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# Perceptions Of Mental Health Stigma And Discrimination In A Mexican American Sample

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PERCEPTIONS OF MENTAL HEALTH STIGMA  
AND DISCRIMINATION IN A MEXICAN AMERICAN SAMPLE

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A Dissertation

Presented to  
the Morgridge College of Education  
University of Denver

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In Partial Fulfillment  
Of the Requirements for the Degree  
Doctor of Philosophy

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by

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June 2009

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Title: PERCEPTIONS OF MENTAL HEALTH STIGMA AND DISCRIMINATION IN A MEXICAN AMERICAN SAMPLE

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## ABSTRACT

The stigma of mental health problems between Mexican Americans and White non-Hispanic European Americans was investigated and measured by attitudes toward seeking help and the amount of social distance desired from individuals with mental health problems. The stigma of mental health has been identified as a barrier to accessing mental health services among Mexican Americans and men in general. Men from both groups access mental health services at a significantly lower rate than women from both groups. This study contributed to research and practice by examining the possible differences in the level of stigma toward mental health problems between Mexican Americans and White non-Hispanic European Americans. This study also explored the relationship between Mexican Americans' acculturation level as well as selected demographic variables and the stigma of mental health problems. There were no significant ethnic or gender differences in the level of stigma toward mental health between the two groups. However, there was a significant gender difference within the White non-Hispanic European American group. Results also indicated that there was no significant relationship between Mexican Americans' acculturation level and the amount of stigma toward mental health. However, there was a significant positive correlation between Mexican Americans' age and the amount of social distance desired from individuals with mental health problems.

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## CHAPTER ONE

### Mental Health Problems and Social Stigma

Over the past 50 years, the assessment, diagnosis, and treatment of mental health problems in the United States and throughout the world have improved immensely. Mental health professionals have refined their abilities and skills in treating mental health problems as well as introduced new medications that even 20 years ago seemed, at best, a dream. These advances have improved the treatment of individuals who suffer from mental health problems, by illuminating the etiology of some disorders and the mechanisms that play a role in their development. With this said, research indicates that almost one-half to two-thirds of people with diagnosable mental disorders do not seek treatment. While there are multiple factors that contribute to people not using mental health services, stigma was identified as one of the foremost barriers contributing to people's decision not to seek treatment (Levin, 2001; Regier, Narrow, Rae, Manderscheid, Locke, & Goodwin, 1993; Sussman, Robins, & Earls, 1987).

Social stigma toward mental health problems results in individuals becoming so embarrassed or ashamed that they often conceal symptoms and fail to seek treatment (Sussman et al., 1987; Wahl, 1999). Research has shown that stigma directly affects clients' participation in therapy and compliance with medication regimens (Ben-Porath, 2002; Sirey, Bruce, Alexopoulous, Perlick, Friedman, Myers, 2001). Other studies have



found that stigma affects individuals with mental health problems in terms of their access to opportunities, such as housing and employment, as well as leads to diminished self-esteem, greater isolation and increased feelings of hopelessness (Corrigan & Penn, 1999; Penn & Martin, 1998).

It is ironic that even with significant pharmacological advances and empirically validated treatment, mental health professionals have yet to understand the impact of mental health stigma. Moreover, many health professionals fail to address the issue of stigma with their patients while in treatment (Surgeon General's Report, 1999). The stigma of mental health has yet to be properly addressed and dealt with in the treatment of individuals with mental health problems.

