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# ETHNIC IDENTITY AND MENTAL HEALTH STATUS: FORMAL AND INFORMAL HELP SEEKING RESOURCES OF CHICANOS A COMPARATIVE STUDY

By

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ABSTRACT

ETHNIC IDENTITY AND MENTAL HEALTH STATUS: FORMAL AND INFORMAL HELP SEEKING RESOURCES OF CHICANOS A COMPARATIVE STUDY

By

Mario Garza

The basic purpose of this study was to determine if persons of Mexican origin in Lansing, Michigan, underutilize traditional, formal mental health services and, if they do, to determine what factor or combination of factors cause this underutilization. A secondary purpose was to compare the Lansing sample, in terms of levels of ethnic identity and mental health status as defined by self-esteem and personal efficacy, with a comparable sample from Texas.

The study is a duplication, in part, of the comprehensive national study of mental health implications of ethnic identification and identity among Chicanos conducted by the Survey Research Center, Institute for Social Research, The University of Michigan.

The study assesses factors that lead to Chicanos utilizing or underutilizing formal and informal mental health services, by examining a person's sense of ethnic identification and ethnic identity, in addition to the usual demographic characteristics, such as age, sex, education, occupation, income, generational distance from Mexico, and Chicano density in the community. Availability of mutual support groups and attitudes toward local mental health services are examined. Effects of utilization of formal and informal resources, ethnic identity and identification are also examined in relation to their

effects on a person's mental health status.

Respondents were first screened to determine if at least one of their parents was of Mexican origin, and therefore eligible to participate in the study. Eligible respondents were then interviewed, utilizing a modified version of the questionnaire developed at the Survey Research Center. The following main conclusions were reached:

1. Persons of Mexican origin tend to underutilize traditional formal mental health services.
2. Persons of Mexican origin utilize informal mental health resources to a greater extent than formal mental health resources.
3. The main factors related to the underutilization of formal resources are levels of personal efficacy and public self-esteem, degree of ethnic identity, and unfamiliarity with mental health centers and services.
4. Persons of Mexican origin in Lansing, Michigan, score slightly higher scores on ethnic identity, self-esteem and personal efficacy scales than do persons of Mexican origin in Texas.

ACKNOWLEDGMENTS

This research was conducted with the assistance of a large number of people. Unfortunately, all of those providing help cannot be named, nevertheless, the assistance provided is greatly appreciated.

Gratitude is expressed to the Michigan Department of Mental Health for providing me with a grant for the field work expenses. Gratitude is also expressed to all persons who willingly gave of their time and consented to the interviews, and to the six students who assisted me in conducting the screenings and the interviews: Joseph and Bobby Ortiz, Oscar Gonzales, David Latoni, Miguel Contreras and Edwardo Frias.

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A very special thanks is extended to Carlos H. Arce from the Institute for Social Research for his suggestions and assistance with the research methods and for providing the data from the Texas sample for comparison.

And most important, I want to thank some very significant people in my life. I want to thank my family, especially my mother and my sister, Yolanda, for their enduring support and encouragement. A very

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# CHAPTER I

# INTRODUCTION

I am Joaquin,
lost in a world of confusion,
caught up in the whirl of a
gringo society,
confused by the rules,
scorned by attitudes,
suppressed by manipulation,
and destroyed by modern society.
My fathers
have lost the economic battle
and won
the struggle of cultural survival.
And now!
I must choose
between
the paradox of
victory of the spirit,
despite physical hunger,
or
to exist in the grasp
of American social neurosis,
sterilization of the soul
and a full stomach.

--from "I am Joaquin"
by Rodolfo Gonzales

## Statement of the Problem

Persons of Mexican origin in Lansing, Michigan, as well as across the United States, continue to underutilize traditional "mainstream" mental health services. In Lansing, traditional mental health services are provided mainly by three centers: St. Lawrence Mental Health Center, Capitol Area Counseling Center, and Ingham Community

Mental Health Center. Mental health services are also provided to the Chicano* community by Cristo Rey Counseling Center.

The 1970 United States Census (the only data available at the start of this research project) gives the total population of Lansing as 130,211 and a total of 5,070 or 3.9 percent for persons of Spanish language (this includes Chicanos, Puerto Ricans, Cubans, South Americans, and other persons of Spanish language background). A look at the statistics available from mental health centers shows that this group of persons of Spanish language is underrepresented.

St. Lawrence Mental Health Center, Capitol Area Counseling Center, and Cristo Rey Counseling Center are in the north part of Lansing where the greater concentration of Chicanos live. Ingham Community Mental Health Center is in the south part of Lansing. With the exception of Cristo Rey, which was established specifically to provide services for the Chicano community, the centers in the north part of Lansing seem to be less utilized or more underutilized. St. Lawrence Mental Health Program claimed they do not do their reports with an ethnic or racial breakdown of clients, so no statistics were provided by this center. Capitol Area Counseling Center reported a total

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*The different labels used to refer to persons of Mexican origin such as Chicano, Mexican American, Spanish, Latino, Hispanic, etc., carry different political, cultural and ideological implications and one of the purposes of the research is to study the preference and implications that a national sample of Mexican-origin persons attach to different name labels. In the research itself and in the questionnaire, the most neutral label used in the national study, persons of Mexican origin, was used. For convenience, the term Chicano is used in this paper to refer to all persons of Mexican origin. The term Hispanic, which seems to be the current popular term, is used to refer to all persons of Spanish language background, i.e., Chicano, Puerto Rican, Cuban, South American, etc.

of 1,134 clients for the year 1978-1979. Of this total, only 18 clients, or 1.5 percent were Hispanic. For the same year, Ingham Community Mental Health Center reported a total of 1,722 clients in their out-patient program with 40, or 2.3 percent of these being Hispanic; a total of 155 clients in their in-patient program with a total of 3, or 1.9 percent Hispanic; and a total of 240 clients in their adult day program with 8, or 3.3 percent of these being Hispanic. Cristo Rey Counseling Center reported a total of 203 clients for 1978-1979; of this total 138, or 67.9 percent were Hispanic.

With the persons of Spanish language or Hispanics making up 3.9 percent of the total population and the average percentage of Hispanic clients at traditional mental health centers being 2.2 percent, Hispanics are underrepresented. Just as Hispanics or Chicanos across the nation (as the review of the literature will indicate), Chicanos in Lansing tend to underutilize traditional mental health services.[1]

## A General Overview of the Study

The Lansing study is a duplication of part of the comprehensive national study of the mental health implication of ethnic identification and identity among Chicanos conducted by the Survey Research Center, Institute for Social Research, University of Michigan, Ann Arbor, Carlos H. Arce, Project Director. The research was done in collaboration with Carlos Arce and the results were compared with the results from Texas, obtained and made available by the Institute for Social Research. The data collected in Lansing, Michigan have become part of the national study and are available to interested scholars and mental health practitioners.

The Lansing study assesses the factors that lead to Chicanos utilizing or underutilizing formal and informal mental health services by examining a person's sense of ethnic identification and ethnic identity, in addition to the usual demographic characteristics such as age, sex, education, occupation, income, generational distance from Mexico, and Chicano concentration in the community. Availability of mutual support groups and attitudes of local mental health services is examined. Besides their effects on utilization of services, ethnic identity and ethnic identification are also examined in relationship to their effects on a person's mental health status.

From his interaction with and observance of the Chicanos in Michigan, the researcher has noticed that the majority of Chicanos in Michigan come to Michigan from Mexico by way of Texas, or from Texas. A comparative analysis between the results obtained from Lansing and the results obtained from Texas by the Institute of Social Research was done to see what are the major differences and what factors are responsible for these differences. The comparison with the Texas sample is also of interest to the researcher since, being from Texas, he hopes to return to and work in Texas.

The general purpose of the study is to determine the causes of or reasons why Lansing Chicanos underutilize mental health services and to make recommendations and suggestions to mental health providers to meet the needs of the Chicano community.

## Rationale for Research

To date, the only comprehensive national study on Chicano identity and its relation to mental health is the one conducted by Carlos

Arce and the Institute for Social Research. The data collected is available as a national resource for utilization and analysis by minority scholars. However, even though Michigan has the second largest number of Chicanos in the Midwest with 96,000, next to Illinois with 412,000 (1976 Federal Government estimate figures), there is not enough statewide data available for conclusive findings. No data for the national study had been collected from the Lansing metropolitan area, which has the third largest number of Chicanos in the state of Michigan (next to Detroit and Saginaw). As was mentioned in the previous section, the data collected in Lansing has become part of the national study data.

## Classes of Variables

Three classes of variables--independent variables, intervening variables, and dependent variables--were studied and the relationships between them were analyzed.

### Independent Variables

The independent variables, or class one variables, are: age, sex, language, birthplace, education, occupation, income, marital status, urban residence, geographical distance from Mexico, generational distance from Mexican ancestry, Chicano density or concentration in the community, availability of mutual support groups, availability of mental health resources, familiarity with mental health resources, attitudes toward mental health providers, types of problems, and frequency of major stress. Language is defined as the language used by respondent in the interview, which will be either English or Spanish. The research in Lansing was conducted with an urban population

or a standard metropolitan statustical area as defined by the U.S. Census. The research in Texas was conducted with an urban population or nine standard metropolitan statistical areas (SMSA's): Brownsville, Corpus Christi, El Paso, Houston, San Antonio, McAllen, Beaumont, Ft. Worth, and Laredo; and with a rural population or four non-metropolitan areas: Comal County, Williamson County, Wilson County, and Willacy County. The comparison with the Texas data also provided a comparison between two samples from different geographical distances from Mexico. Generational distance from Mexico refers to the number of generations born and raised in the United States. Chicano density or concentration refers to what percentage of the community where the respondent resides is of Mexican origin.

## Intervening Variables

The intervening variables, or class two variables, are ethnic identification and ethnic identity. Ethnic identification is defined as a cognitive process, the perception of similarity or common interests with other persons of Mexican origin. Ethnic identity is defined as the cognitive product of that process of identification, indicated by self-labelling in ethnic terms.

## Dependent Variables

Dependent, or class three variables, are personal efficacy and self-esteem (private self-esteem and public self-esteem) as indicators of mental health status and the utilization of formal and informal mental health resources.

Research Objectives and Hypotheses

Three sets of research objectives were used in the study: descriptive, analytic, and comparative.

Descriptive Objectives

Identification and Identity

1. To delineate the multiple group identifications of persons of Mexican origin, and to assess the relative importance of ethnic identification and identification with other groups (social class, occupational, religious, sex, family roles, etc.).

This objective recognizes that most people usually identify with and share common interest with several groups and that one's ethnic group may not be as important in one's social identity as some other group's identification. Respondents were allowed to choose the groups the groups they feel closest to, groups they feel close to but not closest, and groups to which they do not feel close at all. The hypothesis tested under this objective is:

HYPOTHESIS I: The degree of ethnic identity has no effect on the degree of identifying with other social groups, or social roles.

2. To describe the components of ethnic identification from a wide range of ethnic terms that persons of Mexican origin use in talking about themselves.

Respondents were allowed to choose from among a wide range of ethnic terms that refer to persons of Mexican origin. The relationship of the most preferred name label to the ethnic identity cluster(s) were examined. The hypothesis tested under this objective is:

HYPOTHESIS II: Persons who prefer the term Chicano score

higher on the ethnic identity scale.

Mental Health Outcomes

1. To delineate the distributions of persons of Mexican origin along several dimensions of mental health status as indicated by personal efficacy or depression and private and public self-esteem, and to describe the relationships among these dimensions.

A combined scale using two standard measures of personal control and efficacy used on the national study were used on the Lansing study. The first part includes the five personally cast items from the Rotter Internal-External Control scale. The second part includes four Likert-type items traditionally used at the Survey Research Center as a measure of personal efficacy. Both this measure and the Rotter-derived personal control measure were included in another national study of group identification that the Survey Research Center used for comparison purposes. The coefficient alpha of each separate index is improved from .61 for the personal measure and .64 for the personal efficacy measure, to .75 for the combined index (Arce, 1976). Respondents were also asked a few other personally cast questions that make more specific mention of particular areas of life situations.

Self-esteem was measured using the Rosenberg scale. This scale has not been used with adults of Mexican origin, so the reliability and validity for the study was not well established. Rosenberg reported a Guttman scale reproducibility coefficient of .92 for its reliability (Arce, 1976). Respondents were also asked some questions on self-esteem of people in general.

The hypotheses tested under this objective are:

HYPOTHESIS I(a): Personal efficacy and self-esteem are directly related to each other; the higher the level of personal efficacy, the higher the level of self-esteem; the lower the level of personal efficacy, the lower the level of self-esteem.

HYPOTHESIS I(b): The degree of personal efficacy and self-esteem is inversely proportional to the level of frequency of major stress from life problems; the greater the frequency of major stress, the lower the level of personal efficacy and self-esteem.

2. To delineate the various informal and formal resources that persons of Mexican origin utilize for help with mental health problems and to examine the relationships among these help-utilization patterns.

Lansing has both traditional, mainstream and Chicano-oriented formal mental health services available. Both of these types of services seem to be underutilized. Respondents were asked some questions to determine their familiarity with the local mental health services and their attitudes on the adequacy of these services.

Respondents were also asked some open-ended questions about some stress-producing situations. These questions led into some questions about the types of help-seeking resources they utilized for their problems.

The hypothesis tested under this objective is:

HYPOTHESIS II: Persons of Mexican origin underutilize formal mental health resources because they utilize informal mental health resources.

## Analytic Objectives

The major analytic objectives are represented by the three arrows depicted in Figure 1.

1. To analyze the relationships between the independent (class one) variables and ethnic identification and ethnic identity (class two).

Information on some of the independent variables such as age, birthplace, education, occupation, income, marital status, generational distance from Mexico, availability of mutual support groups, familiarity with mental health resources, attitudes toward mental health providers, types of problems, and frequency of major stress were obtained from questions on the questionnaire. The information on the remaining independent variables, such as sex and language, was obtained by observation by the interviewers and the community Chicano density/composition was obtained from the U.S. Census data. Urban residence is a variable that remained constant in the sample from Lansing and in the sample from Texas, used in the Comparative Objective section. Geographic distance from Mexico is a variable that is also used in the comparison analysis with the Texas data. It is assumed that several and a combination of these variables have an effect on the level of ethnic identification and ethnic identity.

The hypotheses tested under this objective are:

HYPOTHESIS I(a): The level of ethnic identity is directly proportional to the degree of Chicano density of concentration in the community; the greater the Chicano density, the greater the level of ethnic identity, and vice-versa.

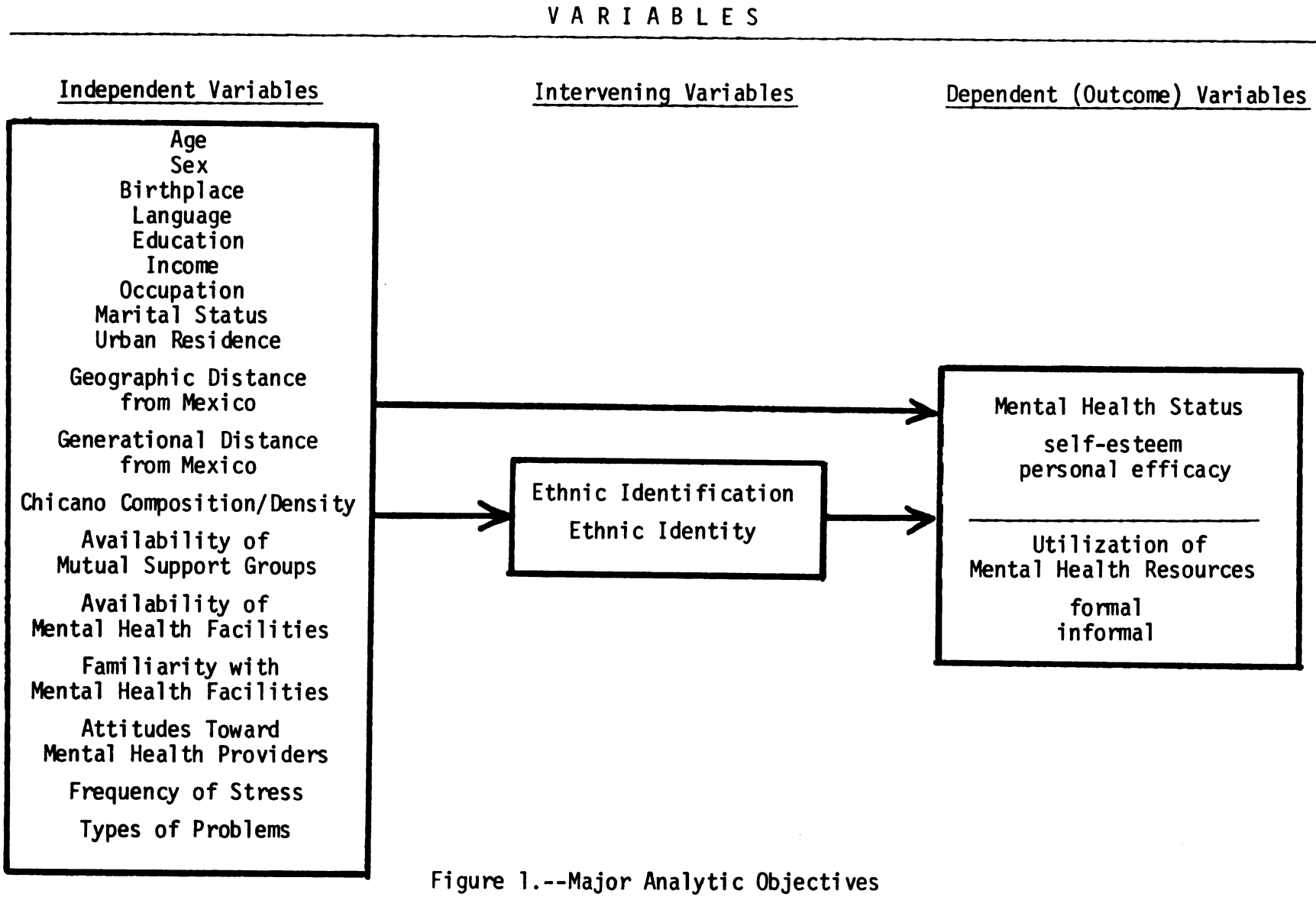



Figure 1.--Major Analytic Objectives

HYPOTHESIS I(b): The greater the generational distance from Mexico, the lower the degree of ethnic identity.

HYPOTHESIS I(c): The level of education has no relation on the level of ethnic identity.

2.A. To analyze the relationships between ethnic identification and identity (class two) and mental health outcomes (class three).

2.B. To analyze the relationship between ethnic identity and both self-esteem and sense of efficacy.

2.C. To analyze the relationships between ethnic identity and attitudes toward and utilization of mental health services.

Previous literature suggests that self-esteem and personal efficacy should be greater among people who have become ethnically identified and whose social identity includes strong ethnic components. Previous literature on utilization of services suggests that stronger ethnic identity would lead to rejection of traditional mental health facilities and greater utilization of informal resources such as the extended family. More recent findings (Padilla et al., 1976) suggest that this may not be true, at least not as a simplistic set of relationships. Multivariate analyses will be used for this objective, with new data suggesting that the relationships between ethnic identity and utilization of help resources may be confounded by many demographic and contextual variables, such as socioeconomic status and ethnic composition of the community.

The hypotheses tested under these objectives are:

HYPOTHESIS II(a): The degree of personal efficacy and self-esteem is directly proportional to the level of ethnic identity; the

higher the level of ethnic identity, the greater the level of personal efficacy and self-esteem and vice-versa.

HYPOTHESIS II(b): (Tentative Assumption) The higher the level of ethnic identity, the greater the utilization of informal mental health resources; the lower the level of ethnic identity, the greater the utilization of formal mental health resources.

3. To analyze the relationships between independent (class one) variables and mental health outcomes (class three).

This is the area in the literature where there are more contradictory hypotheses and conclusions drawn. The review of the literature in Chapter III will show that some of the assumptions on the underutilization of formal mental health resources include attitudes toward formal mental health services, unfamiliarity with services, social economic status, and frequency and severity of mental illness of the Chicano.

The hypotheses tested under this objective are:

HYPOTHESIS III(a): Persons of Mexican origin underutilize formal mental health resources because they are unfamiliar with their services.

HYPOTHESIS III(b): Persons of Mexican origin underutilize formal mental health resources because they have negative attitudes toward these services.

HYPOTHESIS III(c): The utilization of formal mental health services is directly proportional to socioeconomic status; the higher the socioeconomic status, the greater the utilization of formal resources.

HYPOTHESIS III(d): The utilization of informal mental health

resources is directly proportional to Chicano density; the greater the Chicano density, the greater the utilization of informal support resources.

HYPOTHESIS III(e): There is a curvilinear relationship between Chicano density and self-esteem and personal efficacy; higher and lower density results in higher self-esteem and personal efficacy, whereas median density results in lower self-esteem and personal efficacy ("marginality").

HYPOTHESIS III(f): Persons of Mexican origin underutilize formal mental health services because of lower frequency of stress.

Comparative Objective

The only objective under this section is to compare the results from the Lansing area to the results from Texas. All the hypotheses were tested separately with the data collected in Lansing and the data collected in Texas by the Survey Research Center. The results were compared and some of the results also served as a secondary check for some of the conclusions. The sample from Texas included areas of higher Chicano density, so the effect of Chicano density and geographic distance from Mexico was tested.

The hypotheses tested under this objective are:

HYPOTHESIS I(a): The sample from Texas will have a greater level of ethnic identity than the sample from Lansing.

HYPOTHESIS I(b): The sample from Texas will have a greater level of self-esteem and personal efficacy than the sample from Lansing.

Summary

Persons of Mexican origin in Lansing as well as across the United States continue to underutilize traditional mainstream mental health services. This study assesses the factors that lead to Chicanos utilizing or underutilizing formal and informal services by examining one's sense of ethnic identification and ethnic identity, in addition to the usual demographic characteristics such as age, sex, education, occupation, income, generational distance from Mexico, and Chicano concentration in the community. Availability of mutual support groups is also examined. Three classes of variables--independent variables, intervening variables, and dependent variables--were studied and the relationships between them were analyzed. Three sets of research objectives were used in the study: descriptive, analytic and comparative. A total of eighteen hypotheses were tested under these three objectives.

# CHAPTER II

# DESIGN AND METHODOLOGY OF STUDY

## Introduction

The Spanish speaking population of the Lansing area was screened to identify persons of Mexican origin. After persons were identified as being of Mexican origin, and therefore eligible for the study, 100 interviews were conducted in person from four areas of Chicano concentration. Before going into a detailed description of the design and methodology of the study, an overall national picture of persons of Mexican origin or Chicanos of the United States will be given, followed by a brief description of the sample (Lansing Chicanos).

## National Overview of Chicanos

The history of the Chicano or Mexican American in the United States starts over 450 years ago. Chicanos were on American soil and had already founded cities and communities long before the Pilgrims landed on Plymouth Rock. Juan Ponce de Leon landed on the southern coast of Florida in 1513, twenty-one years after Cristobal Colon (or Christopher Columbus as he is called by Anglo historians in American history) first came to the Americas. Hernando Cortez founded Vera Cruz in 1519. Juan de Onate explored what is today the American Southwest back in 1598. St. Augustine, Florida, was founded by the

Spanish in 1565, forty years before Jamestown which is mentioned as the first "American" settlement by most American history books (Cabrera, 1971).

Another important historical date is February 2, 1848. This date is considered by many Chicanos as the historical birthday of the Chicano. On this date, more than half of the Mexicans became citizens of the United States (and subsequently Chicanos) by destiny, or by an act of war. At the end of the Mexican War, known in Mexico as the North American Invasion, the Treaty of Guadalupe Hidalgo was signed. As a result of this treaty, Mexico acknowledged the annexation of Texas by the United States and ceded to the United States the territory that is presently California and most of Arizona and New Mexico. One of the provisions of the treaty was that Mexican nationals were given one year to decide whether they wanted to move to Mexico or remain in their homes and become citizens of the United States (Hernandez, 1969). This is why some Chicanos can claim that we never came to the United States, that it was the United States which came to us. We never moved north, the U.S. border moved south.

To describe a "national Chicano character" would not only be impossible or naive, but unfair to Chicanos. The Chicano in the United States today is a very heterogenous group. Historically, the group includes direct descendants of the original settlers as well as the newly arrived. A few are pure Spanish, while the remainder are mostly Spanish and Indian. Some are mostly Indian, others are mixed with French, other Europeans, and a few with the Black race. Culturally, Chicanos exist in a wide continuum on the acculturation and assimulation spectrum. On the one extreme, there is the "very Mexican

or Indian" and at the other extreme, the "very middlestream Anglo", with a large assortment in between. There are those who are unaware of their heritage and contributions their culture has made, those who are aware of their history and culture and are proud of it, and those who are ashamed of their ancestry as well as some who deny or negate their cultural history. Economically and educationally there are large differences. With regard to morals, attitudes and values, differences exist between a lower class migrant or construction worker, a factory worker, a middle class bureaucrat, and an upper class professional. The differences are found not only between the different states or regions, urban and rural areas, as might be expected, but also within the same town and even within the same family.

One final point that should be made is that the Chicano is the second largest ethnic minority in the United States and the largest in the Southwest. According to 1978 census estimates, there are over twelve million Hispanic Americans in the United States.[2]

Description of the Sample

The history of the Chicano in the Lansing area is hard to find in the literature. Herrera (1976) conducted research on the Chicanos of Ingham County and based on written questionnaires, traced the early Chicano groups as coming to the Lansing area during the early 1920s. Herrera gives the agricultural industry as the main reason for migration of early Chicanos to Michigan. He states that the numbers began increasing during and after World War II due to farmers who brought them into the area to ease the shortage of farm hands. He also credits the steady demand for workers in better paying industrial jobs for the substantial resettlement in Michigan (and

Lansing) of Chicanos from the migratory farm labor stream.

The 1970 U.S. Census shows 36 tracts in Lansing which contain persons of Spanish language, with a total of 5,070 persons. Out of a total population of 130,211 this is 3.9 percent of the total population. The largest concentration of Chicanos is in the north side of Lansing which extends from Groesbeck Golf Course or Wood Street on the east,to the Grand River on the west, and from Sheridan Road on the north to Willow and Saginaw Streets on the south. This area includes census tracts 1, 2, 8 and 32, with a total of 1,429 persons of Spanish language or 28.2 percent of the total number of persons of Spanish language. Herrera (1976) gives as the place of origin of persons of Spanish language in the Lansing area as follows: 70 percent from Texas; 15 percent from Mexico; 10 percent from other states of the Southwest; and 5 percent from Cuba and Puerto Rico and other South American countries.

Rodriguez (1975) conducted a research in the north side of Lansing by sending out 200 questionnaires to a random cross-section of the population. The sample was divided into four groups: Chicano parents, Chicano students, Anglo parents, and Anglo students. This research has provided some interesting biographic and demographic information, as well as some attitudes of the people in an important part of Lansing.

The demographic results obtained by Rodriguez will be summarized first. The Chicano family size was larger than the Anglo family. The average number of children was four for the Anglo family versus six for the Chicano family, or 50 percent more. On the health of the mother, he found that 70 percent of Anglo mothers enjoyed good health,

while only 45 percent of Chicano mothers enjoyed the same condition. Only 28 percent of Chicano mothers worked outside the home, as opposed to 60 percent of Anglo mothers. Another significant difference was that 66 percent of Anglos had the size of the family planned, versus 42 percent among Chicanos, about a 50 percent difference.

Rodriguez found that 84 percent of Anglo parents were born in Michigan, versus a negligible 7 percent of Chicano parents. Anglos also lived in Lansing an average of 22 years, while the average for Chicanos was only 8-1/2 years. On the educational level of the sample, 19 percent of Anglos received a university education and 16 percent had attended a community college. Of the Chicanos, not one had attended a university and only 7 percent had attended a community college. Many of the sample refused to answer the question on educational level, so no statistics were available on the educational level attained.

The unemployment rate among Anglos was 6 percent, versus 47 percent for Chicanos. The ratio of professional and skilled jobs held by Anglos was 86 percent, but 28 percent for Chicanos. In regard to housing, 84 percent of Anglos owned the house or apartment in which they were living, while only 50 percent of Chicanos (35 percent fewer) owned their own dwelling.

Rodriguez summarized the results as follows:

> "...we have a group of Anglo families with smaller number of children, better jobs and income (reflected in the ownership of the house), higher degree of education, and wives enjoying much better health. On the other hand, the rate of divorce among these Anglo families is 32 percent versus a lower 22 percent on the Chicano side." (p. 8)

Rodriguez's research also explored the attitudes on eleven major areas: space, time, work, food, interaction, language, learning, recreation, material goods, art and religion, and health. Space was measured by identification with the neighborhood and community, and by low rate of mobility. The study showed 84 percent of Anglos felt happier about belonging to their neighborhood, versus 78 percent of Chicanos. Chicanos were shown to work in a large percentage outside the neighborhood where they lived, with only 20 percent working in the neighborhood, as opposed to 72 percent of Anglos.

Time was measured in the context of the value of time, the distribution of time and the orientation toward the future. Anglos fared better in the three sections, the most important difference being in regard to the orientation toward the future as measured by the interest in saving money, and the planning for events that are expected in the future. The ratio was 53 percent for the Anglo group, versus 27 percent for Chicanos, which is twice as high on the part of Anglos.

Work was measured in five sections: type of work held at the present time and type of work desired; attitude toward competition and promotion; responsibility on the job; rate of mobility on the job; and preference for types of work which are highly organized. The Anglo group, both parents and students, showed a higher degree of positive attitude than the Chicano group. The Anglo students scored higher than their parents, reflecting the values of the industrialized American society. Rodriguez also emphasized that the Chicano students scored very close to the Anglo group. Rodriguez interpreted this as:

> "...they are entering the mainstream of American life and they have absorbed the appreciation of these values, perhaps because they realize that the submission to these values involves the

> only possibility of personal achievement, social progress and perhaps even survival in the competitive society. On the other hand, the graph shows that Chicano parents do not keep up with these forms of highly organized and competitive work, perhaps because they did not have in their youth the experience of this highly technological age, or perhaps they never wanted to belong to the system or were rejected by it, and so they preferred to develop their lives in the framework of what we can call a pre-industrial socio-economic system." (p. 12)

Attitudes with regard to food were based on: meals as a means to share the togetherness of the family and the relationships with friends; higher or lower degree of adherence to a fixed schedule for meals; and interest in a balanced diet. The Chicano parents scored higher in using the mealtime for family interaction, reflecting the importance of the family for people of Mexican origin. Paradoxically enough, the Chicano students scored the lowest of the four groups on this item, revealing a significant generational deviation from values and patterns of their parents. Sharing meals with friends rather than with the family was very high among Anglo students with 90 percent, the lowest score corresponding to Chicano students. The same result occurred in adherence to a fixed schedule of meals.

Interaction was explored at three different levels: within the family; at neighborhood level; and at community level, Lansing being defined as the community. In the attitude of the interest for the togetherness of the family, the parents of both groups scored significantly higher than the students. In the way they view the authority of the father, the Anglo parents scored the highest with the other three groups being visibly more negative in their attitudes.

The relationship between parents and children was examined in three areas: harmony; plans for the children; and plans for the aged. In all three areas, Chicano parents scored the highest with 90 percent

of the Chicano parents and 74 percent of Chicano students viewing their mutual relationship as being very good, versus only 68 percent of Anglo parents. There was no significant difference in the plans for their children, however, in plans for the aged, Anglo parents had the highest score. These trends reflect the importance of the family for the Chicano. It also reflects the tendency of the Anglo family to break up when the children become adults and move away from home. The Chicano family usually stays together, even when the parents get old, and they continue to live with their married children rather than being sent to rest homes or similar institutions as is very widespread among Anglo families.

As for relationships among neighbors, the interest of the students in both groups was much higher than that of the parents, with only 20 percent of the parents in both groups being interested in their neighborhoods. Interaction on the community level indicated that Anglo parents showed a higher knowledge of the matters involved with a score of 56 percent. Only 28 percent of Anglo students, 9 percent of Chicano students and 12 percent of Chicano parents proved to have any knowledge of the community of Lansing. Only 10 percent of the Chicano parents regularly exercised their right to vote, versus a much higher rate of 59 percent for Anglo parents.

Language was divided into attitudes toward Spanish speaking people and toward the news in Spanish. The attitude toward Spanish speaking people showed a very low score among the Anglo group as a whole, being slightly higher among students than among parents. The interest on the part of Anglos for news programs in Spanish was negligible.

Learning was divided into attitudes toward the school, attitudes toward usefulness of learning, and attitude toward a trade being taught in school. Chicano parents scored the highest on attitude toward learning as a whole. There was no significant difference on approach to usefulness of learning. Chicano students evaluated the counselors very highly, even more than they evaluated either administrators or instructors. This could be because the three schools which these students attended have Chicano counselors but do not have either Chicano administrators or instructors.

On recreation, it was found that the most favored forms of recreation were watching television and miscellaneous forms including bingo, going to bars, pool houses and others. It was significant that practicing exercises and sports was an extremely low form of recreation, especially among the parents with only 8 percent for Anglos and 3 percent for Chicanos.

Attitudes on material goods were examined under: ambition for material goods; preference to spend money on material goods versus saving money; interest in possessing all necessary things; and attitudes toward luxuries. Even though Anglos were expected to be more inclined toward the possession of material goods, the results were that all four groups' scores were very close. The most significant differences in the breaking down of categories was that on the one hand, Chicano parents and students prefer to spend money instead of saving, and on the other hand, the Chicano group reflected the lack of many luxuries which were enjoyed by the Anglo group.

Art was studied by asking questions about knowledge of the existence of and visitation to museums, and knowledge of and attendance to

musical performances. The Anglo group scored significantly higher than the Chicano group, the highest being the Anglo students with 89 percent and the lowest being the Chicano parents with 37 percent. In contrast with art and religion, scores were higher with the Chicano group with Chicano parents scoring 57 percent against 32 percent for Anglo parents.

Health was divided into physical and mental or emotional health. With regard to physical health, results indicated a positive attitude of 89 percent for the Anglo group, versus a 66 percent for the Chicano group. The results could have been affected by the economic conditions of both groups, since questions involved such matters as having a family doctor, dentist, optometrist, yearly check-ups, and the present health of the family. No significant differences appeared with regard to care of mental or emotional health. There was very little concern expressed for this kind of problem on the part of any of the four groups.

Many of the factors mentioned from this study such as employment, generational distance, education, identification with the family, neighborhood and community, interaction with family and friends, relationships between parents and children, relationships among neighbors, economic situation, and attitudes about physical and mental health affect mental health status as well as the utilization or underutilization of mental health services. The Rodriguez study only involved the north side of Lansing which has the highest concentration of Chicanos. The present study concerns a representative sample from the city of Lansing as a whole and factors or variables are examined in relation to mental health.

## The Questionnaire

A modified version of the questionnaire developed by the Survey Research Center was used. It was 35 pages in length, including 40 questions in English and Spanish and 18 questions on the interviewer's observations. The interview involved questions on biographic and demographic information. It included questions on knowledge and attitudes of local mental health centers and programs, and availability and utilization of formal and informal support systems. It also included an ethnic identity scale in addition to a self-esteem scale and a personal efficacy scale (see Appendix A).

The interview was not identified to the respondent as relating to mental health; instead it was identified as a Michigan State University-based study concerned with the opinion and customs of people of Mexican descent in the United States. They were told that from the results and conclusions of the study, recommendations would be developed for agencies and programs dealing with people of Mexican descent.

The interviews were carried out in either English or Spanish, depending upon the preference of the respondent. All interviewers were fluent in both languages. Interviews lasted between a half hour and an hour, and the interviewer's observations section took about 15 minutes.

## Skill and Training of Interviewers

Six students assisted in conducting the interviews. They were Jose Ortiz, Roberto Ortiz, Oscar Gonzales, David Latoni, Miguel Contreras and Edwardo Frias. Frias is a Chicano from Michigan,

Contreras is a Chicano from Arizona, while the other four students are Puerto Rican. The Ortiz brothers and Latoni are from the main island and Gonzales is from Chicago. All the interviewers are native speakers (Spanish language) and are fluent in both Spanish and English, knowledgeable of Chicano cultural values, and are responsible and personable. Jose Ortiz, Latoni and Frias had participated in another dissertation research project on Lansing Chicanos, the Health Services Outreach Project, and had been recommended by Miquela Rivera, the Project Coordinator. Contreras and Frias received independent study credit in social work and the other four students received independent study credit in Spanish.

All interviewers underwent two thorough half-day training sessions which included professional ethics and confidentiality, an orientation of the research project, explanation of the fundamentals of interviewing including probing and bias, and doing actual interviews (not on persons in the sample). All interviewers were also supplied with a training manual which included:

A. Statement by the Survey Research Center on Professional Ethics

B. Overview of National Study

C. Overview of Lansing Study

D. Glossary of Terms Used

E. Criteria for Determining Eligibility

F. Language to be Used

G. Rules for Recording

H. Mechanics of Recording

I. Thumbnail Sketch of Respondent and Interview

J. Editing the Responses

K. Introduction to Interviewing

L. Interviewing

M. Bias

N. Probing

O. Setting up Appointments

P. Reasons and Types of Refusals

The training was carried out under the supervision of Ph.D. Guidance Committee Chairperson Victor Whiteman, whose area of expertise is research methodology and statistics. An attempt was made to bring together the experience in interviewing operations with the sensitivity and insight of styles and procedures that come from past experience with the target population.

Reliability of Interviewing

A combination of methods to check the reliability (and honesty) of the interviewing were utilized. The Project Coordinator (doctoral candidate) conducted a brief follow-up of respondents by phone or in person. Follow-up was done on the first three respondents for each interviewer and randomly on the remainder of the respondents. Respondents were first thanked for their participation and the confidentiality of the study was again emphasized. The follow-up included such questions as:

Did interviewer keep the appointment?

Did you have any problems with the interviewer or with any of the questions?

Do you remember how much time the whole interview took?

Do you have any comments, suggestions or recommendations?

Respondents were remunerated $5.00 per interview. Payments were in cash and interviewers were required to turn in a receipt signed by the respondents. This served as a secondary check system. Also, three of the interviewers did not have their own transportation, so the Project Coordinator drove them to and from several of the interviews and was aware that the interviews were actually being conducted as well as how much time each interview took.

Sampling Method

The general goal of the sampling was to maximize generalizeability and representativeness (under time and fiscal constraints). The attempt was made to obtain a sample that represented all the variations of the Mexican origin population on significant variables and characteristics. A multistage area sample that adequately accounts for the uneven distribution and concentration of the target population was used. The basic procedure consisted of dividing Lansing into four areas of Chicano density or concentration, randomly selecting households, and screening for eligibility. The three stages are described below.

Stage I--Selection of Sites by Density. Since the variables being researched can be affected by ethnic composition and concentration, it was important to obtain an equal and representative sample from areas of different concentrations. The 1970 U.S. Census (which was the latest and most complete data available at the start of the study) shows a total of 46 census tracts in Lansing, one being in Eaton County and the remainder in Ingham County. Out of the total number of tracts, only 36 tracts contain persons of Spanish

language, with a total of 5,070 persons. The percentage of persons of Spanish language was calculated per tract to determine concentrations. The highest percentage is 16.6 percent for tract number 2 in north Lansing. With the largest percentage being a low percentage of 16.6, Lansing was divided into only four basic areas of Chicano concentration: less than 2 percent, 2-5 percent, 5-10 percent, and more than 10 percent. The 1970 U.S. Census shows 15 census tracts in the less than 2 percent concentration, 11 census tracts in the 2-5 percent concentration, 6 census tracts in the 5-10 percent concentration, and 4 census tracts in the more than 10 percent concentration.

Stage II--Random Selection of Households. Since it was not feasible to construct a list of all the households in all tracts, tracts were listed by numerical sequence under their respective groups of concentration and their totals were cumulatively totaled. The less than 2 percent group contained a total of 594 persons of Spanish language or 11.7 percent of the total number of persons of Spanish language; the 2-5 percent group contained 1,888 or 37.2 percent; the 5-10 percent group contained 927 or 18.3 percent; and the more than 10 percent group contained 1,661 or 32.8 percent. This means a sample of 12 persons or 12 percent of the total sample was needed from the less than 2 percent group; 37 persons or 37 percent from 2-5 percent group; 18 persons or 18 percent from the 5-10 percent group; and 33 persons or 33 percent from the more than 10 percent group. It was assumed that 85 percent of the persons of Spanish language were of Mexican origin (eligible to participate in the study). Out of a total of 184 persons of Spanish language screened, 171 persons or 92.9 percent were of Mexican descent and eligible for the study. It was also

assumed that only about 40 percent of persons who were eligible would agree to participate in the study. Out of the 171 persons that were eligible, 105 or 61.4 percent agreed and participated in the study.

Clusters of 18 heads of household were used for every 6 respondents needed; 2 clusters of 18 persons for the less than 2 percent group to obtain 12 samples; 6 clusters for the 2-5 percent group; 3 clusters for the 5-10 percent group; and 5 clusters for the more than 10 percent group (Fig. 2). All the census tracts' totals were cumulatively listed for each concentration group. The starting point for each cluster was determined by the use of a random table. The listing of households for persons of Spanish language was compiled using the Polk Reverse Directory to include persons with phones as well as persons without phones or unlisted numbers, and persons who rent as well as own their own homes. The listing was done alphabetically by street for those tracts randomly selected by the method mentioned above. The starting numerical sequence for each tract randomly selected was determined by the cumulative total listed above. This activity was conducted by the Project Coordinator under the supervision and consultation of Vic Whiteman, Guidance Committee Chairperson, and Carlos Arce, Survey Research Center Project Director.

Of the original 100 interviews done, five interviews were rejected for analysis. One because the respondent was not the head of the household but rather a nephew with the same name as the head of the household who happened to be visiting and answered the door; the four other interviews were rejected because the interviewer's observations section of the questionnaire did not have enough information. Five additional interviews were conducted by the Project Coordinator

| Less than 2% | | | 2-5% | | | 5-10% | | | More than 10% | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| C.T. | Tol. | C. Tol. | C.T. | Tol. | C. Tol. | C.T. | Tol. | C. Tol. | C.T. | Tol. | C. Tol. | |
| 6 | 62 | 62 | 3 | 118 | 118 | 1 | 241 | 241 | 2 | 376 | 376 | |
| 9 | 14 | 76 | 4 | 201 | 319 | 7 | 348 | 589 | 8 | 666 | 1042 | |
| 10 | 15 | 91 | 5 | 106 | 425 | 19 | 96 | 685 | 12 | 374 | 1416 | |
| 11 | 65 | 156 | 20 | 263 | 688 | 32 | 136 | 821 | 13 | 245 | 1661 | |
| 15 | 41 | 197 | 21 | 149 | 837 | 51 | 106 | 927 | | | | |
| 16 | 26 | 223 | 24 | 98 | 935 | 202 | | | | | | |
| 22 | 31 | 254 | 28 | 79 | 1014 | | | | | | | |
| 23 | 12 | 266 | 32 | 146 | 1160 | | | | | | | |
| 25 | 38 | 304 | 36.1 | 242 | 1402 | | | | | | | |
| 26 | 56 | 360 | 36.2 | 167 | 1569 | | | | | | | |
| 27 | 84 | 444 | 37 | 213 | 1782 | | | | | | | |
| | 46 | 490 | 52 | 106 | 1888 | | | | | | | |
| 31 | 21 | 511 | | | | | | | | | | |
| 33 | 38 | 549 | | | | | | | | | | |
| 53 | 45 | 594 | | | | | | | | | | |
| 11.7% | | | 37.2% | | | 18.3% | | | 32.8% | | | 100% |
| 6 | | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 96 |
| 18 | | 18 | 18 | 18 | 18 | 18 | 18 | 18 | 18 | 18 | 18 | 188 |

Figure 2.--Clusters of Heads of Households

in the corresponding concentration sites from the clusters already developed.

