19.8% an obstetrician, 17.8% a surgeon, 9.9% a chiropractor, 3.0% a psychologist; 1.0% a marriage counselor and 1.0% a curandera. Other reasons for non-use of the Center's health services were medical coverage through insurance or a health maintenance organization, or negative attitudes towards the Community Center.

The majority of respondents (96.4%) said they would consider using the Health Program services in the future. If the center is perceived as typically concerned with the delivery of social services, however, and 58.4% of the sample felt others looked down upon people receiving government assistance, perhaps the image of the Center and an element of pride also affect service use. Since ethnicity of the doctor was not important to most respondents, economic and other influences may be most important in determining

health service use among subjects in this sample. Organizational variables may also influence the extent to which individuals use health services (Denton, 1978). Values, expectancies and routine procedures in the health care system may not be congruent with those of the patient seeking help. This discrepancy may result in client dissatisfaction and decreased service use.

In summary, the folk medical dimension of the outreach contact did not significantly increase the rates at which Mexican Americans in the sample used the Health Program services. Folk medicine, therefore, does not appear to be a significant barrier to contemporary health service use by Chicanos. A significant difference in service use was noted for contact itself; in-person outreach is effective in increasing service use.

Health attitudes, perceptions and beliefs were not related to receiving a service in this study and most frequently reflect socioeconomic influences. A more educated person of higher income is physically and mentally healthier and perceives greater control over his health than someone of lower income. A lower income person is frequently not as healthy and may feel less control over his health. This person cannot usually afford doctors, is embarrassed to visit a doctor and typically considers free health services inferior. These findings reflect, perhaps, the differential health care which various social classes of people receive.

Attitudes toward health care may thus reflect past experiences with health care that are determined largely by social class.

Research Issues and Limitations

There are difficulties inherent in any research, and field research presents some special problems of its own. In this study, subject mortality was high on initial contact largely because of the profile of the community. Low income people move often and public records are not always up-to-date. Bad addresses, nonLatino residents and numerous other factors presented some difficulty in completing contacts, but the final sample was acceptable because there were no significant differences between groups on most dimensions.

The time allotted for the outcome measure may not have been long enough for service need to arise for many respondents. Parameters for any field measure may present disadvantages.

An important difficulty in the study was the lack of a check on whether or not subjects in treatment groups received information about the curandera's services in the Health Program. It is possible that the low use of the curandera's services were partially due to lack of knowledge of her services in addition to little belief or perceived need for traditional folk medicine.

Language is an important issue in conducting research with Latinos. For randomly selected and assigned households in which there is no background information, one does not know beforehand what language to speak in a household. The interviewer is thus left to approach the individual as he feels appropriate, being sensitive to linguistic difficulties or preferences the person might have. The interviewer may use his primary language in addressing the subject or he may be assigned a language in which to conduct the interview. Either way, use of a particular language may be prompted in the respondent. One alternative is to allow the person to speak first; the other is to speak in a third language unknown to the subject and note the language in which the subject replies. Neither alternative is appropriate. The issue is important, however, for other concepts and dimensions in Chicano research may vary with language, and results may differ depending on the language spoken.

Translation of instruments is a similar issue in Latino research. Not all statements or expressions can be directly translated; in doing so, the researcher risks "losing something" in the translation. Back-translation is an attempt at equalizing bilingual versions of materials. An English instrument is thus translated into Spanish by one person, then translated back to English by another. With Chicano research, even back-translation has its limitations. Spanish, like any language, varies regionally. In

a place where people of many regions and educational levels are located, it is difficult to obtain a constant, appropriate level of language.

In investigating patterns of health use in this sample, the follow-up questionnaire asked what but not where other health services were received by the individual and family members in the last year. This information might help to better understand their health service utilization patterns.

Research Implications & Future Directions

The questions of health service utilization and correlates of health care posed in this study present important implications for health care research, policy formation and service delivery to Mexican Americans.

The results of this study indicate that in-person contact is most effective in increasing service use among Mexican Americans. The program planner must consider financial and manpower costs involved in conducting outreach and weigh them against the type of information being conveyed and the rates of increased service use noted.

This study further found that an added folk medical dimension of health care did not significantly add to service use by Mexican Americans. These findings indicate that, while folk medicine may influence a Latino's conception of health and illness, their inclusion in health service does not appear to increase the rate at which the person uses

the services. This finding and the relationships between other variables investigated indicate that economic and other factors may play a major role in determining health care use by Mexican Americans. Living conditions and accessibility to services may influence a person's past and current health and the extent to which he is anxious or feels control over his health. The low income person who feels free health services are no good may actually be reflecting previous bad experiences with free health services. It may not be who renders health treatment but the type and quality of services rendered that determine whether or not Chicanos use the services. Health service planners and providers must be sensitive to the needs, lifestyles and frustrations of those with low income. Moderate or no fees, accessibility to services, and flexibility in procedures are possible changes that may help the services better meet the needs of the client. Sensitivity to linguistic differences and cultural values are also important in delivering relevant health services to Mexican Americans.

Future research in this area must address itself to a number of basic and important questions. Sensitive and relevant instruments must be created specifically for research with Mexican Americans in order to avoid difficulties inherent in translation or use of instruments created upon white middle class populations.

The issue of cultural versus socioeconomic factors and expectancies in Mexican American health behavior is important and should be further investigated using a variety of research techniques. Future Mexican American health care research must look at the agreement between patient expectancies and service delivery values and procedures. A discrepancy between the two may result in client dissatisfaction and decreased service use.

Increased service use by Mexican Americans may not be noted until health services are equitable, with existing resources allocated so that benefits are maximized. As noted by Norman (1969), supplying more resources in the same, established ways, will only result in parallel health care systems for those with and without the means to pay for services received. Instead, a reevaluation of medical training programs, health care providers and health system operations are necessary in order to expend resources in the most appropriate manner, sensitive to the populations being served. As long as the low income and minorities are excluded from participating in decision-making, parallel health care systems will continue with these groups receiving lesser services.

Primarily, future research in the health care of Mexican Americans should investigate whether health services benefit Mexican Americans. Research in the determinants of health status among Mexican Americans might explain more about health care choice than do attitudinal correlates. If

the findings of this study are replicated and indicate a significant role of socioeconomic variables in determining Mexican American health care, perhaps health service policy and delivery should address themselves more to the direct relief of economic stress and promotion of health among Chicanos than to focusing upon treatment of illness.

APPENDIX A
HISTORICAL OVERVIEW OF MEXICAN AMERICANS

APPENDIX A

HISTORICAL OVERVIEW OF MEXICAN AMERICANS

Historically, Texas has had the largest percentage of the national Mexican American population. Currently, California's Chicano population approximately equals (if not exceeds) that of Texas. Together, the two states account for approximately seventy-five percent of all Mexican Americans nationally. The other southwestern states of Arizona, New Mexico and Colorado account for most of the remainder (Burma, 1970). World War II introduced masses of Mexican Americans into the industrial labor force in Wisconsin, Michigan, Ohio and Illinois.

Literature on Mexican Americans is not uniform in its terminology. This may reflect the diversity of the group itself and ways they are viewed by other ethnic groups. Termed "Latin Americans" or "Mexican Americans" in Texas, "Spanish Americans" in northern New Mexico and southern Colorado, "Mexican Americans" or "Chicanos" in California or "La Raza" ("The Race") nationally, they are bound across social classes by a sense of nationalism and ethnic identity (Burma, 1970). Mexican Americans live in rural and urban areas. They vary politically, economically, and educationally. Generational differences in values and behavior patterns are frequently noted. This diversity within Mexican Americans is important to consider when studying or

working with them.

The Spanish and Mexican ancestors of the contemporary Chicano settled over four hundred years ago in what is now the Southwestern United States. The Spaniards relied heavily upon native and mixed-blood (mestizo) citizens of Mexico for settling and developing the area. The Mexican people continued to excel in labor and craftsmanship despite Spanish exploitation. Although settling in the Southwest was extensive, the area was sparsely populated.

Gradually the European and native Mexican influences mixed and life for most people became a blend of Spanish and native Mexican or Indian traits. The Mexican language was used for governmental, religious and academic purposes. Roman Catholic practices were modified by Indian customs. Migration and cultural mixture continued.

In 1921 the Republic of Mexico was created (Forbes, 1970). Legislatures and councils were formed and Indians and mestizos were granted full citizenship and equality. The influence of Spanish authoritarian rule, however, frequently subverted attempts at establishing a solidly working republic. Foreign settlers often did not follow Mexican rule. In Texas, for example, Anglo-Texans refused to follow land-title regulations or set their slaves free. The new Republic was fraught with financial difficulties; growth was painful. The Republic gradually grew despite illiteracy and an unequal distribution of wealth and power (Forbes, 1970).

Craftsmen and skilled laborers moved north to California in the 1830's. The Sonoran mining techniques were widely adopted during the California Gold Rush.

Eastern Texas and northern California were most immediately affected by the U. S.-Mexican War of 1846-1848. After 1852 the influence of the Gold Rush changed central California's language to English because Mexican miners were barred from the Sierra Nevada mines. From San Luis Obispo, California to San Antonio, Texas, however, the Mexican lifestyle dominated. Southern California remained a Spanish-speaking area until the 1870's. The Spanish language, bilingual schools, Spanish newspapers and Mexican political representation in government remained until 1878 (Forbes, 1970).

Lifestyles continued to change with the influx of Anglo-Americans from the Eastern United States. Drastic changes occurred because most of these newcomers were unsympathetic to the Mexican culture and unwilling to assimilate. Schools became English-only institutions, new styles of architecture were introduced, and Mexican leadership was stifled. Mexican Americans eventually became the "forgotten Americans" (Sánchez, 1940).

A new surge of Mexican immigrants seeking agricultural employment occurred in the early 1900's. Employment in California, Colorado, Arizona and south Texas resulted in numbers of new Mexican residents, many of whom are

ancestral to the contemporary Chicano (Grebler, Moore & Guzman, 1970).

In the early 1920's Mexican American agricultural workers began moving north to Illinois, Michigan and Ohio in search of seasonal employment. Inadequate housing, poor sanitation, low wages, ill health and continuous moving for employment was and still is a way of life for many migrants. Many families "settled out" into various midwestern communities to establish a more secure life (Salas & Salas, 1972).

The Midwestern Mexican American population grew tremendously in the early 1940's because of the World War II labor shortage. Mexican Americans seeking employment in industrial settings settled in the Midwest; the number of Chicano communities in the region increased (Salas & Salas, 1972). The settling of Mexican Americans in Michigan in general and Lansing in particular will be elaborated in another section of this overview.