### Theories of Mental Health Stigma

#### *Overview of Goffman's Theory of Stigma*

Irving Goffman (1963) defined stigma as “an attribute that is deeply discrediting” (p. 3) and argued that any attribute in a culture that is deemed undesirable, or is devalued in some way, is often stigmatized. He did not believe that negative attributes constitute stigma. Rather, stigma is a phenomenon that results from the interaction between a stereotype and an attribute or characteristic a person is perceived to have and is socially devalued (Goffman, 1963). In a sense, it is the interaction between an attribute and its societal value. Stigma occurs when a person differs, or is presumed to differ, from the norm on a particular dimension, and is negatively evaluated by others. As a result, the person’s whole identity is tainted by that single attribute, and others thus dehumanize the person (Crocker & Quinn, 2000; Goffman, 1963; Jahoda & Markova, 2004). When this

occurs, Goffman speculates that an individual's social identity is spoiled and the public assumes that the person is incapable of fulfilling the role requirement of social interaction (Goffman, 1963; Kurzban & Leary 2001). In some ways, stigma can be viewed as a particular kind of deviance, in that a person's attribute deviates from what is characteristically regarded as the norm (Elliott, Ziegler, Altman & Scott, 1982).

Since individuals are typically embarrassed or ashamed of their stigmatized attributes, they learn to minimize these through various techniques. One way that stigmatized individuals manage their stigmatized condition is through restricting their environment; or in other words, using avoidance (Goffman, 1963). They tend to restrict their environment by restricting the amount of interactions socially that they have with others, and may limit that to a geographical area such as their neighborhood. They do this in an attempt to manage the amount of social rejection they encounter (Goffman, 1963).

Another technique is through concealment. If an individual can conceal their stigmatized attribute, then they will formulate a social identity in which that attribute is minimized, or is not available for other individuals to observe. Goffman (1963) posits that this actually is both a blessing, as well as a burden. It is a blessing that the person is able to wander among the masses, feeling accepted. However, the individual expends such a tremendous amount of energy maintaining this social identity that they often experience a constant level of anxiety and fear about someone "finding out about them."

Overall, stigma occurs when an individual is socially rejected because of a personal attribute that is devalued. The more visible and obtrusive the personal attribute is, the more likely the individual is to be significantly stigmatized and socially rejected. The

product of stigma is typically some form of discrimination. The awareness of the devalued attribute combined with the social rejection results in the stigmatized individual engaging in behaviors which attempt to conceal the stigmatizing attribute (Goffman, 1963).

#### *Overview of Scheff's Theory of Stigma*

Scheff (1966) posited that mental health diagnoses are stigmatized conditions, and as such, individuals with mental health problems are devalued and socially rejected. Scheff proposed that individuals within a society have schemas of what it means to have a mental health problem, and these schemas are negative stereotypes. According to Scheff (1966), members of society have negative stereotypes regarding mental health problems and these stereotypes are instilled in members of society at a very early age through a variety of media; such as television, cartoons, newspapers, movies, etc. Scheff theorized that once a person experiences a mental health problem the individual either becomes labeled with a mental health condition, or does not. Persons labeled with a mental health problem are subjected to the negative stereotypes associated with having such a condition. The social rejection causes the person with a mental health problem to protect themselves by limiting their social interaction with society. Additionally, the social rejection results in the person identifying themselves as a person with a mental health problem and assuming the stigmatized role. Scheff (1966) states that mental health problems are nothing more than behaviors and symptoms which go against social norms, and as a result the behaviors appear to be deviant and contrary to social

expectations. However, once identified and labeled, societal reactions to the labeled individual tend to be negative and stigmatizing (Scheff, 1966).

#### *Overview of Link's Theory of Stigma*

Link and Phelan (2006) state:

Stigma exists when the following interrelated components converge. In the first component people distinguish and label human differences. In the second, dominant cultural beliefs link labeled persons to undesirable characteristics – to negative stereotypes. In a third, labeled persons are placed in distinct categories, so as to accomplish some degree of separation from “us” from “them”. In the fourth, labeled persons experience status loss and discrimination that lead to unequal outcomes. Stigmatization is entirely contingent on access to social, economic and political power that allows identification of differentness, the construction of stereotypes, separation of labeled persons into distinct categories, and the full execution of disapproval, rejection, exclusion and discrimination. Thus, we apply the term stigma when elements of labeling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allows them to unfold. (pg. 2).