Stage III--Screening of Respondents. A critical part of the research involved the correct identification of individuals as respondents. The principal screening method was a set of direct questions asked of potential eligible respondents. Eligible respondents were those indicating that some of their ancestors were born in Mexico and were of Mexican descent (see Appendix B). Eligible respondents were informed of the time required for the interview (one-half hour to one hour), and the amount of remuneration ($5.00) and, as often as possible, the interview was conducted immediately or an appointment was made if respondents agreed to participate in the study.

The student research assistants were given the choice to do some of the screening by telephone with those that had telephone numbers available, or in person with those that did not have telephone numbers. After an initial attempt, it was discovered that the screening could be quicker and more effectively, and that it was easier to get eligible respondents to agree to participate in the study if the screening was done in person. Over 95 percent of the screening was done in person and all of the interviews were conducted in person. The screenings and interviews were conducted by both the Project Coordinator and student research assistants. The screening questionnaire used was also a modification of one used by the Institute of Social Research, Survey Research Center.

A total of 184 persons of Spanish surname were screened. Of these, 171 or 92.9 percent were of Mexican descent (or Chicano). Five or 2.7 percent were from South America; two or 1.1 percent were Cuban;

four or 2.2 percent were Puerto Rican; and the other two or 1.1 percent were non-Hispanic women who had acquired a Spanish surname through marriage.

## Summary

The Spanish speaking population of the Lansing area was screened to identify persons of Mexican origin and therefore eligibility for the study. A modified version of the questionnaire developed by the Survey Research Center was used to conduct 100 interviews. After undergoing two thorough half-day training sessions, six students assisted in conducting the screenings and interviews. Of the total of 184 persons of Spanish surname that were screened, 92.9 percent were of Mexican descent, 2.7 percent were from South America, 1.1 percent were Cuban, 2.2 percent were Puerto Rican, and 1.1 percent were non-Hispanic women who had acquired a Spanish surname through marriage.

# CHAPTER III

# REVIEW OF THE LITERATURE

## Ethnic Identification and Ethnic Identity

There seems to be a good deal of semantic confusion surrounding the terms identity and identification. Dashefsky (1972) has summarized his review of the literature on identification:

> Foote (1951) and Lindesmith and Strauss (1968) have suggested that identification involves linking oneself to others in an organizational sense (as in becoming a formal member of an association), or in a symbolic sense (as in thinking of oneself as a part of a particular group). Stone (1962) argues further that identification subsumes two processes: "identification of" and "identification with." The former involves placing the individual in socially defined categories. . . In Stone's terms it is "identification with" that gives rise to identity. Finally, Winch (1962) follows this interactionist approach to define identification as "the more or less lasting influence of one person. . .on another."
>
> Rosen has gone further in arguing that an individual may identify himself (herself) with others on three levels (1965): First, one may identify oneself with some important person in one's life, e.g., a parent or a friend (i.e., a significant other). Second, one may identify oneself with a group from which one draws one's values, e.g., family or co-workers (i.e., a reference group). Last, one may identify oneself with a broad category of persons, e.g., an ethnic group or occupational group (i.e., a social category). It is on the third level that ethnic group identification occurs. (p. 242)

Dashefsky and Shapiro (1976) have defined ethnic group identification as both a process and a product. They state that ethnic group identification occurs when the group in question in one with whom the individual believes he or she has a common ancestry, based on shared

individual characteristics and/or shared sociocultural experiences. Such groups may be religious, racial, national, linguistic, or geographical.

Zander, Stotland and Wolfe (1960) define group identification as the psychic process whereby an individual sees in himself or herself qualities that are similar to those he or she perceives in his or her group.

Identity has been described differently by different writers, however, most relate it to group identification or resulting from group identification. Dashefsky and Shapiro (1976) have described identity by two major sources: the social roles that constitutes shared definitions of appropriate behavior, and individual life history. They combine these two dimensions to describe four facets of identity: social identity, self-conception, personal identity and ego identity.

Dashefsky and Shapiro defined the concept of social identity as referring to how others identify the person in terms of broad social categories or attributes such as age, occupation, or ethnicity. Self-conception is defined as a cognitive phenomenon which consists of the set of attitudes an individual holds about himself or herself. Both social identity and self-conception are based, in large part, on social roles. In the former, others define appropriate behavior for the individual in such roles, while in the latter, the individual internalizes these definitions to form a part of his or her self-conception.

They define the concept of personal identity as referring to how others define the person, in terms of a unique combination of traits

that come to be attached to him or her. By contrast, they define ego identity as a intrapsychic phenomenon that consists of the psychological core of what the person means to himself or herself. Both personal identity and ego identity are based on the individual's personal experiences. Personal identity is determined by others' perception of the individual's past experiences, while ego identity is based on the same experiences as they have affected the individual.

Gecas (1973) has distinguished self-concept into two major dimensions: the evaluative and the substantive. He further defines the evaluative component as referring to the individual's feelings about himself or herself, his or her self-esteem; while the substantive dimension refers to the content of a person's ideas about himself or herself, typically expressed in the form of identities. Like Gorden (1968) and Sarbin (1971), Gecas defines identity as the cognitive, categorical aspects of the self.

Ethnic identity is also defined in the literature in different terms by different writers. Driedger (1976) defines ethnic identity as a combination of behavioral affirmation, aspirational affirmation and denial of one's ethnicity. Nall (1962) and Kuvlesky and Patella (1971) have employed the usage of Spanish language in several types of settings to measure degree of ethnicity or ethnic identification.

Teske and Nelson (1973, 1976) have developed two scales: the Interaction Scale to measure behavioral aspects, and the Identity Scale to measure emotional aspects of ethnic identity. The Interaction Scale measures usage of Spanish in various settings: membership activity in churches and organizations attended mainly by persons of Mexican origin, in addition to friendship, visitation, and

entertainment patterns. The Identity Scale measures attitudes toward use of Spanish, being labeled Chicano or Mexicano, various organizations, children's knowledge of Mexico's history and culture and knowledge of persons of Mexican origin.

Carlos and Padilla (1974) have distinguished between awareness and loyalty and have developed different measuring scales. They have also distinguished between self-labeling in ethnic terms and cultural awareness and loyalty. They have defined this self-labeling in ethnic terms as the central aspect of ethnic identity.

Acculturation and Mental Health Status

Group identification and resulting social and ethnic identity have been shown by several writers to affect the mental health of members of minority groups. Lewin (1948) in his study of Jews believed that individuals who belong to minority groups need a firm sense of identification with the heritage and culture of their in-group to be able to have a sense of well-being. He introduced the notion of "self-hatred" to refer to negative evaluations that minority status members sometimes hold concerning characteristics of their own group. Erikson (1950) and Clark (1965) later attributed this negative self-image or negative identity as being a result of negative evaluation of the majority toward minority group individuals.

A major cause of psychological stress on minority group members given in the literature is that resulting from conditions of acculturation. A group of over 400 Chicano mental health practitioners who developed "The Chicano Plan for Mental Health" stated that "Some of the most serious problems that must be solved if Chicanos are to

enjoy mental health are those stemming from acculturation" (p. 9). They believe that since Chicanos are frequently torn between two cultures, sooner or later acculturation will lead to a negative state of mental health. They propose that a positive state of mental health will result from an adherence to Chicano culture.

Torrey (1972) in his study of Chicanos in South Texas, states that even if studies show the underutilization of mental health services by Chicanos, this should not be interpreted as Chicanos having a lower incidence of mental illness. He states that most studies of groups who are either poor or in the process of acculturation show a high incidence of mental illness, and that since many Chicanos are both poor and acculturating, they must have a higher incidence of mental illness.

The different results of stress or conflicts caused by acculturation or by a negative personal identity of the Chicano have been studied by several writers. Denfeld and Hopins (1972) conducted a study on minority inmates in Connecticut prisons and reported that increased ethnic identification promoted a decrease in criminal identities. Ramirez (1967) assessed the degree to which Chicanos identified with Mexican family values by investigating 70 Chicano and 70 Anglo middle class Catholic college students. He suggested that Chicanos may be experiencing conflicts as a result of acculturation stres and cognitive dissonance in the area of civil rights.

Alcoholism is another area that has been studied by several researchers. Madsen (1964) analyzed the sociocultural environment which tends to produce a high proportion of problem drinkers among the agringados (acculturated Mexican Americans) of South Texas. Madsen

found that the cultural setting of the agrindado involved value conflicts resulting in loss of identity and community. This loss seems to be conducive to alcoholism. Graves (1967) investigated ethnic differences in excessive drinking and other forms of social problem behaviors among Indians, Chicanos and Anglos living in a southwestern community. He interviewed 221 adults comprising a random, stratified sample. He found that for the Chicano group, acculturation was consistently associated with higher rates of drinking and deviant behavior, whereas within the Indian group, the opposite was true. With the unacculturated members of the two ethnic groups, the Chicano group did not display deviant behavior, whereas the Indian group did. Graves gave four explanations for this paradox: 1) the acculturated ethnic members have limited economic access to the rewards of American society, thus maintaining stronger feelings of relative deprivation, significantly greater alienation and significantly more psychological problem-solving reasons for drinking; 2) the unacculturated Chicanos display strong social and psychological controls from family and church that are internalized; 3) the unacculturated Indians display weak social and psychological controls; and 4) the influence of family and church begins to break down as Chicanos move toward the more secular American norm, whereas Indians, whose non-acculturated background is socially anomic, become mapped into new control structures. These structural changes are paralleled by psychological changes.

Ramirez (1971) conducted a review of the literature to determine whether identification with his ethnic group is an asset or a liability for the Chicano child and adolescent. Studies indicated that acculturation to family values was negatively related to performance

in school. The studies also showed that acculturation which similarly reduces the Chicano's identity with his ethnic group tends to result in negative consequences for psychological adjustment.

Murillo (1971) discusses the intercultural conflicts and dynamics of the Chicano family. He concludes that because of differences between Chicano and Anglo cultures, problems of communication, identification, sex role expectation, and values arise for the Chicano. Murillo believes that of the several choices in coping with the dilemma, the one which offers the Chicano the greatest potential for achieving a satisfying life in this country is to realize his or her creative potential for developing his or her own unique identity.

Not all the studies have found a direct negative relation with acculturation. Fabrega and Wallace (1968) studied the demographic features and value identifications of a sample of psychiatric outpatients and a probability sample of non-patients in border areas of South Texas. They constructed a value orientation scale consisting of "traditional," "mixed or intermediate," and "non-traditional." Their date suggest that there may be a curvilinear relationship between acculturation and psychiatric impairment. They found that the non-patients were overrepresented in both traditional and non-traditional positions of the scale and underrepresented in the mid-region. The converse was true for the patient group. Lopez (1970) tested Fabrega and Wallace's hypothesis on a sample of Chicano college freshmen by studying the relationship between degree of acculturation and anxiety level. He reported inconclusive results, but did report lower levels of anxiety for those Chicano college students

who could ignore Anglo pressures to change and those who could incorporate some Anglo traits.

Effects of Identity on Self-Esteem and Personal Efficacy

Although most writers talk about psychiatric stress and psychiatric breakdown or disability as resulting from acculturation, discussions have usually implied a broad conception of mental health and illness that relate to issues of ethnic identity, self-esteem and personal efficacy. Mental health is also seen or defined in terms of self-esteem by some mental health practitioners. In defining mental health, "The Chicano Plan for Mental Health" quotes the definition from Blakiston's Pocket Medical Dictionary as:

> A relatively enduring state of being in which an individual has effected an integration of his instinctual drives in a way that is reasonably satisfying to himself as reflected in his zest for living and his feeling of self-realization. For most individuals, mental health also implies a large degree of adjustment to the social environment as indicated by the satisfaction derived from their interpersonal relationships as well as their achievements. (p. 5)

"The Chicano Plan for Mental Health" also defines mental health in terms of self-esteem. They define mental health as "the development of a positive self-image and the maintenance of one's esteem" (P. 5).

Despite the fact that mental health is defined in terms of self-esteem and self-esteem is affected by one's social identity, there is very little research on the effects of identity on self-esteem and personal efficacy.

Dworkin (1965) studied the stereotypes and self-images held by 280 native (U.S. born) and foreign (Mexican born) Chicano students and community residents. The statistical comparisons indicated that significantly more foreign subjects held favorable stereotypes and

self-images than did native subjects. Dworkin attributed this to differences in the groups' definition of their present social situation as influenced by whether they employed their prior socioeconomic situation or the socioeconomic situation of the dominant society as a standard of evaluation.

Gecas (1973) studied the self-conceptions of Chicanos by interviewing four family members of 88 families in the Yakima Valley of Washington state. The population was divided into two groups: migrants who follow the crops and are transient to the area, and those who have settled in various communities in the valley. The migrants appeared to be more firmly rooted to structural sources of identity. Migrants more frequently mentioned name, ethnicity, and religion as well as family, work and IDS than did settled Chicanos who were more likely to define themselves in terms of interests, activities and abstract identifications. Migrants also appeared to have a more favorable image of themselves than did settled Chicanos.

The little research which has been done on the Chicano's sense of efficacy and powerlessness has usually focused on fatalism. Some Anglo social scientists (Madsen, 1964a, 1964b; Heller, 1966) have suggested that fatalism is a common Mexican value characteristic. Madsen gives the following difference between Chicanos and Anglos:

> It is generally believed by Mexican-Americans that the good or bad fortune of the individual is predestined and every occurrence in human existence comes to pass because it was fated to do so. Fatalistic philosophy produces an attitude of resignation, which often convinces the Anglo that the Latin lacks drive and determination. What the Anglo tries to control, the Mexican-American tries to accept. (p. 16)

Two years later, Heller perpetuates the same belief:

> . . .the note of fatalism in the attitudes and behavior of Mexican Americans springs from the orientation that the environment cannot be controlled. As for time orientation, the Mexican culture stresses the present and the American culture the future. (p. 19)

The few studies that have scientifically researched this variable have found a contradiction to the expectations of greater fatalism among Chicanos as opposed to Anglos.

Farris and Glenn (1976) compared the responses of Anglos and Chicanos on interview items designed to measure fatalism and familism and found a moderate ethnic difference in fatalism and a larger difference in familism. As a whole, the Chicano respondents were both more fatalistic and more familistic in their responses. Controls for education removed the difference in fatalism, but at each educational level the Chicano group appeared as a whole to have been distinctly more familistic than the Anglo group.

Garza and Ames (1974) gathered data on 204 college students. From this aggregate of respondents, they matched 47 Anglos and 47 Chicanos on socioeconomic background and sex and compared them using Rotter's (1966) I-E scale. They found that Chicanos scored (M=8.79) significantly (t=2.76, p .01) less external than Anglos (M=10.98) on the full I-E scale. Chicanos also scored (M=2.21) significantly (t=3.10, p .01) less external than Anglos (M=3.28) on the luck and fate dimension and on the respect dimension (M=1.89 versus M=2.45; t=2.48, p .02). They explained these differences in terms of cultural values of the Chicano group. They believed that the family centered orientation and the perennial resistance to give up their culture and heritage

suggests belief in internal locus of control inasmuch as they indicate resistance to external influences.

Ethnic Identity and Utilization of Resources

The literature on the direct relationship of ethnic identity to utilization of mental health resources is very scarce. The only major study dealing with this issue is the one by Padilla, Carlos and Keefe (1976) in California. Keefe (1978) reported that only one of the cultural indicators (language usage) had a significant correlation coefficient which led them to conclude that level of acculturation in general is not associated very strongly with mental health clinic contact. However, she cautions that:

> The greater likelihood that English speakers will contact mental health clinics could be interpreted in other ways aside from the possibility that these respondents are more acculturated and therefore more amenable to the treatment offered at the clinics. It may be merely a reflection of the language limitations of the clinic personnel. It could also be the result of the English speakers' greater awareness about the services available. For example, compared to 39 percent of the Spanish-speaking respondents, 57 percent of the English-speaking respondents in this survey know where their neighborhood mental health clinic is located. (p. 102)

Based on the same data, Padilla, Carlos and Keefe (1976, 1978) concluded that ethnic identity did not significantly relate to use of mental health clinics. They also found that while Chicano respondents who spoke Spanish as opposed to English indicated less use of mental health clinics, that was because they used all mental health resources less, including family and friends.

Utilization-Underutilization of Mental Health Services

Demographic studies show that ethnic minority group members, and especially minority group members of low socioeconomic status, receive

less health care than the rest of the population. The research by Hollingshead and Redlich (1958) on social class and mental illness, the ten-year study by Kolk, Bernard and Dohrenwend (1969) on the Washington Heights district of New York, and the study by Strole, Michael, Kirkpatric, Opler and Rennie (1978) on Midtown Manhattan indicate the problem is more serious in mental health care.

Studies dealing with the national delivery of health services to ethnic minority group members indicate that the Chicano receives the least amount of mental health care of any population subgroup. Jaco (1957, 1959) conducted a study designed to include all inhabitants of the state of Texas who sought psychiatric treatment for a psychosis for the first time in their lives during the two-year period 1951-52. A total of 11,304 cases was found and rates were adjusted for sex, age and major ethnic composition (Anglo-American, Chicano and Black) of each of the subregions. The results were that of the total number, 684 (6 percent) were Chicano, 9,557 (84.6 percent) were Anglo-American, and 1,057 (9.4 percent) were Black. The average annual incidence rate per 100,000 population, standardized directly for age and sex composition, was 42 for the Chicano group, 80 for the Anglo group, and 56 for the Black group. Jaco stated that estimates and checks indicated that differences in rates for the three groups were too great to be accounted for entirely in terms of economic and attitudinal differentials.

Karno and Edgerton (1969) conducted a study of the Chicano in California and discovered that while Chicanos made up 9-10 percent of the state's population in 1962-63, the percentages of Chicanos receiving treatment in California were as follows: 2.2 percent

admissions to the state hospital system, 3.4 percent to state mental hygiene clinics, 0.9 percent to the Neuropsychiatric Institute, and 2.3 percent to state and local facilities. The resident in-patient population was 3.3 percent. Other studies also done in the Southwest by Keefe, Padilla and Carlos (1978) and Torrey (1972) have documented this underutilization by Chicanos.

All the literature on Chicanos and mental health services agree on one point--Chicanos continue to underutilize traditional (formal, mainstream) mental health facilities and services. There have been numerous studies, both by Chicanos and non-Chicanos, giving various reasons to explain this underutilization. Most of these studies have been affected by inherent problems in early research. Early ethnographic accounts of Chicanos have usually been a holistic analysis of the interrelationships of the cultural, social, economic, religious, symbolic, and political life of the community. While this approach is necessary to gain a broad understanding of the cultural milieu, it has resulted in variations within the community being overlooked, minimized or disregarded. Stereotypes have been generated and misleading impressions of the Chicano have been created and perpetuated.

Early ethnographic studies also have a scarcity of quantification information. They usually have little information about basic methodological procedure such as the number of the sample or the specific questions asked. When data is quantified, the sample is often small or inadequately identified. These methodological shortcomings have contributed to unsubstantiated generalizations in the literature on Chicanos and mental health. Unsubstantiated statements have formed

much of the basis for designing social services for Chicanos, as well as providing assumptions for social research.

Finally, early research on Chicanos is characterized by the predominance of rural studies. The U.S. Census since 1950 indicates that the Chicano population is overwhelmingly urban-dwelling. One of the problems in current research is distinguishing the characteristics of Chicanos which apply to the group as a whole as well as the different regional areas, as opposed to solely the rural segment.

The numerous reasons that have been suggested for this underutilization can be grouped into three categories: social, economic and cultural aspects of the Chicano; frequency and severity of mental illness of the Chicano; and attributes of mental health clinics and the services they provide. Many of these reasons have resulted from assumptions which this review will attempt to show have been drawn from misleading generalizations from past research which has failed to take into account relevant Chicano socioeconomic and cultural subgroups, regional differences and rural/urban locale.

## Social, Economic and Cultural Aspects

This section is divided into five different areas: attitudes toward formal services, unfamiliarity with services, language and cultural barriers, social-economic status, and reliance on alternative resources or use of informal resources. The section on reliance on alternative resources if further divided into reliance on the extended family, friends, religion, medical doctors, ethnic community workers, and *curanderos* or folk healers.

## Attitudes Toward Formal Services

Several researchers suggest Chicanos have negative attitudes toward mental health centers and therefore do not turn to them for help with emotional problems. Burruel and Chavez (1974), Padilla and Ruiz (1973), and Torrey (1972) believe Chicanos consider majority group institutions as alien, hostile and staffed by Anglos who are regarded as cold. Several researchers see these negative attitudes as resulting from the opinions which Chicanos have of Anglos in general. Kline (1969) states that:

> The Spanish-American's perception of the "Anglo" as cold, exploitive, and insincere leads both to underutilization of available psychiatric services among this group and to special problems in the treatment of those who do seek help. (p. 88)

Madsen's (1961) research in South Texas and Torrey's (1972) research in California also leads them to believe that Chicanos perceive mental health centers as alien and hostile, much like majority institutions at large. A study by Trevino and Bruhn (1977) in Laredo, Texas, seems to confirm this. Laredo was selected as the location for a study because the residents and the mental health center staff were predominantly Chicano and Spanish-speaking. They discovered that 88.5 percent of the patient population was Chicano. This indicated that the out-patient population was representative of the ethnic composition of Laredo since the city was 86 percent Chicano.

Serrano and Gibson (1973) in their research in San Antonio, Texas, deducted that because of their own experiences, Chicanos have learned to teach their children not only how to cope with life, but actually how to defend against the Anglo establishment. This they feel has resulted in:

> . . .social defensiveness which interferes with readiness of the Chicano population to relate to "mental health people" and their apparent defensiveness about being considered "crazy" or "retarded." (p. 1056)

Laosa, Burstein and Martin (1975) in their study in Crystal City, Texas, observed a very similar attitude toward mental health. They stated:

> Like many of the uninformed poor everywhere, some persons were scared away at the mental of "mental health." Many persons associated mental health with insanity and feared commitment to state hospital by seemingly indifferent professionals. Retrospectively, this resistance might have been avoided had the program been offered under a title without such social and cultural implications regarding mental illness or insanity. (p. 441)

Research in this area does not distinguish between the attitudes of the different subgroups. Research is needed to observe the difference, if any, between the upper class, middle class and poor, the rural and urban, the educated and uneducated, as well as regional and generational differences. Keefe, Padilla and Carlos (1978) in their study in Los Angeles, California, found such negative attitudes may not be prevalent in urban areas, even among some of the special subgroups mentioned above.

Studies where attempts to set up mental health centers with the population's sociocultural characteristics in mind demonstrate that indigenous attitudes can change if the services are relevant. Schensul (1974) indicates this in his experience with the Community Mental Health Program, El Centro de la Causa, on Chicano's West Side. The program became involved with a number of action groups in the Chicano community and contributed to indigenous social action and community developments, particularly in activities directed toward meeting the mental health needs of the area residents. As the program expanded its

services, it became the center for activity and action in the community. Different groups such as farmworkers, student organizations, job programs, counseling services, and a variety of community groups established themselves in the building where the mental health program was located. El Centro demonstrated that a group of community residents, through organized action, could run their own programs and control their own resources thus eliminating negative attitudes about mental health programs.

Two separate studies (Laosa, Burstein and Martin, 1975; Martinez, 1977) on the Crystal City Mental Health Outreach Clinic, a Chicano rural mental health clinic in Crystal City, Texas, show how initial negative attitudes can be changed. Laosa, Burstein and Martin attribute this to their public relations work done with the community. They state:

> Emphasis was placed on participation in creative community activities, both with the aim of orienting potential clients to the program's services and to develop good will and a working alliance with respect to mental health objectives. An example of such activities was a Thanksgiving dinner for 120 elderly citizens without family or friends. Such projects were a valuable means for winning the confidence of the community and reducing negative attitudes toward mental health." (p. 442)

Martinez gives two main reasons for the change in attitudes, but the major one he states as follows:

> That the program came to be accepted by the community as well as it has been is undoubtedly due to the man chosen to be its first program director. He was an indigenous, educated community leader who had become a respected member of the new political party then gaining ascendancy in the community--La Raza Unida. Other members of the original staff were also socially and politically prominent in the community, either through holding public office themselves or through close friendships with community leaders. These people aggressively used their public identities to educate the people about the program, the services that were immediately available, and the program's potential usefulness to long-range community growth. . . (p. 634/75)

He also agreed with Laosa et al. when he stated:

> Another reason the mental health clinic became accepted was that an attempt was made from the very beginning to provide concrete help immediately to prospective patients, in the form of social casework. Whenever anyone came into the clinic, an effort was made to see that something both tangible and meaningful was provided. . .The patient's basic needs were therefore to be assessed immediately, so the foundation could be set for working on emotional or interpersonal issues. (pp. 634/75-635/79)

## Unfamiliarity with Services

A common assumption of mental health practitioners working in a Chicano community is that Chicanos underutilize their services because they are unfamiliar with mental health services, their location and the kind of services provided. Knoll (1971) concluded from her experiences with a grass-roots project of Catholic Services of Wayne County (Detroit, Michigan) that the majority of Chicanos do not seek counseling help from family services agencies due to unfamiliarity with these services. Laosa, Burstein and Martin (1975) and Martinez (1977) in their separate consultative efforts to assist in the development of mental health services in the rural community of Crystal City, Texas, both report that initially, people in the community had little knowledge of mental health preventive programs, out-patient care clinics, or outreach work. This is understandable since they did not have mental health services prior to 1971. Philippus (1971) in his two-year study in Denver, Colorado, also reports on the Chicano's unfamiliarity with mental health services.

A close assessment of this literature suggests that if this is true, it may not apply to all Chicano subgroups. Knoll described her subjects as mostly coming from economically and socially deprived rural backgrounds. Laosa et al. and Martinez discussed Chicanos in

a rural community that, as has already been mentioned, had not had any mental health services prior to the services begun in 1971. Philippus' study involved poor Chicanos in housing projects who were primarily Spanish-speaking. Keefe, Padilla and Carlos (1978) in their study of urban Chicanos in southern California, found the first generation is most unfamiliar with the location of local mental health services, while the native born are more knowledgeable than Anglos.

Keefe and Casas (1978) proposed that only the following Chicano subgroups are probably unaware of mental health services: the poor, the Spanish-speaking, the first generation, the aged, and residents of barrios and rural areas. This suggests that level of education, which is intimately tied to all of these characteristics, may actually be the primary determinant of awareness of services.

## Language and Cultural Barriers

Language and cultural barriers as a result of beliefs and attitudes are frequently suggested as explanations for underutilization by Chicanos. Language is not only important because it is basic to communication between client and staff, but because it is also intimately tied to perception. In their five-year social psychiatric research investigation concerning mental illness among Chicanos in two communities in East Los Angeles, Karno and Edgerton (1969) and Edgerton and Karno (1971) found that attitudes toward mental illness and the use of language are related, and that both reflect cultural distinctions with lasting psychological involvements. Edgerton and Karno examined such variables as age, sex, religion, education, occupation, number of years spent in the United States, as well as certain attitudes toward language, education and occupation, and certain beliefs

regarding the etiology of mental illness. When they attempted to relate each of these variables to responses concerning mental illness, they found that these relationships were characteristically few and seldom approached statistical significance. When they combined a number of these variables, they found that the combination which produced the largest number of statistically significant relationships to mental illness responses was: all those persons who were born in the United States, educated nine or more years, and took the interview in English versus those persons who were born in Mexico, educated eight or fewer years, and took the interview in Spanish. However, they discovered that by far the best predictor among all possible variables was simply the language in which the respondent took the interview.

Cultural differences between Anglo Americans and Chicanos have been proposed by such researchers as Torrey (1972) who argues that all mental diseases are culture-bound because the system of classification is culture-bound. Karno and Edgerton (1969) in the study previously mentioned, found no support for Torrey's position. The Karno-Edgerton study found few statistically significant differences between Anglos and Chicanos (who spoke mainly English) in their perceptions of an attitudes toward mental illness.

In a study of three southern California communities covering 666 Chicanos and 340 Anglo Americans, Newton (1978) found that Chicanos have a coherent endemic belief system associated with perception of mental and emotional problems and their treatments. Newton found that Chicanos seek psychiatric help only after recourse to other helping agents and when the problem is so serious that loss of mental control is imminent.

Research by Fabrega, Swartz and Wallace (1968) tends to corroborate this viewpoint by Newton. They compared Chicano schizophrenics with Black and Anglo schizophrenics. Patients were matched by age, sex, IQ estimate, education, and prior psychiatric hospitalizations. They also utilized the psychiatrist's scaled evaluations of the patient's psycho-pathology, the Nurse's Observation Scale for In-Patient Evaluation, and the Holtzman Inkblot Technique. The evidence indicated that the Chicano schizophrenics were more chronic, regressed and disorganized. It was suggested that the families of Chicano patients may be more tolerant of deviant psychotic behavior than families of the other two groups and consequently delay seeking help or hospitalization longer.

Cultural attitudes toward Anglo institutions in general and the belief in folk medicine or curanderismo are often suggested as inhibitors to the use of mental health services. Attitudes toward Anglo institutions has already been discussed under a separate section. Folk medicine and psychological beliefs will be discussed later under the section on reliance on alternative resources.

## Social-Economic Status

Research on health services indicates that social-economic status (SES) has an effect on utilization of services. Rosenblatt and Suchman (1964) established that blue-collar workers and other members of the lower socioeconomic class underutilize medical care services in general. Glasser, Duggan and Hoffman (1975) in their study of members of the United Auto Workers Union discovered that even though coverage of mental health care through prepayment and insurance programs removes the economic barriers to early detection, diagnosis and

treatment of mental disorders, blue-collar workers underutilize mental health services. Since Chicanos are predominantly from the lower socioeconomic class, it is reasonable to assume that SES variables have much to do with the utilization (or underutilization) rate by Chicanos.

Bruhn and Fuentes (1977) indicated that factors which affect beliefs and customs should be considered. They state:

> Everyone's attitude toward illness and health is influenced to some degree by his education, socioeconomic status, and religious beliefs. Many facets of his life play a part in the way the Mexican American recognizes and deals with illness. Beliefs and customs play an important role in influencing Mexican American health practices. (p. 609/21)

A problem common to many of the studies on Chicanos is the lack of control of variables. This has resulted in very important variables such as social status being overlooked. Some sociologists like Broom and Skevky (1952) feel that the control in variables is of special importance in studies of Chicanos because the range of variation of social status in this group seems to be even more constricted than in other important American ethnic groups. McLemore (1963) feels that the effects of cultural and social class variables can be confused in studies on Chicanos. He feels that since educational level is primarily used as an indicator of social class position, and that since low educational level is common among Chicanos, that this characteristic may come to be considered an integral part of Chicano culture.

In his study on cultural differences and medical care, Saunders (1954) gives differences in concepts of disease, in language, in orientation to time, in additudes toward change, and in attitudes toward work and efficiency as among the cultural factors affecting

attitudes toward hospitalization. He also notes that other factors such as differences in social class position may also influence the acceptance of Anglo medical care by Chicanos.

McLemore conducted a study to test empirically the relation of educational level to attitudes toward hospitalization among a sample of Anglos and Chicanos in a single hospital setting. He concluded that in both ethnic groups studied there was a direct relation between level of education and attitudes toward hospitalization, and that there was only slight evidence of an ethnic difference per se in attitudes toward hospitalization. His findings suggest that if there is a correlation between Chicano and Anglo American ethnicity and attitudes toward hospitalization as reported in the literature, it may be a reflection of an underlying connection between those attitudes and differences in average educational levels of members of the two groups.

Nall and Speilberg (1967) take a somewhat different perspective with regard to social-economic status. Nall and Speilberg sampled 53 Chicano subjects in the lower Rio Grande Valley of Texas. They explored culture and social factors related to acceptance or rejection of a modern treatment regime (for treatment of tuberculosis) by Chicanos. They argue that social integration into the Chicano subcommunity, especially into the family unit, is the primary reason for the Chicano's rejection of modern medical treatment. Their findings suggest a "milieu effect" rather than a set of specific and isolated factors inhibiting acceptance of the treatment regime by the subjects of this research. That is, it is the combination of low SES and the sociocultural adaptation to economic scarcity (i.e., reliance on the collective support of family and community) which

affected their behavior. Nall and Speilberg also suggest that this system operates among disadvantaged ethnic minority groups in general and is not peculiarly Chicano.

While these studies do not suggest that social-economic status is the only factor affecting underutilization, they do suggest that it is a contributing factor that should not be ignored or underemphasized.

## Reliance on Alternative Resources or Use of Informal Resources

As mentioned earlier, this section will be subdivided into the following six areas: the extended family, friends, religion, medical doctors, ethnic community workers, and curanderos or folk healers.

Reliance on the extended family. More has been written on the nature and prevalence of the Chicano extended family than on any other facet of his or her life. This is especially true of the literature dealing with mental health. Consistently, most of the literature on the utilization of mental health services by Chicanos gives the Chicano extended family as a factor in explaining their underutilization. The role of the Chicano family has been approached from two major perspectives. The first focuses on the supportive, preventive function of the family which operates in such a way as to lessen some of the effects of stress thereby preventing deterioration into the more severe states of psychological disorder. The second focuses on the tolerant or protective function of the family where they are more tolerant of deviant psychotic behavior in the home, or acting to protectively shield severely disturbed family members from coming into contact with those outside their family, including institutions and their agents.

The assumption that Chicanos have fewer mental health problems because of the supportive function of the family stems primarily from the work of Jaco (1957, 1959, 1960) and Madsen (1964, 1969). Jaco conducted a two-year study involving all bona fide residents of the state of Texas who were diagnosed as having a psychosis and who sought either public or private treatment for the first time in their lives during 1951-52. He found that Chicanos had a lower incidence rate of treated psychosis than Anglos and Blacks. He assumed that Chicanos have a lower incidence of severe psychiatric disorders or mental illness than the other two groups, and that this was due to the preventive function of the Chicano family. In his 1959 report he concluded:

> Since epidemiological data of this kind can only offer etiological hypotheses rather than proof, the influence of the subcultural system of the Spanish speaking group in preventing major mental disorders such as the psychoses from occurring to the same extent as other groups within the same area is still subject to considerably more inquiry. In terms of existing knowledge about their subculture and the known incidence of mental disorders reported in this survey, however, it is likely that the patterns of living peculiar to the Spanish speaking people contribute in some measure to their good mental health status. (p. 484)

Madsen (1969) conducted a four-year study from 1957 to 1961 in Hidalgo County, Texas. His project was a comparative study on differential culture change and mental health among Chicanos and Anglos. He also believed that there may in fact be less mental disorder among Chicanos than among Anglo Americans. He explains this by suggesting that stress falls more heavily upon the Anglo because it falls upon him as an individual, whereas stress among Chicanos is shared and relieved by the family. In discussing stressful situations, he states:

> The family also serves as an anxiety-sharing and anxiety-reducing mechanism in stressful situations. The Chicano seldom faces a crisis alone. Even when a man fails to prove his

> machismo, his family stands behind him and finds external causes for his inability to fulfill the male sex role. (p. 239)

He goes on to say:

> Although anxiety-producing stresses are abundant in both ethnic groups, these stresses tend to produce different kinds of anxiety. Anglo stresses fall squarely on the shoulders of the individual, who has only himself to blame. Stress situations among Mexican Americans are less likely to produce mental illness because they are shared by the family group. Moreover, it may be an important fact that Mexican Americans do not worry about the possibility of mental illness as much as Anglos do. (p. 239)

Neither Jaco nor Madsen provide supporting empirical data for a direct causal relationship, so their conclusions can only be considered speculative.

Other studies that point out the stress-reducing interaction and the extended family mutual-aid mechanism as a source of flexible and enduring emotional support are those of Samora and Lamanna (1967), Frumkin (1961), and Sotomayor (1971). However, none of these studies have examined the relationship between resort to kin for emotional support and any specific mental health indicators such as self-esteem, personal efficacy, anxiety reduction, or perception of well-being. More recent data indicates little difference between Chicanos' and Anglos' tendency to consult with relatives about emotional problems. Keefe, Padilla and Carlos (1978) gathered data on family and mental health over three years (1975 through 1977) in three southern California towns: Santa Barbara, Santa Paula and Oxnard. They concluded that both Anglos and Chicanos rely on their family for help, the fundamental difference being the kinship structure of the two ethnic groups. Chicanos were much more likely than Anglos to have large numbers of their relatives living in the community. The Chicano kin groups were well integrated and encompassed three or more generations. Anglos, on

the other hand, tended to live apart from their extended family or had only a few related households nearby.

Keefe et al. concluded that "there is little reason to believe that the presence of the extended family can be the reason for any alleged lower incidence of mental illness among Mexican Americans" (p. 65). They also mentioned two consequences of reliance by Chicanos on the extended family as virtually the only informal emotional resource:

> First, this means that Mexican Americans who do not have a local kin network are not very likely to have substitute sources of help at hand in times of stress. This is particularly troublesome for Mexican immigrants who are least likely to have a locally integrated kin group. Secondly, those Mexican Americans who lack a well-integrated family may undergo additional stress because theirs does not correspond to the normative or the ideal family system. (p. 66)

They believe the absence of the extended family or its malfunction must be that much more distressing. Rather than accentuating the strength of the Chicano family and its superiority in the alleviation of emotional problems, they emphasized the intensified isolation and stress experienced by those Chicanos who lack supportive families.

Gilbert (1978) conducted a study of second-generation Chicanos living in two southern California locales. The sample of 119 was almost evenly divided between city dwellers and residents of a small town. In each locale, the sample was further broken down into three groups: one-third lived in barrio neighborhoods with 65 to 100 percent Spanish surnamed, one-third lived in very heterogenous neighborhoods with 31 to 64 percent Spanish surnamed, and one-third lived in predominantly "Anglo" neighborhoods with 1 to 30 percent Spanish surnamed. She concluded that much variation exists among families in terms of who is integrated and how they are integrated into the

familial network of interaction and exchange. Factors found to greatly affect variation in family integration include the availability of different kinds of kin, their proximity, the income level of recruiting individuals, and genealogical distance. Her findings stated that the extended family among Chicanos is not a unitary and constant configuration, nor are norms of obligation unvaryingly extended over the entire universe of kin. From these findings, she does not support the idealistic view that all Chicanos have an immediate source of emotional and material help in any and all of their kin.

The Chicano family has also been viewed as being more tolerant of deviant psychotic behavior in the home, thus leading to the avoidance of or delay in seeking treatment. Some have suggested that the family acts as a protective shield keeping severely disturbed family members from coming into contact with non-family members, including hospitals or other mental institutions. Torrey (1972), in discussing the possible explanations for the underutilization of Anglo psychotherapists by Chicanos, blames the family structure for this underutilization. He gives the following explanation:

> Mexican American families are often close and interdependent. They are expected to provide mutual support in crises and not to seek outside help. Taking problems to someone who is not a family member constitutes loss of face for the whole family. Furthermore, it is said that such families tolerate a greater degree of deviant behavior and therefore make psychotherapeutic help less necessary. (p. 119)

As reported earlier, Fabrega, Swartz and Wallace (1968a, 1968b) compared Chicano schizophrenics with Black and Anglo schizophrenics from Texas state mental hospitals. Their comparisons indicated greater severity on the part of the Chicanos. They suggested that Chicanos

delay longer than other groups in seeking psychiatric treatment because their families are more tolerant of deviant behavior.

Burruel-Gonzales (1975) studied the definitional process among Chicanos from Denver, Colorado, and its effect on utilization of mental health services. She found a statistically significant association between family handling of the mental problem and delayed utilization of mental health services. Burruel-Gonzales suggests that the two variables which contribute most extensively to delay in utilization of mental health services were the family initially disregarding the patient's behavior and seeking other forms of assistance for the mental disturbance.

Studies on the Chicano family, especially those comparing it with other ethnic groups, indicate the need to examine the dynamics of family life in search of denominators of satisfaction and dissatisfaction in relationships and the different ways that different groups might get emotional support. Research also seems to need to control certain variables such as education, socioeconomic status, ethnic group biases in the assessment of severity of mental health, etc. However, whatever the shortcomings of research and whatever the basis for emotional support, the actual reliance on kin by Chicanos appears to occur.

Ramirez (1979) in his proposal for research on the role of the Chicano family in seeking mental health help makes a very interesting and valid point. He states that researchers, even Chicano researchers, too often make the unwarranted assumption that greater reliance on traditional mental health resources is the ultimate and apparently ideal goal for Chicanos. He points out that if there is in fact a

culturally dictated Chicano structure which functions in such a way as to buffer and protect an individual under stress, and thereby prevent deterioration into more severe states of disorder, portraying mental health centers as being better resources seems logically to run counter to reinforcing the family's natural helping role.

In their report on research on the family environment of drug using and non-drug using Chicano youth in Detroit, Michigan, Dwarshuis, Kolton, Calvillo, Cruz and Arellano (no date given) stated that the extended family concept was critical for immediate crisis counseling. They found that emotional support can be gained by one of the family members providing individual counseling, or by group counseling shared by the family members. Another critical aspect of the extended family noted by Dwarshuis et al. was that during times of crisis, more attention was focused on problem-solving rather than on trying to understand the behavior. Time was saved in trying to explain a specific life situation and its relation to the person being affected, and more attention could then be focused on the problem.

More and more Chicano mental health practitioners are realizing the importance of the Chicano family in relation to mental health. "The Chicano Plan for Mental Health" (1975), which was developed over a period of four years by some 400 Chicano mental health practitioners, states as much in the first chapter on the concept of the Chicano family. Dr. Ruben Duran, the final editor on this chapter, begins the first paragraph by stating:

> As a Chicano social institution, el concepto de la familia (the concept of the family) has had a profound and positive influence on the thinking and lifestyle of Chicanos for centuries. To be a member of a familia is to have that all-important feeling of belonging, secure psychologically in the knowledge that parents,

> brothers, and sisters, as well as members of the extended family, are equally concerned with one's physical and emotional well-being. The interrelationship between mental well-being and belonging to a familia is self-evident in that for centuries the familia has been the cohesive and protective force of the Chicano culture. . . (p. 1)

In their recommendations for mental health services for the Chicano, Duran goes on to say:

> To promote good mental health, we feel that the family is a social institution in the community must be strengthened not only because of the role it has played in preserving the culture, but also because it has served traditionally as a source of emotional strength and well-being. . . (p. 3)

Among others that recommend the inclusion of the family in mental health services are the Chicano Training Center, Houston, Texas, in the "Curriculum Schema," 1974; the Spanish Speaking Mental Health Research and Development Program, University of California, Los Angeles, in "Delivery of Services for Latino Community Mental Health," 1975; and the Centro del Barrio, Worden School of Social Services, in "Chicano Culture and Mental Health," 1978.

Reliance on friends. Reliance on friends is the least mentioned alternative. Both Madsen (1964b) and Rubel (1966) in their studies of rural Chicanos in the Rio Grande Valley in Texas mentioned the reluctance of Chicanos to expose their personal problems to non-family members. However, they both devoted some time to describing the concept of la palomilla. The word palomilla means moths that, as Madsen describes, "like the young men, cluster in groups around a light in the early evening" (p. 56). This group is described as a friendship organization that is particularistic, persons, voluntary, non-instrumental, has no group name, and is not identified with a particular territory, ingroup sentiments, or even persistence over time.

Both Rubel and Madsen mention the supportive role of the palomilla in two life crises situations: the transition period between betrothal and marriage, and bereavement over a deceased friend. Madsen also mentions that the need for a trusted companion usually leads to the development of a very close friendship with one other member of the palomilla who is known as an amigo de confianza (trusted friend or confidant). These two close friends get to know more about each other and share more than they experience elsewhere outside the family.