The Mexican Americans were not passive during these various periods of transition. Hundreds of thousands had to overcome difficult obstacles in order to survive and improve their standard of living. Mexican Americans nationally experienced prejudice by the majority culture. Language, skin color, economic, educational and political elements have been and continue to be major difficulties the Mexican American must deal with in contemporary society. The

Chicano's background of cooperation and sharing make it difficult for an individual to ease into and advance in a highly competitive, less personalized society. Nonetheless, they have gradually advanced and established secure communities.

There has been a resurgence of Spanish language newspapers, periodicals and mass media broadcasts during the past twenty years. Traditional and contemporary Mexican American theater, music and dance are evidenced today, particularly in the Southwest. Politically, Chicanos have witnessed a few, but insufficient, advancements. In the Southwest there are some Mexican American civic, business and political leaders. Overall, however, they are not adequately represented in all aspects of American life (Forbes, 1970).

Nationally Mexican Americans are heterogeneous, with variations in values, aspirations and lifestyles. The group could be divided according to socioeconomic status, since individuals range from wealthy ranchers or businessmen to migrant workers. Acculturation, or the degree to which the Mexican American adopts values and mannerisms or identifies with the Anglo-American culture is another dimension along which the group may be divided (Forbes, 1970). Regional divisions are usually the most apparent. These factors contribute to the group's diversity; there are also basic elements which Mexican Americans have in common.

Primarily, Mexican Americans are proud of their heritage, preserve and promote it. Local educational agencies, brotherhood societies, historical organizations and patriotic committees are some of the most prevalent Mexican American community-based organizations. The extended family generally practices certain customs and sharing, fostering Mexican American traits as a part of daily life. Arts, cooking, theater and dance, music, religious observances, and other customs are perpetuated in the same way. Spanish language publications and mass media promote further cultural identification (Forbes, 1970).

The use of Spanish is a common bond which also varies among Mexican Americans. Many speak Spanish predominantly, with little or no English. Others are fully bilingual; some speak only English. Many, however, speak a combination of English and Spanish with adequate fluency in neither. The Spanish-speaking person may be at a disadvantage in communicating effectively in an English-speaking culture.

Spanish, like any language, is more than spoken words alone. It is a way of thought and expression of life. The Mexican American may thus find himself unable to express his thoughts and feelings appropriately in English. While it contributes to the individual's culture, one may encounter language difficulties when a less-accepting cultural group is encountered (Abad, Ramos & Boyce, 1977).

Mexican Americans nationally are experiencing cultural transitions which require an adaptive balancing of Mexican and Anglo cultures. This balance may be difficult, but a resurgence of ethnic pride has helped Mexican Americans advance.

Mexican Americans in the Midwest

Very little has been written about the Midwestern Chicano. In the early 1920's Mexican and Mexican American families in the Southwest (particularly in the Rio Grande Valley of Texas) began coming to Illinois, Michigan and Ohio in search of agricultural employment. As seasonal employees, whole families moved from migrant camp to migrant camp harvesting crops. The families were generally large and forced to live in ramshackle housing with little or no plumbing. Wages were low and working hours were long. Usually all able-bodied members of a family worked the fields. At that, an entire family scarcely made enough money to survive (Salas & Salas, 1972). When one crop was harvested, the families moved on to another site ready for harvesting, and the cycle continued. Winters were spent "at home" in Texas; warmer seasons were spent working the fields on the migrant circuit. The numbers of migrants coming to Michigan annually has declined drastically because much work is now done mechanically. The state still witnesses a smaller migrant stream. Many Chicanos currently residing in the Midwest were migrant farmworkers or children

of migrant farmworkers who "settled out" of the migrant stream into various communities. In Michigan, many settled in Imlay City, Capac, Holland, Bad Axe, Caseville, Muskegon, Erie, Pontiac, Monroe, Adrian and Port Huron. Their settlement in Lansing will be discussed later in this section.

Thousands of Mexicans and Mexican Americans moved to the Midwest seeking industrial employment during the World War II labor shortage. Many settled out migrants moved to various cities to work. Barrios or Mexican neighborhoods grew in urban areas. In Michigan, Detroit witnessed the greatest settling by Chicanos (Salas & Salas, 1972).

Mexican Americans in Lansing, Michigan

Many Chicanos came to Lansing, Michigan in the 1920's to harvest crops. As labor demands changed in the 1940's, thousands of workers were employed by industry. Mexican Americans in Lansing are largely migrants to the city, with over half of them being farmworkers or children of farmworkers settling in the area (Haney, 1978). Many Chicanos in Lansing retained agricultural jobs after settling; a large number worked in local factories. Some Chicanos also held government jobs at the state capitol (Haney, 1978). The Chicano community in Lansing developed even more in the 1950's. Many Mexican laborers were imported through contract agreements. Because of the recession, even more migrants from rural South Texas came in search of work in

fields and factories. Though mechanization caused a decline in the demand for migrant farmworkers, Chicano migration to Lansing continued. Chicanos with friendship, kin or former employment ties returned to Lansing and used these supportive networks to adapt to their new life in the city (Haney, 1978).

Lansing Chicanos have been viewed as segregated, culturally distinct, and highly visible (Haney, 1978). Most Mexican Americans reside in the northern section of Lansing. "In Lansing, Chicano-ness was maintained by continued visiting with Texas and Mexican relatives, the influx of new Texas and Mexican immigrants, and the presence of the barrio which served as a symbol of cultural distinctiveness. These factors continued Chicano visibility but also performed supportive functions for the overwhelming majority of poor, uneducated, Mexican-born, and underemployed negatively-selected Lansing migrants" (Haney, 1978, p. 311).

Haney (1978) also noted that the greatest proportion of Lansing's Chicano population was employed in construction or other unskilled manual labor. Many were underemployed in service occupations. Many had little or no formal education and earned less than the average Lansing resident. A sizeable proportion of the Chicanos in Lansing were unemployed and aided by social services. Many of these underemployed or unemployed people were Mexican-born or border region farmworkers. "This segment of the Chicano population is the

most powerless yet largest of all, and the actual size of the un-and underemployed Chicano population of Lansing is probably greater than statistics indicate. Although most analysts would distinguish between the nominally employed and the unemployed, these sectors of the Lansing Chicano population share an important feature. They are all subject to uncertainty, even if they are dependent on transfer payments for subsistence" (Haney, 1978, p. 167). This project is directed to this segment of the population.

APPENDIX B

CURANDERISMO: MEXICAN AMERICAN FOLK MEDICINE

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CURANDERISMO: MEXICAN AMERICAN FOLK MEDICINE

Curanderismo is a term used specifically in transcultural psychiatry to refer to Mexican American folk psychiatry (Gonzales, 1976). Curanderismo may more broadly be viewed as the general domain of Mexican American medical concepts and practices. Typically it does not dichotomize between psychic and somatic difficulties, but views man as having the mind and body balanced and interactive. Illness occurs when man is in disharmony with God, his family, his environment or fellow man (Kiev, 1968). Folk medical beliefs and practices, rituals concerned with health preservation or restoration, and the use of folk curers or curanderos(as) associated with curanderismo are reviewed in this section.

Traditional Mexican and Mexican American folk medicine is derived from 15th and 16th century European medical practices, traditions of the Roman Catholic Church in Spain, and practices of Aztecs, Mayans and other native Mexican tribes (Kiev, 1968). Many concepts are similar to those in modern medicine. Some apart from modern medicine are mal ojo, susto, empacho, mal puesto, and caída de la mollera. Each is briefly described below.

Mal ojo, translated literally as "bad eye," occurs as a result of excessive admiration or desire of one person

towards another. Symptoms include sleeplessness, severe headaches and general malaise. The treatment for the disorder is to have the admirer (who cast the mal ojo unintentionally) caress the victim. Children and women are believed to be most susceptible to mal ojo (Gonzales, 1976).

Susto, or "fright" is believed to result from emotional trauma. Listlessness, unrestful sleep, energy loss and occasional night sweats are characteristic of the disorder. Rubel (1964) noted that susto occurs when an individual's body and soul become detached. When the spirits wander freely, soul loss or susto occurs. If treated at home, the victim is administered herb tea (usually hierba buena), and swept lightly with a palm or other branch, while prayers are being recited. Frequently curanderos(as) are consulted for assistance with susto. The healer will talk with the patient to try to determine the genesis of the illness. The patient may be massaged or sweated when the body and soul are being reunited. The patient may also be swept or rubbed with an object which will draw out the illness (Rubel, 1964).

Empacho, a gastrointestinal blockage, is believed to result when a ball of food clings to the wall of the stomach and obstructs digestion. Empacho is thought to be caused by poor food quality or contamination by an enemy (Gonzales, 1976). Generally, empacho may occur when one individual is allowed to override another person's autonomy. Treatment

for empacho involves ingestion of small doses of greta, a mercury derivative, and prayers recited during the gentle massage and pinching of the spine.

Caída de la mollera (fallen frontanel) usually affects only young children, especially infants with a fragile skull structure. The mollera or frontanel is the top-most section of the skull. It is held in place by the counter-pressure of the upper palate. A blow to the head or other accident may dislodge the frontanel; the mollera may sink. The upper palate depresses and the oral passage-way becomes blocked. Caída de la mollera may also result from pulling the nipple out of the child's mouth too vigorously. When this happens, the frontanel is believed to be sucked down into the palate. One or any combination of three procedures may be used in treating caída de la mollera. An adult may push one finger against the child's palate to push it back into place. The child may also be held over a pan of water so that the tips of the hair are barely touching the water. A poultice made from soap shavings may also be applied to the depression. Use of all three procedures is believed to be most effective in treating this disorder (Gonzales, 1976).

Mal puesto, sorcery, is thought to result from one of three kinds of interpersonal relationships: an unrequited love affair, a lover's quarrel, or invidiousness between individuals or nuclear families (Gonzales, 1976). Mania is

the characteristic symptom of mal puesto; it is characterized by its chronic, incurable nature (Rubel, 1966).

Brujería or witchcraft are terms used interchangeably with mal puesto. Rubel's investigation (1966) found no evidence of brujas or witches causing or curing mal puesto. Illnesses may frequently be attributed to witchcraft, but the sorcerers are usually unspecified. When there are invidious elements, la gente (other people) or los vecinos (the neighbors) are blamed for causing mal puesto. In a lover's quarrel, the individual is easily identified (Gonzales, 1976).