Formal labeling plays a role in the stigmatization process of individuals who have mental health problems. The Modified Labeling Theory posits that society holds general conceptions regarding mental health problems. These stereotypic views are ones in which individuals with mental health problems are devalued and discriminated against (Link, Cullen, Struening, Shrout & Dohrenwend, 1989).

Individuals who develop a mental health problem identify with the stigmatized status of their condition, and as a result view stigmatization by others as a threat (Link et al., 2001). These clients typically respond to their stigmatized status in three ways. Secrecy is one method by which clients choose to conceal their psychiatric condition from the general public, and they do this in an attempt to avoid rejection (Goffman, 1963; Link et al., 2001).

Another method of avoiding stigmatization is through withdrawal. Withdrawal serves as a means of mitigating the impact of stigmatization. Therefore, the person limits the majority of their social interaction to those who are aware and accepting of their condition (Goffman, 1963; Link et al., 2001).

Lastly, clients respond to their stigmatized status by attempting to educate others about their condition. In this case, the client decides to disclose their mental health problem in an attempt to prevent stigmatization or negative responses. In some ways this is seen as attempting to seek help and support from others, but the person also risks being discriminated against (Link et al., 2001).

#### Statement of the Problem

In general, research suggests minority groups hold different beliefs and attitudes regarding mental health problems. The empirical data on Mexican Americans and their stigmatizing attitudes and discriminatory potential toward individuals with mental health problems are limited. The results of the few studies focusing on Mexican Americans and the stigma of mental health have been mixed and limited to English-speaking Mexican Americans. Previous studies have not included monolingual Spanish-speaking Mexican Americans in their research. This study differs in that it used measures in both English and Spanish to measure the stigma of mental health among Mexican Americans and White non-Hispanic European Americans. It also explored whether there are relationships between Mexican Americans' acculturation level as well as other select demographic variables and the stigma of mental health problems and help-seeking attitudes. This is important because previous research has found that Mexican Americans,

in general, underutilize mental health services and the stigma of mental health problems has been identified as a possible contributing factor to their underutilization (DHHS, 1999).

Limited research has been conducted on gender differences in relationship to the stigma of mental health, especially among racial and ethnic minorities. Research results have been mixed depending on racial or ethnic group. For example, Vietnamese Americans were found to hold similar beliefs and attitudes regarding mental health regardless of gender (Atkinson, 1989). Another study looking specifically at gender differences among females of different racial groups, found that African Americans and Hispanics held more negative beliefs and attitudes toward mental health than their European American counterparts (Alvidrez, 1999). Previous research has also demonstrated that males, regardless of ethnic and racial group, present less often than females for mental health services (DHHS, 1999). Furthermore, Mexican American males are significantly less likely to present for mental health services (DHHS, 1999). This study attempted to add to and extend the literature by examining the possible relationship between the stigma of mental health and gender within and between Mexican Americans and White non-Hispanic European Americans.

#### Justification for the Study

The Surgeon General reported that stigma is “The most formidable obstacle to the future progress in the arena of mental illness and health” (DHHS, 1999, p. 3). Furthermore, he also reported that one of the most fundamental barriers to individuals seeking psychiatric treatment was stigma, especially among racial and ethnic minority

groups (DHHS, 1999, 2001). Researchers suggest that conducting stigma investigations with an ethnic and racial minority population “offers the opportunity to deepen our understanding of how stigma works” (Link, Cullen, Mirotznik, & Struening, 1992, p. 87). Studying the stigma of mental health problems is germane to counseling psychology because it negatively affects clients’ help-seeking behavior, participation in therapy, medication compliance, and relapse or reoccurrence of mental health problems.

Second, research involving both majority and minority populations indicates that gender is an important factor in people’s attitudes toward individuals with mental health problems. In general, the results suggest that women tend to hold more positive attitudes toward persons with mental health problems than do men in both White and racial and ethnic minority groups. However, research suggests that Hispanic females tend to hold more negative beliefs and attitudes toward mental health than some women from other racial and ethnic groups (Alvidrez, 1999). Interestingly, no research was found comparing Mexican American women and men concerning their attitudes toward individuals with mental health problems.