Keefe, Padilla and Carlos (1978) in the study already mentioned indicated that friends are less frequently mentioned by Chicanos, but that they are nevertheless a consistent secondary source of support; 26 percent of the first-year (first generation) sample and 16 percent of the second-year (second generation) sample talked to a friend. They concluded that while Anglos and Chicanos both rely frequently on family members, Anglos are more likely than Chicanos to turn to friends as well. Research on the reliance on family, as opposed to friends, should also study the availability of these two support groups, and attitudes toward utilizing these two support groups.

Reliance on religious practitioners. While most studies acknowledge that the majority of Chicanos are Catholic and most of the rest very religious, reliance on institutional religious practitioners for help with mental health-related problems is usually described as very limited. Madsen (1964b) in his study in the Lower Rio Grande Valley, described the Catholic priest as displeased with the folk practices of Chicanos and tried to get them to forsake these beliefs. Madsen believes this caused the Chicanos to disregard Catholic Church dogma and presented the increasing proportions of conversions to

Protestantism as evidence of the lack of strength of the Catholic Church. Gonzales (1967) in his study of Chicanos in New Mexico also reports on the increasing number of Chicanos becoming Protestants.

Grebler, Moore and Guzman (1970) conducted an extensive study in 20 selected urban areas of five Southwestern states as well as Chicago. They concluded that the majority of Chicanos is Catholic and arrived at the following as regards attitudes of the Catholic Church and the Chicano for each other: on the Church's attitude they stated ". . .is the clergy's prevailing view of these people as uninstructed in the faith and deficient in their adherence to the general norms of Church practice" (p. 449); on the Chicano's attitude they stated:

> . . .pastor's concern with strictly religious functions is understandable in light of the religious practice and attitudes of Mexican Americans. What was said previously about the clergy's historical perception of the Mexican immigrant applies to contemporary Mexican Americans as well. Large numbers of Catholics in this population do not conform to the norms of the Church. (p. 473)

Their Los Angeles and San Antonio survey data showed that only 5 percent of those professing a religion are Protestant, so they concluded that statistically, Protestantism is not important in the Chicano population.

Clark (1959) conducted a study in a community in San Jose, California and observed that the Catholic Church is a force for retention of Mexican culture patterns among Chicanos in the United States, and that "it deters assimilation of the group into the majority culture" (p. 117). She also observed that competition between Catholic and Protestant churches intensifies social cleavages in Chicano communities. As in the studies mentioned above, she concluded that religious

practitioners are not an important source of support consulted by Chicanos for mental health problems.

More recent research seems to indicate a difference. A study done by Keefe, Padilla and Carlos (1978) over a three-year period in three towns in the South showed clergymen are one of the four most common sources of support consulted by Chicanos with emotional problems. Clergymen were more commonly consulted with regard to marital (or boyfriend/girlfriend) or family (parent/child) problems. Their study showed 16 percent had seen a clergyman in the past year and 24 percent had seen a clergyman at some time in their lives for an emotional problem.

Future research should pay close attention to the role of religious practitioners in regard to support of mental health problems. Emphasis should be on the strength of religious beliefs, attendance of religious services, and adherence to church practices, as well as to the type of emotional problems that religious practitioners are consulted about. Urban versus rural differences should also be considered.

Reliance on medical doctors. The assumption that Chicanos are afraid and suspicious of physicians and health care facilities and therefore do not utilize them for physical or emotional problems resulted from some early research on Chicanos from rural areas such as studies by Madsen (1961, 1964b) and Saunders (1954). Madsen, after interviewing a few rural Chicanos from Hidalgo County, Texas, concluded:

> The Mexican Americans are highly sensitive to behavior of the physician, which seems to reflect a feeling of unwarranted superiority over other men. A physician may receive some respect

> for his formal training but the Mexican American often feels that the doctor has not learned enough. . .The Mexican American is insulted when his self-diagnosis is dismissed by the physician or denounced as superstition. . .The "immodesty" of the physical examination alienates many Latins. . .The physician's diagnosis is phrased in scientific terms that the lower-class Latin does not understand or even attempt to understand. (pp. 93-95)

Subsequently, Madsen (1964b) observed:

> In spite of their objections to modern medicine, Mexican Americans are going to physicians for treatment of an increasing number of ailments. Latin parents are particularly conscientious about taking sick children to the doctor when there is the slightest cause for alarm even though the cost of medical treatment may impose a severe financial strain on the family. . .In doubtful cases, the family takes the sick member to both a physician and a curer. (pp. 96-97)

Saunders studied six New Mexican families composed of "fifteen adults, twenty-three children, two dogs, three cats, a few rats, mice enough to keep two of the cats sleek and contented, and an assortment of lice, bed-bugs, fleas, roaches, spiders, flies, and other pests" (p. 12). He attempted to place health care behavior in a cultural perspective, and from these six families he concluded that the core of Chicano health culture is folk medicine. He stated that the Chicano sees health as a matter of chance and that there is very little a person can do to maintain it. Saunders suggested that Chicanos believe that many diseases are caused by magic and bewitchment, and a folk healer (curandero) or witch (bruja) is consulted for most diseases. It is only in more serious cases, and only if the disease is thought to be "natural" (i.e., not caused by magic or bewitchment), that a physician should be consulted.

More recent studies report frequent use of scientific health care by Chicanos, especially by urban Chicanos. Farge (1977) conducted a study in three areas in Houston, Texas, chosen for having a significant

percentage of Chicano population, median income, median level of education, and percentage of high school graduates over 25 years of age. He found that of the respondents, only 43.9 percent expressed belief in the effectiveness of folk healers, while 98 percent expressed belief that medical doctors are helpful to people. His sample also confirmed that folk beliefs do not deter an individual Chicano from using clinical services.

Weaver (1973) conducted a survey in Orange County, California, and compared Chicanos and Anglos. He found Chicanos and Anglos express approximately the same level of preference for receiving health care from private physicians or hospitals. He found 57.3 percent of the Chicanos and 58.4 percent of the Anglo respondents received regular medical checkups. For regular dental checkups, the rates were 54.0 percent for the Chicanos and 56.5 percent for the Anglos. These similar rates are interesting since the Chicano sample contains twice as many families reporting a total income of $6,000 or less and averaging 2.4 children, compared with 1.4 children for the Anglo group.

Torrey (1972) mentions Chicanos use physicians rather than Anglo psychotherapists for mental health problems. He believes this is true since most groups with low incomes in the United States probably use family physicians for emotional problems rather than going to a professional psychotherapist. However, he believes this is, at most, a partial explanation for the underutilization of mental health services by Chicanos. He cites Karno and Edgerton's survey in East Los Angeles which revealed that the percentage difference between Chicanos and Anglos in the same area was only 9 percent.

Keefe, Padilla and Carlos (1978) in their three-year study in three southern California towns found that 21 percent of the respondents in the first survey and 25 percent in the second survey went to a medical doctor for an emotional problem. They found physicians are most often consulted for emotional problems not recognized as family related, especially those which have physical symptoms. Respondents mentioned going to a doctor for alcohol related problems and coping with a serious physical illness. Respondents also added that one of the reasons they chose a doctor for help was their belief that some type of medication was required.

Welch, Comer and Steinman (1973) conducted a study in four communities located in two of the four counties that are centers of the Chicano population in Nebraska. They used a mixed rural/urban sample to ascertain their attitudes toward medical care and doctors, and to determine what kinds of medical care they were receiving. They found 91 percent of Chicanos in their sample had a family doctor, compared to 84 percent of Anglos. They found attitudinal characteristics made little difference in health care seeking behaviors. Utilization of health care resources was found to be more related to social characteristics than to attitudes. This finding was related to the availability of some minimal kind of medical care for low income people, and the availability of some kinds of medical care services through school and job.

Most studies seem to support the belief that urban Chicanos appear to accept modern health care, and that medical doctors are readily consulted for both physical and emotional problems. Studies on utilization of physicians for emotional problems should examine the

availability of alternative services, as well as differences in urban/rural sample, education and other social characteristics.

Reliance on ethnic community workers. Probably the least frequently sought source of support mentioned is community leaders and organizations. Among the few researchers to have mentioned them as important are Grebler, Moore and Guzman (1970; Moll, Rueda, Reza, Herrera and Vasquez (1976); and Torrey (1972).

Grebler et al. referred to them as "informal social workers" and described them as:

> . . .individuals who have the respect and trust of people on the neighborhood level. They are persons to whom local residents turn for guidance when they want community projects, or when they need translations from English and from the special language of bureaucracy. They are in many ways the most "natural" of all the ethnic intermediaries. They are not appointed or elected. They draw no salaries and are not even called leaders. (p. 550)

Torrey talks about the same individuals, but calls them by a different name. His description is as follows:

> Another type of psychotherapist used by Mexican Americans are what I have called mental health ombudsmen. These are at least as important mental health resources in Santa Clara County as curanderos are, though I am not aware of descriptions of them elsewhere. They are the community leaders to whom people turn with problems. In some cases these individuals overlap the political leadership as well. Their role is similar to the all-understanding ward bosses of the past who were politically important but who also served as a listener, adviser, legal counsel, social worker, and referee for individual and domestic problems of all kinds. (p. 123)

Keefe, Padilla and Carlos (1978) in their study in southern California found that this source was not utilized that much, or at least not in their sample. They found community leaders were asked for help with an emotional problem by 9 percent of the first-year sample. In the second survey, it was even lower with only 3 percent of Chicano respondents ever consulting a community worker and only 2 percent ever

talking to a member of a voluntary organization to which they belonged.

Reliance on curanderos or folk healers. Perhaps the most controversial and certainly the most "cultural" explanation provided for underutilization of mental health services is the presence of folk medical beliefs and the associated utilization of curanderos or folk healers or curers by Chicanos. There is a growing number of studies on the subject with contradictory hypotheses, results and conclusions. Earlier studies, especially those done in rural areas, state that curanderismo is widely utilized. More recent studies, especially those done in urban cities, state curanderismo is not utilized to any significant level. Some studies state that even though curanderismo is utilized, it is still utilized along with traditional mental health services and is not a cause of underutilization.

The curandero, who has no counterpart in the Anglo culture, has been traced to antecedents in both the Old and New Worlds by several researchers (Graham, 1976; Schendel, 1968; Beltran, 1973; Sharon, 1972; Kramer and Sprenger, 1971). The curandero is said to be the descendant of the old Aztec ticitl. The ticitl belonged to a category of Aztec physicians of the type usually found among Neolithic peoples. They were comparable to the shamans or "medicine men" of the nomadic North American Indians and the "witch doctors" of African tribes. The European counterpart of the curandero was looked upon as a witch in league with the devil rather than a religious figure in the service of God. In some South American countries, it is often difficult to distinguish between a brujo or bruja (sorcerer or witch) and a curandero because like the brujo, the curandero sometimes uses black magic

to cause injury. In Mexico and the United States, the curandero uses only white magic to heal and the brujo uses only black magic to injure.

The curandero or healer has been classified into different kinds and also into different positions of healing power or hierarchy. Romano (1973) classified the healing hierarchy into ten positions. He begins the sphere of influence at its most minimal expression and proceeds to the maximal in terms of numbers of followers and geographic area involved. His hierarchical spectrum follows:

(1) Daughter: This minimal position is usually occupied by the daughter. If the girl continues successfully, she then tends to acquire a reputation and her sphere of healing may extend to include close friends of the family. The fate of child healers is varied--some may continue their work for a number of years, while others quickly go back to the relative obscurity of their own private lives.

(2) Mother: The sphere of influence of the mother in a given household is the membership of that household. Again, the healing ability tends to be differentiated between persons, and when this is coupled with a clear willingness to freely assist neighbors, a particular mother may become a neighborhood healer.

(3) Grandmother: For the grandmother, the sphere of inflience is contained within the broad limits of the extended family, crossing bilaterally as the occasion and her own daughter(s) may deem necessary. Also, the grandmother is the catalyst between the world of the practitioners and the family circle.

(4) Experienced neighbor: This person is normally over 40 or 50 years of age, male or female, single or married, and of relatively good standing in the community. It is only upon specific request that

such a person should render services. The role of this person is less that of a diagnostician and more that of an adjunct to home diagnosis. Most often, his or her performance centers around the giving of instructions on preparation and proper dosage of remedial measures.

(5) Full-time healer: The full-time healer is a person whose healing practices have demanded his or her attention to the exclusion of other activities. This person is either single or married, however, single individuals predominate in this category. This type of person is the one whom most people refer to as curandero or curandera. Only upon relatively complete acceptance by the general public is the term used without qualification, for it is not a term that is granted freely to anyone who claims for himself or herself the power to heal. Common here is also the ascription of his or her power to a divine vision or visitation, and thus the practice takes on the proportions of a divine mission both in the eyes of the healer and his or her followers.

(6) Town or city healer: There is little difference between the town or city healer and his full-time counterpart in the neighborhood as far as specific procedures are concerned. The sphere of influence does vary, and in this category there is crossing of neighborhood lines to encompass the more inclusive urban entity. The reasons for this are varied, such as performing a "dramatic" cure which is reciprocally recognized in an equally dramatic manner by a gift of some consequence, the cure involving a well known or wealthy person, as well as a particularly difficult case. The occasion must elicit widespread interest and a subsequent increase in recognition of the healer's abilities and power.

(7) Regional healer: Much of the foregoing may result in the spreading of the healer's fame and reputation to the surrounding urban and rural regions, and his or her practice may now include these places. At this level, the time required for healing services to the public is so consuming that the reciprocity extends to whatever the practitioner requires to sustain life and his or her practice.

(8) International healer: Usually associated with an internationally famed healer is a cycle of stories concerning various healing experiences which have essentially constituted obstacles which he or she has overcome in the course of his or her fame as practitioner. Throughout the time the healer's fame is spreading, he or she must not flaunt wealth in any ostentatious manner unless it is directly related to his or her practice, such as in the form of a shrine, garden, plants, or any other items which will enhance the setting where the healer has his or her practice.

(9) International religious folk-saint: If exceptional fame is achieved, it may be that the same cycle of stories told during his or her life will continue to be repeated after his or her death, and the reputation of exceptional cures and services is perpetuated. In death, now, the spirit of the healer is considered as being nearer the source of the original power (God), and he or she may be seen as possibly interceding with the Supreme Divinity on behalf of the living. A pattern of reciprocal recognition prevails in a religious form in that candles may not be lit, a wreath of flowers offered, or prayers to his or her spirit may be said. The functions are now in the manner of a saint, although there is no formal recognition by the Catholic Church. This is why Romano uses the term "folk-saint." Other healers

may now use this folk-saint as their patron or guide and adopt him or her as a divine personage, conduct their practices in his or her name, make supplications to his or her spirit, and even construct an altar with his or her name or picture as the main item. In this manner, the folk-saint represents an intermediate, integrating position between the temporal world of healers and the spiritual, as well as formally religious, aspects of healing.

(10) International religious formal saint: The saint stands at the top of the hierarchy, for he or she is considered nearest the ultimate healing power and his or her power is potentially unlimited. Saints may function in a number of different contexts, such as a personal guardian or patron of an individual healer or person, as a regional saint such as Our Lady of Guadalupe is for Mexico as a whole, or internationally recognized with a particular specialty in healing such as Our Lady of Lourdes.

Curanderos have been classified into different kinds by different researchers. Weaver (1970) makes a distinction between: (a) a medico or medica, a curandero or curandera with superior knowledge in treating a particular disease or condition; (b) a sobador or sobadora, a curandero or curandera who is especially adept at massage, or a masseur or masseuse who knows little about other treatments; (c) a partera, a midwife who theoretically restricts her practice to prenatal care and the delivery of babies, but is often also a curandera and sobadora; (d) an albolario or albolaria (sometimes called a medico or medica) who has a special aura of magical or mystical power not associated with other folk specialists since he or she utilizes magical curing techniques. He or she is sometimes also called a divinador or

divinadora (diviner) and is believed to be a reformed witch whose life is under constant threat from revenge seeking witches.

(1972) makes similar distinctions between curanderos. He defines the adivino who simply diagnoses the illness but does not treat it, the albolario who relies mostly on herbs for treatment, the medico who also relies on herbs, and the magico who combines herbs with spiritualism. He puts spiritualists, also called mediums, in a separate category. He also distinguishes between spiritualists and spiritists, the first being thought of as much more religious. Torrey defines the curandero or curandera as a healer who came to his or her profession by divine election, this election being revealed by way of a dream, voice or vision and usually occurring at an early age. Alternatively, or in addition to this election, they may apprentice themselves to an older curandero.

The folk disorders or illnesses are classified by the nature of their causes. Granger (1976) classifies them as being brought on by emotion, dislocation of organs, magic, or a hot/cold imbalance. He also includes two other categories--other folk diseases not specified, and Anglo diseases such as pneumonia or appendicitis. Torrey classifies illnesses into three main causes: natural causes, for example empacho where symptoms are caused by a bolus of food lodged in the intestine; emotional causes, for example susto, caused by fright, bilis, caused by anger, and envidia caused by desire; supernatural causes which may be caused either by God as punishment or by others, for example mal de ojo (evil eye) and mal puesto (witchcraft).

Chicanos consult curanderos for a variety of reasons. They go to a curandero or curandera for physical illnesses, mental illnesses, social and domestic problems, and divining the future. They may consult him or her to have better luck in getting a job or finding a boyfriend or girlfriend. They might consult him or her to get a family member released from jail or prison or to get a winning lottery ticket. The belief in curanderismo and the utilization of curanderos is very contradictory in the literature. Some researchers (Jaco, 1957; Creson, McKinley and Evans, 1969; Bruhn and Fuentes, 1977; Kiev, 1964, 1968; Madsen, 1964; Senter, 1947; Martinez and Martin, 1974; Torrey, 1968, 1969, 1972; Rubel, 1966; Meyer, 1977; Clark, 1959; Saunders, 1954; Schulman, 1960; Granger, 1976; Graham, 1976; and Knoll, 1971) indicate that belief in and utilization of curanderos is widesphread among Chicanos.

Jaco (1957) in his study of all inhabitants of the state of Texas who sought psychiatric treatment for a psychosis states that "the frequency of practicing 'witch-doctors' in the Latin American communities of the Southwest indicates this lesser acceptance of 'Anglo medicine'" (pp. 327-328). Creson, McKinley and Evans (1969) in their study in a small city in Texas found 48 percent of their subjects were members of families that utilized the skills of folk healers and 80 percent had a good knowledge of the tenets of folk medicine. They also found that subjects who believed in folk medicine were also likely to use scientific medicine. Bruhn and Fuentes (1977), based on a review of the literature, concluded that "many Mexican Americans place all their confidence in folk medical treatment and would not consult a licensed physician regardless of the disease" (p. 609). Senter's study in

New Mexico, Granger's study in Arizona, Knoll's study in Michigan, Kiev's study in Texas, and Rubel's and Madsen's separate studies in rural Texas, without giving any specific statistics or figures, either imply or state that Chicanos' use of curanderos as alternatives to conventional psychotherapy in response to emotional problems is widespread. Torrey, in his study in California, does not give any statistics either--but makes this statement:

> Coincidental with the fact that Mexican Americans underutilize Anglo psychotherapists is the fact that they do use their own psychotherapists. These therapists include a broad range of individuals from housewives to traditional curanderos (female: curandera) to community leaders who function as mental health ombudsmen. (p. 119)

Martinez and Martin (1966) conducted a study on 75 Chicana housewives living in a public housing project in a large Southwestern city and found that 97 percent of the women knew about the five folk diseases which they were questioned on. While only one-fifth reported knowledge of a curandera and a similar proportion admitted having sought the services of such healers, they concluded:

> The findings provide additional evidence that belief in folk illnesses and use of folk healers continue to be widespread among urbanized Mexican Americans. Participation in the system of folk beliefs and curative practices by no means, however, precludes reliance upon physicians and use of medical services for health problems not defined by folk concepts. Thus, many Mexican Americans participate in two insular systems of health beliefs and health care. (p. 150)

Meyer (1977) also mentions that it has been his experience as an Anglo psychiatrist that Chicanos have two coexisting systems utilized interchangeably by many patients. Graham (1976) gives the reason for this:

> Thus, it is apparent that for whatever reasons, Mexican Americans continue to rely heavily upon the folk medicine system of their culture, even though they may utilize scientific medicine as well. One of the most significant--and in Anglo culture most often overlooked--reasons for this is that many of the folk cures work, and

> as Saunders points out, "it (folk medicine) requires only occasional success to maintain its vigor." (p. 177)

More recent research, especially on urban areas, indicates that utilization of curanderos is not that widespread. Keefe (1978), Farge (1975, 1977), Keefe, Padilla and Carlos (1978), Padilla (1976), Karno and Edgerton (1969), and Welch, Comer and Steinman (1973) all indicate that the use of curanderos is small or insignificant.

Keefe in her study in three southern California cities, found that curanderos were never mentioned as the first place to go for help when someone has an emotional problem in general, and the use of curanderos by respondents themselves was extremely low, with only 2 percent reporting seeing a curandero in the last year for an emotional problem. Keefe, Padilla and Carlos found in their second survey, only 7 percent (27 respondents) reported ever seeing a curandero. Of these 27 respondents, 4 went to a curandero for a folk illness, and 3 went for an emotional problem.

Karno and Edgerton in their study in East Los Angeles concluded that the underrepresentation of Chicanos in psychiatric treatment facilities was due to a complex of social and cultural factors and of the relatively lesser weighting were such matters as folk medicine, folk psychotherapy, and "Mexican culture" in general. Welch, Comer and Steinman reached a similar conclusion in their study of Chicanos in Nebraska. They stated that their sample showed little evidence of a prevailing "folk" medical culture. They found that attitudes relating to utilization of health care generally resembled those in any low and moderate income community.

Farge conducted a study in Houston, Texas, to test some of the hypotheses of past research on Chicanos. At least in Houston, he found most hypotheses were not confirmed. Saunders' first hypothesis, that folk medical beliefs and practices are the rule among Chicanos, was not confirmed. Of the sample, only 34.9 percent expressed belief in folk illness and 65.1 percent expressed disbelief. Saunders' third hypothesis, that Chicanos who are younger and who have more cultural overlap with Anglos will be more scientific in their health attitudes, also was not confirmed. Two of the components of social-economic status (SES), higher education and having a skilled job, render one less likely to adhere to folk medical beliefs and practices. However, the third component, level of income, was not associated with difference in folk medical beliefs (p. 75). Rubel's hypothesis that folk healers are more identified with Chicanos who esteem their heritage, was not supported (p. 5). Moustafa and Weiss' hypothesis that low utilization of health care services is a function of a negative attitude toward Anglo institutions and a high level of folk medicine was not confirmed. Farge found no difference in utilization between those who showed less or more resistance to Anglo institutions, nor did a high level of belief in folk medicine have any association with utilization (p. 5). Weaver, Martinez and Martin's same hypothesis that folk beliefs do not deter an individual Chicano from using clinical services was confirmed in the sample. It was found that utilization and belief in folk medicine were unassociated.

Frequency and Severity of Mental Illness

Like the literature in the previous section on the utilization of alternative resources, the literature on the mental health status or frequency and severity of mental illness of the Chicano is also contradictory. There is one school of thought which adheres to the belief that Chicanos have fewer emotional problems than Anglos and other groups and therefore, need less mental health care, resulting in Chicanos being underrepresented in mental health services. On the other side, there are those who believe Chicanos are more likely to have certain types of emotional problems as opposed to Anglos and other groups, and their underrepresentation in mental health services only points to a greater rate of underutilization of these services.

The assumption that Chicanos have fewer emotional problems stems generally from early studies on the Chicano family, especially the studies by Jaco (1957, 1959, 1960) and Madsen (1964a, 1964b, 1969). From his study on the inhabitants of the state of Texas who sought psychiatrists for the first time in their lives, Jaco found the rate for Chicanos was lower than for Anglos and non-whites, and he concluded that the Chicano must have a lower frequency of mental illness. He attributed this to certain aspects of the Chicano culture:

> . . .it is also likely that a major part of the Spanish American social structure is functioning as a protection against stress for its members. This is especially true of its kinship system, providing a highly integrated, continuous, and "familistic" unit. Therefore, this sub-culture is more likely than other ethnic groups in Texas today to contain therapeutic agents that may guard against prolonged stress and thus reduce the incidence of psychosis among its members. However, as this sub-culture becomes assimilated into the dominant culture of the Anglos, one can predict that the incidence of mental illness will increase correspondingly and become more like that of the Anglos in form as well as frequency. (1957, p. 328)

Madsen (1969) arrived at the same conclusion from his study in south Texas. He seems to agree with Jaco:

> These facts would seem to reinforce Jaco's theory that the more conservative Mexican American will be mentally healthier than the Anglo American and that the acculturating Mexican American will fall between these two extremes. (p. 221)

Madsen attributes this to several factors. He believes that the Chicano has a sharper sense of identity than the Anglo and has fewer role conflicts. He believes that the Anglo has a number of roles, many of them conflicting, and his self-image shifts as he moves from one social institution to another. Madsen also credits the Chicanos' world-view which enables them to blame failure on witchcraft or fate without suffering the feelings of guilt and self-doubt which plagues Anglos when they experience failure. He also agrees with Jaco that the Chicano family serves as an anxiety-sharing and anxiety-reducing mechanism in stressful situations.

Other researchers argue with this assumption and point out that Chicanos experience as much stress, and possibly even more stress, than do members of comparable ethnic minority groups. Karno and Edgerton (1969) and Torrey (1968, 1969, 1972) point out that Chicanos are subject to five major sources of massive psychological stress indicators which are correlated with mental breakdown or detrimental to adaptive psychological functioning and subsequent need for treatment. These five indicators are: (1) the poverty cycle which results in limited education, lower income, depressed social status, deteriorated housing, and minimal political influence; (2) poor communication skills in English; (3) the survival of traits from a rural agrarian culture which are relatively ineffectual in an urban technological

society; (4) the necessity of seasonal migration for some Chicanos; and (5) the very stressful problem of acculturation to a society which appears prejudicial, hostile and rejecting. They concluded that the consequences of these sources of stress would include a greater incidence of mental illness, and the problem of underutilization of mental health services by Chicanos implies a greater problem. "The Chicano Plan for Mental Health," as mentioned earlier, was developed over a four-year period by over 400 Chicano mental health practitioners and emphasizes the unusual stresses caused by such conditions as discrimination, oppression, poverty and language barriers. The pressures included by Burruel and Chavez (1974) are poverty, poor housing, low educational levels, unemployment, cultural and identity conflicts, and social pathology.

Some researchers argue that Chicanos are more likely than Anglos to experience certain types of emotional problems, or some forms of self-destructive behaviors. Paine (1977) conducted a study in a Chicano community in Houston, Texas, to record beliefs, attitudes and drinking habits of Chicanos. The community is located in the Houston Police Master District 11 which ranks fifth among 20 districts in drunkenness arrests. The district also ranks eleventh in arrests for driving while intoxicated. From their sample of 147, over 65 percent believed an alcoholism problem existed in their community, and over 33 percent considered the problem severe.

Padilla, Ramirez, Morales and Olmedo (1977) conducted a substance abuse survey among 9- to 17-year-olds in five East Los Angeles housing projects. They found 13.1 percent of the respondents, which was 13 times higher than the national sample, had used inhalants the week

before. A high of 28.7 percent, which is twice the national sample, had used marijuana the week before. The use of alcohol was 28.9 percent as compared to the national sample of 32.4 percent. The use of alcohol in the "used ever" category was 50.8 percent for the Chicano East Los Angeles sample as compared to 53.6 percent for the national sample. "The Chicano Plan for Mental Health" mentions that addiction to heroin has been the curse of Chicano males since World War II. They cite the increase in addiction of Chicanos in the Southwest is reflected in the increased admission rate of Chicanos to the Lexington and Forth Worth hospitals. The number of Chicanos in these hospitals for the addicted has increased from 102 in 1961 to approximately 400 by 1967.

Two other types of destructive behavior have been mentioned by Morales (1978) involving Chicanos. These are juvenile delinquency and riot related problems. Morales states that currently in Los Angeles, gang violence against the community as well as between gangs is on the increase. There have also been a rising number of youth killings, of which at least half are attributable to intergang violence. Morales also mentions that approximately 40 riots took place in Chicano communities between 1970 and 1972 in various parts of the Southwest, and in East Los Angeles in particular, there were eight destructive riots during 1970 and 1971.

Caution must be used in interpreting some of the results of research on the different types of destructive behavior by Chicanos. Some studies, like Morales' study on juvenile delinquency and riots and Paine's study on the use of alcohol by Chicanos, do not give comparative data on other groups which makes it difficult or impossible

to state the relative significance of such findings. It is not scientific to state that differences exist without seeing the evidence from more than one group. Even when comparative data is given, care must be taken in its analysis. Statistics may be misused if taken too literally. Morales points out that incidence of riot behavior, drunk-driving arrests and drunkenness may merely reflect variations in police practices. Morales conducted an in-depth study on the problem of police-community relations pertaining to Chicano perceptions of selected law enforcement policies and practices in East Los Angeles. He found that 65 to 80 percent of the sample believed law enforcement officers in East Los Angeles were using "insulting language," "rousting and frisking citizens," "stopping and searching cars without cause or a good reason," and using "unnecessary force" in arrests, custody, and handling riots when they involved Chicano citizens. Morales also states that a second aspect of police practice is the tendency to assign more police to patrol the Chicano community than the white community. This, he believes, increases the likelihood of police observing certain kinds of behavior, such as curfew and traffic violations and drinking behavior. As an example, he gives the number of drunk and drunk-driving arrests. The Chicano area in East Los Angeles, with a population of 258,275, has an average of 9,676 drunk and drunk-driving arrests per year compared to the 95 percent white West Valley area, with a population of 260,832 where there are only 1,552 drunk and drunk-driving arrests per year. Morales notes that 375 officers, averaging 13.5 officers per square mile, were assigned to the Chicano community as compared to 151 officers, averaging 3.5 officers per square mile in the white community.

## Attributes of Mental Health Clinics and Services

Of all the reasons for underutilization of mental health services by Chicanos, attributes of mental health clinics and the services they provide seem to be cited in the literature most often. Both Chicano and non-Chicano writers seem to agree that institutional policies and services themselves discourage Chicanos from utilizing their services or from continuing to utilize their services after initial contact. The following aspects of mental health services have been criticized: the location and accessibility of mental health services; the availability of Chicano mental health professionals, including psychologists, psychiatrists, psychiatric nurses and social workers; traditional middle class clinical and therapeutic orientation; language barriers; and culture-bound diagnosis and treatment.

### Location and Accessibility of Mental Health Services

Most writers that criticize aspects of mental health services mention location and accessibility (Padilla and Ruiz, 1973; Alvarez, 1975; Keefe, Padilla and Carlos, 1978; Burruel and Chavez, 1974; Phillipus, 1971; Torrey, 1969, 1972; Karno and Edgerton, 1969). They mention that mental health services are inaccessible because they are often located too far from the Chicano community. This not only impedes the frequency of self-referrals, but also the cost of transportation and the lack of adequate child care during the absence of the mother serve to decrease the utilization of mental health facilities by Chicanos. Also mentioned is the prohibitive cost of services and inconvenient office hours which are usually inappropriate for the Chicano who cannot take time off from his or her job during the day.

## Availability of Chicano Mental Health Professionals

The lack of availability of Chicano professionals, including psychologists, psychiatrists, psychiatric nurses, and social workers has been mentioned for various reasons. Olmedo and Lopez (1977) and Yamamoto, James and Palley (1968) have found that patients with different cultural backgrounds from the therapists are less often offered or receive intensive therapy. They also feel the experience of being disadvantaged has left some ethnic minority patients with attitudes of distrust, disenchantment and hopelessness which causes them to leave treatment earlier. Kline (1969) states that Chicanos seem to identify psychiatry as "Anglo" and, therefore not a possible source of understanding and support. He feels psychiatric treatment can be relevant, but will not be accepted by the community as long as this identification, with its associated set of expectations, persists. This identification can be changed by the inclusion of Chicano professionals. Torrey (1969) presents a case for the utilization of the "indigenous therapist" in mental health facilities. He defines the term "indigenous therapist" as a person who is sanctioned by a particular culture or subculture to do "psychotherapy" even though he has not received training under accepted Western professional standards. He believes the indigenous therapist could be a useful adjunct to already existing services and a major part of the solution to the mental health manpower problem. He gives the role played by patient expectations in producing psychotherapeutic change as the first source of indirect evidence for the use of indigenous therapists.

## Traditional Clinical and Therapeutic Orientation

The literature on the approaches to traditional treatment and clients of ethnic minority or low socioeconomic status indicate that these approaches contribute to the underutilization of these two groups. Lorion (1973), after reviewing the studies on mental health services and socioeconomic status, concluded:

> Socioeconomic status correlates significantly and negatively with acceptance for and duration of individual psychotherapy, with experience level of assigned therapist, but not with a patient's diagnostic category or source of referral. These findings take on greater significance in that the data were drawn from records of clinics in which ability to pay was not a condition for treatment. (p. 266)

Yamamoto, James and Palley (1968) conducted a study with Anglos, Blacks, and Chicanos at the Los Angeles County General Hospital Psychiatric Out-patient Clinic and found that patients who stay in treatment longer are those who are the most "popular" with the therapists and have demonstrated a congruency of values and attitudes with those of the therapists. The results of their study were that patients from different cultural backgrounds from the therapists are less often offered or receive intensive therapy. They also felt the experience of being disadvantaged left the patients with attitudes of distrust, disenchantment, and hopelessness which caused them to leave treatment earlier.

Karno and Edgerton (1969) in their explanation of the underutilization by Chicanos indicate that the staff of mental health centers do not demonstrate respect, promote self-dignity, nor evidence cultural sensitivity. Karno (1966) states that an important factor operative in the clinic which may significantly contribute to therapeutic failure with ethnic patients is the pervasive use of and reliance upon a

model for the psychiatric historical interview, which derives directly from classical medical history. This formula reviews the patient's life problems, but excludes sociocultural factors when they may be important to diagnosis and treatment.

Burruel and Chavez (1974) also criticize traditional orientation in mental health diagnosis and treatment. They state:

> . . .when a Mexican American person seeks psychiatric services (if he gets that far) which thrive on ventilation and verbalization, he may not compare with his middle class Anglo counterpart, particularly if the therapist is Anglo and he adheres rigidly to the traditional therapeutic mode. One of two things may happen: the therapist may consider the Mexican American patient inept for psychotherapy or the patient may discontinue therapy. The therapist may label these patients "resistant or unmotivated" but rarely do they stop to examine what they may be doing wrong. (pp. 110-111)

Burruel and Chavez believe that the major factor in psychiatric clinics irrelevancy to many Chicanos seems to be that Chicanos faced with mental disorders are also confronted with numerous situational stresses which must be taken care of before they can be helped with their intrapsychic problems. They feel that many mental health professionals see this task as being beneath their professionalism and consequently, people may be turned away. An additional element mentioned by Burruel and Chavez which makes mental health services irrelevant to the Chicano is the one-to-one approach. This places the emphasis on changing the individual rather than the unhealthy environment which may be causing the disturbance.

## Language Barriers

Language barriers have been considered important in two ways. First is that language is basic to communication between clients and staff. Karno (1966) believes that the enormity of the barrier to

emotional relief for the clinic patient who does not speak English cannot be overemphasized. Torrey (1972) also believes in the importance of language for emotional expression. Even though he found the majority of his sample bilingual, he stated:

> Spanish is the language for home and English for elsewhere. However, the last thing a person learns in a second language is to express his feelings. It is not an uncommon observation for a bilingual individual to forget his second language altogether when he becomes sufficiently disturbed. The result is that even bilingual Mexican Americans may find it very difficult to undertake psychotherapy in English. (p. 118)

Karno and Edgerton (1969) concluded from their study that out of 444 subjects, about 40 percent spoke only or mainly Spanish, the rest described themselves as bilingual, while only one respondent out of the 444 claimed to speak only English. They found that while the majority preferred to or could only communicate in Spanish concerning intimate or affectively charged matters, there were very few or no personnel in mental health facilities who spoke Spanish. Torrey found that of the 120 psychotherapists in Santa Clara County community mental health centers, only four spoke Spanish. He noticed even the signs were in English only, in contrast to the county hospital, where all signs were bilingual. This he interpreted as conveying the message that traditional mental health services are for English speakers only.

In addition to being necessary for basic communication, language is also considered important because it has been found to be intimately tied to perception and social behavior. Edgerton and Karno (1971) concluded that language usage and attitudes toward mental illness were related and both reflected cultural distinctions with lasting psychological involvements. Their findings point to the need for mental health professionals who possess both fluency in Spanish and

a sensitive understanding of the culture of Chicano poor. Burruel and Chavez gave the following example:

> Obviously, language is a basic tool in treatment, but how effective can treatment be when words or terms can have different connotations? For example, a Mexican American patient was referred by another agency with a diagnosis of paranoid schizophrenia. This was based on her statements that her ex-husband's ex-wife was "trying to get her" and had put a hex on her. Discussion with the patient in her own language clearly indicated that much of what she was saying was based on a very common folk belief related to brujeria (witchcraft). Is it paranoia, or do we need to know more about the culture to separate that which is common to a group from that which is more clearly individual? (p. 124)

## Culture-Bound Diagnosis and Treatment

Culture-bound diagnosis and treatment is usually given as the most important factor for underutilization of mental health services by Chicanos. Most writers feel the components of psychotherapy are universal in principle but culture-specific in application, and consequently the psychotherapists of the dominant Anglo culture should be irrelevant for subculture Chicanos. Torrey (1972) emphasized this point when he stated:

> One explanation for the underutilization of Anglo psychotherapists by Mexican Americans is that Anglo psychotherapists utilize the four components of psychotherapy geared for Anglo culture and do not adapt them for the Mexican American patients. This is, I believe, the most important explanation of why Mexican Americans underutilize Anglo mental health services. (p. 117)

To confirm any differences in disease classification and categorization of symptoms between the different cultures, Torrey administered a questionnaire to three groups of people: 10 psychiatric residents at Stanford University; 10 anthropology graduate students at Stanford; and 20 students at a high school in San Jose. Of these students, 7 were Black, 7 were Chicano and 6 were Anglo. Torrey found that the words "crazy" and "hears voices" were associated by 90 percent of the

psychiatric residents, 60 percent of the graduate students, and only 16 percent (1 out of 7) of the Chicano students. The word "frightened" with some combination of "crazy" and "hears voices" were associated by 86 percent of the Chicano students, but by only 20 percent of psychiatrists and no graduate students. This gives some indication that an Anglo psychiatrist and a Chicano student share less of a frame of reference than the psychiatrist does with a graduate student.

Burruel and Chavez (1974) agree with Torrey. They state that mental health clinics have continued to utilize the same diagnostic tools with the implication that men and women from different socio-economic and/or cultural orientations will respond similarly when disturbed. They also feel that the cultural context of the patient, which may play a vital role in diagnosis and treatment, is often ignored. Karno's (1966) criticism is that there is a remarkable lack of direct attention given to ethnicity, race, subcultural identity, and bilingualism by clinic personnel. He believes this may be a conscious or unconscious avoidance of the reality of ethnicity, stemming from a hypersensitive concern about not being "discriminating" or "prejudiced" in the clinic setting.

Newton (1978) analyzed part of the data collected by Keefe, Padilla and Carlos during their four-year study in southern California and his research findings did not negate or conflict with other studies which emphasized that Chicanos underutilize mental health services because of language obstacles and/or culturally insensitive delivery systems. Instead, he found that emic perceptions of mental illness also appear to contribute to underutilization. The respondents attributed to themselves and to the Chicano population as a whole such

traits of character as preferences, self-image, and most importantly, pride. By this emphasis upon a self-image of strength of character and pride, these respondents attributed to themselves a major reason for the Chicano's low rate of mental health services use.

## Summary

All the literature on Chicanos and mental health services agree on one point: that Chicanos continue to underutilize traditional, formal mental health facilities and services. The numerous reasons that have been suggested for this underutilization can be grouped into three categories: social, economic, and cultural aspects of the Chicano; frequency and severity of mental illness of the Chicano; and attributes of mental health clinics and the services they provide. The social, economic, and cultural aspects of the Chicano mentioned by the literature as contributing to the underutilization of formal resources are: negative attitudes toward formal services, unfamiliarity with services, language and cultural barriers, social-economic status, and reliance on alternative resources or use of informal resources. Of all the reasons for the underutilization of mental health services by Chicanos, the literature on the attributes of mental health clinics and the services they provide seems to have the most agreement. The following aspects of mental health services have been criticized by both Chicano and non-Chicano writers: the location and accessability of mental health services; the availability of Chicano mental health professionals, including psychologists, psychiatrists, psychiatric nurses, and social workers; traditional middle class clinical and therapeutic orientation; language barriers; and culture-bound diagnosis and treatment.

# CHAPTER IV

# GENERAL FINDINGS

## Language

The respondents were instructed that the interview could be conducted in either English or Spanish, and it was important that the respondent choose the language he or she preferred; the interviewer was not allowed to make that decision. Of the respondents, 53 percent elected to do the interview in English, and 47 percent chose Spanish. The interviewers were also asked to record any side conversations the respondents had with anyone else such as children or adults present, those who came in during the interview, or any conversation by telephone that transpired during the interview. In such interruptions or side conversations, 39 percent of the respondents spoke only English, 9 percent spoke mostly English, 12 percent used both English and Spanish equally, 7 percent spoke mostly Spanish, 18 percent spoke only Spanish, and 15 percent of the respondents had no interruptions or side conversations with anyone.

## Demographic Data

Of the respondents, 57 were male and 43 were female. Their ages ranged from four who were 18 to one who was 64, with a median age of 37 years. Sixty-three percent of the respondents stated they were married, while 13 percent were divorced, 3 were widowed, and the

remaining 21 percent were single.

A substantial majority of the sample, 79 percent were born in the United States, with only 21 percent being born in Mexico. Of the 79 percent that were born in the United States, it is interesting to note that 50 percent, which is half of the whole sample, were born in Texas. Only 21 percent of the sample were born in Michigan, and the rest, 5 percent, were born in the Midwest. The median length of time of residency in Lansing, Michigan, was 15.9 years. The 79 respondents born in the United States were asked how many generations, including themselves, had also been born in the United States. Thirty-two said one generation, 27 said two generations, 12 said three generations, and the remaining 8 said four generations.

In response to a question on what type of community they had been reared in up to age sixteen, 39 percent said they had been raised in a large city, 27 percent said a small city, 13 percent said a town, and 21 percent had grown up on a farm.

Following the interview, all the respondents were rated by the interviewer on their physical features on a scale of 1 to 5, 1 being "European Looking" and 5 being "Indian Looking" (Table 1). On the physical feature scale, 6 respondents were given a rating of 1, 22 were given a 2, 22 were given a 3, 38 were given a 4, and 5 were given a 5. The median score was 3. They were also rated on their skin color on a scale of 1 to 5, with 1 being very light and 5 being very dark (Table 2). On the skin color scale, 6 were given a rating of 1, 22 were given a 2, 29 were given a 3, 35 were given a 4, and 8 were given a 5. The median score on this scale was also around 3.

Table 1.--Physical Features Scale.

| CATEGORY LABEL | SCALE | ABSOLUTE FREQUENCY | PERCENT FREQUENCY |
|---|---|---|---|
| European Looking | 1 | 6 | 6.0 |
| | 2 | 22 | 22.0 |
| | 3 | 22 | 22.0 |
| | 4 | 38 | 38.0 |
| Indian Looking | 5 | 12 | 12.0 |
| Total | | 100 | 100.0 |

Table 2.--Skin Color Scale.

| CATEGORY LABEL | SCALE | ABSOLUTE FREQUENCY | PERCENT FREQUENCY |
|---|---|---|---|
| Very Light | 1 | 6 | 6.0 |
| | 2 | 22 | 22.0 |
| | 3 | 29 | 29.0 |
| | 4 | 35 | 35.0 |
| Very Dark | 5 | 8 | 8.0 |
| Total | | 100 | 100.0 |

Social Economic Status

In regard to education, the range was from 7 who reported no formal education to 2 who reported 18 years of formal education. The median level was 8.7 years. Thirty-three of the sample (33 percent) had at least a high school education. Eighteen of these 33 had beyond a high school education, with 5 respondents (5 percent) of the sample having a Bachelor's degree and 2 respondents (2 percent) having a Master's degree.