The disorders described may be classified as natural and unnatural, or mal naturales and mal artificiales or mal puesto. Mal naturales occur naturally or are Providential; mal artificiales are considered within the devil's realm. The folk illnesses described reflect interpersonal relationships and their difficulties. These disorders are not exclusive or comprehensive, but are the ones most generally described and verified among Mexicans and Mexican Americans.

APPENDIX C
CLIENT CARD

APPENDIX C

CLIENT CARD

CLIENT CARD (TARJETA DE CLIENTE)

DATE

NAME

NOMBRE

Last (Apellido) First (Primer nombre) Middle Initial

ADDRESS

DIRECCIÓN

PHONE

TELÉFONO

DEMOGRAPHICS (DEMOGRÁFICOS)

Age:

Sex:

Edad Sexo: Male (Masculino) Female (Femenino)

Languages spoken: English only

Spanish only

Spanish &

English

Lenguas hablados: No más inglés

No más español

Español e

Inglés

Marital Status: Married

Widowed

Single

Divorced/

Separated

Estado Civil: Casado(a)

Viudo(a)

Soltero(a)

Divorciado(a)/

Separado(a)

NAMES AND AGES OF ALL PEOPLE LIVING IN THE HOME:

NOMBRES Y EDADES DE TODAS LAS PERSONAS VIVIENDO EN CASA:

Name

Age

Name

Age

NOMBRE

Edad

Nombre

Edad

Length of Residence: In Michigan

In Lansing

In current home

Tiempo en Residencia: En Michigan

En Lansing

En el presente

casa

Occupation: Yes

No

What/Where

Occupación: Sí

No

Cuál/Dónde

FINANCIAL RESOURCES (RECURSOS FINANCIEROS)

Primary: Pension Insurance Salary/Wage Social Security
 Primaria: Pensión Seguro Salario/Sueldo Seguro Social

Private Income Support from relative(s)
 Entrada Privada Ayuda de pariente(s)

Supplemental: SSI SSDI DSS (WELFARE) ADC Other
 Suplemental: SSI SSDI DSS (WELFARE) ADC Otro

Approx. income per month
 Entrada aprox. de cada mes: \$

Medicaid card YES NO Medicare card YES NO
 Tarjeta de Medicaid: SÍ NO Tarjeta de Medicare: SI NO

MOBILITY (MOVILIDAD)

Mobile: Walks Drives Public Transp. Private Transp.
 Móvil: Anda Maneja Trans Público Transp. Privado

(Outreach worker note):
 Impaired Walker Crutches Wheelchair Other
 Deteriorado: Andador Muletas Silla de ruedas Otro

MOST IMPORTANT HEALTH NEEDS: (NECESIDADES DE SALUD MÁS IMPORTANTES):

Chronic Problems: (Problemas crónicos):

Other Comments

Outreach Worker

Date

APPENDIX D
CONSENT FORM

APPENDIX D

CONSENT FORM

The outreach worker from the Cristo Rey Health Program has explained to me the reason for his/her visit to my home and the general purposes of the study being conducted. I have been asked to take part in the study, and I understand that if I do I am also free to quit participating at any time with no consequences to me. I understand that the information I give to the outreach workers in this study will be looked at along with the opinions of many others in this community, and that my name will not be used in the findings of the study. If I want to find out about what the study found, I may ask through the Cristo Rey Health Program. I understand that this study may not directly benefit me but may help the Program to better plan health services and further understand people's views on health care.

Participant Date

Outreach Worker Date

FORMA DE CONSENTIMIENTO

El trabajador de extensión del Programa de Salud de Cristo Rey me ha explicado la razón por su visita a mi casa y los objetivos generales del estudio que están conduciendo. Estoy invitada a participar en el estudio, y yo entiendo que si participo, estoy libre a salir de la participación en cualquier tiempo sin consecuencia a mi. Yo entiendo que la información que doy a los trabajadores en el estudio va a estar examinada junta con las opiniones de muchas otras en esta comunidad y que mi nombre no va a estar usado en los resultados del estudio. Si quiero saber que son los resultados del estudio, puedo preguntar por el Programa de Salud de Cristo Rey. Yo entiendo que este estudio posiblemente no va a dar beneficios a mi directamente pero puede ayudar al Programa a planear mejores servicios de salud y entender más las opiniones de la gente sobre el cuidado de salud.

Participante Fecha

Trabajador Fecha

APPENDIX E
THE FOLLOW-UP QUESTIONNAIRE

APPENDIX E

THE FOLLOW-UP QUESTIONNAIRE

Interviewer's Name _____
 Subject No. _____
 Date _____ Time _____ AM/PM

Hello! My name is _____ and I'm from the Cristo Rey Community Center Health Program. Is _____ at home? I'd like to speak with him/her, please (WHEN RESPONDENT IS PRESENT, CONTINUE). _____, I'd like to take a few minutes to ask you a few questions about you and your family's health.

WHEN YOU AND THE RESPONDENT ARE COMFORTABLE, BEGIN THE INTERVIEW.

¡Hola! Mi nombre es _____ y yo soy del Programa de Salud del Centro Comunitario de Cristo Rey. Está _____ en casa? Me gustaría hablar con el/ella, por favor. (WHEN RESPONDENT IS PRESENT, CONTINUE). _____, me gustaría tomar unos minutos para hacerle unas preguntas sobre su salud y la de su familia.

WHEN YOU AND THE RESPONDENT ARE COMFORTABLE, BEGIN THE INTERVIEW.

WILLINGNESS TO USE THE HEALTH PROGRAM

- Q1. Have you heard of the Cristo Rey Health Program?
1. YESGO TO Q2
 2. NOGO to Q16
 3. Other _____

- Q2. How did you hear about the Health Program?
1. television
 2. radio
 3. newspaper
 4. friends
 5. relatives
 6. outreach contact at home . . GO TO Q4
 7. don't remember
 8. other _____

WILLINGNESS TO USE THE HEALTH PROGRAM

- Q1. Ha Ud. oído del Programa de Salud de Cristo Rey?
1. SIGO TO Q2
 2. NOGO TO Q16
 3. Otro _____

- Q2. Cómo supo sobre el Programa de Salud?
1. televisión
 2. radio
 3. periódicos
 4. amigos
 5. parientes
 6. contacto personal con alguien del Programa de Salud . . GO TO Q4
 7. no se acuerda
 8. otro _____

- Q3. Were you contacted by a worker from the Cristo Rey Health Program?
1. Yes
 2. NoGO TO Q16
 3. Other
 4. Can't remember
- Q4. What did you think about the person coming to your home to contact you?

- Q3. Se puso en contacto con Ud. el trabajador del Programa de Salud de Cristo Rey?
1. Si
 2. NoGO TO Q16
 3. Otro
 4. No se acuerda
- Q4. Qué piensa sobre la persona viniendo a su casa a ponerle en contacto con Ud.?

I WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT THE VISIT WHICH THE HEALTH PROGRAM WORKER PAID YOU EARLIER. I'LL READ THE STATEMENT AND YOU CAN SHOW ME YOUR RESPONSE ON THIS CARD (SHOW CARD)

1. Not at all
2. A little
3. Somewhat
4. Quite a lot
5. Very much

- ___Q5. Was it clear what the worker was talking about?
- ___Q6. Did you think the Program would be helpful to you?
- ___Q7. Did the Program seem like it would be a friendly place?
- ___Q8. How much need did you have for their services?

- Q9. Since you were contacted by the Health Program worker, have you used any of the Health Program services?
1. Yes
 2. NoGO TO Q11
 3. Other
 4. Can't remember

ME GUSTARÍA HACERLE UNAS PREGUNTAS. SOBRE LA VISITA QUE LE HIZO EL TRABAJADOR DEL PROGRAMA DE SALUD. VOY A LEER EL DECLARACIÓN Y UD. PUEDE ENSEÑARME SU RESPUESTA EN ESTA TARJETA (SHOW CARD).

1. Nada
2. Un poquito
3. Más o menos
4. Bastante
5. Mucho

- ___Q5. Estaba claro de lo que estaba hablando el trabajador?
- ___Q6. Cree Ud. que el programa le puede ayudar?
- ___Q7. Piensa Ud. que el programa sería un lugar amigable?
- ___Q8. Cuánta necesidad tenía por sus servicios?

- Q9. Desde cuando se puso en contacto con Ud. el trabajador del Programa de Salud, ha usado Ud. algunos de los servicios del Programa de Salud?
1. Si
 2. NoGO TO Q11
 3. Otro
 4. No se acuerda

Q10. What influenced you to come to the Cristo Rey Health Program? (Or, what interested you in the Cristo Rey Health Program?)

1. The services available
2. The social activities
3. Curiosity, I wanted to know more about the Health Program
4. They seemed friendly
5. Other _____

Q11. Has anyone else in the household used any of the Health Program services since you were contacted?

1. YesGO TO QUESTION #12
2. NoGO TO QUESTION #13
3. Don't know
4. Can't remember
5. Other

Q12. Who else in the household has used the services? GO TO Q14.

NAME

RELATION

Q10. Qué le interesó para que viniera al Programa de Salud de Cristo Rey? (O, qué le interesó en el Programa de Salud de Cristo Rey?)

1. Los servicios que hay
2. Las actividades sociales
3. Curiosidad, quería saber más sobre el Programa de Salud
4. Se ven amigables
5. Otro _____

Q11. Desde cuando se puso en contacto con Ud. el trabajador del Programa de Salud, han usados alguien en su casa algunos de los servicios del Programa?

1. SiGO TO QUESTION #12
2. NoGO TO QUESTION #13
3. No sé
4. No se acuerda
5. Otro

Q12. Quién en la casa han usados los servicios? TO TO Q14.

NOMBRE

RELACIÓN

Q13. What influenced you not to contact the Cristo Rey Health Program?

1. had no need
2. don't believe in help like that
3. seemed unfriendly
4. not sure what they were talking about
5. too far away
6. never got around to it
7. other _____

Q14. What are the most important things that the Cristo Rey Health Program might be able to help you with?

Q15. In the future, would you consider calling the Cristo Rey Health Program if the need arises?

1. Yes
2. No
3. Other _____

Q16. Where do you get most of your information about what goes on in the community? (SHOW CARD; CHECK ONLY ONE RESPONSE)

1. television
2. radio
3. newspapers
4. friends
5. relatives
6. neighbors
7. don't know
8. other _____

Q13. Qué le influyó en que no se pusiera en contacto con el Programa de Salud de Cristo Rey?