Third, no significant research examining acculturation and stigma toward mental health pertaining to Mexican Americans was found. This is rather surprising, given that Mexican Americans are the fastest growing minority group in the United States and they underutilize mental health services even though their prevalence rates of mental health mirror that of the majority and other racial and ethnic groups. Furthermore, the Surgeon General (1999, 2001) encouraged future research to focus on culture and its influence in shaping ethnic and racial minority members’ views toward mental health.

## Objectives of the Study

The objective of this study was twofold. First, it was to determine if the stigma of mental health problems and attitudes toward seeking help differed between Mexican American and White non-Hispanic European American males and females. Second, it was to explore the possible relationships between Mexican Americans' acculturation level as well as other select demographic variables and the stigma of mental health problems and attitudes toward seeking help. This study explored the novel concept of Mexican American acculturation level being associated with the amount of social distance desired from individuals with mental health problems, which has not been looked at before in empirical research in the area of mental health stigma. It also explored the novel use of existing quantitative measures of mental health stigma and help-seeking with Mexican Americans, specifically Spanish-speaking individuals, which has not been conducted before in empirical research. This study expanded the current literature on the possible differences between Mexican American and White non-Hispanic European American males and females in regards to the stigma of mental health problems and attitudes toward seeking help. Overall, this study provided information regarding the ethnic and gender differences between Mexican Americans and White non-Hispanic European Americans on measures of mental health stigma and help-seeking. It also provided information regarding the potential relationships between Mexican Americans' acculturation level as well as other demographic variables and mental health stigma and help-seeking.



The cultural sensitivity among members of different ethnic and racial categories should be respected and researchers should examine ethnic and racial sub-groups (Uehara, Takeuchi, and Smukler, 1994). For example, researchers should study Cuban Americans, Chilean Americans, Colombian Americans or Mexican Americans rather than combine all four sub-groups under the overarching Hispanic or Latino category. Researchers often ignore inter-group differences when studying Hispanics as a category. Furthermore, such combining leads to erroneous and inappropriate generalizations. This study followed that suggestion and restricted the focus to one ethnic sub-group – Mexican Americans.

#### Research Questions

*Research Question #1:* Do Mexican Americans and White non-Hispanic European Americans differ in regard to the amount of mental health stigma, as measured by the amount of social distance they desire from individuals with mental health problems and their own attitudes toward seeking help?

*Research Question #2:* Do Mexican American and White non-Hispanic European American males and females differ in regard to the amount of mental health stigma, as measured by the amount of social distance they desire from individuals with mental health problems and their own attitudes toward seeking help?

*Research Question #3:* Is Mexican American acculturation level, as measured by language proficiency, ethnic identity and generation level, related to the stigma of mental health; as measured by help-seeking attitudes and the amount of social distance from individuals with mental health problems?

*Research Question #4:* Is Mexican American age, years of education, participation in counseling and/or mental health services, and level of perceived ethnic discrimination related to the stigma of mental health, as measured by help-seeking attitudes and the amount of social distance from individuals with mental health problems?

### Summary

Stigma affects individuals with mental health problems in adverse ways. Little is known about the stigma of mental health in different ethnic groups as well as within groups such as monolingual Spanish-speaking Mexican Americans. Mental health stigma has been identified as a significant contributor to the avoidance of mental health services by most Americans. Mexican Americans tend to avoid mental health services at a significantly higher rate than White non-Hispanic European Americans. Men access mental health services at a significantly lower rate than women do. This study examined the possible differences and relationships between mental health stigma, ethnicity, gender, and acculturation as well as other demographic variables. Mental health stigma was measured by attitudes toward seeking help and the amount of social distance desired from individuals with mental health problems. The second chapter will review the literature regarding stigma of disabilities, mental health stigma, gender, ethnicity, and socioeconomic status. The third, fourth and fifth chapters will describe the methodology used in this study, the results and discuss the overall research, respectively.