The main job or occupation for the Lansing sample was quite varied. The two largest groups were 20 (20 percent) who worked as auto factory workers and 15 (15 percent) as homemakers (or housewives). The rest were: 8 custodians, 4 auto mechanics, 2 nurses, 3 cosmetoligists, 3 students, 2 teacher's aides, 3 artists, 2 school teachers, 2 community out-reach workers, 2 welders, 3 administrators, 4 clerk-typists, 4 construction workers, 2 farm workers, 2 who did housework for other people, one who cared for the elderly, one school liaison, one secretary, one fence installer, one in real estate, one counselor, one bartender, one sales clerk, one railroad worker, one who did odd jobs, one cook, one waitress, one who took care of other people's children, and 6 did not list a job or occupation.

For convenience in developing a social economic status scale for cross-analysis, occupation was further divided into six categories (Table 3).[3] Eleven (11 percent) of the respondents were classified as professionals, 14 (14 percent) as paraprofessionals, 8 (8 percent) as skilled, 28 (28 percent) as semi-skilled, 30 (30 percent) as unskilled, and the other 9 (9 percent) were students who were not working or respondents who were unemployed and did not give an occupation.

Table 3.--Occupational Status.

| CATEGORY LABEL | ABSOLUTE FREQUENCY | PERCENT FREQUENCY |
|---|---|---|
| No Occupation | 9 | 9.0 |
| Professional | 11 | 11.0 |
| Paraprofessional | 14 | 14.0 |
| Skilled | 8 | 8.0 |
| Semi-skilled | 28 | 28.0 |
| Unskilled | 30 | 30.0 |
| Total | 100 | 100.0 |

Family income also proved to be quite varied. The income levels ranged from 4 (4 percent) who reported making less than $2,000 per year, to 5 (5 percent) who reported an income of $30,000 or more. The income range for most respondents was $15,000 to $19,000, with 19 (19 percent) in this range. The next range was $20,000 to $24,000, with 13 (13 percent) of the respondents in this range. The median income for the whole sample was $12,000 per year (Table 4).

After the interview, the home of the respondent was compared to other homes in the neighborhood by the interviewer. Twenty-two of the respondents' homes were judged better than average, 65 were judged average, and 13 were judged to be below average in comparison to the rest of the homes in the same neighborhood.

## Availability and Utilization of Mutual Support Groups

Much of the literature mentions the stress-reducing interaction and the extended family mutual aid mechanism as a source of flexible and enduring support for Chicanos. The literature on Lansing Chicanos mentions that a great number of Chicanos in Lansing are from Texas.

Table 4.--Income.

| CATEGORY LABEL | FREQUENCY | FREQUENCY | CUMULATIVE PERCENT FREQUENCY |
|---|---|---|---|
| $2,000 | 4 | 4.0 | 4.0 |
| $2,000 to 2,999 | 1 | 1.0 | 5.0 |
| $3,000 to 3,999 | 4 | 4.0 | 9.0 |
| $4,000 to 4,999 | 6 | 6.0 | 15.0 |
| $5,000 to 5,999 | 3 | 3.0 | 18.0 |
| $6,000 to 6,999 | 3 | 3.0 | 21.0 |
| $7,000 to 7,999 | 3 | 3.0 | 24.0 |
| $8,000 to 8,999 | 8 | 8.0 | 32.0 |
| $9,000 to 9,999 | 3 | 3.0 | 35.0 |
| $10,000 to 10,999 | 1 | 1.0 | 36.0 |
| $11,000 to 11,999 | 4 | 4.0 | 40.0 |
| $12,000 to 12,999 | 11 | 11.0 | 51.0 |
| $15,000 to 19,999 | 19 | 19.0 | 70.0 |
| $20,000 to 24,999 | 13 | 13.0 | 83.0 |
| $25,000 to 29,999 | 8 | 8.0 | 91.0 |
| $30,000 plus | 5 | 5.0 | 96.0 |
| | 4 | 4.0 | 100.00 |
| Total | 100 | 100.00 | |

It was therefore necessary to discover the availability of family and its mutual aid mechanism in Lansing.

A high percentage of the respondents, 69 percent, reported that they have relatives living within the area, and 31 percent reported that they had no family or relatives living in the area. The number of relatives in the area ranged from 1 to 60, with an average of 5.3 relatives per respondent. The number of households these relatives lived in ranged from 1 to 15, with an average of 1.4 households.

Of the 51 respondents who reported having a living father, a high percentage of them, 84.3 percent (43 respondents) stated that they visit him from daily to several times a year. Only 8 respondents, 15.7 percent, stated that they hardly ever visit their fathers. There

was a similar response of the 71 respondents who reported having a living mother. Only 11.3 percent (8 respondents) stated that they hardly ever visit their mothers, while 88.7 percent (63 respondents) stated that they visit their mothers from daily to several times during the year.

Of the 92 respondents who have siblings, 76 (82.6 percent) visit them often, while 16 (17.4 percent) stated that they hardly ever visit them. Forty-two of the respondents had children not living at home. Forty-one (97.6 percent) stated that they visit their children often. Only one respondent (2.4 percent) stated that he hardly ever visits his children. Of those with other relatives in the area 56 (65.1 percent) reported visiting their relatives often, and 30 (34.9 percent) reported hardly ever visiting their relatives. Eighty-one of the respondents reported visiting their friends often, 9 answered "hardly ever," and the other 10 respondents did not give an answer to this question.

Eighty-eight (88 percent) of the respondents stated that they had either helped of offered to help relatives or friends with such things as providing clothing, money, food, housing, repairs, furniture, transportation, help finding a job, and getting medical attention. Fifty-eight of the respondents also mentioned getting help or being offered help by family members or friends with similar things--food, clothing, money, housing, repairs, furniture, transportation, and advice.

Although half of the Chicanos living in Lansing are from Texas, a substantial proportion of all the Chicanos in Lansing have relatives living in the area. It also seems these Chicanos have a mutual support system which is utilized often.

Attitudes Toward Local Mental Health Services

There exist several mental health services in the Lansing community, including a Chicano-oriented center. To find out if the Chicano population in Lansing was familiar with the availability of these services, a set of questions were designed. Respondents were asked if they were familiar with the services of Cristo Rey Counseling Center, St. Lawrence Mental Health Program, Capitol Area Counseling Center, Ingham Community Mental Health Center, or other services in the Lansing area. For every program a respondent answered that he or she was familiar with, he or she was asked if he or she would say the services were adequate for most problems, adequate for some problems, or not adequate at all.

Most of the literature states that Chicanos underutilize mental health services because they are unfamiliar with the services (Knoll, 1971; Laosa, Burstein and Martin, 1975; Martinez, 1977; Philippus, 1971). It has been suggested by more recent studies that this only applies to economically and socially deprived rural Chicano subgroups (Keefe, Padilla and Carlos, 1978; Keefe and Casas, 1978). Less than half of the Lansing Chicanos, who are supposedly urban, were not familiar with "mainstream Anglo" mental health services. As was expected, more Chicanos are familiar with the services at Cristo Rey Counseling Center than other "Anglo, mainstream traditional" services. Seventy-one (71 percent) of the sample was familiar with Cristo Rey, while 39 (39 percent) were familiar with St. Lawrence Mental Health Program, 14 (14 percent) were familiar with Capitol Area Counseling Center, 23 (23 percent) were familiar with Ingham Community Mental Health Center, and 11 (11 percent) of the respondents mentioned

being familiar with other services (usually by churches).

A combined scale of familiarity with St. Lawrence Mental Health Program, Capitol Area Counseling Center, and Ingham Community Mental Health Center was developed to find the general, overall familiarity of the sample with traditional, mainstream ("Anglo") formal mental health services.[4] Thirty (30 percent) of the sample were familiar with mental health services, 16 (16 percent) were partly familiar, and 53 (53 percent) were not familiar with mental health services in general (Table 5).

Table 5.--Familiarity with Mental Health Services.

| CATEGORY LABEL | ABSOLUTE FREQUENCY | PERCENT FREQUENCY | CUMULATIVE PERCENT FREQUENCY |
|---|---|---|---|
| Familiar | 30 | 30.0 | 30.0 |
| Partly Familiar | 16 | 16.0 | 46.0 |
| Unfamiliar | 53 | 53.0 | 99.0 |
| No Answer | 1 | 1.0 | 100.0 |
| Total | 100 | 100.0 | |

The attitudes toward these services turned out to be very interesting. Of the 71 who said they were familiar with the services at Cristo Rey Counseling Center, 16 (22.5 percent) thought the services were adequate for most problems, 45 (63.4 percent) thought the services were adequate for some problems, 6 (8.5 percent) thought the services were not adequate at all, and 4 (5.6 percent) had no opinion. Of the 39 that stated they were familiar with the services at St. Lawrence Mental Health Program, 11 of these (28.2 percent) thought the services

were adequate for most problems, 21 (53.8 percent) thought the services were adequate for some problems, one (2.6 percent) thought the services were not adequate at all, and 6 (15.4 percent) had no opinion. Of the four specifically mentioned services and "others," the Capitol Area Counseling Center was the least known and also the one the respondents had the most negative overall attitude about. Only 14 percent of the sample was familiar with its services and of these 14, 2 (14.2 percent) thought the services were adequate for most problems, 8 (57.2 percent) thought the services were adequate for some problems, 2 (14.3 percent) thought the services were not adequate at all, and 2 (14.3 percent) had no opinion. Of the 23 respondents familiar with Ingham Community Mental Health Center, 7 (30.5 percent) thought the services were adequate for most problems, 11 (47.8 percent) thought the services were adequate for some problems, one (4.3 percent) thought the services were not adequate at all, and 4 (17.4 percent) had no opinion. (Ingham Community Mental Health Center is the only center that has two Chicano therapists with Master's degrees in social work on the staff in addition to two Chicano student interns during the time of the present study.) Of the 11 who mentioned they were familiar with other mental health services, 6 (54.5 percent) thought the services were adequate for most problems, 3 (27.3 percent) thought the services were adequate for some problems, none thought the services were not adequate at all, and 2 (18.2 percent) had no opinion.

As with familiarity with mental health services, a combined scale of attitudes toward St. Lawrence Mental Health Program, Capitol Area Counseling Center, and Ingham Community Mental Health Center was developed to find the attitude of the sample toward traditional,

mainstream ("Anglo"), formal mental health services and providers.[5] Thirteen or 30.2 percent of the sample who were familiar or partly familiar thought the services were adequate for most problems. Twenty-three or 53.5 percent thought the services were adequate for some problems, and the other 7 or 16.3 percent thought the services were not adequate at all (Table 6).

Table 6.--Attitudes Toward Service Providers.

| CATEGORY LABEL | ABSOLUTE FREQUENCY | PERCENT FREQUENCY | CUMULATIVE PERCENT FREQUENCY |
|---|---|---|---|
| Favorable | 13 | 13.0 | 13.0 |
| Partly Favorable | 23 | 23.0 | 36.0 |
| Unfavorable | 7 | 7.0 | 43.0 |
| No Answer | 57 | 57.0 | 100.0 |
| Total | 100 | 100.0 | 100.0 |

The attitudes toward these services is very interesting for several reasons. When Cristo Rey Counseling Center, assumed to be a Chicano oriented and Chicano relevant mental health center, is compared to other "Anglo oriented" mental health centers individually, Cristo Rey has the lowest percentage for being adequate at all (with the exception of the Capitol Area Counseling Center which was the least well known). When Cristo Rey is compared to the combined attitudes toward all three "Anglo oriented" mental health providers, it still fares less favorably, with the combined attitudes toward the "Anglo oriented" programs being 30.2 percent for adequacy for most problems, compared to only 22.5 percent for Cristo Rey in this category. As

mentioned in some of the literature (Keefe, Padilla and Carlos, 1978), Chicanos in urban areas do not have negative attitudes toward mental health services. The overall attitude toward the Chicano mental health center and the Anglo mental health services generally was positive. The literature also mentions that attempts to set up mental health centers with the population's social-cultural characteristics in mind demonstrate indigenous attitudes can change if the services are relevant (Schensul, 1972; Laosa, Burstein and Martin, 1975; Martinez, 1977; Burruel and Chavez, 1974). Contrary to the literature, Cristo Rey Counseling Center, which is assumed to be relevant to Chicanos, was believed to be less adequate (by Chicanos!) than the other mental health services provided by Anglos.

Caution should be exercised in interpreting this as simply that Chicanos have negative attitudes about Chicano oriented services, or that they believe Anglos can provide more adequate services. The attitude which the Chicano community has toward Cristo Rey may be due to any one or a combination of reasons. Although not inclusive, the following factors should be considered. What are the qualifications and abilities of present staff to develop culturally syntonic treatment modules and provide culturally relevant and adequate treatment? Although the director of the Cristo Rey Counseling Center is Hispanic (Cuban) with a Master's degree in social work, he is not a Chicano. None of the rest of the staff has much formal education or training in mental health treatment or prevention. What are the qualifications and abilities of the board of directors of the parent organization, not only in providing guidance, but also in monitoring and evaluating the treatment, orientation, and success of the program? None of the

members of the board of directors have any background in mental health. What effect does the physical layout of the center have on the effectiveness of the program? Cristo Rey, in effect, has a monopoly on all Chicano programs in Lansing and has several programs crowded into one building. The whole counseling program is restricted to one room that houses all staff, and individual counseling is sometimes done in the open cubicles of the staff, not conducive to a maximum therapeutic atmosphere. And finally, what effect has the political maneuvering by the Center's director and some of Lansing's Anglo politicians had on the general attitudes toward the Center and its programs?

In 1979, the religious services component of the Center was moved because of ongoing conflicts between the social services director, the religious services directors (priests) through the years, and the social (and political) religious functions of the Center that were causing some Chicanos to cease attending religious services, and even to leave the Catholic Church.

Ethnic Identification

Ethnic identification is defined as a cognitive process, the perception of similarity or common interests with other persons of one's group. Respondents were shown a card with the following common ethnic labels for persons of Mexican origin: Hispanic, American, Hispanic-American, Latino, American of Mexican Descent, Mexican-American, Chicano, Mexican, and "some other name." They were told to look at the different names on the card and to use these or others for answers to a series of questions.

In response to a question on what term they used with their family when speaking about people of Mexican descent, a majority of the respondents, 59 (59 percent), said "Mexican." The other responses were: 12 (12 percent) "Mexican-American," 8 (8 percent) "Chicano," 7 (7 percent) "Latino," 5 (5 percent) "American of Mexican Descent," 4 (4 percent) "Hispanic," 2 (2 percent) "Hispanic-American," 2 (2 percent) "other," and one (1 percent) "American."

The respondents were then asked what name is generally used by other people (in Lansing) of Mexican descent. Both "Mexican" and "Chicano" were given as answers by an equal number of respondents--35 (35 percent). Six (6 percent) said "Hispanic," 6 (6 percent) said "Latino," 5 (5 percent) said "Mexican-American," 3 (3 percent) said "American of Mexican Descent," 2 (2 percent) said "Hispanic-American," one (1 percent) said "Hispanic," and 9 apparently misunderstood the question because they gave other answers that did not pertain to persons of Mexican origin.

Respondents were asked to remember when they were children and were asked what name their fathers and mothers used to refer to people of Mexican descent. Seventy-nine (79 percent) answered their fathers used the term "Mexican," 3 said "Chicano," 2 said "Latino," one said "American," one said "American of Mexican Descent," one said "Mexican-American," and 13 said "other." Most of the respondents, 83 (83 percent), also gave "Mexican" as the name used by their mothers. The other responses in reference to the name used by their mothers were: 3 said "Latino," one said "Hispanic," one said "American," one said "Chicano," and 11 said "other." The term used by their parents seems to have influenced the term they now use. Even though an equal number

of respondents believed that the terms used by other persons of Mexican descent were "Mexican" and "Chicano," the majority of respondents themselves use the term "Mexican." This is interesting since the term "Mexican" applies to a person from Mexico, not to a United States citizen or resident.

Ethnic Identity

Ethnic identity in this study is defined as the cognitive product of the process of identification, indicated by self-labeling in ethnic terms. To determine ethnic identity, respondents were given a social identity deck containing 32 cards (Appendix A1). These 32 cards were made up of eight common use labels for persons of Mexican origin plus familial roles, ethno-political, social class, worker, color, and other social labels. Respondents were asked to look at each card and to keep all the cards that described how they thought about themselves. They were then told to look again at the cards they chose and to pick out three that best described how they thought about themselves. From these three, they were then asked to select the one that described them the best. From these responses, an ethnic identity scale was devised. Respondents were given a "no ethnic identity" score if they did not select any of the ethnic identity terms at all. They were given a "low ethnic identity" score if they selected any of the ethnic terms in the first selection, but none in the three that best described them. They were given a "medium ethnic identity" score if they selected any ethnic term in the three that best described them, but not in the single one that best described them. They were given a "high ethnic identity" score if they selected an ethnic term for the single one that best described them.

Twenty-five (25 percent) of the respondents got a "high ethnic identity" score, 30 (30 percent) got a "medium ethnic identity" score, 35 (35 percent) got a "low ethnic identity" score, 8 (8 percent) got a "no ethnic identity" score, and 2 did not want to choose any three (or the one) that best described them. Of the 25 who got a high score, 7 chose the term "Mexican" as the name that best described them, 7 chose "American of Mexican Descent," 5 chose "Mexican-American," 3 chose "Raza," 2 chose "Chicano," and one chose "Hispanic." No one in the sample chose the two other terms, "Pocho" or "Latino" (Table 7).

Table 7.--Ethnic Identity Scale.

| CATEGORY LABEL | SCORE | ABSOLUTE FREQUENCY | PERCENT FREQUENCY | CUMULATIVE PERCENT FREQUENCY |
|---|---|---|---|---|
| None | 1 | 8 | 8.0 | 8.0 |
| Low | 2 | 37 | 37.0 | 45.0 |
| Moderate | 3 | 30 | 30.0 | 75.0 |
| High | 4 | 25 | 25.0 | 100.0 |
| Total | | 100 | 100.0 | |

The most often chosen single term of the 32 terms that the respondents believed described them the best was "Mother/Father." Twenty-eight or 28 percent of the sample identified with this term the strongest. This strong identification with a familial role term is related to the concept of the importance of the family in the Chicano culture as indicated by the review of the literature.

Mental Health Status

Mental health status was determined by the use of three scales in the interview, a personal efficacy scale[6], a private self-esteem scale[7], and a public self-esteem scale[8]. The scoring was on a scale of 10 to 40, with 40 being the highest.

On the personal efficacy scale, only 6 respondents or 6 percent of the sample got a high score of 40. The median score for the total sample was about 25.8 (Table 8). On the self-esteem scales, the sample fared better on the private self-esteem scale, with most of the concentration of scores on the upper levels. Seventeen respondents, or 17 percent of the sample, got a high score of 40, and the median was about 34.5 (Table 9). Only 4 of the respondents, or 4 percent got a high score of 40 on the public self-esteem scale, with the median on this scale being 25.4. The distribution of scores on this scale was very similar to the distribution on the personal efficacy scale (Table 10).

The frequency of stress was determined by first asking the respondents how often anything bad had happened to them or to someone they loved such as getting sick, losing a job, being in trouble with the police, someone dying, or someone disappointing them, etc. Then they were asked if, when things like this had happened, there had been times when they found it hard to handle, such as by not being able to eat or sleep, drinking too much, staying away from people, feeling depressed or nervous, etc. Sixteen (16 percent) said "often," 27 (27 percent) said "sometimes," 12 (12 percent) said "rarely," and a high percentage of the sample--44 percent--said "never;" and one of the respondents gave no answer (Table 11).

Table 8.--Personal Efficacy Scale.

| SCORE | ABSOLUTE FREQUENCY | PERCENT FREQUENCY | CUMULATIVE PERCENT FREQUENCY |
|---|---|---|---|
| 11 | 2 | 2.0 | 2.0 |
| 13 | 1 | 1.0 | 3.0 |
| 15 | 3 | 3.0 | 6.0 |
| 16 | 1 | 1.0 | 7.0 |
| 18 | 2 | 2.0 | 9.0 |
| 20 | 13 | 13.0 | 22.0 |
| 21 | 5 | 5.0 | 27.0 |
| 23 | 8 | 8.0 | 35.0 |
| 25 | 8 | 8.0 | 43.0 |
| 26 | 10 | 10.0 | 53.0 |
| 28 | 7 | 7.0 | 60.0 |
| 30 | 8 | 8.0 | 68.0 |
| 31 | 3 | 3.0 | 71.0 |
| 33 | 8 | 8.0 | 79.0 |
| 35 | 8 | 8.0 | 87.0 |
| 36 | 6 | 6.0 | 93.0 |
| 38 | 1 | 1.0 | 94.0 |
| 40 | 6 | 6.0 | 100.0 |
| Total | 100 | 100.0 | |

Table 9.--Private Self-Esteem Scale.

| SCORE | ABSOLUTE FREQUENCY | PERCENT FREQUENCY | CUMULATIVE PERCENT FREQUENCY |
|---|---|---|---|
| 23 | 1 | 1.0 | 1.0 |
| 25 | 2 | 2.0 | 3.0 |
| 26 | 4 | 4.0 | 7.0 |
| 28 | 5 | 5.0 | 12.0 |
| 30 | 7 | 7.0 | 19.0 |
| 31 | 8 | 8.0 | 27.0 |
| 33 | 11 | 11.0 | 38.0 |
| 35 | 17 | 17.0 | 55.0 |
| 36 | 10 | 10.0 | 65.0 |
| 38 | 18 | 18.0 | 83.0 |
| 40 | 17 | 17.0 | 100.0 |
| Total | 100 | 100.0 | |

Table 10.--Public Self-Esteem Scale.

| SCORE | ABSOLUTE FREQUENCY | PERCENT FREQUENCY | CUMULATIVE PERCENT FREQUENCY |
|---|---|---|---|
| 10 | 2 | 2.0 | 2.0 |
| 12 | 1 | 1.0 | 3.0 |
| 15 | 1 | 1.0 | 4.0 |
| 17 | 7 | 7.0 | 11.0 |
| 20 | 8 | 8.0 | 19.0 |
| 22 | 5 | 5.0 | 24.0 |
| 25 | 18 | 18.0 | 42.0 |
| 27 | 21 | 21.0 | 63.0 |
| 30 | 7 | 7.0 | 70.0 |
| 32 | 13 | 13.0 | 83.0 |
| 35 | 10 | 10.0 | 93.0 |
| 37 | 3 | 3.0 | 96.0 |
| 40 | 4 | 4.0 | 100.0 |
| Total | 100 | 100.0 | |

Table 11.--Frequency of Stress.

| RESPONSE CATEGORIES | ABSOLUTE FREQUENCY | PERCENT FREQUENCY | CUMULATIVE PERCENT FREQUENCY |
|---|---|---|---|
| Often | 16 | 16.0 | 16.0 |
| Sometimes | 27 | 27.0 | 43.0 |
| Rarely | 12 | 12.0 | 55.0 |
| Never | 44 | 44.0 | 99.0 |
| No Answer | 1 | 1.0 | 100.0 |
| Total | 100 | 100.0 | |

The respondents were also asked to think about the last time something really bad had happened to them and what it was about. The nature of the problems was divided into seven major categories: economic and material, work, education/school, legal, interpersonal/family,

mental health and other stress problems, and physical health problems. The greatest number of problems were in the physical health problems category, where 38 (38 percent) of the respondents mentioned problems. Fifteen (15 percent) mentioned death of a grandparent, sibling, aunt or uncle; 8 mentioned death of a parent or parent-in-law; 7 mentioned poor health or sickness of respondent; 2 mentioned poor health or injury of respondent's sibling; one mentioned poor health or injury of respondent's spouse; one mentioned poor health or injury of respondent's children; one mentioned death or respondent's child; one mentioned death of a close friend; and 2 gave other physical health and well-being related problems.

The next highest category was work problems, wherein 4 mentioned unspecified employment problems not due to self, 3 had been laid off, 2 had problems at work for which respondent blamed himself or herself, one had problems finding a job, and one had quit his or her job.

Mental health and other stress ranked third, with 10 (10 percent) of the respondents mentioning problems in this area. Three mentioned feelings of anxiety or nervousness, 3 mentioned unhappiness or problems due to loneliness or isolation, and one mentioned relocation problems.

There were also 10 problems under the interpersonal/family category. Three had dissolutions of their marriages, 3 had general problems with their children, 2 mentioned unwanted separation from respondent's children, one mentioned unwanted separation from spouse for reasons other than marital dissolution, and one mentioned unwanted separation from someone close. Six (6 percent) mentioned legal problems, 3 of which were about respondent's children; 2 mentioned the

respondent having legal problems, and one mentioned the respondent's spouse having a legal problem. Two (2 percent) of the respondents reported economic problems, one reported a school-related problem, 9 were not willing to give details about their problem, one respondent gave an "Idon't know" answer, 6 (6 percent) mentioned they had never had a serious problem, and 6 (6 percent) did not give an answer (Table 12).

Table 12.--Nature of Problems.

| CATEGORY LABEL | ABSOLUTE FREQUENCY | PERCENT FREQUENCY |
|---|---|---|
| None | 6 | 6.0 |
| Economic | 2 | 2.0 |
| Work | 11 | 11.0 |
| School | 1 | 1.0 |
| Legal | 6 | 6.0 |
| Family | 10 | 10.0 |
| Mental Health | 10 | 10.0 |
| Physical Health | 38 | 38.0 |
| Other | 16 | 16.0 |
| Total | 100 | 100.0 |

Utilization of Informal Health Resources

Reliance on alternative resources, especially on the extended family, has been given as an important factor in explaining the underutilization of formal mental health resources (Jaco, 1957, 1959, 1960; Madsen, 1964, 1969; Samora and Lamanna, 1967; Frumkin, 1961; Sotomayor, 1971; Torrey, 1972; Ramirez, 1979; and "The Chicano Plan for Mental Health," 1975). Reliance on friends is mentioned as a secondary source of support (Madsen, 1964; Rubel, 1966; and Keefe, Padilla and

Carlos, 1978). To determine how much the Lansing sample utilized informal resources, the respondents were shown a card containing a list of 13 persons who are most often utilized and were asked to name any of these persons they had talked to when they had had a serious problem (Appendix A3). A substantial number, 80 (80 percent), reported they had talked to one or more of the persons on the card. Sixty-five of these mentioned they talked to a family member while the other 15 mentioned they talked to a friend, neighbor or co-worker. The family member talked to most often was the spouse at 33 percent. Other percentages were: mother--9 percent, brother--6 percent, other relative--6 percent, sister--4 percent, son--3 percent, father--2 percent, and daughter--2 percent (Table 13).

Table 13.--First-Ranked Non-Professional.

| CATEGORY LABEL | ABSOLUTE FREQUENCY | PERCENT FREQUENCY |
|---|---|---|
| Spouse | 33 | 33.0 |
| Son | 3 | 3.0 |
| Daughter | 2 | 2.0 |
| Father | 2 | 2.0 |
| Mother | 9 | 9.0 |
| Brother | 6 | 6.0 |
| Sister | 4 | 4.0 |
| Relative | 6 | 6.0 |
| Friend | 10 | 10.0 |
| Neighbor | 1 | 1.0 |
| Co-worker | 4 | 4.0 |
| No Answer | 20 | 20.0 |
| Total | 100 | 100.0 |

The Lansing sample supports that part of the literature which states that the Chicano family is very supportive and many Chicanos utilize the family in times of serious problems. Sixty-nine of the respondents had mentioned they had family and relatives living in the area, and about 83.7 percent reported they visited their family regularly; 94.2 percent of those who have the support system of the family available utilized the family.

Utilization of Formal Health Resources

Utilization of curanderos (folk healers) has been given, or implied, as a major reason for the underutilization of traditional mental health services by Chicanos (Jaco, 1957; Creson, McKinley and Evans, 1969; Bruhn and Fuentes, 1977; Kiev, 1964, 1968; Madsen, 1964, 1973; Senter, 1947; Martinez and Martin, 1974; Torrey, 1968, 1969, 1972; Rubel, 1966; Meyer, 1977; Clark, 1959; Saunders, 1964; Schulman, 1960; Granger, 1976; Graham, 1976; and Knoll, 1971). Other writers have also mentioned reliance on religious practitioners (Grebler, Moore and Guzman, 1970; Clark, 1959; and Keefe, Padilla and Carlos, 1978) and on medical physicians (Madsen, 1961, 1973; Saunders, 1954; Farge, 1977; Weaver, 1973; Torrey, 1972; Keefe, Padilla and Carlos, 1978; and Welch, Comer and Steinman, 1973). To determine the utilization of these resources and others, respondents were shown a card containing 13 terms with curandero, doctor, clergyman/priest, mental health practitioners and other persons sometimes utilized (Appendix A5). Respondents were asked to look at the list of persons, and indicate whether they had ever talked to them about any serious problems. The utilization of these formal resources was much less, with only 43

(43 percent) indicating they had ever utilized any of these resources. The one most utilized was clergyman/priest (13 percent), followed by doctor (11 percent), social worker (5 percent), counselor (4 percent), lawyer (4 percent), nurse (1 percent), psychiatrist (1 percent), psychologist (1 percent), teacher (1 percent), "other person not on this list" (1 percent), and only one person (1 percent) went to a curandera. The curandera happened to be her grandmother, so even this can be interpreted as someone going to a family member, as opposed to consulting a curandera.

These results do not support the literature and the underutilization of mental health services by Lansing Chicanos cannot be explained in terms of reliance on curanderos as doctors, clergy or priest, or other non-mental health practitioners. These results also point out that Lansing Chicanos do not go to traditional formal resources such as psychiatrists, psychologists, or social workers for serious mental health problems (Table 14).

Table 14.--First-Ranked Professional.

| CATEGORY | ABSOLUTE FREQUENCY | PERCENT FREQUENCY |
|---|---|---|
| Clergyman/priest | 13 | 13.0 |
| Counselor | 4 | 4.0 |
| Curandero(a) | 1 | 1.0 |
| Doctor | 11 | 11.0 |
| Lawyer | 4 | 4.0 |
| Nurse | 1 | 1.0 |
| Psychiatrist | 1 | 1.0 |
| Psychologist | 1 | 1.0 |
| Social Worker | 5 | 5.0 |
| Teacher | 1 | 1.0 |
| Other | 1 | 1.0 |
| No Answer | 57 | 57.0 |
| Total | 100 | 100.0 |

Summary

Of a sample of 100 respondents, 25 received a "high ethnic identity" score, 30 received a medium score, 30 received a low score, and 8 received a "no identity" score. Mental health status was determined by the use of three scales: a personal efficacy scale, a private self-esteem scale, and a public self-esteem scale. The scoring was on a scale of 10 to 40, with 40 being the highest on all three scales. The median scores were 25.8 for personal efficacy, 34.5 for private self-esteem, and 25.4 for public self-esteem. The Lansing sample supported that part of the literature which states that the family is very supportive, and many of the sample utilized the family in times of serious problems. However, the sample did not support that part of the literature which explains the underutilization of mental health services in terms of reliance on curanderos or doctors, clergy or priests, or other non-mental health practitioners. The sample also showed that Lansing Chicanos do not go to traditional formal resources such as psychiatrists, psychologists, or social workers for serious mental health problems.

# CHAPTER V

# ANALYSIS OF DATA

The data were analyzed and the hypotheses tested by bivariate correlation analysis. Most variables were first tabulated into frequency distribution tables or scales before they were correlated. The Chi-square test of statistical significance was used between variables that were measured at the nomial level or when the order of, distance between, or categories within a variable was not important. Cramer's V was used as a measure of association for all variables tested by the Chi-square test to compare results between the Lansing and the Texas samples. The Pearson Product-Moment correlation coefficient was used as a more appropriate measure when both variables were ordinal or interval. The t-Test was used to test one of the hypotheses, the F-Test for curvilinearity was also used once to test one of the hypotheses, and the ANOVA Test was used to test two of the hypotheses. A correlation was considered statistically significant if the probability of occurrence was less than or equal to .05.

## Identification and Identity

There are six hypotheses on ethnic identification and identity. Two are under the descriptive objectives on how identity and identification relate to each other; three are under the analytic objectives on how ethnic identity is affected by the independent variables; and

the last one is under the comparative objectives on how the Lansing sample compares with the Texas sample.

HYPOTHESIS: The degree of ethnic identity has no effect on the degree of identifying with other social groups or social roles.

The ethnic identity scale was cross-tabulated separately with each of the 32 social terms. Of the non-ethnic terms, 8 were associated with a statistical significance: "Foreigner" (Chi=8.17594, V=.29, sig=.0425), "Mother/Father" (Chi=10.87856, V=.33, sig=.0124), "Daughter/Son" (Chi=11.81582, V=.34, sig=.0080), "Man/Woman" (Chi=26.44566, V=.51, sig=.0000), "Brother/Sister" (Chi=22.18038, V=.47, sig=.0001), "Family Breadwinner" (Chi=13.49523, V=.37, sig=.0037), "Spanish Speaker" (Chi=8.11363, V=.28, Sig=.0437), and "United States Native" (Chi=8.26360, V=.29, sig=.0409) (Table 15).

The Chi-square test also showed that of the 8 ethnic terms, "Mexican," "Pocho/Pocha," "American of Mexican Descent," "Mexican-American," "Hispanic," "Latino/Latina," "Chicano/Chicana," and "Raza," only 4 terms were correlated to a statistical significance with the ethnic identity scale: "Mexican" (Chi=20.89590, V=.45, sig=.0001), "American of Mexican Descent" (Chi=13.73245, V=.37, sig=.0033), "Mexican-American" (Chi=20.22117, V=.45, sig=.0002), and "Hispanic" (Chi=8.99069, V=.30, sig=.0294) (Table 16).

The hypothesis was partly supported by the sample since some of the social terms and not all of the ethnic terms were correlated to a statistical significance.

The ethnic identity scale from the Texas sample (N=346) was also cross-tabulated separately with each of the 32 social terms. The Chi-square test showed that all 8 ethnic terms were correlated to a

Table 15.--Association of Ethnic Identity with Social Terms.

| ETHNIC IDENTITY | SOCIAL TERMS | | | | | | | | | | | | | | | | Row Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Foreigner | | Mother/Father | | Daughter/Son | | Woman/Man | | Sister/Brother | | Family Breadwinner | | Spanish Speaker | | U. S. Native | | |
| | No | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No | Yes | |
| None (count) | 8 | 0 | 2 | 6 | 8 | 0 | 7 | 1 | 8 | 0 | 8 | 0 | 3 | 5 | 7 | 1 | |
| (row pct) | 100.0 | 0.0 | 25.0 | 75.0 | 100.0 | 0.0 | 87.5 | 12.5 | 100.0 | 0.0 | 100.0 | 0.0 | 37.5 | 62.5 | 87.5 | 12.5 | 8 |
| Low | 33 | 4 | 8 | 29 | 15 | 22 | 6 | 31 | 10 | 27 | 12 | 25 | 6 | 31 | 13 | 24 | |
| | 89.2 | 10.8 | 21.6 | 78.4 | 40.5 | 59.5 | 16.2 | 83.8 | 27.0 | 73.0 | 32.4 | 67.6 | 16.2 | 83.8 | 35.1 | 64.9 | 37 |
| Moderate | 27 | 3 | 3 | 27 | 10 | 20 | 2 | 28 | 5 | 25 | 11 | 19 | 5 | 25 | 16 | 14 | |
| | 90.0 | 10.0 | 10.0 | 90.0 | 33.3 | 66.7 | 6.7 | 93.3 | 16.7 | 83.3 | 36.7 | 63.3 | 16.7 | 83.3 | 53.3 | 46.7 | 30 |
| High | 17 | 8 | 12 | 13 | 12 | 13 | 5 | 20 | 12 | 13 | 13 | 12 | 11 | 14 | 14 | 11 | |
| | 68.0 | 32.0 | 48.0 | 52.0 | 48.0 | 52.0 | 20.0 | 80.0 | 48.0 | 52.0 | 52.0 | 48.0 | 44.0 | 56.0 | 56.0 | 44.0 | 25 |
| Column Total | 85 | 15 | 25 | 75 | 45 | 55 | 20 | 80 | 35 | 65 | 44 | 56 | 25 | 75 | 50 | 50 | |
| | 85.0 | 15.0 | 25.0 | 75.0 | 45.0 | 55.0 | 20.0 | 80.0 | 35.0 | 65.0 | 44.0 | 56.0 | 25.0 | 75.0 | 50.0 | 50.0 | 100 |

Table 16.--Association of Ethnic Identity Scale with Ethnic Terms.

| ETHNIC IDENTITY | ETHNIC TERMS | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Mexican | | American of Mexican Descent | | Mexican-American | | Hispanic | | Row Total |
| | No | Yes | No | Yes | No | Yes | No | Yes | |
| None | 8 | 0 | 8 | 0 | 8 | 0 | 8 | 0 | |
| (count) | | | | | | | | | |
| (row pct) | 100.0 | 0.0 | 100.0 | 0.0 | 100.0 | 0.0 | 100.0 | 0.0 | 8 |
| Low | 15 | 22 | 12 | 25 | 13 | 24 | 17 | 20 | |
| | 40.5 | 59.5 | 32.4 | 67.6 | 35.1 | 64.9 | 45.9 | 54.1 | 37 |
| Moderate | 10 | 20 | 10 | 20 | 5 | 25 | 13 | 17 | |
| | 33.3 | 66.7 | 33.3 | 66.7 | 16.7 | 83.3 | 43.3 | 56.7 | 30 |
| High | 3 | 22 | 12 | 13 | 7 | 18 | 14 | 11 | |
| | 12.0 | 88.0 | 48.0 | 52.0 | 28.0 | 72.0 | 56.0 | 44.0 | 25 |
| Column | 36 | 64 | 42 | 58 | 33 | 67 | 52 | 48 | |
| Total | 36.0 | 64.0 | 42.0 | 58.0 | 33.0 | 67.0 | 52.0 | 48.0 | 100 |

statistical significance: "Mexican" (Chi=36.72, V=.33, sig=.00), "Pocho/Pocha" (Chi=8.88, V=.16, sig=.03), "American of Mexican Descent" (Chi=30.32, V=.30, sig=.00), "Mexican-American" (Chi=28.89, V=.29, sig=.00), "Hispanic" (Chi=9.36, V=.17, sig=.02), "Latino/Latina" (Chi=9.20, V=.16, sig=.03), "Chicano/Chicana" (Chi=8.23, V=.16, sig=.04), and "Raza" (Chi=10.94, V=.18, sig=.01).

Of the remaining social terms, 12 were statistically significant in the Texas sample: "Mother/Father" (Chi=32.53, V=.31, sig=.00), "Woman/Man" (Chi=24.87, V=.27, sig=.00), "Middle Class" (Chi=13.43, V=.20, sig=.00), "Sister/Brother" (Chi=10.11, V=.17, sig=.02), "Wife/Husband" (Chi=30.67, V=.30, sig=.00), "White" (Chi=21.76, V=.25, sig=.00), "American" (Chi=9.94, V=.17, sig=.02), "United States Citizen" (Chi=18.11, V=.23, sig=.00), "Family Breadwinner" (Chi=13.86, V=.20, sig=.00), "English Speaker" (Chi=12.08, V=.19, sig=.01), "Spanish Speaker" (Chi=18.75, V=.24, sig=.00), and "United States Native" (Chi=23.05, V=.26, sig=.00).

It seems the Lansing sample identifies not only with less ethnic labels (4, or 50 percent of the labels versus 8, or 100 percent of the labels for the Texas sample), but also with less social labels (8, or 25 percent versus 12, or 38 percent) than the Texas sample in general. However, a comparison between the Lansing sample and the Texas sample on both ethnic terms and other social terms that were correlated significantly in both samples showed that there is a higher degree of association with the Lansing sample for all terms: "Mexican" (Cramer's V=.46 for Lansing, and .33 for Texas); "American of Mexican Descent" (V=.37, and .30 respectively); "Mexican-American" (V=.45, and .29 respectively); "Hispanic" (V=.30, and .17 respectively); "Mother/Father"

(V=.33, and .31 respectively); "Man/Woman" (V=.51, and .27 respectively); "Brother/Sister" (V=.47, and .17 respectively); "Family Breadwinner" (V=.37, and .20 respectively); "Spanish Speaker" (V=.28, and .24 respectively); and "United States Native" (V=.29, and .26 respectively).

HYPOTHESIS: Persons who prefer the term Chicano score a higher score on the ethnic identity scale.

Two separate tables were constructed. One was constructed from those that preferred the term "Chicano" and those who preferred any other term when speaking with their family; and the second table was constructed from those that preferred the term "Chicano" and those who preferred any other term when speaking with persons who are not of Mexican descent. These two tables were separately cross-tabulated with the ethnic identity scale. The t-Test showed no statistical significance between the term used with family and ethnic identity (t=1.69 with 98 degrees of freedom with a probability of .098). However, the difference between terms used with persons who are not of Mexican descent and ethnic identity proved to be statistically significant (t=2.53 with 98 degrees of freedom with a probability of .013).

In the Texas sample, the opposite results occurred. The ANOVA analysis showed terms used with family to be statistically significant with ethnic identity (F=7.412, prob=.01) while terms used with persons who are not of Mexican descent were not statistically significant with ethnic identity (F=.014, prob=.90). In the Texas sample, 33 respondents out of 346, or 9.5 percent, preferred the term "Chicano" when speaking about people of Mexican descent with their family, compared to 8 respondents in the Lansing sample or 8 percent. Of these 33, one or .3 percent had a zero ethnic score, 13 or 3.6 percent had a low

ethnic score, 10 or 2.9 percent had a moderate ethnic score, and 9 or 2.6 percent had a high ethnic score compared to zero percent, one percent, 2 percent, and 3 percent, respectively, for the Lansing sample. The Texas sample also showed only 20 5.8 percent preferred the term "Chicano" when speaking about people of Mexican descent with persons who are not of Mexican descent. Of these 20, 1.4 percent had a zero ethnic score, 11 or 3.2 percent had a low ethnic score, 3 or zero percent had a moderate ethnic score, and 4 or 1.2 percent had a high ethnic score compared to zero percent, zero percent, 4 percent, and 4 percent, respectively, for the Lansing sample.

The hypothesis was partly supported by both samples. These differences might be explained by several factors or a combination of these factors: the same term or label might have different political or cultural connotations to different people; some ethnic terms are regional (different regions of the country prefer and use different terms); the news media continues to change the terms they use, and the media uses different terms in different parts of the country. The common term being used by the media in Lansing this year is "Hispanic," as opposed to "Latino" used last year.

An important distinction between the Lansing sample and the Texas sample was that the Texas sample seemed more comfortable in using the term "Mexican" with both family (171 or 50 percent) and with the public (105 or 34 percent), compared with the Lansing sample who use the term "Mexican" with family (61 or 61 percent) and with the public or persons who are not of Mexican descent (22 or 22 percent).

The Chi-square test showed no statistical significance between the ethnic identity scale and the table of all ethnic terms used with

the family when speaking about persons of Mexican origin with either the Lansing sample (Chi=31.81610, V=.56, sig=.0611), or the Texas sample (Chi=20.51, V=.14, sig=.49). Cramer's V shows a higher degree of association for the Lansing sample (V=.56) than for the Texas sample (V=.14). The Chi-square test showed no statistical significance either between the ethnic identity scale and the table of all ethnic terms used with persons who are not of Mexican origin when speaking about persons who are of Mexican origin for the Lansing sample (Chi=25.49301, V=.50, sig=.3794), and the Texas sample (Chi= 27.43, V=.17, sig=.16). As in the previous comparison, the Lansing sample had a higher degree of association (V=.50) than the Texas sample (V=.17).