1. no tengo necesidad
2. no creo en ese tipo de ayuda
3. no se ven amigables
4. no estoy segura de lo que hablan
5. está muy retirado
6. nunca pensé en hacerlo
7. otro _____

Q14. Cuáles son las cosas más importantes del Programa de Salud de Cristo Rey que tal vez se pueden ayudar?

Q15. En el futuro, usaría el Programa de Salud de Cristo Rey si lo necesitará?

1. Si
2. No
3. Otro _____

Q16. A dónde obtiene su información sobre lo que pasa en la comunidad? (SHOW CARD; CHECK ONLY ONE RESPONSE)

1. televisión
2. radio
3. periódicos
4. amigos
5. parientes
6. vecinos
7. no sé
8. otro _____

Q17. Did any member of your family currently living with you see these health care providers any time during the last year? (GIVE RESPONSE CARD) Please tell me which members of your family.

Names of people (relation)

Your family or regular doctor _____

General practitioner _____

Obstetrician or gynecologist - women's doctor _____

Surgeon--one who does operations _____

Chiropractor _____

Psychologist _____

Marriage Counselor _____

Curandero(a) _____

Q17. Cuál miembro de su familia que está viviendo con Ud. actualmente ha visitado a alguno de éstas personas relacionadas con la salud? (GIVE RESPONSE CARD)

Nombres de los parientes

Su doctor familiar o regular _____

Practicante general _____

Obstétrico o doctor de mujeres _____

Cirujano (uno que hace operaciones) _____

Ciropático _____

Psicólogo _____

Consejero de Matrimonio _____

Curandero(a) _____

Q18. Do you have complaints or suggestions in general about the way Mexican Americans are treated by health agencies? (NOTE ALL RESPONSES)

Q18. Tiene Ud. algunas quejas o sugerencias en general sobre el modo como los mexicanos americanos son tratados por las agencias de salud? (NOTE ALL RESPONSES)

Q19. I am going to read you a list of areas which people feel are problems for Mexican Americans and other Spanish-speaking people. For each area, please tell me if it is: (GIVE RESPONDENT CARD)

1. No problem
2. Somewhat of a problem
3. Very important problem

☐ Housing
☐ Employment
☐ Health Care
☐ Income
☐ Crime
☐ Getting an education
☐ Nutrition and Food
☐ Transportation
☐ Loneliness

Q19. Le voy a leer una lista de areas que la gente siente que son problemas para mexicanos americanos y otra gente de habla española. Por cada area, por favor digame si: (GIVE RESPONDENT CARD)

1. No es problema
2. Algo de problema
3. Problema muy importante

☐ Casa, domicilio, a lugar en que vivir
☐ Empleo
☐ Cuidado de salud
☐ Entrada de dinero
☐ Crimen
☐ Obteniendo un educación
☐ Nutrición y comida
☐ Transportación
☐ Soledad, sentimiento de melancolía

SCALE TO MEASURE HEALTH PERCEPTIONS

I WOULD LIKE TO ASK YOU A FEW QUESTIONS ABOUT YOUR HEALTH. I WILL READ A STATEMENT AND WOULD APPRECIATE IT IF YOU WOULD SHOW ME YOUR RESPONSE ON THIS CARD (SHOW CARD)

1. Definitely false
2. Mostly false
3. Don't know
4. Mostly true
5. Definitely true

___ Q20. According to the doctors I've seen, my health is now excellent

___ Q21. I seem to get sick a little easier than other people.

SCALE TO MEASURE HEALTH PERCEPTIONS

ME GUSTARÍA HACERLE UNAS CUANTAS PREGUNTAS SOBRE SU SALUD. VOY A LEER UNA FRASE Y LE AGRADECERÍA SI UD. ME ENSEÑARA SU RESPUESTA EN ESTA TARJETA (SHOW CARD)

1. Definitivamente falsa
2. Casi falsa
3. No sé
4. Casi verdad
5. Definitivamente verdad

___ Q20. En acuerdo con los doctores que he visto, mi salud está ahora excelente.

___ Q21. Yo veo que me pongo enfermo(a) más fácil que otra gente.

1. Definitely false
2. Mostly false
3. Don't know
4. Mostly true
5. Definitely true

- ___Q22. I feel better now than I ever have before.
- ___Q23. I will probably be sick a lot in the future.
- ___Q24. I never worry about my health.
- ___Q25. I don't like to go to the doctor.
- ___Q26. I was so sick once I thought I might die.
- ___Q27. I'm not as healthy now as I used to be.
- ___Q28. I worry about my health more than other people worry about their health.
- ___Q29. When I'm sick I try to just keep going as usual.
- ___Q30. My body seems to resist illness very well.
- ___Q31. Getting sick once in a while is part of my life.
- ___Q32. I'm as healthy as anybody I know.
- ___Q33. I've never had an illness that lasted a long period of time.
- ___Q34. When I'm sick I try to keep it to myself.

1. Definitivamente falsa
2. Casi falsa
3. No sé
4. Casi verdad
5. Definitivamente verdad

- ___Q22. Me siento mejor ahora que antes.
- ___Q23. Probablemente me enfermaré mucho en el futuro.
- ___Q24. Nunca me preocupo de mi salud.
- ___Q25. No me gusta ir al doctor.
- ___Q26. Una vez estaba tan enferma que creía que iba a morir.
- ___Q27. No estoy tan sano(a) ahora como lo estaba antes.
- ___Q28. Me preocupo de mi salud mas que otra gente se preocupa sobre su salud.
- ___Q29. Cuando estoy enfermo(a) trato de seguir lo mismo de siempre.
- ___Q30. Mi cuerpo se ve que resiste enfermedad muy bien.
- ___Q31. Enfermándome de vez en cuando es una parte de mi vida.
- ___Q32. Estoy tan sano(a) como cualquier persona que conozco.
- ___Q33. Nunca he tenido una enfermedad que ha dilatado mucho tiempo.
- ___Q34. Cuando estoy enfermo(a), trato de mantenerlo en privado.

1. Definitely false
2. Mostly false
3. Don't know
4. Mostly true
5. Definitely true

___Q35. I have been feeling bad lately.

___Q36. When there is something going around I usually catch it.

___Q37. When I think I am getting sick, I fight it.

1. Definitivamente falsa
2. Casi falsa
3. No sé
4. Casi verdad
5. Definitivamente verdad

___Q35. Me he estado sintiendo mal en estos días.

___Q36. Cuando un a enfermedad está pasando, yo usualmente lo agarro.

___Q37. Cuando creo que me estoy enfermado, no le doy importancia.

HEALTH LOCUS OF CONTROL SCALE

THE NEXT FEW QUESTIONS WHICH I WILL ASK ARE ABOUT YOUR IDEAS ON HEALTH AND ILLNESS. I WILL READ THE SENTENCE AND ASK THAT YOU INDICATE YOUR RESPONSE ON THIS CARD. (SHOW CARD)

1. Strongly disagree
2. Moderately disagree
3. Slightly disagree
4. Slightly agree
5. Moderately agree
6. Strongly agree

___Q38. If I take care of myself, I can avoid illness.

___Q39. Whenever I get sick it is because of something I've done or not done.

___Q40. Good health is largely a matter of luck.

___Q41. No matter what I do, if I am going to get sick, I will get sick.

HEALTH LOCUS OF CONTROL SCALE

LAS PRÓXIMAS PREGUNTAS QUE LE VOY A HACER SON SOBRE SUS IDEAS SOBRE LA SALUD Y ENFERMEDAD. VOY A LEER LA FRASE Y PEDIRLE QUE INDÍQUE SU RESPUESTA EN ESTA TARJETA. (SHOW CARD)

1. Definitivamente no estoy de acuerdo
2. No estoy de acuerdo
3. Casi no estoy de acuerdo
4. Casi estoy de acuerdo
5. Estoy de acuerdo
6. Definitivamente estoy de acuerdo

___Q38. Si me cuido, puedo evitar enfermedades.

___Q39. Cuando me enfermo es porque algo he hecho o no he hecho.

___Q40. Buena salud es cosa de suerte.

___Q41. No importa lo que yo hago, si me voy a enfermar, yo me enfermaré.

___Q42. Most people do not realize the extent to which their illnesses are controlled by accidental happenings.

1. Strongly disagree
2. Moderately disagree
3. Slightly disagree
4. Slightly agree
5. Moderately agree
6. Strongly agree

___Q43. I can only do what my doctor tells me to do.

___Q44. There are so many strange diseases around, that you can never know how or when you might pick one up.

___Q45. When I feel ill, I know it is because I have not been getting the proper exercise or eating right.

___Q46. People who never get sick are just plain lucky.

___Q47. People's ill health results from their own carelessness.

___Q48. I am directly responsible for my own health.

___Q42. Mucha gente no se da cuenta en que grado sus enfermedades son controladas por accidentes.

1. Definitivamente no estoy de acuerdo
2. No estoy de acuerdo
3. Casi no estoy de acuerdo
4. Casi estoy de acuerdo
5. Estoy de acuerdo
6. Definitivamente estoy de acuerdo

___Q43. Sólo puedo hacer lo que me dice mi doctor.

___Q44. Hay tantas enfermedades extrañas alrededor, que Ud. nunca sabe como o cuando puede agarrar una enfermedad.

___Q45. Cuando me siento mal, yo sé que es porque no he estado haciendo ejercicios apropiados o comiendo bien.

___Q46. La gente que no se enferma tiene buena suerte.

___Q47. La mala salud de la gente resulta de su propio descuido.

___Q48. Directamente soy responsable por mi propia salud.

INDEX OF PSYCHOLOGICAL WELL-BEING

HERE IS A LIST THAT DESCRIBES SOME OF THE WAYS PEOPLE FEEL AT DIFFERENT TIMES. I WILL READ YOU THE STATEMENT. PLEASE SHOW ME ON THE CARD HOW OFTEN YOU FEEL EACH OF THESE WAYS. (SHOW CARD)

INDEX OF PSYCHOLOGICAL WELL-BEING

AQUI HAY UNA LISTA QUE DESCRIBE ALGUNAS MANERAS EN QUE LA GENTE SE SIENTE EN DIFERENTES TIEMPOS. VOY A LEER A UD. UNA FRASE. POR FAVOR ENSEÑEME EN LA TARJETA QUE SEGUIDO SE SIENTE DE ESA MANERA. (SHOW CARD)

1. Never
2. Sometimes
3. Often

___Q49. Very lonely or remote from other people.

___Q50. Depressed or very unhappy.

___Q51. Bored.

1. Never
2. Sometimes
3. Often

___Q52. So restless you couldn't sit very long in a chair.

___Q53. Vaguely uneasy about something without knowing why.

___Q54. On top of the world.

___Q55. Particularly excited or interested in something.

___Q56. Pleased about having accomplished something.

HEALTH CARE ATTITUDES

THE NEXT QUESTIONS ASK ABOUT YOUR ATTITUDES TOWARDS HEALTH CARE. I'LL READ THE STATEMENT AND YOU CAN REPLY "YES" OR "NO" IF YOU AGREE OR DISAGREE WITH EACH STATEMENT.