## Definition of Terms

The following terms are used throughout this study, therefore, a definition is provided to aid in understanding.

*Stigma.* When the following interrelated components converge: 1) people distinguish and label human differences; 2) dominant cultural beliefs link labeled persons to undesirable characteristics and negative stereotypes; 3) labeled persons are placed in distinct categories so as to accomplish some degree of separation of “us” from “them”; and 4) labeled persons experience status loss and discrimination that lead to unequal outcomes (Link & Phelan, 2006).

*Stigma of Mental Health Problems.* When mental health problems and/or their associated symptoms are perceived as negative attributes and persons with such problems are devalued by the general population. Furthermore when these attributes are perceived by others, it results in exclusionary behaviors (discriminatory potential) toward the individual with the mental health problem. Individuals with mental health problems may be perceived as more dangerous. The general population may be more socially avoidant and distant from persons with mental health problems and hold negative attitudes toward individuals with mental health problems (Corrigan & Penn, 1999, Link & Phelan, 2006, Martin, Pescosolido, Olafsdottir & McLeod, 2007, Scheef, 1966,).

*Mental Health:* “The successful performance of mental functions, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity” (DHHS, 1999, p. 4).

*Mental Health Problems:* “Signs and symptoms of insufficient intensity or duration to meet the criteria for any mental disorder, but cause distress that matches some of the signs and symptoms of mental disorders and warrants active efforts in health promotion, prevention and treatment” (DHHS, 1999, p. 5).

*Mexican American:* “A Mexican or person of Mexican descent living in the United States” (Wordnetweb, 2008).

*Acculturation:* “Cultural modification of an individual, group, or people by adapting to or borrowing traits from another culture” (Merriam-Webster, 2003, p.24).

*Ethnic Identity:* "One's sense of belonging to an ethnic group, and the part of one's thinking, perceptions, feelings and behavior that is due to ethnic group membership" (Rotheran & Phinney, 1987, p. 13).

*Ethnicity:* “Refers to a common ancestry through which individuals have evolved shared values and customs” (McGoldrick, Giordano & Pearce, 1996).

*Language Proficiency:* “The degree to which a person understands, speaks, reads or writes a language” (Adams12.org, 2008).

## CHAPTER TWO

### Stigma of Mental Health

The Surgeon General (1999) reported that at any given time 20% of the population of the United States has a diagnosable mental disorder. Of that 20%, two-thirds of all people with a mental disorder do not seek treatment (DHHS, 1999). Additionally, the American Psychiatric Association (1994) reported that the lifetime prevalence of major depressive disorder appears to be 10-25% for women, and 5-12% for men. Similar to the general population, two-thirds of diagnosed depressed individuals do not seek out any form of medical or mental health treatment for their depression (National Institute of Mental Health, 1996). Of the individuals who do seek treatment, 74% prefer to receive treatment from their primary care physician, as opposed to a mental health professional (Ben-Porath, 2002; Regier, Hirschfeld, Goodwin, & Burke, 1988).

These findings beg the question of why three-quarters of the individuals with diagnosable psychiatric conditions do not present for treatment. The Surgeon General (1999) indicated that one factor leading to the non-presentation of individuals for treatment was stigma. Stigma of mental health is manifested by distrust, discrimination, fear, embarrassment, anger and/or avoidance (DHHS, 1999). The stigma of mental health leads some individuals in the general population to avoid socializing, employing, or even residing with or near individuals with mental health problems (Corrigan & Penn, 1999;

DHHS, 1999; Penn & Martin, 1998). The stigma of mental health in its most egregious form results in outright discrimination and avoidance, as well as ostracizing individuals with mental health problems from mainstream society (DHHS, 1999). Furthermore, according to the Surgeon General (1999), the stigma of mental health interferes with an individual's ability to participate fully in society, and may impact their feelings of self-worth and self-confidence.