HYPOTHESIS: The level of ethnic identity is directly proportional to the degree of Chicano density or concentration in the community; the greater the Chicano density, the greater the level of ethnic identity, and vice-versa.

The Pearson Product-Moment correlation coefficient test showed no statistical significance between ethnic identity and density (r= -.04968, sig=.3118) (Table 17). This hypothesis was not supported by the sample. Lansing has a rather small percentage of Chicanos with only 3.9 percent of the total population being persons of Spanish language background. The concentration or density of Chicanos is very low, with the highest density being only 16.6 percent of the population in a United States Census tract. The level of density was also cross-tabulated with other variables such as familiarity with mental health services, attitudes toward mental health services, frequency of stress, private self-esteem, public self-esteem, personal efficacy, utilization of informal resources, and utilization of formal

Table 17.--Ethnic Identity and Density.

| DENSITY | ETHNIC IDENTITY | | | | |
|---|---|---|---|---|---|
| | None | Low | Moderate | High | Row Total |
| Less than 2% (count) | 1 | 5 | 2 | 4 | 12 |
| (row pct) | 8.3 | 41.7 | 16.7 | 33.3 | 33.3 |
| 2 to 5% | 2 | 14 | 12 | 9 | 37 |
| | 5.4 | 37.8 | 32.4 | 24.3 | 37.0 |
| 5 to 10% | 1 | 7 | 5 | 5 | 18 |
| | 5.6 | 38.9 | 27.8 | 27.8 | 18.0 |
| Greater than 10% | 4 | 11 | 11 | 7 | 33 |
| | 12.1 | 33.3 | 33.3 | 21.2 | 33.0 |
| Column Total | 8 | 37 | 30 | 25 | 100 |
| | 8.0 | 37.0 | 30.0 | 25.0 | 100.0 |

resources; and there was no significance between density and any of these variables.

The Texas sample, which ranged from zero percent to 100 percent Chicano with a mean of 50.6 percent, did not show any statistical significance either between density and identity (r=-.0796) and (Chi= 10.22, V=.12, sig=.12). The Chi-square test for the Lansing sample was (Chi=2.88396, V=.17, sig=.9687). So it seems that the concentration of Chicanos in the community has no effect on the level of ethnic identity for persons of Mexican origin.

HYPOTHESIS: The greater the generational distance from Mexico, the lower the degree of ethnic identity.

The Pearson Product-Moment correlation showed no statistical significance between the ethnic identity scale and the generational table (r=.02104, sig=.4251) (Table 18). The generational table was

Table 18.--Ethnic Identity and Generations in the United States.

| GENERATIONS IN UNITED STATES | ETHNIC IDENTITY | | | | Row Total |
|---|---|---|---|---|---|
| | None | Low | Moderate | High | |
| Zero | | | | | |
| (count) | 0 | 2 | 1 | 1 | 4 |
| (row pct) | 0.0 | 50.0 | 25.0 | 25.0 | 4.9 |
| One | 3 | 15 | 5 | 9 | 32 |
| | 9.4 | 46.9 | 15.6 | 28.1 | 38.6 |
| Two | 1 | 12 | 10 | 4 | 27 |
| | 3.7 | 44.4 | 37.0 | 14.8 | 32.5 |
| Three | 2 | 4 | 4 | 2 | 12 |
| | 16.7 | 33.3 | 33.3 | 16.7 | 14.5 |
| Four | 1 | 1 | 4 | 2 | 8 |
| | 12.5 | 12.5 | 50.0 | 25.0 | 9.6 |
| Column Total | 7 | 34 | 24 | 18 | 83 |
| | 8.4 | 41.0 | 28.9 | 21.7 | 100.0 |

also cross-tabulated with familiarity with mental health services, attitudes toward mental health services, frequency of stress, private self-esteem, public self-esteem, personal efficacy, utilization of formal resources, and utilization of informal resources; and there was no statistical significance between the number of generations in the United States and any of these variables.

The national survey did not include a question to determine the generational distance of the respondents. However, the National Institute for Social Research constructed a comparable generational table for the Texas sample for the purpose of comparison with the Lansing sample. The Chi-square test showed no statistical significance between generational distance and ethnic identity (Chi=11.09,

V=.13, sig=.09). The Chi-square test for the Lansing sample was Chi= 9.69, V=.31, sig=.6426. Generational distance, like density, also seems to have no effect on the degree or level of ethnic identity.

HYPOTHESIS: The level of education has no relation to the level of ethnic identity.

The Pearson Product-Moment correlation shows no statistical significance (r=.14833, sig=.0704) (Table 19), so this hypothesis was supported by the data. The sample was small (100 respondents) with r being greater than .14, indicating that if the sample were larger, education might be significant. The Pearson Product-Moment correlation with the Texas sample between education and ethnic identity also showed no statistical significance (r=.0831).

Table 19.--Ethnic Identity and Education.

| LEVEL OF EDUCATION | ETHNIC IDENTITY | | | | Row Total |
|---|---|---|---|---|---|
| | None | Low | Moderate | High | |
| None | | | | | |
| (count) | 0 | 2 | 2 | 3 | 7 |
| (row pct) | 0.0 | 28.6 | 28.6 | 42.9 | 7.0 |
| Grammar | 4 | 16 | 11 | 7 | 48 |
| (1 to 8) | 8.3 | 33.3 | 43.6 | 14.8 | 48.0 |
| High School | 4 | 15 | 10 | 8 | 37 |
| (9 to 12) | 10.8 | 40.5 | 27.0 | 21.6 | 37.0 |
| Some | 0 | 4 | 7 | 7 | 18 |
| College | 0.0 | 22.2 | 38.9 | 38.9 | 18.0 |
| Column | 8 | 37 | 30 | 25 | 100 |
| Total | 8.0 | 37.0 | 30.0 | 25.0 | 100.0 |

Education was also correlated with familiarity with mental health services, attitudes toward mental health services, frequency of stress,

private self-esteem, public self-esteem, personal efficacy, utilization of formal resources, and utilization of informal resources. The correlation was only significant with three of these variables. The correlation with familiarity with mental health services (r=.19765, sig=.0249) was moderately statistically significant compared to private self-esteem (r=.37596, sig=.0001) and public self-esteem (r=.30717, sig=.0009) which were highly statistically significant.[9]

The correlation of ethnic identity with the other independent variables of birthplace, language, income, occupational status, and availability of relatives in the area proved to be significant only with language (r=-.2140, sig=.0169), and occupation status (r=.22178, sig=.0173). The interesting finding about language is that English was found to be positively correlated to ethnic identity and Spanish was found to be inversely related to ethnic identity. This might be because of the very small percentage of Chicanos in Lansing. Chicanos have less chances of speaking Spanish, less chances of learning Spanish, etc., so they become more comfortable with English, and prefer English to Spanish. Other factors such as "Chicano Week Celebration" at local grammar and high schools, cultural classes at local churches, celebration of Mexican holidays by different groups (for example, the traditional celebration of the 16th of September, Mexico's day of independence that is celebrated every year in Lansing and other Michigan cities), and orientation by parents at home, which need to be researched, might contribute to the degree of ethnic identity in Lansing. Also, the Chicano Movement has made ethnic identity more of a political identity than a historical or cultural one (nationally).

HYPOTHESIS: The sample from Texas will have a greater level of ethnic identity than the sample from Lansing.

The frequency distribution table for ethnic identity for the Lansing sample shows 8 (8 percent) scored a "zero" ethnic identity score, 37 (37 percent) scored a "low" score, 30 (30 percent) scored a "moderate" score, and 25 (25 percent) scored a "high" score. Assigning values of 1 for zero, 2 for low, 3 for moderate, and 4 for high, as in the Texas sample, the mean score for the Lansing sample was 2.72.

The frequency distribution table for the Texas sample indicated that 13 or 3.8 percent scored a "zero" ethnic identity score, 201 or 59.5 percent scored a "low" score, 75 or 22.2 percent scored a "moderate" score, and 49 or 14.5 percent scored a "high" score, with a mean score of 2.47.

The two mean scores are almost equal, with the Lansing sample receiving the higher score. The one-way ANOVA Test between the Texas ethnic identity scale and the Lansing scale showed no significance at the .05 level ($F=6.95$ with 1 to 436 degrees of freedom). The hypothesis was not supported by the study since the Lansing sample had a slightly higher mean score than the Texas sample. The Texas sample might have had more respondents scoring a "low" score because of a greater concentration. They are constantly exposed to the culture in daily interactions with their peers, neighbors, fellow workers, radio and television programs in Spanish, movies, plays, concerts, newspapers, etc., and they might see this as a normal way of life and take it for granted; while the Lansing sample, because of their small concentration, get their ethnic culture in an "emphasized" manner in special cultural classes and yearly ethnic celebrations. The Lansing

sample might be more conscious of their singularity and ethnic difference as an American living in Europe might be more conscious of being American due to living with a majority which is different from himself.

Mental Health Status: Self-Esteem and Personal Efficacy

There are five hypotheses on mental health status defined in this study as self-esteem and personal efficacy. The first one is under the descriptive objectives on how self-esteem and personal efficacy relate to each other; three are under the analytical objectives on how self-esteem and personal efficacy are affected by the different independent variables; and the last one is under the comparative objectives on how the Lansing sample compares to the Texas results from the national study.

HYPOTHESIS: Personal efficacy and self-esteem are directly related to each other; the higher the level of personal efficacy, the higher the level of self-esteem; the lower the level of personal efficacy, the lower the level of self-esteem.

The Pearson Product-Moment correlation showed both private self-esteem and public self-esteem to be statistically significant to personal efficacy. The level of significance of the correlation with the private self-esteem scale was (r=.26017, sig=.0045) and with the public self-esteem scale was (r=.35095, sig=.0002). As these two sets of figures indicate, the correlation with the public self-esteem scale was highly significant and also more correlated than with the private self-esteem scale. This hypothesis was strongly supported by the sample.

The Texas sample also showed a very high statistical significance between personal efficacy and private self-esteem (r=.361, sig=.0000004),

and public self-esteem (r=.279, sig=.0000111). This hypothesis was strongly supported by both samples.

HYPOTHESIS: The degree of personal efficacy and self-esteem is directly proportional to the level of ethnic identity; the higher the level of ethnic identity, the greater the level of personal efficacy and self-esteem and vice-versa.

The Pearson Product-Moment correlation showed no statistical significance of ethnic identity with either personal efficacy (r=.08299, sig=.2058), private self-esteem (r=-.08050, sig=.2130), or public self-esteem (r=.02813, sig=.3906). This hypothesis was not supported by the sample.

Fabrega and Wallace (1968) have suggested that there could be a curvilinear relationship between acculturation and psychiatric impairment, so ethnic identity was also tested by the F-test for curvilinearity with personal efficacy, private self-esteem, and public self-esteem. The F-test did not show any statistical significance: personal efficacy (F=1.30865, sig=.275), private self-esteem (F= .97258, sig=.382), and public self-esteem (F=.18777, sig=.829).

The Texas sample did not show any statistical significance between ethnic identity and personal efficacy (r=.0214), private self-esteem (r=-.0508), and public self-esteem (r=.464). The hypothesis was not supported by either sample.

HYPOTHESIS: There is a curvilinear relationship between Chicano density and self-esteem and personal efficacy; higher and lower density results in higher self-esteem and personal efficacy, whereas median density results in lower self-esteem and personal efficacy ("marginality").

The F-test for curvilinearity showed no statistical significance between ethnic identity and private self-esteem (F=.97258, sig=.382),

public self-esteem (F=.18777, sig=.829), and personal efficacy (F= 1.30865, sig=.275). The hypothesis was not supported by the sample.

The Pearson Product-Moment correlation did not show any statistical significance on a lineal regression between ethnic density and private self-esteem (r=-.102453, sig=.4043), public self-esteem (r= -.01171, sig=.4540), personal efficacy (r=-.00238, sig=.4906).

Density was also cross-tabulated with familiarity with mental health services, attitudes toward mental health services, frequency of stress, utilization of formal resources, and utilization of informal resources; no statistical correlation was found. At least in Lansing, density has no effect on any of the variables researched in this study.

The F-test for curvilinearity was not available from the Texas sample, however, the Pearson Product-Moment correlation showed no statistical significance between Chicano density and private self-esteem (r=-.0375), public self-esteem (r=-.0590), and personal efficacy (r=-.0398). In the Texas sample, density was only statistically correlated with years of education (r=-.112, sig=.037) and total family income (r=-.237, sig=.00014).

HYPOTHESIS: The degree of personal efficacy and self-esteem is inversely proportional to the level of frequency of major stress from life problems; the greater the frequency of major stress, the lower the level of personal efficacy and self-esteem.

The Pearson Product-Moment correlation showed a very high statistical correlation between frequency of stress and personal efficacy (r=-.44163, sig=.0000) (Table 20) and public self-esteem (r=-.21796, sig=.0147) (Table 21), but not with private self-esteem (r=-.03016, sig=.3829).[10] These results support part of the hypothesis.

Table 20.--Personal Efficacy and Frequency of Stress.

| PERSONAL EFFICACY | FREQUENCY OF STRESS | | | | | Row Total |
|---|---|---|---|---|---|---|
| | Often | Sometimes | Rarely | Never | No Answer | |
| Low (10-20) | | | | | | |
| (count) | 9 | 10 | 2 | 1 | 0 | 22 |
| (col pct) | 56.3 | 37.0 | 16.7 | 2.3 | 0.0 | 22.0 |
| Medium | 5 | 14 | 4 | 22 | 1 | 46 |
| (21 | 31.3 | 51.9 | 33.3 | 50.0 | 100.0 | 46.0 |
| High | 2 | 3 | 6 | 21 | 0 | 32 |
| (31 | 12.5 | 11.1 | 50.0 | 47.7 | 0.0 | 32.0 |
| Column | 16 | 27 | 12 | 44 | 1 | 100 |
| Total | 16.0 | 27.0 | 12.0 | 44.0 | 1.0 | 100.0 |

Table 21.--Public Self-Esteem and Frequency of Stress.

| PUBLIC SELF-ESTEEM | FREQUENCY OF STRESS | | | | | Row Total |
|---|---|---|---|---|---|---|
| | Often | Sometimes | Rarely | Never | No Answer | |
| Low | | | | | | |
| (count) | 6 | 6 | 2 | 5 | 0 | 19 |
| (col pct) | 37.5 | 22.2 | 16.7 | 11.4 | 0.0 | 19.0 |
| | 7 | 16 | 4 | 23 | 1 | 51 |
| Medium | 43.6 | 59.3 | 33.3 | 52.3 | 100.0 | 51.0 |
| | 3 | 5 | 6 | 16 | 0 | 30 |
| High | 18.6 | 18.5 | 50.0 | 36.4 | 0.0 | 30.0 |
| Column | 16 | 27 | 12 | 44 | 1 | 100 |
| Total | 16.0 | 27.0 | 12.0 | 44.0 | 1.0 | 100.0 |

If the respondents see the majority of stress resulting from something they have no control over such as a relative dying, not getting a job or promotion because of racial discrimination, having financial problems because of the economy, etc., it might affect their personal efficacy and public self-esteem while still feeling good about themselves as individuals and still having a high private self-esteem.

The private self-esteem scale was also cross-tabulated with birthplace, language, education, income, occupational status, generational distance from Mexico, and availability of mutual support groups. The Pearson Product-Moment correlation showed private self-esteem to be statistically correlated with education (r=.37596, sig=.0001), income (r=.25542, sig=.0060), occupational status (r=.22942, sig=.0144), and availability of mutual support groups in the area (r=.18320, sig=.0340) with education being the most significant variable.[11]

Public self-esteem was cross-tabulated with birthplace, language, education, occupational status, generational distance from Mexico, and availability of mutual support groups. The Pearson Product-Moment correlation shows a statistical correlation with language (r=-.28309, sig=.0022), education (r=.30717, sig=.0009), and occupational status (r=.25930, sig=.0065), with education being the most significant variable as with private self-esteem.[12]

As with private self-esteem and public self-esteem, personal efficacy was also cross-tabulated with birthplace, language, education, income, occupational status, generational distance from Mexico, and availability of mutual support groups. The Pearson Product-Moment correlation showed that, unlike private and public self-esteem,

personal efficacy was only statistically correlated with income (r= .20180, sig=.0243).

The Texas sample also showed a statistical significance only between frequency of stress and personal efficacy (r=-.398, sig=.0000001), and public self-esteem (r=-.140, sig=.010), but not with private self-esteem (r=.0107).

HYPOTHESIS: The sample from Texas will have a greater level of self-esteem and personal efficacy than the sample from Lansing.

The personal efficacy scale from the Texas sample showed a mean score of 26.055, compared to 27.08 for the Lansing sample. The mean scores for the private self-esteem scale for the Texas sample were 34.510 compared to 34.57 for the Lansing sample; for the public self-esteem scale the mean score for the Texas sample was 25.793 compared to 27.00 for the Lansing sample. The mean scores for both samples were very close, with the mean scores for private self-esteem being almost equal, and the personal efficacy and public self-esteem scores being slightly higher for the Lansing sample.

The one-way ANOVA Test between the personal efficacy scales for the Texas sample and the Lansing sample (F=1.86 with 1 to 442 degrees of freedom), the private self-esteem scales (F=.01 with 1 to 439 degrees of freedom), and the public self-esteem scales (F=2.37 with 1 to 436 degrees of freedom) showed no significance at the .05 level for any of the three tests. This hypothesis was not supported by the study since the Lansing sample had slightly higher mean scores.

It seems that persons of Mexican origin in Lansing maintain the same level of personal efficacy and self-esteem as their counterparts in Texas despite their small concentration and isolation from their

"motherland." With 50 percent of the respondents from the Lansing sample being originally from Texas, there should be many similarities between personal efficacy and self-esteem scores, just as there were between both samples' ethnic identity scores.

Utilization of Mental Health Resources

There were seven hypotheses to be tested on utilization of mental health resources. One of the hypotheses is under the descriptive objectives on how the utilization of formal and informal mental health resources relate to each other; and the other six hypotheses are under the analytic objectives on how the various independent variables affect the utilization of either or both formal and informal mental health resources.

HYPOTHESIS: Persons of Mexican origin underutilize formal mental health resources because they utilize informal mental health resources.

The Pearson Product-Moment correlation showed a very high statistical significance between utilization of formal and informal resources (r=.27190, sig=.0032). The cross-tabulation showed that of the 80 respondents utilizing informal resources, 40 also utilized formal resources and the other 40 did not. Of the 43 respondents that utilized formal resources, 40 utilized informal resources while only 3 did not. Sixteen of the total respondents did not utilize any resources at all (Table 22). This hypothesis was not supported by the sample since there was a positive correlation between the utilization of formal and informal resources, not a negative one.[13]

Table 22.--Utilization of Formal and Informal Mental Health Resources.

| FORMAL RESOURCES | INFORMAL RESOURCES | | Row Total |
|---|---|---|---|
| | Yes | No | |
| Yes | 40 | 3 | 43 |
| (row percent) | 93.0 | 7.0 | 43.4 |
| (column percent) | 50.0 | 15.8 | |
| No | 40 | 16 | 56 |
| (row percent) | 71.4 | 28.6 | 56.6 |
| (column percent) | 50.0 | 84.2 | |
| Column Total | 80 | 19 | 99 |
| | 80.8 | 19.2 | 100.0 |

The Texas sample also showed a high positive statistical significance between utilization of formal and informal resources (r=.148, sig=.008). This hypothesis was not supported by the Texas sample.

HYPOTHESIS: (Tentative Assumption) The higher the level of ethnic identity, the greater the utilization of informal mental health resources; the lower the level of ethnic identity, the greater the utilization of formal mental health resources.

The Pearson Product-Moment correlation of ethnic identity with the utilization of both formal (r=.06615, sig=.2566) and informal (r=.12725, sig=.1047) mental health resources showed no statistical significance for the Lansing sample. The Texas sample also showed no significance for utilization of formal (r=.0353) or informal (r=.0013) mental health resources. The multiple linear regression with stepwise addition of variables showed that ethnic identity was significant at .017 with a Beta of -.344 with utilization of formal resources and not significant with utilization of informal resources (Tables 23 and

24). This hypothesis (tentative assumption) was partly supported by the sample.

Table 23.--Standardized Beta Weights and Significance--Formal Resources.

| VARIABLES | BETA | F | SIGNIFICANCE | ZERO-ORDER CORRELATION |
|---|---|---|---|---|
| Familiarity with Formal Services | .4499323 | 11.276158 | .003 | .47629 |
| Sex* | -.2062761 | 2.738560 | .114 | -.28871 |
| Public Self-Esteem | -.7188170 | 20.355764 | .000 | -.30675 |
| Personal Efficacy | .6378037 | 17.401691 | .000 | .23684 |
| Marital Status** | .6731362 | 15.468522 | .001 | .09968 |
| Ethnic Identity | -.3440863 | 6.781815 | .017 | .04369 |
| Generations in United States | .2195509 | 3.321184 | .083 | .02717 |
| Income | .2484979 | 2.887794 | .105 | .00816 |
| Relatives in Area | -.2150453 | 2.716957 | .115 | -.22630 |
| Frequency of Stress | -.2155354 | 2.453853 | .133 | .04557 |
| (Constant) | | .9615757 | .339 | |

* Sex is coded: 1=male, 2=female.
** Marital Status is coded: 1=married, 2=divorced, 3=widowed, and 4=single. Due to the nominal level of measurement of this variable, the association may be overstated and the sign may be misleading.

Table 24.--Standarized Beta Weights and Significance--Informal Resources.

| VARIABLES | BETA | F | SIGNIFICANCE | ZERO-ORDER CORRELATION |
|---|---|---|---|---|
| Years of Formal Education | -.1345928 | .559002 | .462 | -.41851 |
| Personal Efficacy | .6803522 | 15.528732 | .001 | .37151 |
| Income | -.4763121 | 8.041535 | .009 | -.37188 |
| Public Self-Esteem | -.3765461 | 4.356835 | .048 | -.07636 |
| Ethnic Identity | -.2771051 | 3.557742 | .072 | -.14834 |
| Density | -.2472123 | 2.590763 | .121 | -.09143 |
| Familiarity with Formal Services | -.2238112 | 2.244756 | .148 | .01109 |
| (Constant) | | 5.544870 | .027 | |

HYPOTHESIS: Persons of Mexican origin underutilize formal mental health resources because they are unfamiliar with their services.

The Pearson Product-Moment correlation showed familiarity with mental health resources to be very highly significant with utilization of formal resources (r=.27132, sig=.0033). The cross-tabulation showed 66 percent of the respondents who were familiar with the services utilized them, while only 33 percent of those who were familiar did not utilize these services. Of those not familiar with the services, 34 percent utilized them anyway, while 66 percent did not (Table 25). This hypothesis was supported by the data.

Table 25.--Familiarity and Utilization of Formal Resources.

| UTILIZED FORMAL RESOURCES | FAMILIARITY WITH FORMAL RESOURCES | | | Row Total |
|---|---|---|---|---|
| | Familiar | Partly Familiar | Unfamiliar | |
| Yes | 20 | 4 | 18 | 42 |
| (row percent) | 47.6 | 9.5 | 42.9 | 42.4 |
| (column percent) | 66.7 | 25.0 | 34.0 | |
| No | 10 | 12 | 35 | 57 |
| (row percent) | 17.5 | 21.1 | 61.4 | 57.6 |
| (column percent) | 33.3 | 75.0 | 66.0 | |
| Column Total | 30 | 16 | 53 | 99 |
| | 30.3 | 16.2 | 53.5 | 100.0 |

The national study did not collect any data on the respondents' familiarity with mental health resources, so this hypothesis could not be tested with the Texas sample.

HYPOTHESIS: Persons of Mexican origin underutilize formal mental health resources because they have negative attitudes about these services.

The Pearson Product-Moment correlation showed no statistical significance between attitudes toward mental health services and utilization of formal resources (r=.13452, sig=.1949). The number of respondents who were familiar with the services (to be able to have some attitude about them) was very small at 43. Of these respondents, 13 thought the services were favorable, 23 thought the services were somewhat favorable, and 7 thought the services were unfavorable. The hypothesis was not supported by the sample.

The national study did not collect any data on the respondents' attitudes on mental health resources, so this hypothesis could not be

tested with the Texas sample.

HYPOTHESIS: The utilization of formal mental health services is directly proportional to socioeconomic status; the higher the socioeconomic status, the greater the utilization of formal resources.

Socioeconomic status was measured by three different variables: income, education, and occupational status. The Pearson Product-Moment correlation showed no statistical significance between income and either utilization of formal resources (r=.04702, sig=.3246) or utilization of informal resources (r=.08288, sig=.2123). The Pearson correlation also showed no significance between education and utilization of formal resources (r=.07637, sig=.2251), however, it did show a statistical significance between education and utilization of informal resources (r=.18393, sig=.0342). The correlation between occupational status and utilization of formal resources was almost significant (r=.17187, sig=.0517), but was not significant with utilization of informal resources (r=.12451, sig=.1212).

The national sample did not tabulate their occupational data by occupational status so the Texas sample was not correlated by this variable. However, the correlation by income and education gave the same results as with the Lansing data. The Pearson Product-Moment correlation showed no statistical significance between income and utilization of formal resources (r=.144) or informal resources (r=.0998) and education and utilization of formal resources (r=.0488). As with the Lansing sample, the Texas sample showed a significant correlation between education and the utilization of informal resources (r=.150, sig=.008). The hypothesis was not supported by either the Lansing sample or the Texas sample.

HYPOTHESIS: The utilization of informal mental health resources is directly proportional to Chicano density; the greater the Chicano density, the greater the utilization of informal support resources.

The Pearson Product-Moment correlation showed no statistical significance between Chicano density and utilization of formal resources (r=.03926, sig=.3491) and utilization of informal resources (r=-.03836, sig=.3531). The Pearson correlation for the Texas sample also showed no significant correlation between density and utilization of formal resources (r=.0515) and informal resources (r=-.0066). This hypothesis was not supported by either sample.

HYPOTHESIS: Persons of Mexican origin underutilize formal mental health services because of lower frequency of stress.

The Pearson Product-Moment correlation showed no statistical significance between utilization of formal resources and frequency of stress (r=.10721, sig=.1442). There was, however, a significant correlation between utilization of informal resources and frequency of stress (r=.22056, sig=.0141). The comparison with the Texas sample showed no statistical significance between frequency of stress and utilization of formal resources (r=-.0222) and informal resources (r=-.0570). This hypothesis was not supported by either sample.

Utilization of formal resources was also cross-tabulated with the following variables: private self-esteem, public self-esteem, personal efficacy, birthplace, language, generational distance, availability of mutual support groups, and types of problems. Of these variables, only seeking help from a lawyer was statistically significant (Chi= 15.91125, V=.40, sig=.0437). Utilization of informal resources was also cross-tabulated with the same preceeding variables. Utilization of informal resources was statistically significant with: private

self-esteem (r=.28072, sig=.0024), language (r=.19192, sig=.0279), frequency of stress (r=.22056, sig=.0141), and seeking help from the father (Chi=26.25302, V=.51, sig=.0010).

Since the utilization of formal and informal mental health resources may not be due to a simplistic set of relationships, but may be confounded by many demographic and contextual variables, a multiple linear regression with step-wise addition of variables was done. The variables used in this multiple regression analysis for both utilization of formal and informal resources were: age, sex, birthplace, interview language, years of formal education, income, occupational status, marital status, generations in the United States, density, relatives in the Lansing area, familiarity with mental health services, attitudes toward service providers, frequency of stress, type of problem, ethnic identity, private self-esteem, public self-esteem, personal efficacy, and utilization of either formal or informal resources.

The analysis of utilization of formal resources had a multiple correlation of .86273, F=5.2187, and significance of .000. Ten variables were added to the equation before the F-level or tolerance level was insufficient for further computation: familiarity with services, sex, public self-esteem, personal efficacy, marital status, ethnic identity, generations in the United States, income, relatives in the area, and frequency of stress. Of these ten variables, only five were significant when the other variables were kept constant: familiarity (sig=.003), public self-esteem (sig=.000), personal efficacy (sig=.000), marital status (sig=.001), and ethnic identity (sig=.017 (see Table 23, page 142).

The analysis of utilization of informal resources had a multiple correlation of .75907, F=4.46710, and significance of .003. Eight variables were added to the equation before the F-level or tolerance level was insufficient for further computation: years of formal education, personal efficacy, income, public self-esteem, ethnic identity, density, and familiarity with mental health services. Of these eight variables, only three were significant when the other variables were held constant: personal efficacy (sig=.001), income (sig=.009), and public self-esteem (sig=.048). Ethnic identity was not significant with the utilization of informal resources as it was with utilization of formal resources (see Table 24, page 143).

Summary

The data were analyzed and the hypotheses tested by both bivariate correlation analysis and multiple linear regression analysis. The tests used were: Chi-square, Cramer's V, t-Test, F-Test for curvilinearity, Pearson Product-Moment correlation, and Multiple Linear Regression with step-wise addition of variables. The major conclusions were that the main reasons for the underutilization of formal mental health resources by Chicanos in Lansing, Michigan, are the levels of personal efficacy and public self-esteem, degree of ethnic identity, and unfamiliarity with mental health centers and services; and that persons of Mexican origin in Lansing, Michigan, scored slightly higher scores on ethnic identity, self-esteem, and personal efficacy than do persons of Mexican origin in Texas.

# CHAPTER VI

# SUMMARY, CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS

## Adequacy of Sample

It was assumed that not all Spanish surnamed persons would be eligible for the study (that is, be of Mexican origin) and that not all of those eligible would want to or be able to participate in the study. To allow for this and also to get a more accurate estimate of the percentage of persons of Mexican origin in Lansing, more persons were screened (184) than were needed for the study (100). Out of the total of 184 persons that were screened, 171 persons were of Mexican origin and eligible for the study. Most of the eligible persons agreed to participate in the study with a few indicating that the interview would be more convenient at a later date. The necessary 105 interviews (5 were rejected for being incomplete) were done at the earliest convenient time for the respondents.

A limitation of the Lansing study was that the last sampling step resulted in a non-random selection of 61.4 percent of the total found to be eligible, resulting in limited conclusions from a small participation rate. The other 38.6 percent might have given different answers resulting in different conclusions. A limitation in the comparison with the Texas sample was that the Texas sample was taken from both urban and rural areas, with differences uncontrolled in comparisons

with the urban sample from Lansing. The results from the study should be generalized to the Lansing Chicano population only, and not to Chicanos in other parts of the United States.

Summary of Results

Of the 100 persons of Mexican origin interviewed, 57 were male and 43 were female. Of these respondents, a majority seemed to prefer English to Spanish, with 53 (53 percent) electing to do the interview in English, and the other 47 (47 percent) choosing Spanish. In side conversations or interruptions during the interview, 39 (39 percent) spoke only English, while 18 (18 percent) used only Spanish.

A substantial majority of the sample, 79 (79 percent) were born in the United States, with only 21 (21 percent) born in Mexico. Fifty of the respondents or 63 percent born in the United States were from Texas, and only 21 of the total sample were born in Michigan. The median length of time of residency in Lansing, Michigan, was 15.9 years, and the number of generations born in the United States ranged from one to four generations.

The median level of education was 8.7 years of formal education. The main job or occupation was quite varied, with the two largest groups being auto factory workers for males, and homemakers (or housewives) for females. The total family income was also quite varied, ranging from under $2,000 to over $30,000 per year, with the median income being $12,000. A majority of the sample, 65 percent, lived in homes judged better than average compared to the rest of the homes in the same neighborhood by the interviewers.

Even though only 21 percent of the sample reported being from Lansing, a very high percentage of the respondents (69 percent) reported that they have relatives living in the area. The number of relatives in the area ranged from one to 60, with an average of 5.3 relatives per respondent. Most respondents with relatives in the area indicated they visited them often, and had either helped or had been helped with such things as food, clothing, money, housing, repairs, furniture, transportation, and advice from relatives or friends. Most of the Chicanos in Lansing seem to have a mutual support system which is utilized often.

Less than half of the total sample (39 percent) were familiar with traditional, mainstream "Anglo" formal mental health services. A majority of the sample (71 percent) were familiar with the services at Cristo Rey Counseling Center, a Chicano-oriented mental health center. The overall attitude toward mental health services was positive, with a greater number of respondents familiar with services feeling that Anglo-oriented centers were more adequate for most problems, rather than the Chicano-oriented program at Cristo Rey.

The majority of the respondents preferred the term "Mexican" when speaking to members of their own families, but preferred the term "Chicano" when speaking to people who are not of Mexican origin. On the ethnic identity scale, the greatest number was 39 with a "low" score, 30 with a "moderate" score, 25 with a "high" score, and 8 with a "no ethnic identity" score. The single term most identified with respondents was "Mother/Father," indicating a strong identification with the concept of family.

The mental health status of the sample was measured by three scales: a personal efficacy scale, a private self-esteem scale, and a public self-esteem scale with scoring on each scale of 10 to 40. The median score was 25.8 for the personal efficacy scale, 34.5 for the private self-esteem scale, and 25.4 for the public self-esteem scale.

Only a little more than half of the sample or 55 percent indicated experiencing any great stress from "rarely" to "often;" and a great portion of the sample (44 percent) indicated they had never experienced any great stress from any situation. Only 10 percent of the respondents mentioned having any mental health related problems, with most of the problems mentioned being related to physical health, especially the death of a close relative.

Most of the sample (80 percent) indicated going to an informal resource in times of stress or problems. The family was the source most often utilized, with the spouse being the family member most utilized for help, support and comfort. Forty-three (43 percent) also indicated utilizing formal resources, with clergymen or priests being the most utilized for help and advice.

## Conclusions and Implications

### Hypotheses

HYPOTHESIS: The degree of ethnic identity has no effect on the degree of identifying with other social groups, or social roles.

This hypothesis was partly supported by the sample since some of the social terms were correlated to a statistical significance. Mental health practitioners need to be aware that Chicanos identify

strongly with other social groups and social roles, especially with familial and biological roles, and that situations or circumstances which disrupt a function such as that of "Family Breadwinner" may contribute to stress or some social dysfunction.

HYPOTHESIS: Persons who prefer the term Chicano score a higher score on the ethnic identity scale.

This hypothesis was partly supported since terms used with persons who are not of Mexican descent and ethnic identity proved to be statistically significant. This implies that the Lansing Chicano is more sensitive about what ethnic term or label he prefers to use with non-Chicanos as opposed to Chicanos, and especially with members of the family. Non-Chicanos that interact with Chicanos need to be aware of which labels are acceptable or "safe" since some might object to labels with such connotations as "too radical," "conservative," "angloized," etc.

HYPOTHESIS: The level of ethnic identity is directly proportional to the degree of Chicano density or concentration in the community; the greater the Chicano density, the greater the level of ethnic identity, and vice-versa.

This hypothesis was not supported by either sample, even though the Texas sample had a much higher concentration of Chicanos. Mental health practitioners should be aware that regardless of the community that Chicano clients might be from, ethnic identity should be considered in diagnosis and treatment.

HYPOTHESIS: The greater the generational distance from Mexico, the lower the degree of ethnic identity.

This hypothesis was not supported by the sample. Regardless of what generation they are, people are exposed to a variety of variables such as news media which might influence their ethnic identity. The

implication for social work practice is that the new arrivals as well as fifth generation Chicanos might have the same degree of ethnic identity.

HYPOTHESIS: The level of education has no relation to the level of ethnic identity.

This hypothesis was supported by the sample. The implication for social work practice is that no assumptions concerning ethnic identity should be made on the basis of a Chicano client's education level.

HYPOTHESIS: The sample from Texas will have a greater level of ethnic identity than the sample from Lansing.

This hypothesis was not supported by the study. It seems that the Lansing sample is exposed to several variables such as smaller concentration, special ethnic classes and events, fewer Chicano models, etc., which might contribute to a greater feeling of difference or singularity. The implication for social work practice in general is that regardless of where the Chicano population being considered for any type of social work intervention is from, consideration should be given to ethnic identity.

HYPOTHESIS: Personal efficacy and self-esteem are directly proportional to each other; the higher the level of personal efficacy, the higher the level of self-esteem; the lower the level of personal efficacy, the lower the level of self-esteem.

This hypothesis was supported by the study. If either personal efficacy or self-esteem are used as indicators of mental health status, they should be considered as being associated directly with each other.

HYPOTHESIS: The degree of personal efficacy and self-esteem is directly proportional to the level of ethnic identity; the higher the level of ethnic identity, the greater the level of personal efficacy and self-esteem and vice-versa.

This hypothesis was not supported by the sample. Ethnic identity might be more a political awareness than a cultural or social awareness. While level of ethnic identity may not influence mental health status, certain cultural values and roles should still be considered (such as the role the family should play in treatment; what social, familial, and sex role expectations may be affecting the client, etc.) in social work practice.

HYPOTHESIS: There is a curvilinear relationship between Chicano density and self-esteem and personal efficacy; higher and lower density results in higher self-esteem and personal efficacy, where median density results in lower self-esteem and personal efficacy ("marginality").

This hypothesis was not supported by the sample. As a single variable, density was not correlated to any dependent or intervening variable. The implication for social work intervention is that Chicanos, regardless of what type of community they may be from, may still need mental health treatment or services.

HYPOTHESIS: The degree of personal efficacy and self-esteem is inversely proportional to the level of frequency of major stress from life problems; the greater the frequency of major stress, the lower the level of personal efficacy and self-esteem.

This hypothesis was partly supported by the sample, since frequency of stress was correlated with personal efficacy and public self-esteem, and not with private self-esteem. The implication for therapy is that life situations where the individual feels he has no control over or is influenced by what other individuals feel or think, are more stressful than situations where the individual feels he has some influence or control.

HYPOTHESIS: The sample from Texas will have a greater level of self-esteem and personal efficacy than the sample from Lansing.

This hypothesis was not supported by the study, although the Lansing sample had slightly higher mean scores. The implication for social work intervention is that regardless of where the client is from, he or she is still going to be influenced by the same variables that affect personal efficacy and self-esteem such as education, income, occupational status, and availability of mutual support groups.

HYPOTHESIS: Persons of Mexican origin underutilize formal mental health resources because they utilize informal mental health resources.

This hypothesis was not supported by the sample since the correlation between the utilization of formal and informal resources was a positive correlation. The utilization of informal resources has long been used as the reason for the underutilization of formal resources by Chicanos, when most recent scientific studies conclude that even though Chicanos continue to utilize informal resources, this does not prevent them from utilizing formal resources. Mental health providers should "not blame the victim" for their underutilization of formal resources, but rather should look at the formal services themselves and evaluate what element(s) of the services provided might be contributing to underutilization.

HYPOTHESIS: The higher the level of ethnic identity, the greater the utilization of informal resources; the lower the level of ethnic identity, the greater the utilization of formal mental health resources.

This hypothesis was partly supported by the sample. The multiple linear regression analysis showed that ethnic identity was significantly correlated at .017 with a Beta of -.344 (Table 23, p. 142) with

utilization of formal resources. Mental health providers should consider that regardless of level of ethnic identity, Chicanos will need and utilize both formal and informal mental health services.

HYPOTHESIS: Persons of Mexican origin underutilize formal mental health resources because they are unfamiliar with their services.

This hypothesis was supported by the sample. Unfamiliarity with mental health services was the most significant variable for the underutilization of formal mental health services in Lansing. If mental health providers are interested and sincere about providing more services for the Chicano community in Lansing, they must make the community more aware of the services they provide.

HYPOTHESIS: Persons of Mexican origin underutilize formal mental health resources because they have negative attitudes about these services.

This hypothesis was not supported by the sample. Only a very small percentage (43 percent) of the sample was familiar enough with these services to be able to have some attitudes about them. Respondents had the most positive attitudes toward Ingham Community Mental Health Center which is the only center with two Chicano therapists, a factor which mental health providers should consider.

HYPOTHESIS: The utilization of formal mental health services is directly proportional to socioeconomic status; the higher the socioeconomic status, the greater the utilization of formal resources.

This hypothesis was not supported by the sample. There was no correlation between utilization of formal resources and income, education, or occupational status. The same results were obtained from the Texas sample, indicating that SES might not be related to

utilization of formal resources. Mental health providers that plan to promote their services in the Chicano community should try to promote their services throughout the whole community--to all social economic levels.

HYPOTHESIS: The utilization of informal mental health resources is directly proportional to Chicano density; the greater the Chicano density, the greater the utilization of informal resources.

This hypothesis was not supported by the sample. Density was found not to be significant and not correlated to any dependent or intervening variable. Although this hypothesis deals with utilization of informal resources, the implication is that formal mental health resources should be promoted throughout the Chicano community, regardless of density.

HYPOTHESIS: Persons of Mexican origin underutilize formal mental health services because of lower frequency of stress.

This hypothesis was not supported by the sample. This implies that persons of Mexican origin suffer enough stress that they require mental health services just as does the rest of the population.

Ethnic Identity

The degree of ethnic identity was found to have no effect on the degree of identification with other social groups such as Catholic, middle class, parent, spouse, etc. Ethnic identity was also found to have no effect on a person's feeling of self-esteem and personal efficacy, or on the utilization of informal mental health resources.

Ethnic identity was not affected by birthplace, education, income, generational distance from Mexico, Chicano concentration or density in the community, or availability of relatives in the area. The only

factors found in the study that were related to ethnic identity were utilization of formal or professional resources, occupational status and the language the respondent chose for the interview. The study showed the higher the occupational status, the higher the degree of ethnic identity. Respondents who preferred English for the interview tended to score higher on the ethnic identity scale, suggesting that ethnic identity might be becoming more of a political awareness phenomenon than a historical or cultural one.

The comparison with the Texas sample resulted in the same conclusions as the Lansing sample. The hypotheses supported by the Lansing sample were also supported by the Texas sample, and the hypotheses not supported by the Lansing sample were likewise not supported by the Texas sample. In comparing levels of ethnic identity between the two samples, the results were similar, with the Lansing sample slightly higher with a mean of 2.72, compared to 2.47 for the Texas sample.

Mental Health Status

It was concluded that personal efficacy was not affected by such factors as birthplace, language, education, occupational status, generational distance from Mexico, density, availability of mutual support groups, or ethnic identity. It was only influenced by income, frequency of stress, and both private and public self-esteem, with the most influential being frequency of stress.

There was a difference in that some factors affected both private and public self-esteem, and some factors affected only one. Neither one was affected by birthplace, generational distance, density, or ethnic identity, and both were affected by education, and occupational

status. Only private self-esteem was affected by income and availability of mutual support groups; and only public self-esteem was affected by language preferred and frequency of stress. The most significant factor for both private and public self-esteem was education.

The comparison with the Texas sample was the same as in the preceding section, with the same hypothesis either being supported by both samples or not supported by either sample. The comparison between the scales for personal efficacy, private self-esteem and public self-esteem was also similar, with the mean scores for private self-esteem being almost equal at 34.51 for the Texas sample and 34.57 for the Lansing sample. As in the comparison between ethnic identity scores, the Lansing sample was slightly higher than the Texas sample on the personal efficacy scale and the public self-esteem scale.

Utilization of Mental Health Resources

The underutilization of formal mental health resources by Chicanos (at least in Lansing, Michigan) cannot be accounted for by such factors as utilization of informal resources, birthplace, language, education, income, occupational status, generational distance from Mexico, density, availability of mutual support groups, frequency of stress, or type of problem. The bivariate correlation analysis showed that the only factor to have an influence on utilization of formal resources was familiarity with centers and services. Contrary to most of the literature, utilization of informal resources did not prevent the Lansing sample from utilizing formal or professional resources. Forty (93 percent) of the 43 respondents that indicated going to a formal or professional resource also indicated utilizing an informal resource.[13]

The bivariate correlation analysis also showed that utilization of informal resources was influenced by level of private self-esteem, language preferred, education, and frequency of stress, with level of private self-esteem being the most significant. The higher the level of private self-esteem, the greater the utilization of informal resources. The correlation of language and education with utilization of informal resources is interesting because the greater the use of English, the higher the rate of utilization of informal resources; and the higher the level of education, the greater the utilization of informal mental health resources.