1. YES/AGREE
2. NO/DISAGREE

___Q57. Sometimes I'm embarrassed to go to a doctor.

___Q58. I can't afford doctors.

1. Nunca
2. De vez en cuando
3. Seguido

___Q49. Muy solo(a) o retirado(a) de otra gente.

___Q50. Deprimada o muy infeliz.

___Q51. Aburrido(a).

1. Nunca
2. De vez en cuando
3. Seguido

___Q52. Tan agitada que no puede sentarse por mucho tiempo en una silla.

___Q53. Algo ansiosa sobre algo sin saber porqué.

___Q54. Me siento maravillosamente bien.

___Q55. Particularmente excitada o interesada en algo.

___Q56. Contenta en haber cumplido algo.

HEALTH CARE ATTITUDES

LAS PRÓXIMAS PREGUNTAS SON SOBRE SU ACTITUD SOBRE EL CUIDADO DE SALUD. VOY A LEER UNA AFIRMACIÓN Y UD. PUEDE CONTESTAR "SI" O "NO" SI ESTÁ DE ACUERDO O NO ESTÁ DE ACUERDO CON CADA AFIRMACIÓN.

1. SI/ESTOY DE ACUERDO
2. NO/NO ESTOY DE ACUERDO

___Q57. Algunas veces tengo vergüenza ir al doctor.

___Q58. No puedo pagar por doctores.

- | | |
|--|--|
| ___Q59. Free health services are no good. | ___Q59. Cuidados de salud que son gratis no son buenos. |
| ___Q60. The kind of food you eat has an impact on your health. | ___Q60. El tipo de comida que come tiene impacto sobre su salud. |
| ___Q61. Medicine at the grocery store is just as good as the doctor's medicine. | ___Q61. Medicina en la tienda de comida es tan buena como medicina del doctor. |
| ___Q62. I have doubts about some things that doctors say they can do. | ___Q62. Dudo sobre algunas cosas que los doctores dicen que pueden hacer. |
| 1. YES/AGREE
2. NO/DISAGREE | 1. SI/ESTOY DE ACUERDO
2. NO/NO ESTOY DE ACUERDO |
| ___Q63. Are you familiar with <u>curanderismo</u> ?
IF YES, GO TO Q64.
IF NO, GO TO Q70. | ___Q63. Sabe Ud. algo acerca del <u>curanderismo</u> ?
IF YES, GO TO Q64.
IF NO, GO TO Q70. |
| ___Q64. Do you think <u>curanderos(as)</u> can help people to feel better? | ___Q64. Cree Ud. que los <u>curanderos(as)</u> pueden ayudar a la gente a sentirse mejor? |
| ___Q65. A <u>curandero(a)</u> can do more good for you than a medical doctor can. | ___Q65. Una <u>curandera</u> puede hacer más bien para Ud. que un doctor puede hacer. |
| ___Q66. <u>Curanderos</u> are hard to find in this community. | ___Q66. Las <u>curanderas</u> están difícil de encontrar en ésta comunidad. |
| ___Q67. If a doctor cannot help me or someone I am close to with a health problem, I will seek the help of a <u>curandero(a)</u> . | ___Q67. Si un doctor no me puede ayudar o a alguien cerca de mi que tiene un problema de salud, yo buscaré la ayuda de un <u>curandero</u> . |
| ___Q68. I cannot afford a <u>curandero(a)</u> . | ___Q68. No puedo pagar a un <u>curandero</u> . |
| ___Q69. I feel more comfortable in visiting a <u>curandero</u> than I do seeing a doctor. | ___Q69. Me siento más comfortable visitando un <u>curandero</u> que ir a un doctor. |

DEMOGRAPHICS

NOW THE LAST QUESTIONS I'D LIKE TO
ASK YOU ARE ABOUT YOU AND YOUR
FAMILY.

Q70. What is your name?

Q71. What is your phone number,
please?

Q72. Are you currently: (SHOW CARD)

☐ Married

☐ Divorced/Separated

☐ Widowed

☐ Single

Q73. What is your age?

Q74. Please list the names of the
people currently living in
your home. Also, please give
their ages.

NAME	AGE
------	-----

Q75. What is the highest grade in
school which you completed?

Q76. Did you serve in the U.S.
military?

1. YESGO TO Q77.
2. NOGO TO Q79.

Q77. What branch?_____

Q78. What dates?_____

DEMOGRAPHICS

AHORA LAS ÚLTIMAS PREGUNTAS QUE
ME GUSTARÍA HACERLE SON SOBRE UD.
Y SU FAMILIA.

Q70. Cómo se llama Ud.?

Q71. Qué es su numero de telé-
fono, por favor?

Q72. Está ahora Ud.: (SHOW CARD)

☐ Casado(a)

☐ Divorciado(a)/Separado(a)

☐ Viudo(a)

☐ Soltero(a)

Q73. Cuántos años tiene Ud.?

Q74. Por favor liste los nombres
y las edades de todas las
personas viviendo ahora en
su casa.

NOMBRE	EDAD
--------	------

Q75. Cuál es el grado que Ud.
completó en la escuela?

Q76. Sirvió Ud. en las fuerzas
armadas de los Estados Unidos?

1. SIGO TO Q77.
2. NOGO TO Q79.

Q77. En cuál servicio?_____

Q78. Qué fecha?_____

- | | |
|---|--|
| Q79. Are you currently employed?
1. YESGO TO Q80.
2. NOGO TO Q81. | Q79. Está empleado(a) Ud. ahora?
1. SIGO TO Q80.
2. NOGO TO Q81. |
| Q80. What is your occupation?

_____ | Q80.Cuál es su ocupación?

_____ |
| Q81. What is your spouse's occupation?

_____ | Q81.Cuál es el ocupación de su esposo(a)?

_____ |
| Q82. How long have you lived in Michigan?_____ | Q82. Cuánto tiempo ha vivido Ud. en Michigan?_____ |
| Q83. In Lansing?_____ | Q83. En Lansing?_____ |
| Q84. In your current home?_____ | Q84. En su casa corriente?_____ |
| Q85. Is Lansing your original hometown?
1. YESGO TO Q87.
2. NOGO TO Q86. | Q85. Es Lansing su ciudad de origen?
1. SIGO TO Q87.
2. NOGO TO Q86. |
| Q86. In what city or town were you raised?_____ | Q86. En cuál pueblo o ciudad creció?_____ |
| Q87. What is your primary source of income? (CARD)
____Pension
____Insurance
____Salary/Wage
____Social Security
____Private Income
____Support from relatives | Q87.Cuál es su fuente primaria de entrada de dinero?
____Pensión
____Seguridad
____Entrada de dinero/sueldo
____Seguridad social
____Entrada de dinero privada
____Ayuda por sus parientes |
| Q88. Do you have a supplementary income?
____None
____SSI (Supp. Security Income)
____SSDI (Disability insurance)
____ADC (Aid to Dependent Children)
____Other_____ | Q88. Tiene Ud. algún tipo de entrada de dinero suplemental?
____Ningún
____SSI (Entrada suplemental del gobierno)
____SSDI (Seguridad de discapacidad)
____ADC (Ayuda a niños dependientes)
____Otro_____ |
| Q89. What is your approximate income per month?_____ | Q89.Cuál es su entrada de dinero aproximadamente de cada mes?

_____ |

- | | |
|---|--|
| Q90. Do you have a Medicaid card? | Q90. Tiene Ud. una tarjeta de Medicaid? |
| 1. YES | 1. SÍ |
| 2. NO | 2. NO |
| Q91. Do you have a Medicare card? | Q91. Tiene Ud. una tarjeta de Medicare? |
| 1. YES | 1. SÍ |
| 2. NO | 2. NO |
| Q92. Do you walk to various places in the community? | Q92. Camina Ud. a varias lugares en la comunidad? |
| 1. YES 2. NO | 1. SÍ 2. NO |
| Q93. Do you drive to various places in the community? | Q93. Maneja Ud. a varias lugares en la comunidad? |
| 1. YES 2. NO | 1. SÍ 2. NO |
| Q94. Do you ride the bus to go to various places in the community? | Q94. Pasea Ud. en el autobús para ir a varias lugares en la comunidad? |
| 1. YES 2. NO | 1. SÍ 2. NO |
| Q95. Do you have someone to drive you to various places in the community? | Q95. Tiene alguien que le lleva a varias lugares en la comunidad? |
| 1. YES 2. NO | 1. SÍ 2. NO |

FOR THE FOLLOWING QUESTIONS, PLEASE
SELECT YOUR RESPONSES FROM THESE
CHOICES (SHOW CARD).

1. fluently
2. fairly well
3. can get by, but do not speak very well
4. very poorly
5. not at all

- ___Q96. How well do you speak Spanish?
- ___Q97. How well do you understand written Spanish?
- ___Q98. How well do you understand spoken Spanish?

POR LOS SIGUIENTES PREGUNTAS, POR
FAVOR ESCOGE UD. SU RESPUESTA DE
ÉSTA SELECCIÓN (SHOW CARD).

1. muy bien
2. bien
3. algo bien, pero no muy bien
4. no muy bien
5. definitivamente nada

- ___Q96. Sabe Ud. hablar inglés? Si Ud. puede hablar, lo habla:
- ___Q97. Entiende Ud. el inglés escrito? Si Ud. entiende, lo entiende:
- ___Q98. Entiende Ud. el inglés hablado? Si Ud. entiende, lo entiende:

Q99. Do you listen to Spanish-language radio broadcasts?

1. YES 2. NO

___Q100. What phrase best describes you when you are in need of medical care? (CARD)

1. Always make a point to go to a Mexican American physician if one is available.
2. Prefer to go to a Mexican American physician if one is available.
3. It does not really matter whether the physician is Mexican American or not.
4. Prefer to go to an Anglo physician even if a Mexican American physician is available.
5. Always make a point of going to an Anglo physician, even if a Mexican American physician is available.

Q101. To the best of your knowledge, is there a Mexican physician in your community?

1. YESGO To Q102.
2. NoGO TO Q103.

Q102. What is his/her name?

Q99. Escucha programas del radio en la lengua española?

1. SÍ 2. NO

___Q100. Cuál frase lo describe mejor cuando Ud. está en necesidad de cuidado medico? (CARD)

1. Siempre trato de ir a un doctor mexicano americano si lo hay.
2. Prefiero ir a un doctor mexicano americano si lo hay.
3. Realmente no me importa si es un doctor mexicano americano o no.
4. Prefiero ir a un doctor americano aunque hay un doctor mexicano americano.
5. Siempre trato de ir a un doctor americano, aunque haya un doctor mexicano americano.

Q101. En lo que está familiarizado(a), sabe si hay un doctor mexicano en la comunidad?

1. SíGO TO Q102.
2. NOGO TO Q103.

Q102. Cómo se llama?

Q103. Do you think a lot of people tend to think poorly about people who receive help from the government such as food-stamps or Medicaid?

1. YES
2. NO
3. Don't know
4. Other _____

Q104. Do you know anyone in the area who might be interested in the Cristo Rey Health Program and some of the services we can provide? (NOTE NAMES AND ADDRESSES IF OFFERED)

THANK PERSON FOR THEIR TIME AND ENCOURAGE THEM TO CALL AND USE THE HEALTH PROGRAM SERVICES.

Q103. Cree Ud. que mucha gente piensa mal sobre la gente que recibe ayuda del gobierno como estampillas de comida o medicaid?

1. Sí
2. NO
3. No sé
4. Otro _____

Q104. Conoce Ud. a alguien que puede estar interesado(a) en el programa de Salud de Cristo Rey y algunos servicios que podemos entregar? (NOTE NAMES AND ADDRESSES IF OFFERED)

THANK PERSON FOR THEIR TIME AND ENCOURAGE THEM TO CALL AND USE THE HEALTH PROGRAM SERVICES.

APPENDIX F
FOLLOW-UP QUESTIONNAIRE FREQUENCIES

APPENDIX F

FOLLOW-UP QUESTIONNAIRE FREQUENCIES

<u>ITEM</u>	<u>RESPONSE</u>	<u>FREQUENCY</u>	<u>PERCENT</u>
1. Has subject heard of program?	Yes	86	85.1
	No	15	14.9
	Total	101	100.0
2. How did subject hear of Program:			
	<u>TV</u>		
	Yes	3	3.0
	No	98	97.0
	Total	101	100.0
	<u>Radio</u>		
	Yes	11	89.1
	No	90	10.9
	Total	101	100.0
	<u>Newspaper</u>		
	Yes	4	4.0
	No	97	96.0
	Total	101	100.0
	<u>Friends</u>		
	Yes	25	24.8
	No	76	75.2
	Total	101	100.0
	<u>Relatives</u>		
	Yes	8	7.9
	No	93	92.1
	Total	101	100.0
	<u>Outreach Contact</u>		
	Yes	56	55.4
	No	45	44.6
	Total	101	100.0
	<u>Don't Remember</u>		
	Yes	0	0.0
	No	101	100.0
	Total	101	100.0
	<u>Other</u>		
	Yes	12	11.9
	No	89	88.1
	Total	101	100.0
3. Was Subject Contacted?	Yes	56	55.4
	No	45	44.6
	Total	101	100.0

<u>ITEM</u>	<u>RESPONSE</u>	<u>FREQUENCY</u>	<u>PERCENT</u>
4. Subject's Reaction to Contact	Neutral	6	5.9
	Positive	49	48.5
	Negative	1	1.0
	Not Contacted	45	44.6
	Total	101	100.0
5. Was Outreach Information Clear?	Not Contacted	45	44.6
	A Little	2	2.0
	Somewhat	7	6.9
	Quite a Lot	22	21.8
	Very Much	25	24.8
	Total	101	100.0
6. Would Program be helpful?	Not Contacted	45	44.6
	Not at All	13	12.9
	A Little	6	5.9
	Somewhat	10	9.9
	Quite a Lot	10	9.9
	Very Much	17	16.8
	Total	101	100.0
7. Did Program seem like a friendly place?	Not Contacted	45	44.6
	Not at All	2	2.0
	A Little	3	3.0
	Somewhat	6	5.9
	Quite a Lot	27	26.7
	Very Much	18	17.8
	Total	101	100.0
8. How much need for program services did subject have?	Not Contacted	45	44.6
	Not at All	16	15.8
	A Little	17	16.8
	Somewhat	6	5.9
	Quite a Lot	5	5.0
	Very Much	12	11.0
	Total	101	100.0
9. Did subject use services since outreach contact?	Not Contacted	45	44.6
	Yes	5	5.0
	No	51	50.4
	Total	101	100.0
10. What influenced use of services?	None Used	96	95.0
	Services Available	5	5.0
	Social Activities	0	0.0
	Curiosity	0	0.0
	Seemed Friendly	0	0.0
	Other	0	0.0
	Total	101	100.0

<u>ITEM</u>	<u>RESPONSE</u>	<u>FREQUENCY</u>	<u>PERCENT</u>
11. Did other household members use services?	Yes	5	5.0
	No	96	95.0
	Total	<u>101</u>	<u>100.0</u>
12. Number of family members using services	None	96	95.0
	1	2	2.0
	2	2	2.0
	3	0	0.0
	4	1	1.0
	Total	<u>101</u>	<u>100.0</u>
13. Influence not to contact program	Control group	37	38.9
	No Need	30	31.6
	Don't believe in type of help	0	0.0
	Unfriendly	2	2.1
	Unclear info.	2	2.1
	Too far	0	0.0
	Never got around to it	9	9.5
	Other/I don't know	15	15.8
	Total	<u>95</u>	<u>100.0</u>
14. Areas of possible assistance by program	None	5	5.0
	Clinic	14	13.9
	Info. & Referral	4	4.0
	Education	2	2.0
	Prevention/Immun.	12	11.9
	Not questioned	64	63.4
	Total	<u>101</u>	<u>100.0</u>
15. Would call program in future	Not questioned	45	44.6
	Yes	53	52.4
	No	3	3.0
	Total	<u>101</u>	<u>100.0</u>
16. Source of Community Information:			
	<u>TV</u>		
	Yes	33	32.7
	No	68	67.3
	Total	<u>101</u>	<u>100.0</u>
	<u>Radio</u>		
	Yes	23	22.8
	No	78	77.2
	Total	<u>101</u>	<u>100.0</u>

<u>ITEM</u>	<u>RESPONSE</u>	<u>FREQUENCY</u>	<u>PERCENT</u>
16. Source of Community Info. (Continued):			
<u>Newspapers</u>	Yes	33	32.7
	No	68	67.3
	Total	101	100.0
<u>Friends</u>	Yes	31	30.7
	No	70	69.3
	Total	101	100.0
<u>Relatives</u>	Yes	9	8.9
	No	92	91.1
	Total	101	100.0
<u>Neighbors</u>	Yes	6	5.9
	No	95	94.1
	Total	101	100.0
<u>Don't Know</u>	Yes	0	0.0
	No	101	100.0
	Total	101	100.0
<u>Other</u>	Yes	10	9.9
	No	91	90.1
	Total	101	100.0
17. Number in household using:			
	Number:		
<u>Family Doctor</u>	1	31	30.7
	2	25	24.8
	3	18	17.8
	4	10	9.9
	5	8	7.9
	6	2	5.9
	7	0	0.0
	8	1	1.0
	Total	101	100.0
<u>General Practitioner</u>	0	73	72.3
	1	13	12.9
	2	8	7.9
	3	1	1.0
	4	5	5.0
	5	1	1.0
	Total	101	100.0

<u>ITEM</u>	<u>RESPONSE</u>	<u>FREQUENCY</u>	<u>PERCENT</u>
17. Number in house- hold using (Continued):			
<u>OB/GYN</u>	0	81	80.2
	1	19	18.8
	2	0	0.0
	3	1	1.0
	Total	101	100.0
<u>Surgeon</u>	0	83	82.2
	1	13	12.9
	2	4	4.0
	3	1	1.0
	Total	101	100.0
<u>Chiropractor</u>	0	91	90.1
	1	5	5.0
	2	2	2.0
	3	1	1.0
	4	1	1.0
	5	1	1.0
	Total	101	100.0
<u>Psychologist</u>	0	97	96.0
	1	4	4.0
	Total	101	100.0
<u>Marriage</u> <u>Counselor</u>	0	100	99.0
	1	1	1.0
	Total	101	100.0
<u>Curandera</u>	0	100	99.0
	1	1	1.0
	Total	101	100.0
18. Opinion of treat- ment of Chicanos by health personnel	None/Neutral	81	80.2
	Positive	7	6.9
	Negative	13	12.9
	Total	101	100.0
19. Needs of Hispan- ics:			
<u>Housing</u>	No Problem	41	40.6
	Somewhat a Problem	31	30.7
	Very Impt. Problem	29	28.7
	Total	101	100.0

<u>ITEM</u>	<u>RESPONSE</u>	<u>FREQUENCY</u>	<u>PERCENT</u>
19. Needs of Hispanics (Continued):			
<u>Employment</u>	No Problem	43	42.6
	Somewhat a Problem	21	20.8
	Very Impt. Problem	37	36.6
	Total	<u>101</u>	<u>100.0</u>
<u>Health Care</u>	No Problem	50	49.5
	Somewhat a Problem	25	24.8
	Very Impt. Problem	26	25.7
	Total	<u>101</u>	<u>100.0</u>
<u>Income</u>	No Problem	41	20.6
	Somewhat a Problem	21	20.8
	Very Impt. Problem	39	38.6
	Total	<u>101</u>	<u>100.0</u>
<u>Crime</u>	No Problem	52	51.5
	Somewhat a Problem	27	26.7
	Very Impt. Problem	22	21.8
	Total	<u>101</u>	<u>100.0</u>
<u>Education</u>	No Problem	43	42.6
	Somewhat a Problem	23	22.8
	Very Impt. Problem	34	33.7
	Blank	1	1.0
	Total	<u>101</u>	<u>100.0</u>
<u>Nutrition</u>	No Problem	57	56.4
	Somewhat a Problem	20	19.8
	Very Impt. Problem	24	23.8
	Total	<u>101</u>	<u>100.0</u>
<u>Transportation</u>	No Problem	54	53.5
	Somewhat a Problem	26	25.7
	Very Impt. Problem	21	20.8
	Total	<u>101</u>	<u>100.0</u>
<u>Loneliness</u>	No Problem	63	62.4
	Somewhat a Problem	22	21.8
	Very Impt. Problem	16	15.8
	Total	<u>101</u>	<u>100.0</u>