The multiple linear regression with step-wise addition of variables of utilization of formal resources showed that five of the variables were statistically significant. The five variables were: familiarity with services, public self-esteem, personal efficacy, marital status, and ethnic identity. The multiple regression of utilization of informal resources showed that three variables were statistically significant. The three variables were: personal efficacy, income, and public self-esteem.

## Recommendations

It was mentioned in the literature review that Oscar Ramirez, in his proposal for research, made the statement that:

> Researchers, even Chicano researchers, too often have made the unwarranted assumption that greater reliance on traditional mental resources is the ultimate and apparently ideal goal for Chicanos. (p. 10)

Without arguing the point whether or not Chicanos should rely more on traditional mental health resources, it stands to reason that there are some Chicanos who do need to utilize traditional mental health resources, and there are some Chicanos that might not be getting this

needed service.

The following recommendations are made for those mental health centers wanting to improve or increase their services with the Chicano community. The recommendations are divided into five major areas: community relations or out-reach, staffing, training, programs and services, and research and evaluation.

## Community Relations or Out-Reach

Before mental health services are utilized, the community must be aware of their existence and the services they offer. The Chicano community in this study had little knowledge of some of the mental health centers and their services. Culturally relevant information concerning mental health education should be developed in both English and Spanish, taking into consideration the values, beliefs and educational level of the local Chicano population, and disseminated. Local media with a Chicano audience should be utilized, as well as local Spanish language media such as newspapers like El Renacimiento, television programs like "Tele-Revista," and various radio programs in Spanish.

## Staffing

Chicano clients will obtain maximum benefit from therapists or counselors knowledgeable in Chicano ethnohistory and culture. In order to be effective, the therapist or counselor must speak the language of the client, both literally and figuratively. The present study showed that the mental health center which most of the respondents felt was adequate for most problems was the only center that employed two Chicano therapists in addition to two Chicano students doing their social work field placement there. Mental health centers

should increase the availability of bilingual/bicultural professionals, paraprofessionals and staff. The initial contact is very important to the continuation of therapy, therefore contact with a bilingual/bicultural receptionist might determine if certain Chicano clients receive the services they need. Once treatment begins, knowledge about cultural differences and about the degree of tolerance for these differences is necessary to help alleviate emotional problems emanating from a cultural context. (The argument always given is that there are no "qualified" Chicano therapists. At the time of this writing, there were seven Chicanos in Lansing with Master's degrees in social work. Only three were employed, and only two of those were employed in a mental health setting.

## Training

The research also indicated an underrepresentation of Chicanos as therapists and counselors in mental health services delivery. A short range solution to this problem is to teach Spanish and Chicano culture to non-Chicano therapists and counselors, and to teach counseling skills to Chicanos at the paraprofessional level. To be effective with Chicanos, the therapist should be trained to know and understand the cultural backgrounds of their Chicano clients. Ideally, both Chicanos and Anglos or other non-Chicano therapists should receive training in comparative cultural systems as part of their professional education.

## Programs and Services

Because of the importance and reliance of the family, mental health therapy with Chicanos should incorporate an extended family perspective. Since the family is relevant in the etiology of the

problem and its alleviation, the therapist should investigate the significance of the family in the client's life. If the client's family lacks cohesion and integration, this is atypical of ethnic groups as a whole and may be a significant locus of stress. If a client does not have the availability of his or her family for support, this could also be a source of greater potential stress than among Anglos in similar circumstances.

Mental health services should tap into existing informal resources utilized by the Chicano community such as friends, relatives, teachers, priests/clergymen, and medical doctors. Ideally, mental health services should have a community worker or ombudsman who has ties to the Chicano community and who can help develop a system of referrals, so that attention can be given to preventative mental health care, in addition to treatment.

Quite often stress and other psychological dysfunctions were due to the socioeconomic conditions of the sample. Mental health services should be willing to intervene, when possible, to improve the socioeconomic conditions of their clients. This would require giving attention to the external needs of clients, such as helping them to find jobs, housing, or meet the basic needs of their families.

## Research and Evaluation

Although the results of the Lansing study and the Texas study were very similar, the Lansing community is very different from other Chicano communities in that Lansing has a lower Chicano concentration, isolation from Mexico and the Southwest, a lack of role models such as lawyers, doctors, state representatives and senators, etc., among other variations. Because of the great differences, mental health

centers should foster research at the local level. Empirically-based research should entail both ethnographic and survey data gathering.

Mental health centers should evaluate their treatment as well as their preventative and out-reach services in relation to the Chicano community. Therapists working with Chicano clients should make a concerted effort to publish their research results on evaluation of therapy and out-reach services among Chicanos. The mental health care of Chicanos will only be improved through the dissemination of research findings from the different Chicano communities which, as has already been stressed throughout this study, are quite varied from each other.

La Raza!
Mejicano!
Español!
Latino!
Hispano!
Chicano!
or whatever I call myself,
I look the same
I feel the same
I cry
and
sing the same.

--from "I am Joaquin"
by Rodolfo Gonzales

# FOOTNOTES

## FOOTNOTES

1. The 1980 United States Census report gives the new percentage of Hispanics in Lansing as 6.3 percent. This more recent information indicated that the underrepresentation of Lansing Chicanos at traditional mental health centers is greater than previously believed. Reasons for this underrepresentation or underutilization in Lansing are further discussed on page 160.

2. The United Shates Bureau of the Census, Current Population Reports (Series P-20, No. 339), "Persons of Spanish Origin in the United States: March 1978," United States Government Printing Office, Washington, D.C. gives the estimated population at 12,046,000.

3. The occupational status scale was constructed by classifying those who worked in a white-collar profession or business which required some college training as professionals: administrator, counselor, nurse, artist, and teacher; those that worked in a white-collar profession that required less college training as paraprofessionals: teacher's aide, school liaison, secretary, community out-reach worker, real estate agent, clerk-typist, and cosmetologist; those that worked in a blue-collar job that required some training or a license as skilled: auto mechanic, fence installer, welder, and cook; those that worked in a blue-collar job that required less training as semi-skilled: cares for elderly, bartender, sales clerk, assembly line, auto factory worker, railroad worker, waitress, takes care of children, and houseworker; and those that worked in a blue-collar job that required no training or skill as unskilled: farm worker, custodian, homemaker, construction worker, and odd jobs.

4. The table for familiarity with traditional, mainstream Anglo mental health services was constructed by combining or adding one answer for each respondent in the order of: "familiar with the services," "not too familiar," and "not familiar" for any one of the following centers--St. Lawrence Mental Health Program, Capitol Area Counseling Center, or Ingham Community Mental Health Center. For example, if a respondent gave "familiar with the services" as an answer for any one of the three centers mentioned above, the respondent was included in the "familiar" category only. The respondent who did not give a "familiar with the services" answer was then placed in a "not too familiar" category to be included in the "partly familiar" category only, and the same process was followed for "not familiar" answers.

5. The table for attitudes toward service providers was constructed the same way as the table mentioned in the preceeding footnote. One answer for each respondent was combined in the order of: "adequate for most problems," "adequate for some problems," and "not adequate at all" for any one of the three centers.

6. The personal efficacy scale was constructed by performing a factor analysis on six of the variables which constitute Question 40.

Question: How often:

A. Do you feel that you are very alone?
B. Do you feel down, low in spirits?
C. Do personal worries affect you physically?
D. Do you feel sad?
E. Do you feel lonely, even when you are among friends?
F. Do you feel bored?

Response categories were:

1--Most of the time
2--Sometimes
3--Rarely
4--Never

The individual score on this scale is the mean of valid responses to the variable listed above (if at least five are valid) times 10. Invalid values are: 8 (Don't know) and 9 (Missing data). The range was from 10 to 40, with a higher score indicating a higher incidence of personal efficacy.

7. The private self-esteem scale was constructed by performing a factor analysis on Question 37. Two factors resulted by using the Kaiser criterion. Factor 1 was used to create the private self-esteem scale and Factor 2 was used to create the public self-esteem scale.

Question: I have some statements that describe the way some people feel. I'll read them one at a time and you just tell me whether they're very true, somewhat true, not very true, or not true at all for you.

A. I feel that I am useful and needed.
B. I feel sure my life will work out the way I want.
C. I have hopes about the future.
D. I feel that I am a person of worth, at least as much as others.
E. I am able to do things as well as most other people.
F. I feel good about myself.

All the items in this index were questions stated in a positive manner. All the items that constitute public self-esteem were questions that were stated in a negative manner. Response categories were:

1--Very true
2--Somewhat true
3--Not very true
4--Not true at all

The individual score on this scale is the mean of the valid responses to the variables listed above (if at least five are valid) times 10. Invalid values are: 8 (Don't know) and 9 (Missing data). The range was from 10 to 40, and the variable values were reversed so that the higher the score, the higher the individual's self-esteem.

8. The public self-esteem scale was constructed by performing a factor analysis on Question 37. Two factors resulted by using the Kaiser criterion. Factor 1 was used to create the private self-esteem scale as described above and Factor 2 was used to create the public self-esteem scale.

Question: I have some statements that describe the way some people feel. I'll read them one at a time and you just tell me whether they're very true, somewhat true, not very true, or not true at all for you.

A. No one cares much what happens to me.
B. I wish that people would pay more attention to me.
C. I wish that people liked me more.
D. These days, I really don't know who I can count on.

All the items in this index were questions stated in a negative manner. All the items that constitute the private self-esteem scale were questions stated in a positive manner. Response categories were:

1--Very true
2--Somewhat true
3--Not very true
4--Not true at all

The individual score on this scale is the mean of the valid responses to the variables listed above (if at least three are valid) times 10. Invalid values are: 8 (Don't know) and 9 (Missing data). The range was from 10 to 40, with the higher the score, the higher the individual's self-esteem.

9. The direction (sign) of the correlation between education and familiarity with services was reversed (from - to +) to show a true direct relationship, since familiarity with services is coded in descending order (1=familiar, 2=somewhat familiar, and 3=not familiar) while education is coded in ascending order (from no education to more education).

10. The direction (sign) of the correlation between frequency of stress and personal efficacy and self-esteem was reversed (from + to -) to show a true inverse relationship, since frequency of stress is coded in descending order (from often to never) while the personal efficacy

and self-esteem scales are coded in ascending order (from low to high).

11. The direction (sign) of the correlation between private self-esteem and occupational status was reversed (from - to +) to show a true direct relationship since private self-esteem was coded in ascending order (from low to high) while occupational status was coded in descending order (from professional to unskilled).

12. The direction (sign) of the correlation between public self-esteem and occupational status was reversed (from - to +) to show a true direct relationship since public self-esteem was coded in ascending order (from low to high) while occupational status was coded in descending order (from professional to unskilled).

13. It should be kept in mind that formal resources in this study includes not only mental health professionals, but also non-mental health professionals, i.e., clergy/priests, doctors, nurses, lawyers, police, teachers, and others. Only 11 percent of the sample utilized a "traditional" mental health professional (see Table 14, page 119).

# APPENDICES

# APPENDIX A.

## GENERAL QUESTIONNAIRE

# APPENDIX A.

## GENERAL QUESTIONNAIRE

CASE NUMBER: _____

SITE NUMBER: _____

CENSUS NUMBER: _____

ETHNIC IDENTITY AND MENTAL HEALTH STATUS:

UTILIZATION OF FORMAL AND INFORMAL HELPING RESOURCES

A COMPARATIVE STUDY

Interviewer's Name: _____

Date: _____

Day of Week: _____

Time of Day: _____

Length of Interview: _____

Receipt Number: _____

RECORD EXACT TIME HERE:

_____

ESPAÑOL

IF RESPONDENT'S LANGUAGE PREFERENCE IS DEFINITELY SPANISH, SKIP TO BOX BELOW AND READ INTRODUCTION.

IF R APPEARS TO BE BILINGUAL OR IF YOU ARE IN DOUBT:

¿Cómo prefiere que le haga las preguntas, en español? Or if you wish, in English? IF NECESSARY, ADD: El cuestionario tiene las preguntas en los dos idiomas, so it could be in either language -- English or Spanish?

IF R IS RELUCTANT TO CHOOSE AND INDICATES THAT EITHER IS FINE:

Mi oficina no quiere que yo decida esto y requiere que yo sólo le pregunte su preferencia. Why don't you choose -- in English? ¿o en espanol?

5. ESPAÑOL

1. ENGLISH → READ ENGLISH INTRODUCTION

↓ INTRODUCCION

Primero quiero asegurarle que esta entrevista es totalmente voluntaria y si hay algo que no quiera contestar, por favor dígame y sigo con la siguiente pregunta. También quiero recordarle que la entrevista será completamente confidencial. Nadie va a saber la respuesta que usted nos dé.

También quiero explicarle de lo que se trata esta entrevista. Nos interesan las opiniones y las costumbres de la gente de descendencia mexicana en los Estados Unidos. Le haré preguntas sobre la cultura, la familia, y otras cosas.

-3-

| RECORD EXACT TIME HERE: _____ | :1-3 |
|---|---|

01

ENGLISH

:6

IF RESPONDENT'S LANGUAGE PREFERENCE IS DEFINITELY ENGLISH, SKIP TO BOX BELOW AND READ INTRODUCTION. :7-9

IF R APPEARS TO BE BILINGUAL OR IF YOU ARE IN DOUBT:

How would you prefer that I ask the questions; in English? O si usted prefiere, en español? IF NECESSARY, ADD: The questionnaire has the questions in both languages, de manera que puede ser en cualquiera de los dos idiomas -- inglés, o español?

IF R IS RELUCTANT TO CHOOSE AND INDICATES THAT EITHER IS FINE:

My office doesn't want me to decide that and requires that I only ask you about your preference. Escoja usted por favor. -- ¿en inglés? Or in Spanish?

| 1. ENGLISH | 5. ESPAÑOL → READ SPANISH INTRODUCTION | :10 |
|---|---|---|

INTRODUCTION

First I want to assure you that this interview is completely v-luntary and if there is something you would prefer not to answer, please tell me and I will go on to the next question. I also want to remind you that the interview will be completely confidential. No one will know what answers you give me.

I also wnat to tell you a little about what the interview will cover. We are interested in the opinion and customs of people of Mexican descent in the United States. I will ask you questions about the culture, the family, and other things.

-4-

Voy a comenzar haciéndole unas preguntas en general

1. RECORD RESPONDENT'S SEX

   1 [M] 2 [F]

2. ¿Qué edad tiene?

   _____
   (in years)

3. ¿Es usted casado/casada, divorciado/divorciada, viudo/viuda, o soltero/soltera?

   1 [C] 2 [D] 3 [V] 4 [S]

4. ¿Cómo se llama el lugar donde usted nació?

   [_____ Lugar] [_____ Estado] [_____ País]

5. IF R BORN OUTSIDE U.S. ¿En qué año se vino a los Estados Unidos para quedarse?

   [AÑO: _____]

6. ¿Cuántos años ha vivido en Lansing, Michigan?

   [_____ AÑOS] [TODA MI VIDA] → GO TO 8

7. Hasta la edad de 16 años, ¿se crió usted en un rancho, en un pueblo, en una ciudad chica, en un suburbio, o en una ciudad grande?

   [1. RANCHO] [2. PUEBLO] [3. CIUDAD CHICA] [4. SUBURBIO]

   [5. CIUDAD GRANDE] [7. OTRO] (SPECIFY) _____

8. IF R WAS BORN IN THE U.S. Incluyendo hasta usted, cuántas generaciones de su familia han nacido en los Estados Unidos?

   _____

9. ¿Cuántos años de educación formal ha completado?

   _____

10. a. ¿Qué es su trabajo o su ocupación principal - el trabajo a que se dedica normalmente?

    _____

    _____

    b. ¿En qué clase de negocio o industria es este trabajo?

    _____

    _____

I am going to start by asking you some general questions

1. RECORD RESPONDENT'S SEX

   1 [M] 2 [F] :11

2. How old were you on your last birthday? :12-13

   _____ (in years)

3. Are you married, divorced, widowed, or single? :14

   1 [M] 2 [D] 3 [W] 4 [S]

4. What was the name of the place where you were born? :15-20

   [_____ NAME OF PLACE] [_____ STATE] [_____ COUNTRY]

5. IF R WAS BORN OUTSIDE U.S. In what year did you come to U.S. to stay? :21-22

   [YEAR: _____]

6. How many years have you lived in Lansing, Michigan? :23-24

   [_____ YEARS] [ALL MY LIFE] → GO TO 8

7. Up to the age of 16, did you mostly grow up on a farm, in a town, in a small city, in a suburb, or in a large city? :25

   [1. FARM] [2. TOWN] [3. SMALL CITY] [4. SUBURB] [5. LARGE CITY]

   [7. OTHER] (SPECIFY) _____

8. IF R WAS BORN IN THE U.S. Including up to yourself, how many generations in your family have been born in the United States? :26-27

   _____

9. How many years of formal education have you completed? :28-29

   _____

10. a. What is your main job or occupation - the kind of work you normally do? :30-32

    _____

    _____

    b. What kind of business or industry is this job? :33-35

    _____

    _____

11. (HAND R CARD 21) Ahora vea esta tarjeta. ¿Me puede decir por favor cuál de estas letras representa lo que ganó toda su familia durante el año pasado? Esta cifra debe incluir todos los salarios, pensiones, y cualquier otra entrada de dinero.

a. (01) Menos de $2000
b. (02) $2000 a $2999
c. (03) $3000 a $3999
d. (04) $4b00 a $4000
e. (05) $5000 a $5999
f. (06) $6000 a $6999
g. (07) $7000 a $7999
h. (08) $8000 a $8999
i. (09) $9000 a $9999
j. (10) $10000 a 10999
k. (11) $11000 a $11999
l. (12) $12000 a $14999
m. (13) $15000 a $19999
n. (14) $20000 a $24999
o. (15) $25000 a $29999
p. (16) $30000 o más

12. ¿Tiene parientes que viven en esta área?

1. [SI] 5. [NO] → GO TO 13

a. En total, ¿cuántos tiene? _____ NUMERO
b. ¿En cuántas casas viven? _____ NUMERO

13. Ahora por favor dígame qué tan seguido pasa aunque sea unos minutos con la siguiente gente, ya sea visitando o por teléfono. Usando esta tarjeta (HAND R CARD 10) ¿habla con su papá diariamente, varias veces por semana, varias veces por mes, varias veces por año, o casi nunca?

| | DIARIAMENTE | VARIAS VECES POR SEMANA | VARIAS VECES POR MES | VARIAS VECES POR AÑO | CASI NUNCA | N/A |
|---|---|---|---|---|---|---|
| a. Su papá | 1 | 2 | 3 | 4 | 5 | 9 |
| b. Su mamá | 1 | 2 | 3 | 4 | 5 | 9 |
| c. Sus hermanos/ hermanas | 1 | 2 | 3 | 4 | 5 | 9 |
| d. Sus hijos/hijas que no viven con Ud. | 1 | 2 | 3 | 4 | 5 | 9 |
| e. Sus otros parientes | 1 | 2 | 3 | 4 | 5 | 9 |
| f. Sus amigos/as | 1 | 2 | 3 | 4 | 5 | 9 |

11. (HAND R CARD 21) Now would you look at this card? Could you please tell me which letter comes closest to the total income of your family last year? This income figure should include all salaries, pensions, and other income sources. :36-37

a. (01) Less than $2000
b. (02) $2000 to $2999
c. (03) $3000 to $3999
d. (04) $4000 to $4999
e. (05) $5000 to $5999
f. (06) $6000 to $6999
g. (07) $7000 to $7999
h. (08) $8000 to $8999
i. (09) $9000 to $9999
j. (10) 10000 to 10999
k. (11) $11000 to $11999
l. (12) $12000 to $14999
m. (13) $13000 to $19999
n. (14) $20000 to $24999
o. (15) $25000 to $29999
p. (16) $30000 or more

12. Do you have any relatives that live within this area? :38

1. [SI] 5. [NO] → GO TO 13

a. In total, about how many are there? _____ NUMBER :39-46

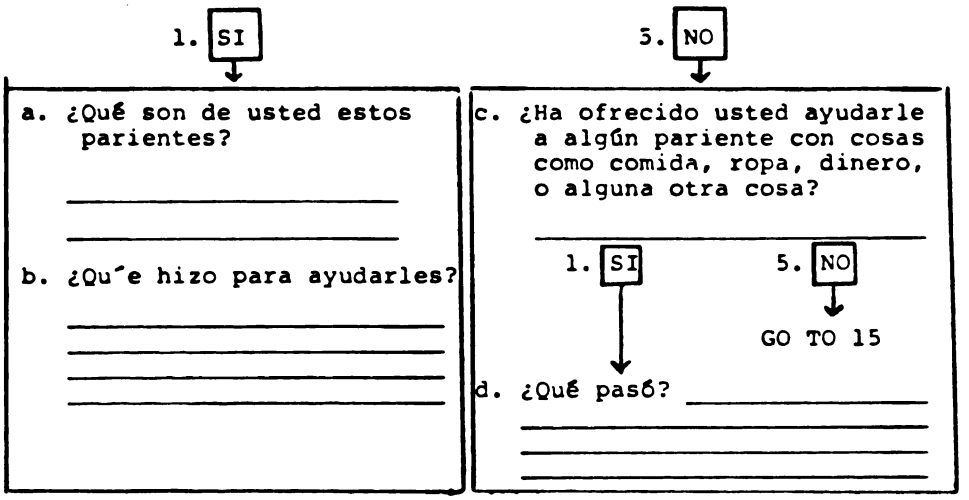
b. In how many households do they live? _____ NUMBER :41-42

13. Now, please tell me how often you spend at least a few minutes with people either by visiting or telephoning them. Using this card, (HAND R CARD 10), do you talk with your father daily, several times a week, several times a month, several times a year, or hardly ever?

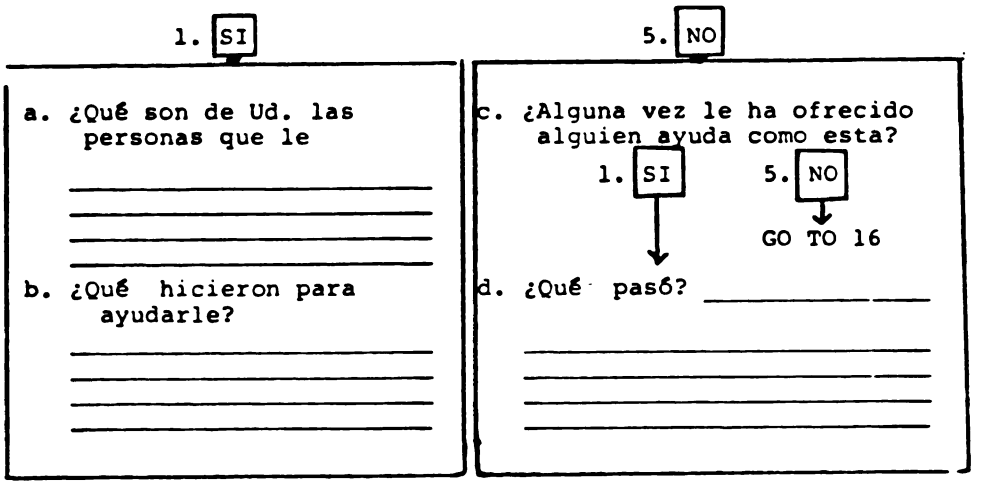
| | DAILY | SEVERAL TIMES A WEEK | SEVERAL TIMES A MONTH | SEVERAL TIMES A YEAR | HARDLY EVER | N/A |
|---|---|---|---|---|---|---|
| a. Your father | 1 | 2 | 3 | 4 | 5 | 9 :43 |
| b. Your mother | 1 | 2 | 3 | 4 | 5 | 9 :44 |
| c. Your brothers/sisters | 1 | 2 | 3 | 4 | 5 | 9 :45 |
| d. Children not living at home | 1 | 2 | 3 | 4 | 5 | 9 :46 |
| e. Your other relatives | 1 | 2 | 3 | 4 | 5 | 9 :47 |
| f. Your friends | 1 | 2 | 3 | 4 | 5 | 9 :48 |

-8-

14. La gente se puede ayudar unos a los otros en diferentes maneras. ¿Le ha ayudado usted a algún pariente con cosas como comida, ropa, dinero, o alguna otra cosa?




15. ¿Ha pedido usted ayuda como esta de alguien?



-9-

14. People can help each other in different ways. Have you ever helped out any relative with things such as food, clothing, money or anything else?

1. YES

a. What is your relationship to those you helped?

b. What did you do to help out?

_____
_____
_____
_____

5. NO :49

c. Have you ever offered to help any relative with such things as food, clothing, money or anything else? :50-53

1. YES 5. NO :54-57

GO TO 15

d. What happened? _____ :58

_____ :59-52

_____

15. Have you ever asked for help like this from anyone?

1. YES

a. What is your relationship with those who helped?

_____
_____
_____
_____

b. What did they do to help

_____
_____
_____
_____

5. NO :63

c. Has anyone ever offered to help out like this? :64-67

_____

1. YES 5. NO :68-71

GO TO 16

d. What happened? _____

_____ :72

_____

_____ :73-76

-10-

16. Ahora necesitamos información tocante a los servicios que existen en la comunidad. Voy a mencionar varios programas que existen en en Lansing y quisiera que me diga si:

1. a. conoce o está enterado/a de los servicios
2. b. sabe un poco de los servicios
3. c. no conoce o está enterado/a de los servicios

1. Cristo Rey Counseling Center _____
2. St. Lawrence Mental Health Program _____
3. Capital Area Counseling Center _____
4. Ingham Community Mental Health Center _____
5. Algunos otros _____

IF ANSWER IS c. not familiar FOR ALL FIVE, GO TO QUESTION 18.

17. IF ANSWER IS a. or b. FOR ANY CENTER, ASK FOR EVERY ANSWER. Usted mencionó que está enterado/a de los servicios en _____ Diría usted que los servicios:

1. a. son adecuados para toda clase de problemas
2. b. son adecuados solamente para ciertos problemas
3. c. no son adecuados para ningún problema

1. Cristo Rey Counseling Center _____
2. St. Lawrence Mental Health Program _____
3. Capital Area Counseling Center _____
4. Ingham Community Mental Health Center _____
5. Algunos otros _____

16. Now we need to get some information on services available in the community. I am going to mention several programs available in Lansing, and I would like for you to tell me if you are: : 1-3

1. a. familiar with the services :02
2. b. not too familiar
3. c. not familiar

1. Cristo Rey Counseling Center _____ :6
2. St. Lawrence Mental Health Program _____ :7
3. Capital Area Counseling Center _____ :8
4. Ingham Community Mental Health Center _____ :9
5. Others _____ :10

IF ANSWER IS c. Not familiar FOR ALL FIVE, GO TO QUESTION 18

17. IF ANSWER IS a. or b. FOR ANY CENTER, ASK FOR EVERY ANSWER. You mentioned that you are familiar with the services at _____. Would you say that the services are:

1. a. adequate for most problems
2. b. adequate for some problems
3. c. not adequate it all

1. Cristo Rey Counseling Center _____ :11
2. St. Lawrence Mental Health Program _____ :12
3. Capital Area Counseling Center _____ :13
4. Ingham Community Mental Health Center _____ :14
5. Others _____ :15

USE THE GREEN SOCIAL IDENTITY CARDS FOR WOMEN; BLUE ONES FOR MEN

18. La gente piensa de sí misma en varios modos. Aquí están unas tarjetas. Fíjese en cada una y quédese con las que indican uno de los modos en que usted piensa de sí mismo(a). Devuélvamela si no piensa de sí en ese modo.

AS R RETURNS CARDS, CIRCLE NUMBERS OF RETURNED CARDS AND SET THEM ASIDE.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| 15 | 16 | 17 | 18 | 19 | 20 | 21 |
| 22 | 23 | 24 | 25 | 26 | 27 | 28 |
| 29 | 30 | 31 | 32 | | | |

19. Ahora fíjese en todas esas tarjetas que usted escogió. Por favor escoja las tres que mejor describen cómo piensa usted de sí mismo(a).

ENTER NUMBERS (3) HERE: ☐☐☐

20. De estas tres, ¿cuál lo/la describe mejor? ENTER NUMBER HERE: ☐

1. IF R SAYS TWO OR ALL THREE EQUAL → GO TO 21

2. IF ONE RESPONSE GIVEN → GO TO 22

21. Indicaré aquí que éstas son inguales, pero por favor, ¿podría tratar de decidir entre ellas, aunque sean casi iguales?

BEST TWO OR THREE: ☐☐☐

BEST ONE: ☐

22. Como usted notó, algunos de los términos que vimos son diferentes nombres de gente de descendencia mexicana. Nos gustaría hacerle algunas preguntas acerca de esto. (HAND R CARD 2.) Por favor vea estos términos que están en la tarjeta. Puede usar esos o cualquier otro para sus respuestas.

IN QUESTIONS BELOW, IF R ANSWERS WITH ANOTHER TERM, ENTER 8 IN BOX, WRITE WHAT THE TERM IS, AND ASK: AFTER THAT, WHICH TERM IS NEXT?

Con su familia, cuando habla de gente de descendencia mexicana, ¿cuál de estos nombres usa? Si usa algún otro nombre que no está en la tarjeta, dígame por favor. ☐ If 8: _____ Después de ese, ¿cuál sigue? ☐

23. Y aquí, generalmente, ¿cuál nombre usan las personas de descendencia mexicana? ☐ If 8: _____ Después de ese, ¿cuál sigue? ☐

-13-

USE THE GREEN SOCIAL IDENTITY CARDS FOR WOMEN; BLUE ONES FOR MEN

18. People think of themselves in many ways. Here are some cards. Look at each one and keep all the cards that describe how you think about yourself. Give the card back to me if you don't think of yourself that way.

AS R RETURNS CARDS, CIRCLE NUMBERS OF RETURNED CARDS AND SET THEM ASIDE.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | :16-29 |
| 8 | 9 | 10 | 11 | 12 | 13 | 14 | :30-43 |
| 15 | 16 | 17 | 18 | 19 | 20 | 21 | :44-57 |
| 22 | 23 | 24 | 25 | 26 | 27 | 28 | :58-71 |
| 29 | 30 | 31 | 32 | | | | :72-79 |

19. Now look at those you chose. Please pick out the three that best describe how you think about yourself. :1-3 03

ENTER NUMBERS HERE: ☐☐☐ :6-11

20. Of these three, which really describes you best? ☐ :12-13
ENTER NUMBER HERE:

1. IF R SAYS TWO OR ALL THREE EQUAL → GO TO 21

2. IF ONE RESPONDE GIVEN → GO TO 22

21. I'll indicate here that they are equal, but could you try anyway to make a choice between them, even though they are almost equal?

BEST TWO OR THREE: ☐☐☐

BEST ONE: ☐

22. As you noticed, some of the terms we looked at are different names for people of Mexican descent. Now, I'd like to ask you some questions about them. (HAND R CARD 2) Please look at the terms that are on this card. You can use these and others for your answers.

IN QUESTIONS BELOW, IF R ANSWERS WITH ANOTHER TERM, ENTER 8 IN BOX, WRITE WHAT THE TERM IS, AND ASK: AFTER THAT, WHICH TERM IS NEXT?

With your family, when you speak about people of Mexican descent, which of these names do you use? If you use some other term that is not on the card, be sure and tell me.

If 8: _____
☐ After that which is next? ☐ :14-15

23. Around here, what name is generally ed by people of Mexican descent?

If 8: _____
☐ After that which is next? ☐ :16-1

24. ¿Cuál de ellos usa Ud. con más frecuencia con personas que no son de descendencia mexicana? ☐ If 8: _____ Y después de ese, ¿cual sigue? ☐

25. En su experiencia personal, ¿qué nombre usan ellos con más frecuencia? ☐ If 8: _____ Y después de ese, ¿cuál sigue? ☐

26. Muchas cosas diferentes influyen en los nombres que usamos y algunas veces los nombres que usamos cambian. Pensando de cuando usted era niño, ¿cuál nombre usaba su padre para referirse a las personas de descendencia mexicana? ☐ If 8: _____ Y después de ese, ¿cuál sigue? ☐

27. ¿Y su madre? ¿Cuál nombre usaba para referirse a las personas de descendencia mexicana? ☐ If 8: _____ Y después de ese, ¿cuál sigue? ☐

CHECKPOINT A

DOES R HAVE CHILDREN?

1. YES | 5. NO → GO TO 30

28. ¿Qué nombre usan sus hijos para describirse a sí mismos? ☐ If 8: _____ Y después de ese, ¿cuál sigue? ☐

29. ¿Cuál preferiría usted que usaran? ☐ If 8: _____ Y después de ese, ¿cuál sigue? ☐

GO TO 31

30. Si usted tuviera hijos, ¿cuál de estos nombres preferiría que usaran? ☐ If 8: _____ Y después de ese, ¿cuál sigue? ☐

31. Durante la vida a casi todas las personas o a alguno de sus seres queridos le sucede algo malo. Me refiero a cosas como enfermedades, desempleo, dificultades con la policía, etc. O cuando alguien muere o cuando alguien se va o lo desilusiona a uno. O quizás algo importante que usted quería no se logró. ¿Diría usted que cosas como éstas le han sucedido muy seguido, de vez en cuando, o casi nunca?

1. MUY SEGUIDO | 2. DE VEZ EN CUANDO | 3. CASI NUNCA

24. Which one do you use most with people who are not of Mexican descent? ☐ If 8: _____ After that which is next? ☐ :18-19

25. From your own personal experience, what name do they use most often? ☐ If 8: _____ After that which is next? ☐ :20-21

26. Many different things influence the names we use and sometimes these names change. Thinking back to when you were a child, what name did your father use to refer to people of Mexican descent? ☐ If 8: _____ After that which is next? ☐ :22-23

27. How about your mother? What name did she use to refer to people of Mexican descent? ☐ If 8: _____ After that which is next? ☐ :24-25

CHECKPOINT A

| DOES R HAVE CHILDREN? | |
|---|---|
| 1. YES | 5. NO → GO TO 30 |

28. What name do your children normally use to describe themselves? ☐ If 8: _____ After that which is next? ☐ :26-27

29. What name would you prefer they use? ☐ If 8: _____ After that which is next? ☐ :28-29

GO TO 31

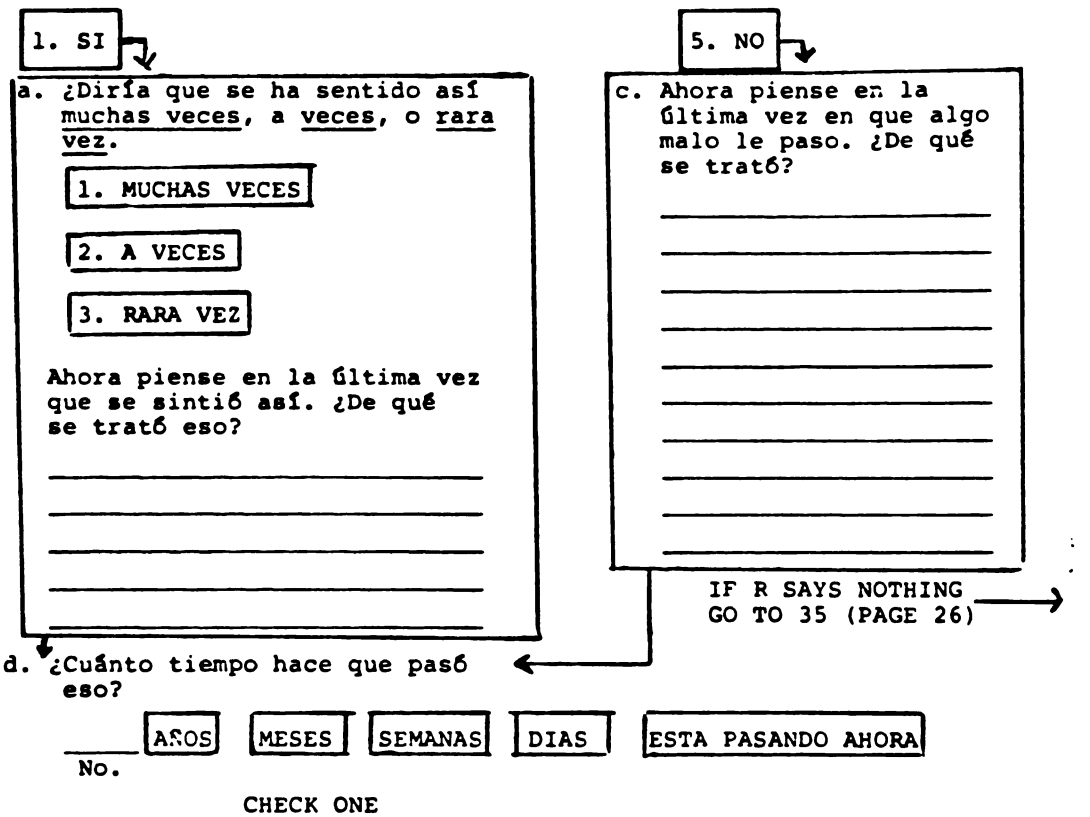
30. If you had children, what name would you prefer they use? ☐ If 8: _____ After that which is next? ☐ :30-31

31. Over their lives most people have something bad happen to them or to someone they love. By that I mean things like getting sick, losing a job, or being in trouble with the police, etc. Or like when someone dies, leaves, or disappoints you. Or maybe just something important you wanted to happen didn't happen. Would you say that things like these have happened to you alot, now and then, or hardly ever?

☐ 1. ALOT ☐ 2. NOW AND THEN ☐ 3. HARDLY EVER :32

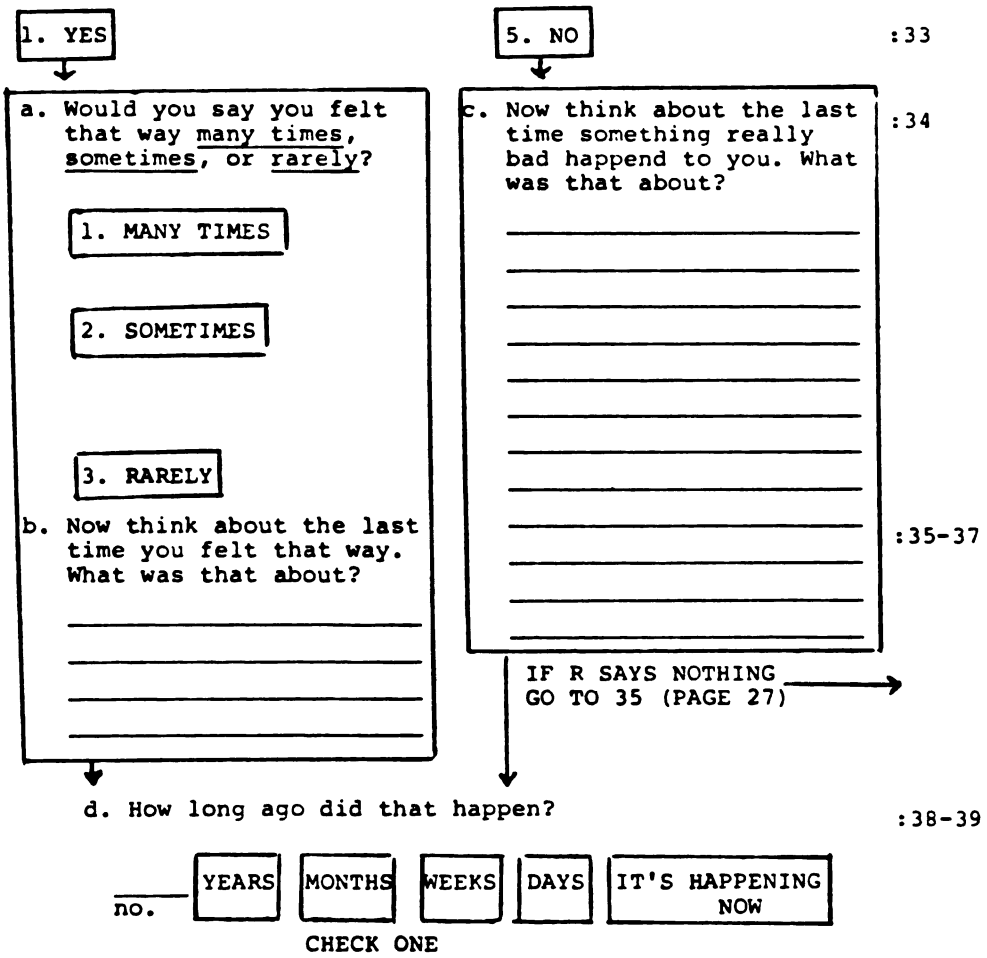
-16-

32. Cuando cosas como éstas le han sucedido, ¿ha habido ocasiones cuando no podía con ellas? Por ejemplo, no podía dormir, o que comía o tomaba demasiado, o se alejaba de la gente o se enojaba con ellas, o se sentía tan deprimido(a) o nervioso(a) que no podría hacer nada. ¿Le han ocurrido cosas parecidas a éstas?




33. Cuando tales cosas suceden, alguna gente habla de ellas con otras personas. (HAND R CARD 4) Habló Ud. con alguna de estas personas sobre eso? Para cada persona, escoja solo la descripción que mejor le corresponda. Si más de una persona con quien habló corresponde a la misma descripción; por ejemplo, si habló con más de un amigo, por favor dígame.

32. When things like this have happened to you have there been times when you found it hard to handle? That is, when you could not sleep, or ate or drank too much, or stayed away from people, or got angry at them or felt so depressed or nervous that you could not do much of anything. Have things similar to these even happened to you?




33. When things like that happen, some people talk it over with other people. (HAND R CARD 4). Did you talk to any of these people about that? For each person, choose the one descrption that fits them best. If more htan one person you talke to fits the same description; for example, if you talked to more than one friend, please tell me.

-18-

☐ CHECK HERE IF R SAYS "TALKED TO NO ONE" ON THE LIST. THEN TURN TO 34 (PAGE 22)

BELOW, CHECK THE APPROPRIATE CATEGORY FOR EACH PERSON MENTIONED BY RESPONDE

CARD 4

| | | |
|---|---|---|
| ESPOSO | HERMANO | AMIGO/AMIGA |
| ESPOSA | HERMANA | VECINO/VECINA |
| HIJO | COMPADRE/COMADRE | COMPAÑERO DE TRABAJO |
| HIJA | PADRINO/MADRINA | |
| PADRE | OTRO FAMILIAR/O PARIENTE | |
| MADRE | (ESPECIFIQUE POR FAVOR) | |

| | a. IF R TALKED TO MORE THAN 3 PEOPLE ASK: Bien, me dice que hablo con No.____ personas, ¿con cuáles 3 habló más sobre esta situación? PERSON: | b. ¿Es hombre o mujer esta persona | c. ¿Es mayor, menor o mas o menos de la misma edad que usted? | d. ¿Es de descendencia mexicana esta persona? |
|---|---|---|---|---|
| 1. | | 1. HOMBRE<br>2. MUJER | 1. MAYOR<br>2. MISMA<br>3. MENOR | 1. SI<br>2. NO<br>8. NS |
| 2. | | 1. HOMBRE<br>2. MUJER | 1. MAYOR<br>2. MISMA<br>3. MENOR | 1. SI<br>5. NO<br>8. NS |
| 3. | | 1. HOMBRE<br>2. MUJER | 1. MAYOR<br>2. MISMA<br>3. MENOR | 1. SI<br>5. NO<br>8. NS |

-19-

☐ CHECK HERE IF R SAYS "TALKED TO NO ONE" ON THE LIST. THEN TURN TO 34 (PAGE 23)

:40

BELOW, CHECK THE APPROPRIATE CATEGORY FOR EACH PERSON MENTIONED BY RESPONDENT.