<u>ITEM</u>	<u>RESPONSE</u>	<u>FREQUENCY</u>	<u>PERCENT</u>
<u>HEALTH PERCEPTIONS</u>			
<u>SCALE ITEMS 20-37</u>			
20. Health Perception: Now Excellent	Definitely False	10	9.9
	Mostly False	14	13.9
	Don't Know	20	19.8
	Mostly True	27	26.7
	Definitely True	30	29.7
	Total	<u>101</u>	<u>100.0</u>
21. Health Perception: Get Sick Easier	Definitely False	8	7.9
	Mostly False	16	15.8
	Don't Know	7	6.9
	Mostly True	29	28.7
	Definitely True	41	40.6
	Total	<u>101</u>	<u>100.0</u>
22. Health Perception: Feel better now than before	Definitely False	14	13.9
	Mostly False	15	14.9
	Don't Know	9	8.9
	Mostly True	35	34.7
	Definitely True	28	27.7
	Total	<u>101</u>	<u>100.0</u>
23. Health Perception: Will be sick in future	Definitely False	6	5.9
	Mostly False	11	10.9
	Don't Know	46	45.5
	Mostly True	15	14.9
	Definitely True	23	22.8
	Total	<u>101</u>	<u>100.0</u>
24. Health Perception: Never Worry	Definitely False	18	17.8
	Mostly False	28	27.7
	Don't Know	2	2.0
	Mostly True	23	22.8
	Definitely True	30	29.7
	Total	<u>101</u>	<u>100.0</u>
25. Health Perception: Don't like to go to Doctor	Definitely False	39	38.6
	Mostly False	20	19.8
	Don't Know	2	2.0
	Mostly True	12	11.9
	Definitely True	28	27.7
	Total	<u>101</u>	<u>100.0</u>

<u>ITEM</u>	<u>RESPONSE</u>	<u>FREQUENCY</u>	<u>PERCENT</u>
26. Health Perception: So sick—thought they'd die	Definitely False	13	12.9
	Mostly False	13	12.9
	Don't Know	3	3.0
	Mostly True	14	13.9
	Definitely True	58	57.4
	Total	<u>101</u>	<u>100.0</u>
27. Health Perception: Not as happy now as in past	Definitely False	18	17.8
	Mostly False	39	38.6
	Don't Know	7	6.9
	Mostly True	15	14.9
	Definitely True	22	21.8
	Total	<u>101</u>	<u>100.0</u>
28. Health Perception: Worry about health more than others worry about theirs	Definitely False	23	22.8
	Mostly False	30	29.7
	Don't Know	12	11.9
	Mostly True	16	15.8
	Definitely True	19	18.8
	Blank	1	1.0
	Total	<u>101</u>	<u>100.0</u>
29. Health Perception: When sick, keep going as usual	Definitely False	40	39.6
	Mostly False	42	41.6
	Don't Know	3	3.0
	Mostly True	9	8.9
	Definitely True	7	6.9
	Total	<u>101</u>	<u>100.0</u>
30. Health Perception: Resist illness well	Definitely False	5	5.0
	Mostly False	17	16.8
	Don't Know	2	2.0
	Mostly True	45	44.6
	Definitely True	32	31.7
	Total	<u>101</u>	<u>100.0</u>
31. Health Perception: Getting sick is part of life	Definitely False	8	7.9
	Mostly False	10	9.9
	Don't Know	3	3.0
	Mostly True	40	39.6
	Definitely True	40	39.6
	Total	<u>101</u>	<u>100.0</u>
32. Health Perception: Healthy as anybody	Definitely False	13	12.9
	Mostly False	16	15.8
	Don't Know	15	14.9
	Mostly True	37	36.6
	Definitely True	20	19.8
	Total	<u>101</u>	<u>100.0</u>

<u>ITEM</u>	<u>RESPONSE</u>	<u>FREQUENCY</u>	<u>PERCENT</u>
33. Health Perception: Never had long illness	Definitely False	27	26.7
	Mostly False	12	11.9
	Don't Know	1	1.0
	Mostly True	21	20.8
	Definitely True	40	39.6
	Total	<u>101</u>	<u>100.0</u>
34. Health Perception: When sick keep it to self	Definitely False	28	27.7
	Mostly False	31	30.7
	Don't Know	3	3.0
	Mostly True	19	18.8
	Definitely True	19	18.8
	Blank	1	1.0
	Total	<u>101</u>	<u>100.0</u>
35. Health Perception: Feeling bad lately	Definitely False	38	37.6
	Mostly False	19	18.8
	Don't Know	1	1.0
	Mostly True	27	26.7
	Definitely True	16	15.8
	Total	<u>101</u>	<u>100.0</u>
36. Health Perception: Usually catch what's going around	Definitely False	7	6.9
	Mostly False	13	12.9
	Don't Know	3	3.0
	Mostly True	31	30.7
	Definitely True	47	46.5
	Total	<u>101</u>	<u>100.0</u>
37. Health Perception: When getting sick, I fight it	Definitely False	37	36.6
	Mostly False	37	36.6
	Don't Know	2	2.0
	Mostly True	11	10.9
	Definitely True	14	13.9
	Total	<u>101</u>	<u>100.0</u>

HEALTH LOCUS OF
CONTROL: ITEMS 38-48

38. If I take care, I avoid illness	Strongly Disagree	54	53.5
	Moderately Disagree	19	18.8
	Slightly Disagree	16	15.8
	Slightly Agree	5	5.0
	Moderately Agree	4	4.0
	Strongly Agree	3	3.0
	Total	<u>101</u>	<u>100.0</u>

<u>ITEM</u>	<u>RESPONSE</u>	<u>FREQUENCY</u>	<u>PERCENT</u>
39. Sickness is be- cause of something I've done or not done	Strongly Disagree	23	22.8
	Moderately Disagree	18	17.8
	Slightly Disagree	13	12.9
	Slightly Agree	10	9.9
	Moderately Agree	23	22.8
	Strongly Agree	14	13.9
	Total	101	100.0
40. Good health is a matter of luck	Strongly Disagree	33	32.7
	Moderately Disagree	12	11.9
	Slightly Disagree	5	5.0
	Slightly Agree	13	12.9
	Moderately Agree	20	19.8
	Strongly Agree	18	17.8
	Total	101	100.0
41. If I'm going to get sick, I'll get sick	Strongly Disagree	12	11.9
	Moderately Disagree	13	12.9
	Slightly Disagree	9	8.9
	Slightly Agree	13	12.9
	Moderately Agree	24	23.8
	Strongly Agree	30	29.7
	Total	101	100.00
42. ITEM OMITTED FROM INTERVIEW			
43. Do what doctor tells me	Strongly Disagree	9	8.9
	Moderately Disagree	17	16.8
	Slightly Disagree	16	15.8
	Slightly Agree	15	14.9
	Moderately Agree	18	17.8
	Strongly Agree	26	25.7
	Total	101	100.0
44. Never know when you might pick up disease	Strongly Disagree	7	6.9
	Moderately Disagree	2	2.0
	Slightly Disagree	5	5.0
	Slightly Agree	5	5.0
	Moderately Agree	24	23.8
	Strongly Agree	55	54.5
	Total	101	100.0
45. If ill, it's because of poor exercise or not eating right	Strongly Disagree	29	28.7
	Moderately Disagree	26	25.7
	Slightly Disagree	16	15.8
	Slightly Agree	11	10.9
	Moderately Agree	7	6.9
	Strongly Agree	12	11.9
	Total	101	100.0

<u>ITEM</u>	<u>RESPONSE</u>	<u>FREQUENCY</u>	<u>PERCENT</u>
46. People who never get sick are lucky	Strongly Disagree	18	17.8
	Moderately Disagree	14	13.9
	Slightly Disagree	12	11.9
	Slightly Agree	11	10.9
	Moderately Agree	18	17.8
	Strongly Agree	28	27.7
	Total	<u>101</u>	<u>100.0</u>
47. Ill health results from carelessness	Strongly Disagree	39	38.6
	Moderately Disagree	27	26.7
	Slightly Disagree	12	11.9
	Slightly Agree	11	10.9
	Moderately Agree	4	4.0
	Strongly Agree	8	7.9
	Total	<u>101</u>	<u>100.0</u>
48. I am directly responsible for my own health	Strongly Disagree	70	69.3
	Moderately Disagree	20	19.8
	Slightly Disagree	5	5.0
	Slightly Agree	1	1.0
	Moderately Agree	2	2.0
	Strongly Agree	3	3.0
	Total	<u>101</u>	<u>100.0</u>
<u>INDEX OF PSYCHOLOGICAL</u>			
<u>WELL-BEING: ITEMS 49-56</u>			
49. Lonely	Never	36	35.6
	Sometimes	55	54.5
	Often	10	9.9
	Total	<u>101</u>	<u>100.0</u>
50. Depressed or very unhappy	Never	26	25.7
	Sometimes	59	58.4
	Often	16	15.8
	Total	<u>101</u>	<u>100.0</u>
51. Bored	Never	35	34.7
	Sometimes	46	45.5
	Often	20	19.8
	Total	<u>101</u>	<u>100.0</u>
52. Restless	Never	53	52.5
	Sometimes	35	34.7
	Often	13	12.9
	Total	<u>101</u>	<u>100.0</u>