CARD 4

| | | |
|---|---|---|
| :41 HUSBAND | :46 BROTHER | :51 FRIEND |
| WIFE | :47 SISTER | :52 NEIGHBOR |
| :42 SON | :48 COMPADRE/COMADRE | :53 CO-WORKER |
| :43 DAUGHTER | :49 PADRINO/MADRINA | |
| :44 FATHER | :50 OTHER RELATIVE OR FAMILY MEMBER (PLEASE SPECIFY) | |
| :45 MOTHER | | |

| a. IF R TALKED TO MORE THAN 3 PEOPLE ASK: OK, you say you talked to ___ persons, with which 3 did you talk more about this situation? PERSON: | b. Is this person a man or a woman? | c. Is (he/she) older, younger or about the same age as you? | d. Is this person of Mexican descent? |
|---|---|---|---|
| 1. | 1. MALE<br>2. FEMALE | 1. OLDER<br>2. SAME<br>3. YOUNGER | 1. YES<br>5. NO<br>8. DK |
| 2. | 1. MALE<br>2. FEMALE | 1. OLDER<br>2. SAME<br>3. YOUNGER | 1. YES<br>5. NO<br>8. DK |
| 3. | 1. MALE<br>2. FEMALE | 1. OLDER<br>2. SAME<br>3. YOUNGER | 1. YES<br>5. NO<br>8. DK |
| :54-55<br>:56-57<br>:58-59 | :60<br>:61<br>:62 | :63<br>:64<br>:65 | :66<br>:67<br>:68 |

| e. ¿Habla español esta persona? | f. ¿Qué hizo esta persona con quien habló usted acerca de esta situación?<br>(PROBE FULLY FOR COMPLETE RESPONSE) | g. Además de eso, ¿cuáles de estas cosas ocurrieron cuando habló con esta persona?<br>(SHOW CARD 5) |
|---|---|---|
| 1ª persona<br>1. SI<br>5. NO<br>8. NS | | a Me escuchó<br>b Me animó o me consoló<br>c Me dijo a quien debería ver<br>d Me dio o me prestó dinero<br>e Me mostró una manera nueva de ver las cosas<br>f Me dio consejos<br>g Me ayudó a hacer algo<br>h Tomó alguna acción por mí |
| 2ª persona<br>1. SI<br>2. NO<br>8. NS | | a Me escuchó<br>b Me animó o me consoló<br>c Me dijo a quien debería ver<br>d Me dio o prestó dinero<br>e Me mostró una manera nueva de ver las cosas<br>f Me dio consejos<br>g Me ayudó a hacer algo<br>h Tomó alguna acción por mi |
| 3ª persona<br>1. SI<br>2. NO<br>8. NS | | a Me escuchó<br>b Me animó o me consoló<br>c Me dijo a quien debería ver<br>d Me dio o me prestó dinero<br>e Me mostró una manera nueva de ver las cosas<br>f Me dio consejos<br>g Me ayudó a hacer algo<br>h Tomó alguna acción por mi |

-21-

| e. Does this person speak Spanish? | f. What did this person you talked to do about this situation? (PROBE FULLY FOR COMPLETE RESPONSE) | g. Other than that, which of these happened when you talked to this person? (SHOW CARD 5) |
|---|---|---|
| 1st person<br>1. YES<br>5. NO<br>8. DK | | a Listened to me<br>b Cheered or comforted me<br>c Told me who to see<br>d Gave or loaned me money<br>e Showed me a new way to look at things<br>f Gave me advice<br>g Helped me do something<br>h Took action for me |
| 2nd person<br>1. YES<br>2. NO<br>8. DK | | a Listened to me<br>b Cheered or comforted me<br>c Told me who to see<br>d Gave or loaned me money<br>e Showed me a new way to look at things<br>f Gave me advice<br>g Helped me do something<br>h Took action for me |
| 3rd person<br>1. YES<br>1. NO<br>8. DK | | a Listened to me<br>b Cheered or comforted me<br>c Told me who to see<br>d Gave or loaned me money<br>e Showed me a new way to look at things<br>f Gave me advice<br>g Helped me do something<br>h Took action for me |

:69 :70 :71 ==  :1-3 04  :6-11 :12-17 :18-23  :24-31 :32-39 :40-47

-22-

34. A veces uno habla con personas profesionales en agencias, oficinas, u otros lugares. (HAND CARD 6). ¿Habló con algunas de estas personas sobre este asunto? Como hicimos antes, por cada persona, escoja la descripción que mejor le corresponda. Si más de una persona con quien Ud. habló corresponde a la misma descripción por ejemplo, si habló con más de un maestro, por favor dígamelo.

☐ CHECK HERE IF R SAYS "TALKED TO NO ONE" ON THE LIST. THEN TURN TO 35 (PAGE 26)

BELOW, CHECK THE APPROPRIATE CATEGORY FOR EACH PROFESSIONAL MENTIONED BY THE RESPONDENT

CARD 6

| | | | |
|---|---|---|---|
| CLERIGO/SACERDOTE/ PASTOR | ABOGADO | PSICOLOGO | OTRA PERSONA QUE NO ESTA EN ESTA LISTA (ESPECIFIQUE QUIEN, POR FAVOR) |
| CONSEJERO | PARTERA | TRABAJADORA SOCIAL | |
| CURANDERO/A | ENFERMERA | MAESTRO/A | |
| DOCTOR | POLICIA | OTRA GENTE COMO: faith healers, espiritistas, yerberos, sobadoras (especifique quien por favor) | |
| | PSIQUIATRA | | |

| a. IF R TALKED TO MORE THAN 3 PEOPLE ASK: Bien, me dice que habló con __ personas, ¿con cuáles 3 habló más sobre esta situación? OCCUPATION OF PROFESSIONAL: | b. ¿Es hombre o mujer esta persona? | c ¿Es de descendencia mexicana esta persona? | d. ¿Habla español esta persona? | e. En su opinion, ¿esta persona conoce la cultura mexicana? |
|---|---|---|---|---|
| 1. | 1. HOMBRE<br>2. MUJER | 1. SI<br>5. NO<br>8. NS | 1. SI<br>5. NO<br>8. NS | 1. SI<br>5. NO<br>8. NS |
| 2. | 1. HOMBRE<br>5. MUJER | 1. SI<br>5. NO<br>8. NS | 1. SI<br>5. NO<br>8. NS | 1. SI<br>5. NO<br>8. NS |
| 3. | 1. HOMBRE<br>2. MUJER | 1. SI<br>5. NO<br>8. NS | 1. SI<br>5. NO<br>8. NS | 1. SI<br>5. NO<br>8. NS |

34. Sometimes we talk with professional people in agencies, offices, or other places. (HAND R CARD 6). Did you talk to any of these people about the matter? Like we did before, for each person, choose the description that fits them best. If more than one person you talked to fits the same description, for example, if you talked to more than one teacher, please tell me.

☐ CHECK HERE IF R SAYS "TALKED TO NO ONE" ON THE LIST, THEN TURN TO 35 (PAGE 27) :48

BELOW, CHECK THE APPROPRIATE CATEGORY FOR EACH PROFESSIONAL MENTIONED BY THE RESPONDENT

| | | | | |
|---|---|---|---|---|
| :49 CLERGYMAN/PRIEST PASTOR | :53 LAWYER | :58 PSYCHOLOGIST | :62 ANOTHER PERSON NOT ON THIS LIST (Please specify who) | |
| :50 COUNSELOR | :54 MIDWIFE | :59 SOCIAL WORKER | | |
| :51 CURANDERO/A | :55 NURSE | :60 TEACHER | | |
| :52 DOCTOR | :56 POLICE | :61 OTHER PEOPLE LIKE: faith healers, espiritistas, yerberos, sobadoras (PLEASE SPECIFY) | | |
| | :57 PSYCHIATRIST | | | |

| a. IF R TALKED TO MORE THAN 3 PEOPLE ASK: OK, you say you talked with ___ persons, with which 3 did you talk more about his situation? OCCUPATION OF PROFESSIONAL: | b. Is this person a man or a woman? | c. Is this person of Mexican descent? | d. Does this person speak Spanish? | e. In your opinion, does this person know Mexican culture? |
|---|---|---|---|---|
| 1. | 1. MALE<br>2, FEMALE | 1. YES<br>5. NO<br>8. DK | 1. YES<br>5. NO<br>8. DK | 1. YES<br>5. NO<br>8. DK |
| 2. | 1. MALE<br>2. FEMALE | 1. YES<br>5. NO<br>8. DK | 1. YES<br>5. NO<br>8. DK | 1. YES<br>5. NO<br>8. DK |
| | 1. MALE<br>2. FEMALE | 1. YES<br>5. NO<br>8. DK | 1. YES<br>5. NO<br>8. DK | 1. YES<br>5. NO<br>8. DK |
| :63-64 | :69 | :72 | :75 1-3 | :6 |
| :65-66 | :70 | :73 | :76 05 | :7 |
| :67-68 | :71 | :74 | :77 | :8 |

-24-

| f. ¿Cómo supo de esta persona? | g. ¿Está asociada esta persona con una agencia, clínica u otra organización | |
|---|---|---|
| 1. | 1. SI 5. NO 8. NS | GO TO h1 |
| 2. | 1. SI 5. NO 8. NS | GO TO h2 |
| 3. | 1. SI 5. NO 8. NS | GO TO h3 |

| h. Recuerda el nombre del lugar o la clase de lugar donde habló con esta persona? (ENTER NAME OR TYPE OF PLACE) | i. ¿Qué hizo esta persona con quien habló Ud. acerca de la si- | j. Además de eso, ¿cuáles de estas cosas ocurrieron cuando habló con con esta persona? (SHOW CARD 5) |
|---|---|---|
| h1. | | a Me escuchó<br>b Me animó o me consoló<br>c Me dijo a quien debería ver<br>d Me dio o me prestó dinero<br>e Me mostró una manera nueva de ver las cosas<br>f Me dio consejos<br>g Me ayudó a hacer algo<br>h Tomó alguna acción por mi |
| h2. | | a Me escuchó<br>b Me animó o me consoló<br>c Me dijo a quien debería ver<br>d Me dio o me prestó dinero<br>e Me mostró una manera nueva de ver las cosas<br>f Me dio consejos<br>g Me ayudó a hacer algo<br>h Tomó alguna acción por mi |
| h3. | | a Me escuchó<br>b Me animó o me consoló<br>c Me dijo a quien debería ver<br>d Me dio o me prestó dinero<br>e Me mostró una manera nueva de ver las cosas<br>f Me dio consejos<br>g Me ayudó a hacer algo<br>h Tomó alguna acción por mí |

-25-

| f. How did you know about this person? | g. Is this person conected with an agency, clinic or other organization? | |
|---|---|---|
| 1. | 1. YES 5 NO 8 DK | GO TO h1 |
| 2. | 1. YES 5 NO 8 DK | GO TO h2 |
| 3. | 1. YES 5 NO 8 DK | GO TO h3 |
| :9-14 | :15-18 | |

| h. Do you remember the name of the place or the kind of place where you talked to this person? (ENTER NAME OR TYPE OF PLACE) | i. What did this person you talked to do about this situation? | j. Other than that, which of these things happened when you talked to this person? (SHOW CARD 5) |
|---|---|---|
| h1. | | a Listened to me<br>b Cheered or comforted me<br>c Told me who to see<br>d Gave or loaned me money<br>e Showed me a new way to look at things<br>f Gave me advice<br>g Helped me do something<br>h Took action for me |
| h2. | | a Listened to me<br>b Cheered or comforted me<br>c Told me who to see<br>d Gave or loaned me money<br>e Showed me a new way to look at things<br>f Gave me advice<br>g Helped me do something<br>h Took action for me |
| h3. | | a Listened to me<br>b Cheered or comforted me<br>c Told me who to see<br>d Gave or loaned me money<br>e Showed me a new way to look at things<br>f Gave me advice<br>g Helped me do something<br>h Took action for me |

| | | |
|---|---|---|
| :19-20 | :25-30 | :43-50 |
| :21-22 | :31-36 | :51-58 |
| :23-24 | :37-42 | :59-66 |

-26-

35. Ahora quiero preguntarle lo que pasa cuando hace planes. Lleva a cabo sus planes o de costumbre pasan cosas que cambian sus planes?

| 1. LLEVA A CABO SUS PLANES | 2. CAMBIAN SUS PLANES | 8. NO SABE |
|---|---|---|

36. ¿Qué diría que es más cierto para usted: que su vida saldrá como usted quiere o que no está muy seguro/a de cómo saldrá su vida?

| 1. COMO QUIERE | 2. NO ESTA SEGURO | 8. NO SABE |
|---|---|---|

37. Ahora tenemos algo diferente. (HAND R CARD 7) Tengo unas frases que describen como se sienten algunas personas. Las leeré una por una y me dice si son muy ciertas, algo ciertas, no muy ciertas, o absolutamente no son ciertas para Ud.

| | MUY CIERTAS | ALGO CIERTAS | NO MUY CIERTAS | ABSOLUTAMENTE NO CIERTAS |
|---|---|---|---|---|
| a. Siento que soy útil y que me necesitan | 1 | 2 | 3 | 4 |
| b. A nadie le importa mucho lo que me pasa. | 1 | 2 | 3 | 4 |
| c. Me siento seguro de que mi vida resultará como quiero | 1 | 2 | 3 | 4 |
| d. Tengo esperanzas en el futuro | 1 | 2 | 3 | 4 |
| e. Quisiera que la gente me prestara más atención | 1 | 2 | 3 | 4 |
| f. Siento que soy una persona de mérito, al menos tanto como otros. | 1 | 2 | 3 | 4 |
| g. Deseo que la gente me quisiera mas de lo que me quiere | 1 | 2 | 3 | 4 |
| h. Puedo hacer cosas tan bien como otras personas | 1 | 2 | 3 | 4 |
| i. Estos dias verdaderamente no se con quien puedo contar | 1 | 2 | 3 | 4 |
| j. Me siento contento/a conmigo mismo/a | 1 | 2 | 3 | 4 |

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35. Now I want to ask you about what happens when you make plans. Do you get to carry out things the way you thought, or do things usually come up that change your plans?

| 1. THE WAY YOU THOUGHT | 2. HAVE TO CHANGE PLANS | 8. DON'T KNOW | :67 |
|---|---|---|---|

36. What would you say is more true for you: that your life will turn out the way you want or that you're not sure how your life will turn out?

| 1. THE WAY I WANT | 2. NOT SURE | 8. DON'T KNOW | :68 |
|---|---|---|---|

37. Now we have something different. (HAND R CARD 7) I have some statements that describe the way some people feel. I'll read them one at a time and you just tell me whether they're very true, somewhat true, not very true, or not true at all for you.

| | VERY TRUE | SOMEWHAT TRUE | NOT VERY TRUE | NOT TRUE AT ALL | |
|---|---|---|---|---|---|
| a. I feel that I am useful and needed | 1 | 2 | 3 | 4 | :69 |
| b. No one cares much what happens to me. | 1 | 2 | 3 | 4 | :70 |
| c. I feel sure my life will work out the way I want. | 1 | 2 | 3 | 4 | :71 |
| d. I have hopes about the future. | 1 | 2 | 3 | 4 | :72 |
| e. I wish that people would pay more attention to me. | 1 | 2 | 3 | 4 | :73 |
| f. I feel that I am a person of worth, at least as much as others | 1 | 2 | 3 | 4 | :74 |
| g. I wish that people liked me more than they do. | 1 | 2 | 3 | 4 | :75 |
| h. I am able to do things as well as most other people. | 1 | 2 | 3 | 4 | :76 |
| i. These days, I really don't know who I can count on. | 1 | 2 | 3 | 4 | :77 |
| j. I feel good about myself. | 1 | 2 | 3 | 4 | :78 |

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38. ¿Qué tan seguido cree que la gente recibe el respeto que merece, todo el tiempo, la mayoría del tiempo, de vez en cuando, o nunca?

| 1. TODO EL TIEMPO | 2. MAYORIA DEL TIEMPO | 3. VEZ EN CUANDO | 4. NUNCA |
|---|---|---|---|

39. ¿Qué tan seguido cree que aunque una persona se esfuerce, de cualquier manera su valor es ignorado, todo el tiempo, la mayoría del tiempo, de vez en cuando, o nunca?

| 1. TODO EL TIEMPO | 2. MAYORIA DEL TIEMPO | 3. VEZ EN CUANDO | 4. NUNCA |
|---|---|---|---|

40. Usando las respuestas en esta página (HAND R CARD 8)

| ¿Qué tan seguido: | CASI TODO EL TIEMPO | A VECES | RARA VEZ | NUNCA |
|---|---|---|---|---|
| a. Se siente que está muy solo/a? ¿Diría usted que casi todo el tiempo, a veces, rara vez, o nunca? | 1 | 2 | 3 | 4 |
| b. Se siente desanimado/a? | 1 | 2 | 3 | 4 |
| c. Le afecta físicamente las preocupaciones personales? | 1 | 2 | 3 | 4 |
| d. Se siente triste? | 1 | 2 | 3 | 4 |
| e. Se siente solo aunque esté entre amigos? | 1 | 2 | 3 | 4 |
| f. Se queda sin expresar sus sus opiniones para evitar disgustos? | 1 | 2 | 3 | 4 |
| g. Siente usted que tiene dificultad para hacer amistades nuevas? | 1 | 2 | 3 | 4 |
| h. Se siente aburrido/a? | 1 | 2 | 3 | 4 |

38. How often do you think people get the respect that they deserve, all of the time, most of the time, some of the time, or never? 1-3 06

[1. ALL] [2. MOST] [3. SOME] [4. NEVER] :6

39. How often do you think that no matter how hard a person tries, his/her worth is still ignored, all of the time, most of the time, some of the time, never?

[1. ALL OF THE TIME] [2. MOST OF THE TIME] [3. SOME OF THE TIME] [4. NEVER] :7

40. Using the answers on this sheet (HAND R CARD 8)

| How often: | MOST OF THE TIME | SOMETIMES | RARELY | NEVER | |
|---|---|---|---|---|---|
| a. Do you feel that you are very alone, would you say, most of the time, sometimes, rarely, or never? | 1 | 2 | 3 | 4 | :8 |
| b. Do you feel down, low in spirits? | 1 | 2 | 3 | 4 | :9 |
| c. Do personal worries affect you physically? | 1 | 2 | 3 | 4 | :10 |
| d. Do you feel sad: | 1 | 2 | 3 | 4 | :11 |
| e. Do you feel lonely, | 1 | 2 | 3 | 4 | :12 |
| f. Do you keep your opinions to yourself to avoid arguments? | 1 | 2 | 3 | 4 | :13 |
| g. Do you feel you have trouble making new friends? | 1 | 2 | 3 | 4 | :14 |
| h. Do you feel bored? | 1 | 2 | 3 | 4 | :15 |

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ENDING STATEMENT

RECORD EXACT TIME _____

1. EXPRESE SENSIBILIDAD/ENTENDIMIENTO DE LO PERSONAL DE LAS PREGUNTAS Y DEL TIEMPO QUE TOMO LA ENTREVISTA.

2. ASEGURE AL RESPONDEDOR DE LA SEGURIDAD Y ANONIMIDAD CON LA CUAL SE VA A TRATAR LA INFORMACION. SI ES NECESARIO, EXPLIQUE EL PROCESO DE COMO SE PROCESARA LA INFORMACION.

3. PREGUNTELE AL RESPONDEDOR SI TIENE COMENTARIOS O SUGERENCIAS SOBRE LA ENTREVSITA QUE (EL/ELLA) QUIERA QUE USTED ESCRIBA:

_____

_____

_____

_____

4. DELE LAS GRACIAS AL RESPONDEDOR. DELE LOS $5.00 Y QUE FIRME EL RECIBO. ASEGURE QUE EL DOMICILIO Y NUMERO DE TELEFONO ESTE INCLUIDO. APUNTE EL NUMERO DEL RECIBO EN EL FRENTE DEL CUESTIONARIO. EXPLIQUE QUE QUIZAS SU SUPERINTENDENTE LE HABLARA PARA COMPROBAR QUE SE HIZO LA ENTREVISTA.

_____

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ENDING STATEMENT

RECORD EXACT TIME _____

1. EXPRESS EMPATHY/UNDERSTANDING FOR THE PERSONAL NATURE OF THE QUESTIONS AND FOR THE LENGTH OF THE INTERVIEW

2. ASSURE RESPONDENT OF THE ANONYMITY AND SECURITY OF THE INFORMATION. IF NECESSARY, EXPLAIN PROCEDURES FOR HANDLING THE INFORMATION

3. ASK FOR COMMENTS OR SUGGESTIONS REGARDING THE INTERVIEW WHICH THE RESPONDENT WOULD LIKE YOU TO WRITE:

_____

_____

_____

_____

_____

4. THANK RESPONDENT. GIVE HIM/HER THE $5.00 AND HAVE HIM/HER SIGN RECEIPT. MAKE SURE THE RECEIPT INCLUDES RESPONDENT'S ADDRESS AND PHONE NUMBER, RECORD RECEIPT NUMBER IN FRONT OF QUESTIONNAIRE. EXPLAIN TO RESPONDENT THAT YOUR SUPERVISOR MIGHT CALL HIM/HER TO VERIFY THAT INTERVIEW WAS DONE.

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INTERVIEWER OBSERVATIONS

(TO BE FILLED OUT IMMEDIATELY AFTER INTERVIEW IS COMPLETED)

1. The respondent's attitude at the beginning of the interview was: :1-2 06 :16

| 1. COOPERATIVE, HELPFUL | 2. NEUTRAL, RELAXED | 3. NERVOUS, UNCERTAIN | 4. ANTAGONISTIC |
|---|---|---|---|

2. The respondent's attitude at the end of the interview was:

| 1. MORE COOPERATIVE, HELPFUL | 2. NO CHANGE FROM THE BEGINNING OF THE INTERVIEW | 3. LESS COOPERATIVE HELPFUL | :17 |
|---|---|---|---|

3. The respondent's interest at the beginning of the interview was:

| 1. VERY INTERESTED | 2. SOMEWHAT INTERESTED | 3. NOT VERY INTERESTED | :18 |
|---|---|---|---|

4. The respondent's interest at the end of the interview was:

| 1. MORE INTERESTED | 2. NO CHANGE FROM THE BEGINNING OF THE INTERVIEW | 3. LESS INTERESTED | :19 |
|---|---|---|---|

5. Did the respondent seem to be hurrying to get the interview over?

| 1. YES | 5. NO | :20 |
|---|---|---|

6. Was there anyone else present during the interview?

| 1. YES | 5. NO → GO TO 7 (NEXT PAGE) | :21 |
|---|---|---|

a. How many people? _____ Who? _____ :22

_____

b. How did this affect the interview? _____

_____ :23-2

_____

_____

_____

7. The respondent's understanding of the questions was:

[1. EXCELLENT] [2. GOOD] [3. FAIR] [4. POOR] :26

8. Which were problem questions? (IF NONE, PLEASE NOTE; IF YES, GIVE SECTION AND QUESTION NUMBERS)

_____

_____

_____ :27-4

_____

a. What did you do about these problems and/or difficulties?

_____

_____

_____

_____ :47-4

_____

9. Please describe the respondent's ability to express himself/herself on the scale below:

| 1 | 2 | 3 | 4 | :49 |
|---|---|---|---|---|
| EXCELLENT VOCABULARY; VERY ARTICULATE | | | LIMITED VOCABULARY EXPRESSES SELF WITH GREAT DIFFICULTY | |

10. Were there any questions you think the respondent did not seem to answer frankly or honestly?

[1. YES] [5. NO] → GO TO 11 :50

↓

a. Which questions were these and why do you doubt the answers:

_____ :51-70

_____

_____ :71-72

11. Aproximately how many interruptions (at least a minute or so long) were there?

_____ NUMBER OF INTERRUPTIONS :73

12. Please recall all verbal interruptions during the interview, and rate the entire verbal interactions according to the scale below:

| | 1 ONLY ENGLISH | 2 MOSTLY ENGLISH | 3. BOTH EQUALLY | 4 MOSTLY SPANISH | 5 ONLY SPANISH | 9 NONE | |
|---|---|---|---|---|---|---|---|
| a. telephone conversations | | | | | | | :74 |

| | | | | | | |
|---|---|---|---|---|---|---|
| b.conversations with children | 1. ONLY ENGLISH | 2.MOSTLY ENGLISH | 3.BOTH EQUALLY | 4.MOSTLY SPANISH | 5. ONLY SPANISH | 9.NONE |
| c.conversations with adults | 1. ONLY ENGLISH | 2.MOSTLY ENGLISH | 3.BOTH EQUALLY | 4.MOSTLY SPANISH | 5. ONLY SPANISH | 9.NONE |
| d.other: | 1. ONLY ENGLISH | 2.MOSTLY ENGLISH | 3. BOTH EQUALLY | 4.MOSTLY SPANISH | 5.ONLY SPANISH | 9.NONE |

13. Please check all that you noticed: 1-3 07

| | | | |
|---|---|---|---|
| a. | Mexican cooking | 1. YES 5. NO | :6 |
| b. | Mexican music and records | 1. YES 5. NO | :7 |
| c. | Religious items-Virgins, velas,palmas,etc. | 1. YES 5. NO | :8 |
| d. | Spanish books,magazines,newspapers,etc. | 1. YES 5. NO | :9 |
| e. | Mexican calendar of any sort | 1. YES 5. NO | :10 |
| f | Mexican artifacts (weaving,pottery,art,etc) | 1. YES 5. NO | :11 |
| g. | Pictures of Kennedys, Juárez, or Hidalgo | 1. YES 5. NO | :12 |
| h. | Family portraits | 1. YES 5. NO | :13 |
| i. | Mexican radio or T.V. programs on | 1. YES 5. NO | :14 |
| j. | Political/revolutionary pictures and posters | 1. YES 5. NO | :15 |

14. Using the following scale, how would you describe the respondent's sking color:

1 2 3 4 5 :16

VERY LIGHT/ GÜERO — VERY DARK MORENO

15. And how would you describe the respondent's physical features? :17

1 2 3 4 5

EUROPEAN LOOKING — INDIAN LOOKING

16. And finally, how would you describe the respondent's accent? :18

IN ENGLISH: 1 2 3 4 8. DON'T KNOW

1 = NO NOTICEABLE SPANISH/MEXICAN ACCENT
4 = HEAVY SPANISH/ MEXICAN ACCENT

IN SPANISH: 1 2 3 4 8. DON'T KNOW :19

1 = NO NOTICEABLE ENGLISH/AMERICAN ACCENT
4 = HEAVY ENGLISH/ AMERICAN ACCENT

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17. Compared to other homes in this neighborhood, would you say the respondent's house was better than average, average, or below average?

| 1. BETTER THAN AVERAGE | 2. AVERAGE | 3. BELOW AVERAGE |
|---|---|---|

18. Thumbnail sketch of the respondent and the interviewing situation. Please include everything mentioned in the thumbnail outline distributed during interviewer training (SEE INTERVIEWER'S TRAINING MANUAL).

# APPENDIX A1.

## SOCIAL IDENTITY DECK

APPENDIX A1.

# SOCIAL IDENTITY DECK

**SOCIAL IDENTITY DECK**

**ENGLISH**

| | FEMALE | MALE |
|---|---|---|
| 1. | BLUE COLLAR WORKER | BLUE COLLAR WORKER |
| 2. | FOREIGNER | FOREIGNER |
| 3. | MOTHER | FATHER |
| 4. | DAUGHTER | SON |
| 5. | MEXICAN | MEXICAN |
| 6. | POCHA | POCHO |
| 7. | WOMAN | MAN |
| 8. | MIDDLE CLASS | MIDDLE CLASS |
| 9. | AMERICAN OF MEXICAN DESCENT | AMERICAN OF MEXICAN DESCENT |
| 10. | SISTER | BROTHER |
| 11. | WIFE | HUSBAND |
| 12. | MEXICAN AMERICAN | MEXICAN AMERICAN |
| 13. | CATHOLIC | CATHOLIC |
| 14. | HISPANIC | HISPANIC |
| 15. | WHITE | WHITE |
| 16. | INDIAN | INDIAN |
| 17. | AMERICAN | AMERICAN |
| 18. | UNITED STATES CITIZEN | UNITED STATES CITIZEN |
| 19. | FAMILY BREADWINNER | FAMILY BREADWINNER |
| 20. | BROWN | BROWN |
| 21 | POOR | POOR |
| 22. | IMMIGRANT | IMMIGRANT |
| 23. | FARMWORKER | FARMWORKER |
| 24. | LATINA | LATINO |
| 25. | ENGLISH SPEAKER | ENGLISH SPEAKER |
| 26. | SPANISH SPEAKER | SPANISH SPEAKER |
| 27. | UNITED STATES NATIVE | UNITED STATES NATIVE |
| 28. | WORKING CLASS | WORKING CLASS |
| 29. | CHOLA | CHOLO |
| 30. | CHICANA | CHICANO |
| 31. | RAZA | RAZA |
| 32. | MESTIZA | MESTIZO |

# SOCIAL IDENTITY DECK

## SPANISH

| | FEMALE | MALE |
|---|---|---|
| 1. | TRABAJADORA OBRERA | TRABAJADOR OBRERO |
| 2. | EXTRANJERA | EXTRANJERO |
| 3. | MADRE | PADRE |
| 4. | HIJA | HIJO |
| 5. | MEXICANA | MEXICANO |
| 6. | POCHA | POCHO |
| 7. | MUJER | HOMBRE |
| 8. | DE CLASE MEDIA | DE CLASE MEDIA |
| 9. | AMERICANA DE DESCENDENCIA MEXICANA | AMERICANO DE DESCENDENCIA MEXICANA |
| 10. | HERMANA | HERMANO |
| 11. | ESPOSA | ESPOSO |
| 12. | MEXICO-AMERICANA | MEXICO-AMERICANO |
| 13. | CATOLICA | CATOLICO |
| 14. | HISPANA | HISPANO |
| 15. | BLANCA | BLANCO |
| 16. | INDIA | INDIO |
| 17. | AMERICANA | AMERICANO |
| 18. | CIUDADADA AMERICANA | CIUDADANO AMERICANO |
| 19. | SOSTEN DE LA FAMILIA | SOSTEN DE LA FAMILIA |
| 20. | MORENA | MORENO |
| 21. | POBRE | POBRE |
| 22. | INMIGRANTE | INMIGRANTE |
| 23. | TRABAJADORA CAMPESINA | TRABAJADOR CAMPESINO |
| 24. | LATINA | LATINO |
| 25. | DE HABLA INGLESA | DE HABLA INGLESA |
| 26. | DE HABLA ESPAÑOLA | DE HABLA ESPAÑOLA |
| 27. | NATIVA DE LOS ESTADOS UNIDOS | NATIVO DE LOS ESTADOS UNIDOS |
| 28. | DE CLASE OBRERA | DE CLASE OBRERA |
| 29. | CHOLA | CHOLO |
| 30. | CHICANA | CHICANO |
| 31. | RAZA | RAZA |
| 32. | MESTIZA | MESTIZO |

# APPENDIX A2.

## CARD 2--ETHNIC LABELS

# APPENDIX A2.

## CARD 2--ETHNIC LABELS

CARD 2

| | |
|---|---|
| 0. HISPANIC | 0. HISPANO |
| 1. AMERICAN | 1. AMERICANO |
| 2. HISPANIC-AMERICAN | 2. HISPANO-AMERICANO |
| 3. LATINO | 3. LATINO |
| 4. AMERICAN OF MEXICAN DESCENT | 4. AMERICANO DE DESCENDENCIA MEXICANA |
| 5. MEXICAN-AMERICAN | 5. MEXICO-AMERICANO |
| 6. CHICANO | 6. CHICANO |
| 7. MEXICAN | 7. MEXICANO |
| 8. SOME OTHER NAME | 8. ALGUN OTRO NOMBRE |

# APPENDIX A3.

## CARD 4--NON-PROFESSIONAL HELPING RESOURCES

# APPENDIX A3.

## CARD 4--NON-PROFESSIONAL HELPING RESOURCES

**CARD 4 (EVEN)**

| | |
|---|---|
| MY HUSBAND | MI ESPOSO |
| MY WIFE | MI ESPOSA |
| A SON | UN HIJO |
| DAUGHTER | UNA HIJA |
| MY FATHER | MI PADRE |
| MY MOTHER | MI MADRE |
| A BROTHER | UN HERMANO |
| A SISTER | UNA HERMANA |
| A COMPADRE OR COMPADRE | UN COMPADRE O UNA COMADRE |
| A PADRINO OR MADRINA | UN PADRINO O UNA MADRINA |
| OTHER RELATIVE OR FAMILY MEMBER | OTRO FAMILIAR O PARIENTE |
| A FRIEND | UN AMIGO O UNA AMIGA |
| A NEIGHBOR | UN VECINO O UNA VECINA |
| A CO-WORKER | UN COMPAÑERO O UNA COMPAÑERA DE TRABAJO |

# APPENDIX A4.

## CARD 5--ASSISTANCE PROVIDED RESPONSE CATEGORIES

# APPENDIX A4.

## CARD 5--ASSISTANCE PROVIDED RESPONSE CATEGORIES

**CARD 5**

| | |
|---|---|
| LISTENED TO ME | ME ESCUCHO |
| CHEERED OR COMFORTED ME | ME ANIMO O ME CONSOLO |
| TOLD ME WHO TO SEE | ME DIJO A QUIEN DEBERIA VER |
| GAVE OR LOANED ME MONEY | ME DIO O ME PRESTO DINERO |
| SHOWED ME A NEW WAY TO LOOK AT THINGS | ME MOSTRO UNA MANERA NUEVA DE VER LAS COSAS |
| GAVE ME ADVICE | ME DIO CONSEJOS |
| HELPED ME DO SOMETHING | ME AYUDO A HACER ALGO |
| TOOK ACTION FOR ME | TOMO ALGUNA ACCION POR MI |

# APPENDIX A5.

## CARD 6--PROFESSIONAL HELPING RESOURCES

# APPENDIX A5.

## CARD 6--PROFESSIONAL HELPING RESOURCES

**CARD 6 (EVEN)**

| | |
|---|---|
| **A PRIEST, PASTOR, OR CLERGYMAN** | **UN SACERDOTE, PASTOR O CLERIGO** |
| **A COUNSELOR** | **UN CONSEJERO** |
| **A CURANDERO OR CURANDERA** | **UN CURANDERO O UNA CURANDERA** |
| **A DOCTOR** | **UN DOCTOR** |
| **A LAWYER** | **UN ABOGADO** |
| **A MIDWIFE** | **UNA PARTERA** |
| **A NURSE** | **UNA ENFERMERA** |
| **A POLICEMAN** | **UN POLICIA** |
| **A PSYCHIATRIST** | **UN PSIQUIATRA** |
| **A PSYCHOLOGIST** | **UN PSICOLOGO** |
| **A SOCIAL WORKER** | **UNA TRABAJADORA SOCIAL** |
| **A TEACHER** | **UN MAESTRO O UNA MAESTRA** |
| **OTHER PEOPLE LIKE FAITH HEALERS, YERBEROS, SOBADORAS** | **OTRA GENTE COMO ESPIRITISTAS, YERBEROS, SOBADORAS** |
| **ANOTHER PERSON NOT IN THIS LIST** | **OTRA PERSONA QUE NO ESTA EN ESTA LISTA** |

# APPENDIX A6.

## CARD 7--ACCURACY RESPONSE CATEGORIES

# APPENDIX A6.

## CARD 7--ACCURACY RESPONSE CATEGORIES

CARD 7

| | |
|---|---|
| VERY TRUE | MUY CIERTO |
| SOMEWHAT TRUE | ALGO CIERTO |
| NOT VERY TRUE | NO MUY CIERTO |
| NOT TRUE AT ALL | ABSOLUTAMENTE NO CIERTO |

# APPENDIX A7.

## CARD 8--FREQUENCY RESPONSE CATEGORIES

# APPENDIX A7.

## CARD 8--FREQUENCY RESPONSE CATEGORIES

**CARD 8**

| | |
|---|---|
| MOST OF THE TIME | CASI TODO EL TIEMPO |
| SOMETIMES | A VECES |
| RARELY | RARA VEZ |
| NEVER | NUNCA |

# APPENDIX A8.

## CARD 10--FREQUENCY OF VISITATION RESPONSE CATEGORIES

# APPENDIX A8.

## CARD 10--FREQUENCY OF VISITATION RESPONSE CATEGORIES

CARD 10

| | |
|---|---|
| DAILY | DIARIAMENTE |
| SEVERAL TIMES A WEEK | VARIAS VECES POR SEMANA |
| SEVERAL TIMES A MONTH | VARIAS VECES POR MES |
| SEVERAL TIMES A YEAR | VARIAS VECES POR AÑO |
| HARDLY EVER | CASI NUNCA |

# APPENDIX A9.

## CARD 21--INCOME

# APPENDIX A9.

## CARD 21--INCOME

CARD 21

| | |
|---|---|
| A. LESS THAN $2,000 | A. MENOS DE $2,000 |
| B. $2,000 TO $2,999 | B. $2,000 A $2,999 |
| C. $3,000 TO $3,999 | C. $3,000 A $3,999 |
| D. $4,000 TO $4,999 | D. $4,000 A $4,999 |
| E. $5,000 TO $5,999 | E. $5,000 A $5,999 |
| F. $6,000 TO $6,999 | F. $6,000 A $6,999 |
| G. $7,000 TO $7,999 | G. $7,000 A $7,999 |
| H. $8,000 TO $8,999 | H. $8,000 A $8,999 |
| I. $9,000 TO $9,999 | I. $9,000 A $9,999 |
| J. $10,000 TO $10,999 | J. $10,000 A $10,999 |
| K. $11,000 TO $11,999 | K. $11,000 A $11,999 |
| L. $12,000 TO $14,999 | L. $12,000 A $14,999 |
| M. $15,000 TO $19,999 | M. $15,000 A $19,999 |
| N. $20,000 TO $24,999 | N. $20,000 A $24,999 |
| O. $25,000 TO $29,999 | O. $25,000 A $29,000 |
| P. $30,000 OR MORE | P. $30,000 O MAS |

# APPENDIX B.

# SCREENING QUESTIONNAIRE

# APPENDIX B.

## SCREENING QUESTIONNAIRE

SCREENING QUESTIONNAIRE

INTERVIEWER'S NAME _____

SITE NUMBER _____

CENSUS NUMBER _____

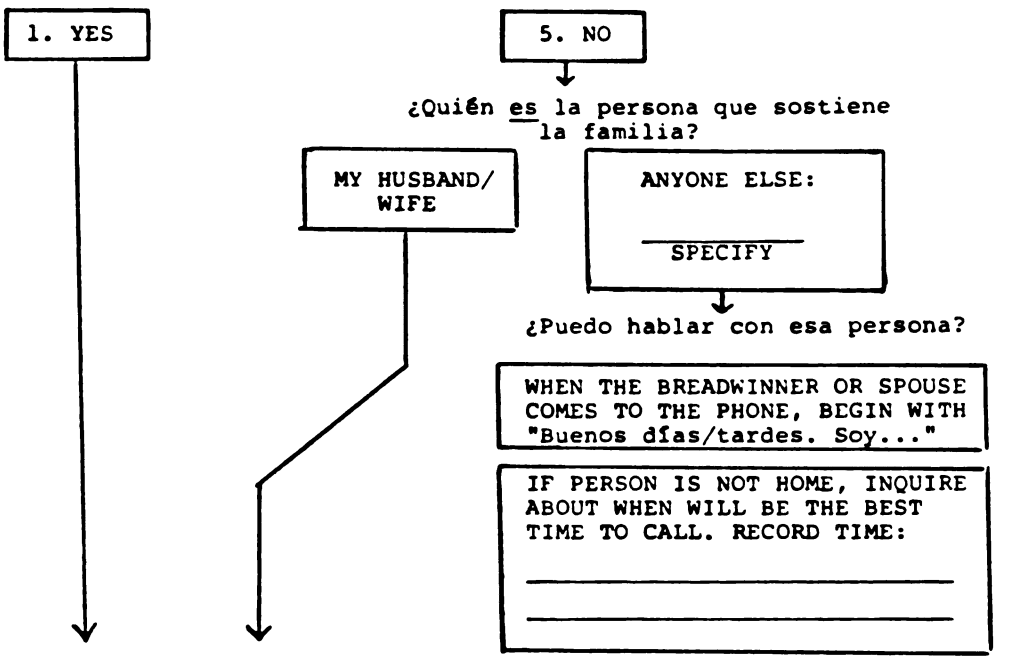
DATE _____

DAY OF WEEK _____

TIME OF DAY _____

SCREENING RESULT _____

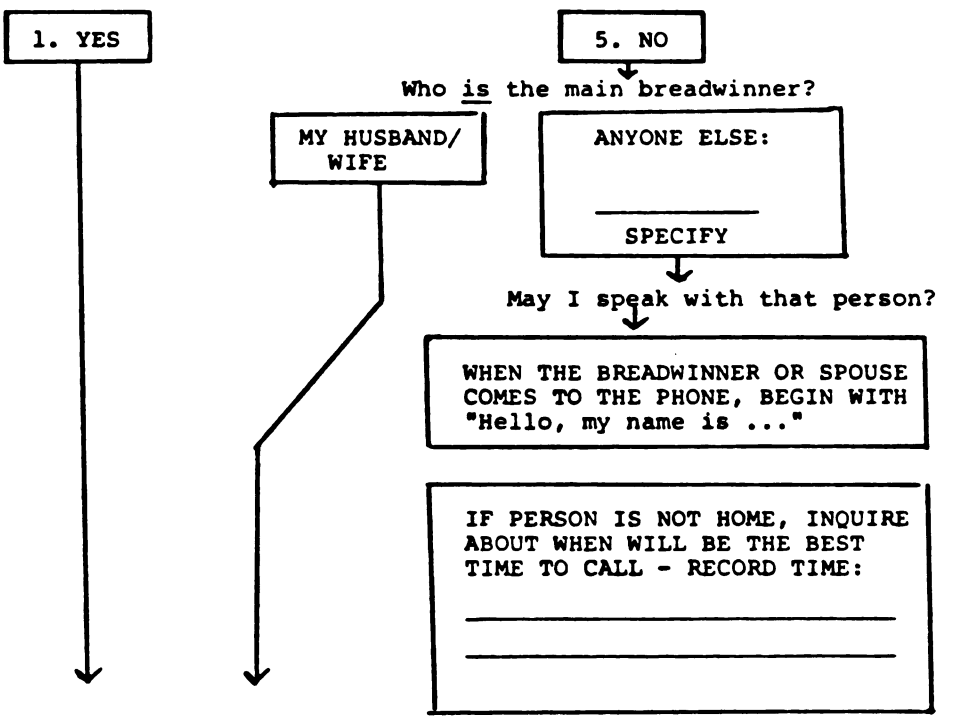
Buenos dias/buenas tardes. Soy _____. Soy estudiante de la Universidad de Michigan State trabajando en un proyecto. Nos interesa averiguar algo acerca de las diferentes nacionalidades en los Estados Unidos. Me gustaría hacerle unas cuantes preguntas. ¿Es Ud. la persona que sostiene la familia?




Como usted ha de saber, mucha gente aquí en los Estados Unidos se ha interesado mucho en los orígenes de sus antepasados. Estamos interesados en lo que la gente sabe y siente acerca de sus propias raíces y me gustaría hacerle unas cuantas preguntas que solamente nos tomarán un par de minutos. Pienso que a usted le agradarán estas preguntas. Es algo similar a un árbol genealógico de su familia. La entrevista es totalmente confidencial y voluntaria.

-3-

Hello, my name is _____. I am a student at Michigan State University working on a research proyect. We are interested in learning about various nationality groups in the U.S. I would like to ask you a few questions. Are you the main breadwinner in this home?




As you may know, people in the U.S. nowadays have become more aware of their background and their ancestors. We are very interested in what people know and feel about their own roots and I'd like to ask you a few questions that will take only a couple of minutes. I think you'll enjoy it; it's kind of like doing a family tree. The interview is strictly confidential and voluntary.