<u>ITEM</u>	<u>RESPONSE</u>	<u>FREQUENCY</u>	<u>PERCENT</u>
53. Vaguely uneasy	Never	34	33.7
	Sometimes	53	52.5
	Often	14	13.9
	Total	<u>101</u>	<u>100.0</u>
54. On top of the world	Never	13	12.9
	Sometimes	55	54.5
	Often	33	32.7
	Total	<u>101</u>	<u>100.0</u>
55. Excited or interested	Never	11	10.9
	Sometimes	58	57.4
	Often	32	31.7
	Total	<u>101</u>	<u>100.0</u>
56. Pleased about accomplishment	Never	9	8.9
	Sometimes	38	37.6
	Often	54	53.5
	Total	<u>101</u>	<u>100.0</u>
<u>HEALTH CARE ATTITUDES</u>			
57. Embarrassed to go to a doctor	Yes/Agree	45	44.6
	No/Disagree	56	55.4
	Total	<u>101</u>	<u>100.0</u>
58. Can't afford doctors	Yes/Agree	46	45.5
	No/Disagree	55	54.5
	Total	<u>101</u>	<u>100.0</u>
59. Free health services are no good	Yes/Agree	24	23.8
	No/Disagree	77	76.2
	Total	<u>101</u>	<u>100.0</u>
60. Kind of food you eat has an impact on your health	Yes/Agree	55	54.5
	No/Disagree	46	45.5
	Total	<u>101</u>	<u>100.0</u>
61. Over-the-counter medicine as good as prescribed medicine	Yes/Agree	31	30.7
	No/Disagree	70	69.3
	Total	<u>101</u>	<u>100.0</u>
62. Doubts about doctors' abilities	Yes/Agree	63	62.4
	No/Disagree	38	37.6
	Total	<u>101</u>	<u>100.0</u>
63. Familiar with <u>Curanderismo</u>	Yes/Agree	60	59.4
	No/Disagree	41	40.6
	Total	<u>101</u>	<u>100.0</u>

<u>ITEM</u>	<u>RESPONSE</u>	<u>FREQUENCY</u>	<u>PERCENT</u>
64. <u>Curanderos</u> make people feel better	Yes/Agree	29	28.7
	No/Disagree	31	30.7
	Not familiar	41	40.6
	Total	101	100.0
65. <u>Curanderos</u> do more good than medical doctors	Yes/Agree	9	8.9
	No/Disagree	51	50.5
	Not familiar	41	40.6
	Total	101	100.0
66. <u>Curanderos</u> hard to find in the community	Yes/Agree	38	37.6
	No/Disagree	22	21.8
	Not familiar	41	40.6
	Total	101	100.0
67. Will seek help of <u>curandero</u> if doctor can't help	Yes/Agree	13	12.9
	No/Disagree	47	46.5
	Not familiar	41	40.6
	Total	101	100.0
68. Cannot afford <u>curandero</u>	Yes/Agree	21	20.8
	No/Disagree	38	37.6
	Not familiar	41	40.6
	Total	101	100.0
69. Feels more comfortable with <u>curandero</u> than with doctor	Yes/Agree	7	6.9
	No/Disagree	53	52.5
	Not familiar	41	40.6
	Total	101	100.0
70. Participant's Name	- - - - -	- - - - -	- - - - -
71. Participant's Phone	- - - - -	- - - - -	- - - - -
72. Marital Status	Married	74	73.3
	Divorced/Separated	16	15.8
	Widowed	3	3.0
	Single	8	7.9
	Total	101	100.0
73. Age	18-25 years	21	20.8
	26-35 years	32	31.7
	36-45 years	20	19.8
	46-55 years	15	14.9
	56-65 years	8	7.9
	66-78 years	5	4.9
	Total	101	100.0

<u>ITEM</u>	<u>RESPONSE</u>	<u>FREQUENCY</u>	<u>PERCENT</u>
74. Number of Children residing in house- hold	0	15	14.9
	1	15	14.9
	2	19	18.8
	3	31	30.7
	4	6	5.9
	5	9	8.9
	6	4	4.0
	7	1	1.0
	8	1	1.0
	Total	<u>101</u>	<u>100.0</u>
75. Highest grade completed	Years/Grade:		
	0	8	7.9
	1	1	1.0
	2	2	2.0
	3	5	5.0
	4	3	3.0
	5	6	5.9
	6	5	5.0
	7	12	11.9
	8	6	5.9
	9	8	7.9
	10	11	10.9
	11	8	7.9
	12	20	19.8
	13	2	2.0
	14	2	2.0
	16	1	1.0
	21	1	1.0
	Total	<u>101</u>	<u>100.0</u>
76. U.S. Military Service	Yes	10	9.9
	No	<u>91</u>	<u>90.1</u>
	Total	<u>101</u>	<u>100.0</u>
77. Branch of Military	Did not serve	91	90.1
	Army	7	6.9
	Navy	3	3.0
	Total	<u>101</u>	<u>100.0</u>
78. Era of Military Service	Did not serve	91	90.1
	WWII era	6	5.9
	Korean era	2	2.0
	Vietnam era	2	2.0
	Total	<u>101</u>	<u>100.0</u>
79. Currently Employed	Yes	40	39.6
	No	<u>61</u>	<u>60.4</u>
	Total	<u>101</u>	<u>100.0</u>

<u>ITEM</u>	<u>RESPONSE</u>	<u>FREQUENCY</u>	<u>PERCENT</u>
80. Participants' Occupation	- - - - -	- - - - -	- - - - -
81a. Spouse Employed	Not relevant	26	25.7
	Yes	44	43.6
	No	31	30.7
	Total	<u>101</u>	<u>100.0</u>
81b. Spouse's Occupation	- - - - -	- - - - -	- - - - -
82. Years living in Michigan	0-5 years	11	10.9
	6-10 years	15	14.8
	11-15 years	12	11.9
	16-20 years	17	16.8
	21-25 years	19	18.9
	26-30 years	5	4.9
	31-35 years	12	11.9
	36-40 years	6	5.9
	41-45 years	2	2.0
	46-50 years	0	0.0
	51-60 years	1	1.0
	61-70 years	1	1.0
	Total	<u>101</u>	<u>100.0</u>
83. Years living in Lansing	0-5 years	16	15.8
	6-10 years	20	19.8
	11-15 years	17	16.9
	16-20 years	17	16.9
	21-25 years	13	12.9
	26-30 years	5	4.9
	31-35 years	6	5.9
	36-40 years	5	4.9
	41-45 years	1	1.0
	46-50 years	0	0.0
	51-60 years	0	0.0
	61-70 years	1	1.0
	Total	<u>101</u>	<u>100.0</u>
84. Years in Current Home	1-5 years	50	49.5
	6-10 years	18	17.8
	11-15 years	20	19.8
	16-20 years	6	5.9
	21-25 years	5	5.0
	26-30 years	1	1.0
	31-35 years	1	1.0
	Total	<u>101</u>	<u>100.0</u>

<u>ITEM</u>	<u>RESPONSE</u>	<u>FREQUENCY</u>	<u>PERCENT</u>
85. Is Lansing original home- town?	Yes	16	15.8
	No	85	84.2
	Total	<u>101</u>	<u>100.0</u>
86. City or Town where raised (region)	Midwest	27	26.7
	Southwest	49	48.5
	Mexico	20	19.8
	Western U.S.	1	1.0
	Other	4	4.0
	Total	<u>101</u>	<u>100.0</u>
87. Primary Source of Income	None	24	23.8
	Pension	8	7.9
	Salary/Wage	59	58.4
	Social Security	8	7.9
	Private Income	1	1.0
	Support by relatives	1	1.0
	Total	<u>101</u>	<u>100.0</u>
88. Supplementary Income	None	65	64.4
	SSI	3	3.0
	SSDI	3	3.0
	ADC	25	24.8
	Welfare/Other	5	5.0
	Total	<u>101</u>	<u>100.0</u>
89. Approximate Monthly Income	Blank	2	2.0
	\$0-100	3	3.0
	100-499	24	23.7
	500-999	43	42.6
	1000-1499	18	17.8
	1500-1999	7	6.9
	2000-2999	2	2.0
	3000-3999	1	1.0
	4000+	1	1.0
	Total	<u>101</u>	<u>100.0</u>
90. Medicaid Card	Yes	40	39.6
	No	61	60.4
	Total	<u>101</u>	<u>100.0</u>
91. Medicare Card	Yes	11	10.9
	No	90	89.1
	Total	<u>101</u>	<u>100.0</u>
92. Subject walks to various places in community	Yes	34	33.7
	No	67	66.3
	Total	<u>101</u>	<u>100.0</u>

<u>ITEM</u>	<u>RESPONSE</u>	<u>FREQUENCY</u>	<u>PERCENT</u>
93. Subject drives to various places in community	Yes	72	71.3
	No	29	28.7
	Total	<u>101</u>	<u>100.0</u>
94. Subject rides bus to various places in community	Yes	21	20.8
	No	80	79.2
	Total	<u>101</u>	<u>100.0</u>
95. Subject has someone drive them to various places in community	Yes	55	54.5
	No	46	45.5
	Total	<u>101</u>	<u>100.0</u>
<u>LANGUAGE FLUENCY</u>			
96. <u>Speaks</u> opposite language of interview	Fluently	36	35.6
	Fairly well	19	18.8
	Get by, but not very well	17	16.8
	Very poorly	22	21.8
	Not at all	7	6.9
	Total	<u>101</u>	<u>100.0</u>
97. <u>Understand</u> written opposite language of interview	Fluently	22	21.8
	Fairly well	17	16.8
	Get by, but not very well	14	13.9
	Very poorly	21	20.8
	Not at all	27	26.7
	Total	<u>101</u>	<u>100.0</u>
98. <u>Understands</u> spoken language opposite of interview	Fluently	41	40.6
	Fairly well	30	29.7
	Get by, but not very well	16	15.8
	Very poorly	14	13.9
	Not at all	0	0.0
	Total	<u>101</u>	<u>100.0</u>
99. Listens to Spanish-language radio broadcasts	Yes	82	81.2
	No	19	18.8
	Total	<u>101</u>	<u>100.0</u>
100. Medical preference	Always prefers M.A. doctor	6	5.9
	Prefers M.A. doctor	17	16.8
	Does not matter	66	65.3
	Prefers A.A. doctor	7	6.9
	Always prefers A.A. doctor	5	5.0
	Total	<u>101</u>	<u>100.0</u>

<u>ITEM</u>	<u>RESPONSE</u>	<u>FREQUENCY</u>	<u>PERCENT</u>
101. Knowledge of Mexican American doctor in community	Yes	27	26.7
	No	74	73.3
	Total	<u>101</u>	<u>100.0</u>
102. Name of Mexican American doctor	- - - - -	- - - - -	- - - - -
103. Do others think poorly of government assistance recipients	Yes	59	58.4
	No	32	31.7
	Don't Know	8	7.9
	Blank	1	1.0
	Other	1	1.0
	Total	<u>101</u>	<u>100.0</u>
104. Names of referrals to Cristo Rey Health Program	- - - - -	- - - - -	- - - - -

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