-4-

BE PREPARED TO USE THESE PROBES:

A) IF ANCESTRY RESPONSE IS "SPANISH," "LATIN AMERICAN," "HISPANIC," "LATINO," ETC/, ASK:

¿A cuál país se refiere?

B) IF ANCESTRY RESPONSE IS "AMERICAN," ASK:

¿Y sus orígenes antes de eso? ¿De cuál país vinieron sus antepasados?

1. Primero, quisiera saber algo acerca del origen o nacionalidad de sus padre. ¿De qué descendencia es su padre?

_____ IF MEXICAN ONLY, CHECK BOXES A AND B THEN GO TO Q.4

2. ¿De qué descendencia es el padre de él?

_____ IF MEXICAN CHECK BOX [A]

3. ¿De qué descendencia es la madre de él?

IF MEXICAN CHECK BOX [B]

4. ¿De qué descendencia es su madre?

_____ IF MEXICAN ONLY, CHECK BOXES C AND D; THEN GO TO Q.7

5. ¿De qué descendencia es el padre de ella?

_____ IF MEXICAN CHECK BOX [C]

6. ¿De qué descendencia es la madre de ella?

_____ IF MEXICAN CHECK BOX [D]

RESPONDENT IS ELIGIBLE - IF ANY TWO OF [A] [B] [C] or [D] ARE CHECKED

BE PREPARED TO USE THESE PROBES:

A) IF ANCESTRY RESPONSE IS "SPANISH," "LATIN AMERICAN," "HISPANIC," "LATINO," ETC., ASK:

What country do you mean by that?

B) IF ANCESTRY RESPONSE IS "AMERICAN," ASK:

What about root before that? What country did your ancestors originally come from?

1. To begin, I would like to know about your parents' national origins. What is you father's ancestry?

_____ IF MEXICAN ONLY, CHECK BOXES A AND B THEN GO TO Q.4

2. What was his father's ancestry

_____ IF MEXICAN CHECK BOX [A]

3. What was his mother's ancestry?

_____ IF MEXICAN CHECK BOX [B]

4. What is your mother's ancestry?

_____ IF MEXICAN ONLY, CHECK BOXES C AND D; THEN GO TO Q.7

5. What was her father's ancestry?

_____ IF MEXICAN CHECK BOX [C]

6. What was her mother's ancestry?

_____ IF MEXICAN CHECK BOX [D]

RESPONDENT IS ELIGIBLE - IF ANY TWO OF

[A] [B] [C] or [D] ARE CHECKED

BE PREPARED TO USE THESE PROBES:

A) IF ANCESTRY RESPONSE IS "SPANISH, "LATIN AMERICAN," "HISPANIC," "LATINO," ETC/, ASK

¿A cual país se refiere?

B) IF ANCESTRY RESPONSE IS "AMERICAN," ASK:

¿Y sus orígenes antes de eso? ¿De cual país vinieron sus antepasados?

7. Ahora, me gustaría hacerle las mismas preguntas acerca de los padres de su esposa/esposo.

IF R IS NOT MARRIED CHECK HERE ☐ AND GO TO NEXT PAGE.

¿De qué descendencia es el padre de su esposo/a, o sea la descendencia de su suegro?

_____

IF MEXICAN ONLY, CHECK BOXES E AND F AND GO TO Q.10

8. ¿De qué descendencia es el padre de su suegro?

_____

IF MEXICAN CHECK BOX [E]

9. ¿De qué descendencia es la madre de su suegro?

_____

IF MEXICAN CHECK BOX [F]

10. ¿De qué descendencia es su suegra?

_____

IF MEXICAN ONLY, CHECK BOXES G AND H AND GO TO NEXT PAGE

11. ¿De qué descendencia es el padre de su suegra?

_____

IF MEXICAN CHECK BOX [G]

12. ¿De qué descendencia es la madre de su suegra?

_____

IF MEXICAN CHECK BOX [H]

RESPONDENT'S SPOUSE IS ELIGIBLE - IF ANY TWO OF

[E] [F] [G] or [H] ARE CHECKED

BE BE PREPARED TO USE THESE PROBES:

A) IF ANCESTRY RESPONSE IS "SPANISH," "LATIN AMERICAN," "HISPANIC," "LATINO," ETC., ASK:

What country do you mean by that?

B) IF ANCESTRY RESPONSE IS "AMERICAN," ASK:

What about before that? What country did your ancestors originally come from?

7. Now I would like to ask you the same questions about the parents of your wife/husband or the person you live with.

IF R IS NOT MARRIED CHECK HERE AND GO TO NEXT PAGE.

What is your father-in-law's ancestry?

_____ IF MEXICAN ONLY, CHECK BOXES E AND F AND GO TO Q. 10

8. What was his father's ancestry?

_____ IF MEXICAN CHECK BOX [E]

9. What was his mother's ancestry?

_____ IF MEXICAN CHECK BOX [F]

10. What is your mother-in-law's ancestry

_____ IF MEXICAN ONLY, CHECK BOXES G AND H AND GO TO NEXT PAGE

11. What was her father's ancestry?

_____ IF MEXICAN CHECK BOX [G]

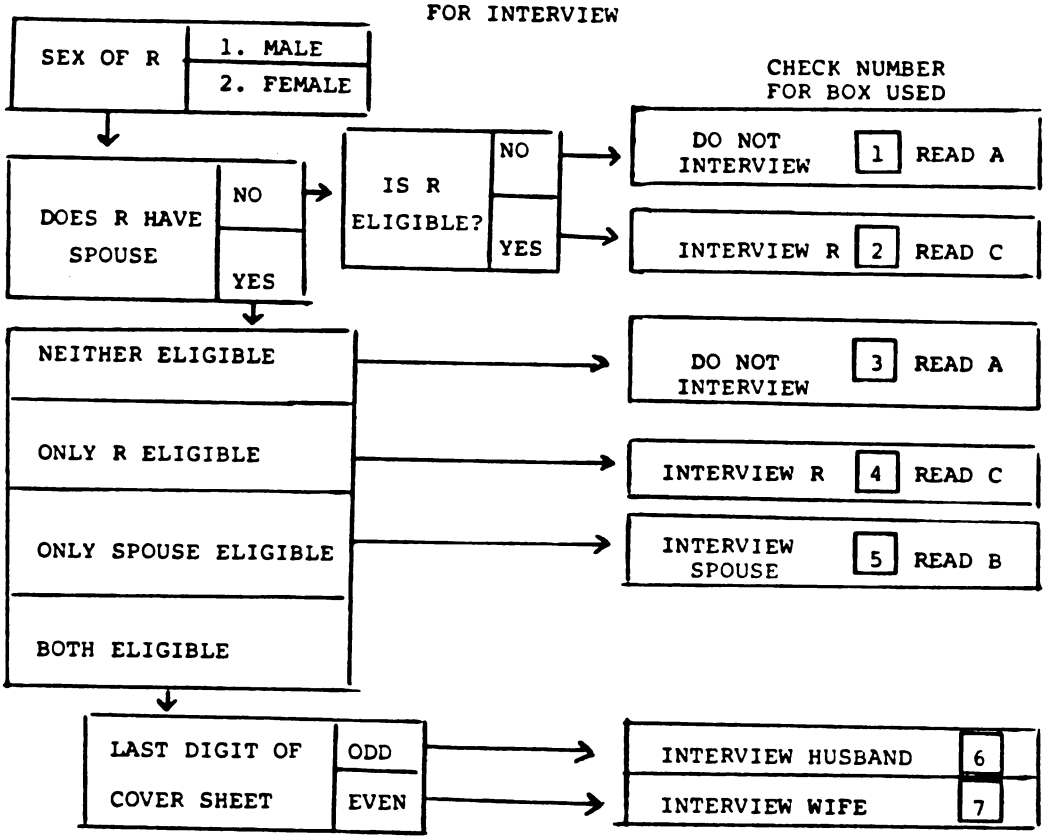
12. What was her mother's ancestry?

_____ IF MEXICAN CHECK BOX [H]

RESPONDENT'S SPOUSE IS ELIGIBLE - IF ANY TWO OF

[E] [F] [G] or [H] ARE CHECKED

DECISION CHART FOR SELECTING PERSON FOR INTERVIEW



-10-

STATEMENT A

DO NOT INTERVIEW ANYONE

Muchísimas gracias. La información que nos ha proporcionado nos permitirá organizar un mapa de nacionalidades en algunas regiones del país. En el futuro posiblemente nos interese entrevistarlo/a con más detalle, pero le avisaremos. Muchas gracias por su ayuda.

STATEMENT B

INTERVIEW SPOUSE

Su esposo/esposa es una de las personas que quisiéramos entrevistar en mayor detalle. Quisiera hacer la entrevista ahora mismo si es posible. ¿Podría hablar con él/ella?

IF NOT AVAILABLE, TRY TO MAKE APPOINTMENT.
WHEN INTERVIEW IS TO BE CONDUCTED:
A. CONFIRM ETHNIC ELIGIBILITY INFORMATION ON PAGES 6-7
B. EXPLAIN STUDY
C. BEGIN THE INTERVIEW

STATEMENT C

INTERVIEW SCREEN RESPONDENT

En esta ocasión, queremos entrevistar a personas que son de descendencia mexicana. Toda la información que nos dé es completamente confidencial: nos interesan únicamente respuestas anónimas y claro que Ud. es libre de no contestar las preguntas que no quiera. La entrevista se toma aproximadamente media hora y se le pagará $5.00 si participa con el proyecto.
(MAKE APPOINTMENT IF RESPONDENT AGREES)

-11-

STATEMENT A

DO NOT INTERVIEW ANYONE

Thank you very much. The information you provided will allow us to understand the ethnic make-up of some areas and regions of the country. In the future we may be interested in interviewing you at greater length, and we will contact you in advance. Thank you very much for your time.

STATEMENT B

INTERVIEW SPOUSE

Your wife/husband is one of the people we would like to interview in greater detail. I would like to conduct the interview with him/her right now if at all possible. May I speak to him/her?

IF NOT AVAILABLE, TRY TO MAKE APPOINTMENT.

WHEN INTERVIEW IS TO BE CONDUCTED:
A. CONFIRM ETHNIC ELIGIBILITY INFORMATION ON PAGES 6-7
B. EXPLAIN STUDY
C. BEGIN THE INTERVIEW

STATEMENT C

INTERVIEW SCREEN RESPONDENT

At this time we want to interview persons of Mexican ancestry, and you are someone whose opinions we are interested in obtaining. All of the information you give us will remain confidential and your identity will be anonymous. No one will know who you are. Also, you are free not to answer any questions with which you feel uncomfrotable. The approximate time for the interview is about one half hour, and you will be paid $5.00 if you participate in the study.
(MAKE APPOINTMENT IS RESPONDENT AGREES)

# APPENDIX C.

# INTERVIEWER TRAINING MANUAL

# APPENDIX C.

## INTERVIEWER TRAINING MANUAL

### INTERVIEWER TRAINING MANUAL

### TABLE OF CONTENTS

I

## STATEMENT OF PROFESSIONAL ETHICS

All interviewers for the Survey Research Center are expected to understand that their professional activities are directed and regulated by the following statements of policy:

The Center undertakes a study only after it has been evaluated in terms of its importance to society and its contribution to scholarly knowledge. It does not conduct studies which are, in its opinion, trivial, of limited importance, or which would involve collecting information that could be obtained more easily by other means, and it does not undertake secret research or conduct studies for the sole benefit of one individual, company, or organization. The Center is a community of scholars whose findings are available to everyone. Every effort is made to disseminate research results as widely as possible; this is done through books, journal and magazine articles, news releases, papers presented at professional meetings, and in the classroom.

The rights of human subjects are a matter of primary concern to the Center and all study procedures are reviewed to ensure that individual respondents are protected at each stage of research. While it is the Center's policy to make study findings public, the utmost care is taken to ensure that no data are released that would permit any respondent to be identified. All information that links a particular interview to a specific respondent is removed as soon as the interview is received at the Center; this information is maintained in special confidential files while the study is in progress, and is destroyed after the study closes. Interviews themselves are identified only by numbers.

The Center's strict precautions to protect the anonymity of respondents will be undermined if the interviewer does not treat information concerning respondents with equal regard. Interviewers perform a professional function when they obtain information from individuals in personal interviews, and they are expected to maintain professional ethical standards of confidentiality regarding what they hear and observe in the respondent's home. All information about respondents obtained during the course of the research is privileged information, whether it relates to the interview itself or includes extraneous observations concerning the respondent's home, family, and activities.

# First National Studies of Minority Groups Explore Racial/Ethnic Identity and Mental Health

An exciting new direction in social research is being explored by ISR researchers who are making the first attempts ever to identify and interview large national samples of racial or ethnic minority groups. Two separate ISR studies currently underway are carefully examining the attitudes and experiences of Chicanos and black Americans. Both studies focus on the relationships between racial or ethnic identity and mental health.

Carlos H. Arce, study director with ISR's Survey Research Center, is directing the national survey of people of Mexican origin, and the national survey of the black population is headed by James S. Jackson, faculty associate with ISR's Research Center for Group Dynamics.

New methodological techniques and innovative interviewing approaches are being devised for the studies. Representative samples of these minority groups cannot be easily found because of the relatively small numbers within the population and their geographic dispersion. Sampling difficulties present a complex problem for both studies, particularly for the Chicano study. "It is relatively easy to locate and select respondents among the Chicano population in East Los Angeles, for example; it is quite a bit more difficult to do so in Minneapolis—or even in West Los Angeles, for that matter," Arce explains.

The mental health needs of Chicanos and blacks and how these needs are being met, or not being met, are a primary focus of the two studies. Both are concerned with the special stresses and pressures that many Chicanos and blacks in this country face—including socioeconomic hardship, discrimination, and poor physical environment or health. The researchers are also exploring the resources these minority individuals use to deal with the problems and psychic distress they may experience—both the formal mental health resources and the informal helping networks such as family, friends, or ethnic community.

The two new studies represent a comprehensive effort to develop a national data base for comparison with past, less systematic social research on minorities and with future national and local studies. Both studies will provide comprehensive assessments of several kinds of attitudes and experiences among the minority groups. "In addition to assessing ethnic identity and mental health," Arce says, "our study will address language attitudes and use, attitudes about family and family relationships, labor market experience and economic well-being, political participation, and general attitudes about

James S. Jackson

**There may be a need for programs and clinics that are more sensitive to the role of broader social and economic determinants of personal problems.**

perceived quality of life."

In the past there have been very few comprehensive studies on Chicanos and no attempts to create a large, representative sample. The present study includes the collaborative efforts of more than 15 Chicano researchers from several disciplines. Data from the study will be immediately released to the Chicano research community, Arce says, so that a variety of analytic studies can be carried out and appropriate policy applications pursued.

**Having bilingual interviewers who are familiar with both the Mexican and American cultures is particularly important.**

In contrast to the paucity of research on Chicanos, there is a vast literature about black Americans, including research related to mental health issues. But much of the scientific literature on blacks has been contradictory, Jackson notes, and, again, none of the previous research has been based upon representative samples of this minority group.

Another unique feature of the ISR studies of ethnic identity and mental health is their use of Chicano and black field staff to conduct interviews for the respective surveys. Previous methodological studies have shown that individuals seem more comfortable and respond more openly with interviewers of their own race or ethnic background. And for the Chicano study, having bilingual interviewers who are familiar with both the Mexican and American cultures is particularly important, Arce points out.

Arce and Jackson will also be carefully examining the language of the survey questions to determine the extent to which they are understood and interpreted by respondents in the manner intended by the researchers. "In effect," Jackson says, "we will be asking a sizable group of blacks and Chicanos what the words and concepts mean to *them*—not simply assume that all segments of American society interpret or use language identically."

A related concern addressed by the two studies is the effect of cultural influences on the way in which individuals experience or define mental health problems. The literature on persons of Mexican origin, Arce explains, has characterized them as viewing illness as fatalistic and supernatural, making them reject modern medicine in favor of alternative health resources, which may include family, friends, and even *curanderos* or faith healers.

Carlos H. Arce

"Much has been written about the inadequacy of traditional psychiatric facilities for dealing with the problems of blacks, other minorities, and people of lower educational and economic status," Jackson adds. "Considerable concern has been expressed over the type of treatment offered by traditional psychotherapists and many writers question the emphasis on intrapsychic functioning and point to the need for community-based programs and clinics that are more sensitive to the role of broader social and economic determinants of personal problems."

The two ISR studies, Arce and Jackson say, represent the first systematic research on how minority persons react to the issue of mental health and on how they view the different mental health resources. ■

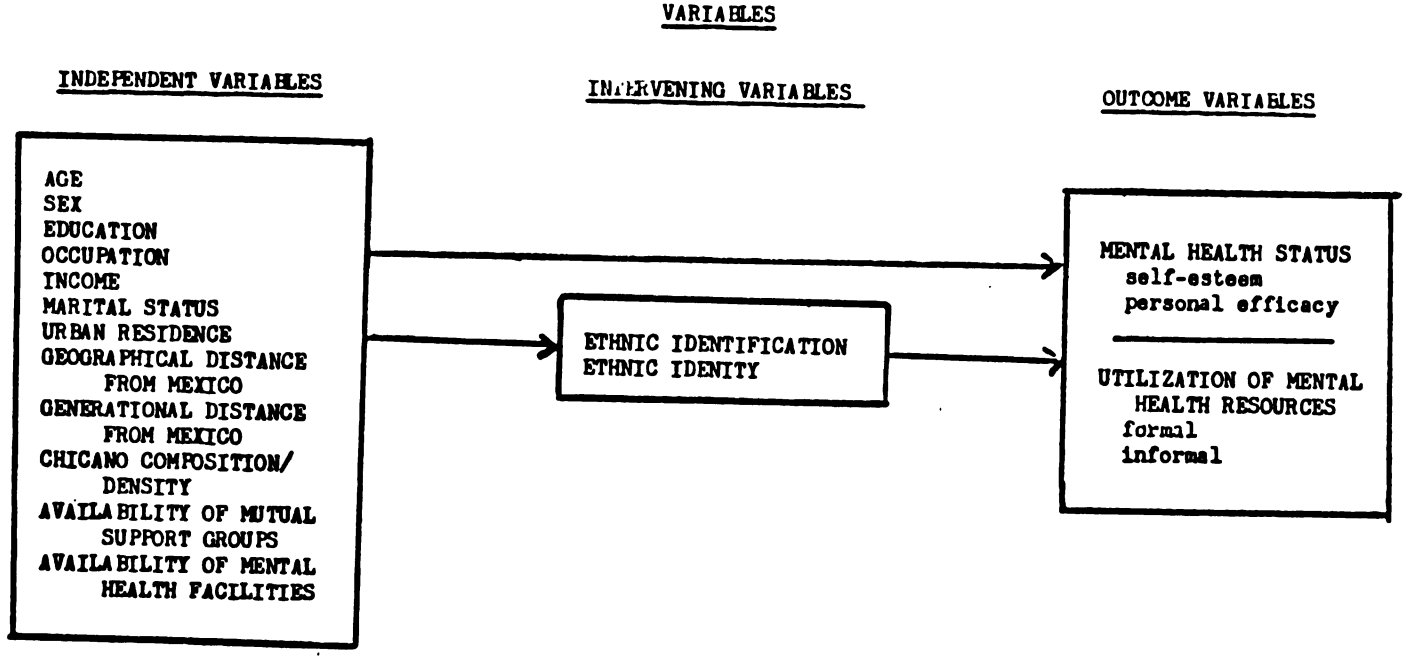
*For further information about these two studies contact Carlos H. Arce or James S. Jackson at the Institute.*

# III

## OVERVIEW OF LANSING STUDY

The Lansing Study is a suplication of part of the comprensive national study of the mental health implication of ethnic identification and identity among Chicanos conducted by the Survey Research Center, Institute for Social Research, University of Michigan, Ann Arbor, Carlos H. Arce, Project Director. The research will be done in collaboration with Carlos Arce and the results will be compared and analyzed with the results obtained by SRC from Texas. The data to be collected in Lansing will become part of the national study and will be available to interested scholars and mental health practioners.

Individual and community-contextual variables will be study as the independent variables. Ethnic identification and identity will be study as intervening variables. Mental health status as defined by self-esteem and personal efficacy, and attitudes and utilization of formal and informal mental health helping resources will be study as the outcome variables. (See attached diagram.)


VARIABLES
INDEPENDENT VARIABLES
INTERVENING VARIABLES
OUTCOME VARIABLES
AGE
SEX
EDUCATION
OCCUPATION
INCOME
MARITAL STATUS
URBAN RESIDENCE
GEOGRAPHICAL DISTANCE FROM MEXICO
GENERATIONAL DISTANCE FROM MEXICO
CHICANO COMPOSITION/ DENSITY
AVAILABILITY OF MUTUAL SUPPORT GROUPS
AVAILABILITY OF MENTAL HEALTH FACILITIES
ETHNIC IDENTIFICATION
ETHNIC IDENITY
MENTAL HEALTH STATUS
self-esteem
personal efficacy
UTILIZATION OF MENTAL HEALTH RESOURCES
formal
informal

# IV

## GLOSSARY OF TERMS USED

Attitudinal Questions (Probing) Inappropriate interviewer behavior where the interviewer, in probing the Respondent for further information, states the question in such a way that the Respondent picks up on the Interviewer expectations and is therefore, "led" to a response.

Directive Questions (Probing) Inappropriate interviewer behavior which can either change or limit the frame of reference of the question, or limit the response possibilities. A probe is also directive if it suggests possible answers to the Respondent either directly or by providing information in addition to that which the "R" and the original question have already given.

Head of Household That member of the household who is the main breadwinner; the "economic dominant" in the household; provides the major share of financial support for the household even if household includes two or more families.

Housing Unit (HU) A room or group of rooms occupied or vacant and intended for occupancy as separate living quarters. In practice, living quarters are considered separate and therefore a HU when the occupants live and eat apart from any other group in the building, AND THERE IS EITHER direct access from the outside or through a common hall, OR, complete kitchen facilities for the exclusive use of the occupants, regardless of whether or not they were used.

Listing The enumeration of the housing units within a well-defined geographic area.

Non-Directive Questions (Probing) Appropriate Interviewer behavior which does not affect any limitation or change in the frame of reference of the question; the frame of reference of the response should not be limited or changed, either

Probing Interviewing technique applied mainly when information is not complete, responses need clarification, and to (in some degree) press the R for an answer.

PSU Primary Sampling Unit; it consists of a county, or group of adjacent counties.

Respondent ("R") That person who is either the head of household or the spouse of the head of the household of a selected HU.

Segment The smallest geographic area of selection.

Bias To influence; to cause people to behave or respond differently. Two main areas of bias when interviewing involve two methods of communicating; verbally or non-verbally.

Screening The determination of the ethnic ancestry of residents in a HU through a brief interview using the Screening Questionnair. The objective being to identify persons of Mexican ancestry.

## GLOSSARY TERMS CON'T.

**Probability Sample** The type of sample that gives each unit or element in the population an equal chance of being included in the sample. Also called a "simple random sample", and in principle consists of selecting the sample through methods of proabability theory so that the sample size does not differ by more than a certain margin from the true size of the population. The term "probability sample" usually refers to the type of random sample selected when investigators conduct national surveys. The logic involved is that every single citizen in the continental U.S. has an equal chance of being selected in the final sample.

**Coding** A term referring to the processing of collected information from questionnaires or interview schedules. Information collected through questionnaires have to be transformed in a language which is machine readable. The process of this transformation represents the "coding" process. Typically, data becomes coded into computer IBM cards which are fed into the computer for purposes of calculating percentages and other assorted statistics.

**Data Analyses** Refers to the process whereby one examines what one has collected from questionnaires (from the overall survey.) This process usually follows from coding processes. Essentially, one conducts data analyses for purposes of verifying something. It consists of numerical calculations oriented toward answering specific questions that one wants to ask from the data collected (thus the term data analyses). In surveys, typical types of questions involve looking for specific relationships between variables we have measured. For example, one might want to see whether, for the total sample, there is a relationship between family size and parents' expectations of their children's success. Data analysis is useless unless one wants to ask specific questions. Most questions are asked with some sort of theory in mind, such as looking at what has been done before in other surveys with what one has found out in the present survey.

**Variables** Variables are forms of representing specific categorizations of human characteristics or behavior, of human groupings, and the like. It is a theoretical definition of social phenomena which permit investigators to categorize and examine the world around us in a more orderly and systematic fashion. Examples of variables are: sex, social class, race, and so on. Variables can be represented by one item or question in the survey, but usually the phenomena that one tries to look at is so complex that they have to be constructed by several items or questions. For the most part, if this is the case, the set of items are labelled a scale.

**Scales** Usually refers to a set of items or questions oriented toward measuring something. Scales are usually validated before the actual survey and are, for the most part, sufficiently reliable in measuring what we try to measure. A simple example of a scale is a ruler, where one can use it to measure length, distance, etc. Scales in surveys usually measure some aspect of human behavior that we are interested in finding out. Thus, there are scales to measure extent of ethnicity, degree of communication with relatives, feelings toward specific groups, and the like.

V

CRITERIA FOR DETERMINING ELIGIBILITY FOR THE STUDY:

BELOW ARE THE CRITERIA FOR ELIGIBILITY OF PERSONS AND HOUSEHOLDS FOR THE SAMPLE THAT WILL BE DETERMINED THROUGH QUESTIONS ASKED IN THE SCREENING QUESTIONNAIRE.

1. A household is considered eligible for the National Study of People of Mexican Descent if the principal breadwinner or his/her spouse or both are of Mexican ancestry.

2. A person (principal breadwinner or spouse) is considered to be of Mexican ancestry regardless of the number of generations in the United States.

3. The criterion for degree of Mexican ancestry necessary for eligibility are:

   a. Either the father or mother of the person, or both, be reported to be fully or solely of Mexican descent; OR

   b. Both the father and the mother of the person be reported to be half or more of Mexican ancestry.

4. The determination of ancestry or national origin in the survey will be made from responses by a person to a question about his/her parents' "roots" before they or their ancestors came to the United States.

VI

WHAT LANGUAGE DO I USE FOR INITIALLY GREETING THE R?

Starting at the time you reach the doorstep of the person you will be interviewing, you should be observing closely any clues which will help you to determine the R's preferred language. Observe the neighborhood you are in. Is it predominantly Spanish-speaking or English-speaking? In what language are posters, street signs, and advertisements? Are there children playing in the street? What language are they speaking? Can you see names written on the mailboxes? If so, are they Spanish names or English ones? Pay close attention to verbal cues between family members ("Juan, ve quien esta en la puerta") and finally, to the language spoken by the R ("Quien es?" "Who is it?").

A. If you are greeted in Spanish, respond in Spanish.

B. If you are greeted in English, respond in English.

C. If you are greeted in "accented" English, wait for more cues which will give you a more clear idea of whether or not the person is displaying a mastery/pride in using English or if he does not know that you speak Spanish.

D. If the R has not said anything so far and you are not sure what language to greet him in, use English. Start your conversation by asking "Did you receive the letter?" If the person you are interviewing does not understand you, looks puzzled, or goes to get someone who can speak English, switch to Spanish.

WHAT LANGUAGE DO I USE IN SCREENING?

At this point, if you feel absolutely certain that the R only speaks Spanish or only speaks English, conduct the screening interview in the preferred language. If you are not sure, attempt to find out more definitely the language in which the R feels most comfortable by following the next step.

THE LANGUAGE OF THE INTERVIEW:

If the R has only spoken Spanish up to this point,you can probably assume that Spanish is his preferred language. If English is being spoken and there is still some uncertainty, at this point give the R the option to make a choice. Ask him "What language do you feel most at ease using, English or Espanol."

In cases where the R says it doesn't matter, the interviewer should stress that is is important for the R to decide.

WHAT DO I DO IF THE R SWITCHES FROM ONE LANGUAGE TO THE OTHER?

If the R answers a question, only one time, with a complete switch in language (a whole sentence), continue questioning in the same language you were using before.

If the R answers a question two consecutive times in the other language, the interviewer should switch to the language just used by the R.

If the R switches languages in the middle of a sentence ( "Soy puro Chicano, and I am proud of it") continue using the original preferred language. If this occurs more than three consecutive times, switch to the other language.

If the R inserts single words of the other language into a sentence (No se nada de los Teamsters) or borrows words from one language, (Morales no deveria de quitear), keep using the originally preferred language.

It is alright to switch languages only if:

A. The R specifically requests a change.

B. He asks for a clarification in meaning using the other language more than two consecutive times.

REMEMBER:

A. Questions should always be asked as stated on the questionnaire;

B. Be sensitive to how the R is feeling. Be careful not to insult him, making sure that he is comfortable and at ease during the interview.

VII

RULES FOR RECORDING INTERVIEW RESPONSES

1. Write down the R's responses immediately during the interview. Relevant information can be lost or distorted if you try to remember later what R said.

2. Use the R's own words. This is called "verbatim recording" and is essential. We want to learn about the phrasing, grammatical usage and other peculiarities of R's speech. Essential to this particular study is the usage of trans-lingual replies. That is, if an R crosses linguistic lines while responding, this should be indicated. If an R starts out an interview by responding in Spanish, and changes mid-sentence or halfway through the questionnaire to using English, your recording should reflect those patterns.

3. Do not summarize or paraphrase the R's answers. This practice creates an artificial and dangerous communications gap and can lead to distorted results.

4. Include everything that pertains to the question objectives. Regardless of length, your recording should note everything that R said that pertains to the objectives of the question. However, some R's will digress from the subject and talk at length about subjects that have no bearing on the question matter at all. These discourses should be omitted from the recorded interview i

a. You are certain that what is being said has no bearing on the aims of the question;

b. You make marginal notes to indicate that a digression took place. For example: (Here R talked at length about his son's war experiences.)

5. Include all probes, comments and explanations which you made during the course of the interview. Do this at the location which corresponds to the question.

6. Hold the R's interest. Don't become overly absorbed in the questionnaire to the point that you lose focus on the R. A good technique for keeping up with the R is to repeat his responses as you write them down. This also serves to let the R know that you are listening and recording his every word.

VIII

MECHANICS OF RECORDING AND EDITING

Basic "Musts" for recording responses:

1. Use a pencil to record--a #2 black lead pencil. Carry several sharpened ones with you so that you always have one for immediate use.

2. Your writing must be legible. Regardless of how well the interview went, it will be useless if it is unreadable. When you edit a questionnaire be sure that all of your writing is legible.

3. Use parentheses to indicate your own words, probes, observations. The use of parentheses distinguishes the use of your words as opposed to those of the R. Use them in the following situations:

A. All probes you make in the interview;
B. All remarks you make to the R;
C. Comments you wish to make to the coders, for example:

   1. Description of R's behavior;
   2. Summaries of R's digressions;
   3. Cross references, marginal notes;
   4. Reasons why questions were not asked.

4. Cross reference relevant material in the interview. During editing cross-reference responses to one question which also apply to other questions. This will let the coder know that the answer is also relevant to another question.

5. Account for each question in the questionnaire. For each question, you must either record an answer, or explain why it was not asked or answered. Standard abbreviations for unasked questions include:

"INAP"--Innapropriate or Inapplicable; to be used only when the questionnaire instructs you to skip questions.

"SLASH MARK /"--May be drawn across an entire page or group of questions in place of or in conjunction with INAP

"SKIPPED"--If a question is skipped intentionally or inadvertently, write in the margin and give an explanation.

IX

KEY POINTS IN EDITING:

1. Make sure all entries are legible.

2. Make sure inappropriate questions are marked as such and that those questions marked "INAP" are really inappropriate as determined by questionnaire guidelines.

3. Make sure all unclear responses are clarified by your parenthetical notes.

4. Make sure all your probes and other such remarks of your own are in parentheses.

5. Make sure you have provided a thumbnail sketch that will give the reader a good idea of what the R was like and laso of what the interview situation and climate were like.

SUMMARY NOTES ON EDITING:

1. Keep in mind that someone who was not present during the interview will be reading and examining your completed interview; and that the goal is to make the coder feel as though she cr he was present;

2. The best time to edit an interview is right after you have taken it. This allows you to keep fresh thoughts and reactions in mind. If it is not possible to edit an interview right away, absolutely do not let more than one day lapse between the interview and your editing it.

X

THUMBNAIL SKETCHES

At the end of each questionnaire you will find a space for recording observations you make about the R and the interview. This is called a "Thumbnail sketch." The idea here is to give coders a capsule description of what the R is like. Coders read the Thumbnail sketches before reading through the questionnaires in order to gain some insight into what the R's personality is like.

Earlier we mentioned that an I's keen observations about environment and special conditions or situation is important. This is where those observations come into play.

Thumbnail sketches should include the following types of information:

1. The R's and R's family's attitudes towards you and the survey;

2. Unusual circumstances and events that had bearing on the interview, such as interruptions, language difficulties, and so on;

3. Feelings you might have had about the R and the interview, things you sense or suspect;

4. Anything else that happened while you were at R's house that had bearing on the survey's objectives.

Please don't make requests for answers or for materials in the Thumbnail sketch. Field office personnel should be asked pertinent, instructional questions.

One final comment about Thumbnail sketches: Respondents have a legal right to come to Ann Arbor and ask to look at their interviews, including comments in the Thumbnail sketch. Be careful to use appropriate and tactful comments, particularly about the Respondent and personal topics.

XI

INTRODUCTION TO INTERVIEWING:

I Getting into the role:
A. Expelling Interviewer fears; looking, feeling funny about approaching the R; of being turned down, and the task in general.

B. Not opening up to the R; exercising self-restraint and learning techniques of tactful neutrality of your personal opinion.

C. The Reporter Role; Interviewer demands of time, privacy, and intimacy.

II Bias:
A. What it is, how it is created and how to avoid it.

1. Style, appearance;
2. Verbal and non-verbal communications;
3. Asking questions; making mistakes, changing questions by adding words, subtracting words or rearranging the wording of the questions;
4. "Leading" the R's answers.

III Probing--Introduction to controlled, non-directive pro

A. Objectives of the probing techniques--to get the R to elaborate on or clarify responses. Objective is to motivate R to explore and report their opinions and sentiments without biasing responses.

B. Six types of controlled, non-directive probes:

1. Pausing--waiting expectantly for a R to complete thoughts, sentences.

2. Re-reading the question, particularly if the R seems to have misunderstood the question or gives an incomplete or unrelated response.

3. Asking for more specific information or a response which indicates clearly what the R is thinking.

4. Stressing generality when the R is unable to be specific; usage of terms such as "generally."

5. Stressing subjectivity--"your opinion" and "your best estimate."

6. Zeroing in when R can't remember situations; helping terms such as "what season?"

XII

INTERVIEWING

BASIC GOAL: *TO COLLECT ACCURATE INFORMATION BY USING SOUND INTERVIEWING PRACTICES.*

INTERVIEWING HINTS:

1. Avoid creating a scenario which will make the R uncomfortable; avoid creating an impression of "cross-examination" with the R. Don't react to the replies which R gives, no matter how outrageous or silly they appear.

2. Read each question slowly. Reading them rapidly will tend to force the R to respond in like manner. Create an atmosphere of calm, relaxed behavior.

INTERVIEWING SPECIFICS:

1. Ask the questions EXACTLY as they are worded in the questionnaire. Do not change the questions by adding or omitting words, even though you think it might make more sense to the R. Don't be presumptuous about the R's ability to comprehend the questions.

2. Ask the questions in the exact order in which they appear in the questionnaire. They appear in the questionnaire in the order of our specific purposes, so please don't rearrange them.

3. Ask EVERY question in the questionnaire even though R may have appeared to have given an answer already. The only exception to this rule is if the checkpoints indicate that you should do so, or if other questionnaire instructions direct you to skip over a particular section.

4. If R seems to have misunderstood a question, REPEAT THE QUESTION EXACTLY AS IT APPEARS ON THE QUESTIONNAIRE. Do not try to help the R by re-phrasing it. If R still has difficulty, skip the question and go on to the next one.

5. If R is hesitant to answer personal questions, try to explain the reasons that they are being asked. If R is persistent in refusing, in a very calm, matter of fact manner, go on to the next question.

## XIII

BIAS:

Interviewer bias consists of subtle, yet serious, interferences in the recording or elicitation of survey responses from the R. Bias is most often an inadvertent, or unintentional and, thereby, unconscious act, which interviewers must minimize in order to ensure the collection of reliable and precise data. The overall effect of bias is that of affecting or altering the results of the survey, artifically increasing or decreasing the value of the data being collected.

Interviewer biases fall into two major categories, verbal and non-verbal communications. Verbal biases make up the larger of the two categories and the following examples indicate potential sources of bias:

A. Reacting to the R's responses; sometimes interviewers may want to relax the R or to make R feel more comfortable during the interview, either by reassuring them, or by using empathetic listening techniques. Comments that are reactions to the R's responses, no matter how supportive--if they are NOT neutral--are incorrect interviewer behavior. These are such remarks as: "Oh, really?" or "Yes, uh huh." Any remark that hints of approval or judgment commentary to R's replies is to be avoided.

B. Leaving out specific words, shortening the questions, or substituting words, accenting portions of the questions or certain words, is incorrect. Likewise, rearranging the response categories can have inadvertent effects on the R's responses.

C. Interview pace--are you rushing the R by reading the questions at a rapid pace? R's tend to pick up cues from the I., and this could produce a fear, or reluctance on the R's part to give thought before giving a response to the question. Similarly affecting the R is his ability to hear each question--are you clearly enunciating the questions? Are you using an audible tone of voice? Are you passing on cues which indicate impatience, fatigue, or general discomfort? These manners can affect the R or generate discomfort and should be a concern to you.

D. Interviewers' overall expectations of responses can bias the R., particularly in questions that may sound similar to others, or that require similar types of information. If you encounter a situation where you ask a question that calls for a response that may support or contradict information previously given, DON'T confront the R with this fact.

E. In situations where the R is stuck for a word, an adjective or descriptive term, be cautious to avoid suggesting a proper word or term for the R. Don't put words in the R's mouth, or answer for or suggest answers to the questions. Also in this area, don't assume you know what the R means or is trying to express.

EXAMPLES OF NON-VERBAL BIASES INCLUDE:

A. Shifting uncomfortably or uneasily in your chair. This can indicate to the R that he is taking too long to respond to survey questions, resulting in hurried or unthought answers.

B. Facial expressions can give away your feelings towards R's answers to questions, particularly feelings of disagreement, surprise, or disgust. Be careful not to show your feelings to R's responses.

C. Tapping your fingertips or pencil on the table top can, again, indicate to the R that he is taking too long to answer the questions, and that your actions are indicating growing impatience.

D. Don't keep looking at your watch. Since you have to record the time in certain sections of the questionnaire, one suggestion we'd like to make is to take your watch off and place it in front of you in a convenient spot, so that your time observations are inconspicuous. By having to look at your wrist for the time, the R can mistakenly think that he is taking too long with his replies.

XIV

PROBING

TWO MAJOR FUNCTIONS:

1. To motivate the R to communicate more fully so that responses are clarified, enlarged upon, or explained more thoroughly;

2. To help R focus upon the specific content of the interview, thereby eliminating irrelevent or unecessary information.

**********

*SUCCESSFUL PROBING REQUIRES THAT YOU RECOGNIZE IMMEDIATELY JUST HOW THE RESPONDENT'S ANSWER HAS FAILED TO MEET THE OBJECTIVE OF THE QUESTION, AND THEN BE ABLE TO FORMULATE A NEUTRAL PROBE TO ELICIT THE INFORMATION NEEDED.*

**********

SEVERAL KINDS OF PROBES:

1. Pausing--waiting expectantly, thereby allowing the R to gather thoughts about the question.

2. Re-reading the question. If R misunderstands or misses part of the question, this can serve as a helpful aid.

3. Asking for more specific information, particularly when R gives general answers to questions calling for specific responses.

4. Stressing generality--used when R has a hard time providing a general response. Use terms such as "Usually" or "Generally" or "Mainly."

5. Stressing subjectivity--used when R has a hard time conceptualizing intent of the question. Stressing the need for R's opinions, as opposed to seeking a "correct" answer or opinion.

6. Zeroing in--some questions call for R remembering events which have happened in the past. Zeroing in provides a framework for recalling past events by using helping terms such as "What season?"

PROBING:

"NEUTRAL QUESTIONS OR COMMENTS USED TO OBTAIN CLEARER AND FULLER RESPONSES FROM THE R WITHOUT INTRODUCING BIAS"

The following lists are comprised of the most commonly used probes used in interviewing:

| ENGLISH PROBES | | SPANISH PROBES | |
|---|---|---|---|
| Interviewer's probe | Abbreviation | Interviewer's probe | Abbreviation |
| Repeat question | (RQ) | Repita pregunta | (RP) |
| Anything else? | (AE or ELSE?) | ¿Otra Cosa Mas? | (OC) |
| Any other reason? | (AO?) | ¿Alguna Otra Razon? | (OR) |
| Any others? | (Other?) | ¿Algunos Otros? | (AO) |
| How do you mean? | (How Mean?) | ¿Cómo quiere decir? | (Cómo) |
| Could you tell me more about your thinking on that? | (Tell more) | ¿Me puede decir más sobre sus pensamientos? | (Diga más |
| Would you tell me what you have in mind? | (What in mind?) | ¿Me puede decir en que esta pensando? | (Qué pien |
| What do you mean? | (What mean?) | ¿Qué quiere decir? | (Qué dice |
| Why do you feel that way? | (Why?) | ¿Porqué siente asi? | (PSA) |
| Which would be closer to the way you feel? | (Which closer?) | ¿Cuál es más parecido a lo que siente? | (Cuál par cido?) |

If you find that you need to use probes which are not on this page, the only rule is to make sure that it is a controlled, non-directive question or statement that fulfills the same objective, that is, to elicit a clarified response from R, or to help R focus on the question.

Please be careful to explain any probes which you use on your own, so that our coders understand what prompted R to respond in a particular manner.

XV

## SETTING UP APPOINTMENTS

At times you will find a respondent who is willing to be interviewed, but unavailable at the moment. Use discretion in setting up a definite appointment for an interview, but keep in mind the amount of time projected for a particular primary area. Also keep in mind that setting up an appointment may be a way of trying to get rid of the interviewer and avoiding being home at a particular time. For this reason try to conduct interviews and avoid appointments.

** Good times for appointments are often the times that are bad for making initial calls, e.g., early in the morning, or durthe lunch hour. Try not to set up appointments during hours which are most productive for initial calls.

** Be prepared to do other work during odd time periods between appointments when there is too little time to conduct another interview. This might include listing, screening, (especially in low eligibility segments) editing interviews, completing reports, or communicating with your team leader. Interviewers should travel with a "mini-office" in the trunk of their cars.

** If a respondent breaks an appointment, try stopping by, unannounced, when you are in the neighborhood.

** Use the interviewer card for personal notes, such as "Sorry I missed you..." when you are unable to find anyone at home. If the appointment was broken and you feel that the respondent is cooperative but absent-minded, you might leave your telephone number and ask him to call you to arrange a convenient time, adding something like "I will be back in your neighborhood on Thursday and Friday."

XVI

## REASONS AND TYPES OF REFUSALS

TYPE A--Reservations/objections about surveys or about research and expressions of anti-government or anti-establishment attitudes. Comments such as: "Surveys are useless or not worthwhile," "They don't do any good," or "Research is a waste of time," "We are always being asked for our opinions, but nothing ever comes of it," "The government wants to know too much," or "These things are used to find ways to control or to take advantage of people."

TYPE B--Explicit or implicit (verbal or non-verbal) concerns about threats to privacy, personal security, confidentiality. Any apparent sign respondent feels vulnerable, overly suspicious, or threatened by authorities.

TYPE C--Comments about lack of time: "too busy," "don't have any time" or "I work a double shift and week-ends."

TYPE D--General refusal or non-availability. Non-specific reasons or just plain "NO!" General comment such as "not interested." Multiple reasons, including some of types A,B, and C.

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