### *Stigma of Physical Handicaps*

Researchers in the 1960s began to focus on stigma and its impact on various populations (Elliott et al., 1982). For example, physical disabilities have been found to be highly stigmatized conditions. Saetermoe and colleagues (2001) found that the severity of a disability, especially physical disabilities, have a strong impact on how they are perceived by others. Murphy (1995) reported that individuals with physical disabilities experienced significant stigma in the form of discrimination and social rejection. It appears that socially, as well as culturally, individuals with physical disabilities are devalued and therefore are discriminated against by others.

### *Stigma of Obesity*

There appears to be a growing body of evidence suggesting that individuals that are obese are stigmatized by the general population. Obese individuals are not only stigmatized, but the negative attitudes that reinforce the stigmatization of obese individuals is accepted, and even encouraged, in American society. Furthermore, they identified that these negative attitudes are reinforced through the media, cultural beliefs, and societal perspectives on individuals who are obese (Wang, Brownwell, & Wadden,

2004). They also found that overweight individuals tended to internalize the social stigma, resulting in self-stigma.

Hebl and Turchin (2005) reported that research has consistently shown that stereotypes consistently view obese individuals as lazy, undisciplined and unhappy (Allon, 1982; Crandall, 1994; Fallon, 1990; Hebl & Mannix, 2003). Several studies have found that obese individuals are discriminated against in professional and employment arenas (Hebl & Kleck, 2002; Roehling, 1999). Hebl and Xu (2001) found that obese individuals were discriminated against in healthcare settings by numerous healthcare workers. They found that obese patients did not receive as much appointment time with physicians, and actually had more negative interactions with healthcare professionals (Hebl & Xu, 2001). Kristeller & Hoerr (1997) reported that physicians indicated that they intervene less often with obese patients than they do with non-obese patients. Obesity is also associated with increased incidences of depression, social isolation, and suicidal ideation (Strauss & Pollack, 2003). From these findings, it is apparent that obesity is another condition which is stigmatized by the general population.

### *Stigma of Race*

Another highly stigmatized condition is race. It is apparent that skin color is an attribute which is highly stigmatized. For example, the Ku Klux Klan, Aryan Nation, National Alliance and other organizations clearly stigmatize race. Racial discrimination and the stigmatization of race are apparent in such historical events as slavery and segregation. Many studies have documented the impact of stigma of race on the psychological well-being of individuals. However, an interesting study conducted by

Guyll, Matthews, and Bromberger (2001) found that stigma directly impacted the physiologic health of women who had been confronting, as well as experiencing racial stigma. Specifically, they found that these women exhibited greater cardiovascular health issues than women who were not confronted with racial stigma. Similarly, the study conducted by Blascovich, Mendes, Hunter, Lickel, and Kowai-Bell (2001) found that individuals interacting with racially different partners exhibited increased threat responses and had poorer performance, as compared with individuals interacting with racially similar partners. Another study by Richeson and Trawalter (2005) found that a person's race, along with information about the person, whether positive or negative, directly affected participants' opinions about other individuals of the same racial group. This suggests that race is an attribute that is stigmatized and affects an individual's initial judgments about people.

#### The Impact of the Stigma of Mental Health Problems

One of the most crucial questions regarding stigma and its relationship to mental health is: how does the stigma of mental health impact individuals, and to what extent? The Surgeon General (1999) stated that stigma was one of the major factors impeding the future progress of mental health. Moreover, he indicated that the stigma of mental health can no longer be tolerated because it contributes to the burden of mental health problems. In other words, the stigma of mental health impacts not only the progress that could be made in the treatment of mental health problems, but exacerbates the person's mental condition.



### *The Individual and the Stigma of Mental Health Problems*

The stigma of mental health causes the person to feel socially rejected and experience significant shame about their condition (Link et al., 2006). In turn, this results in self-stigma which causes a reduction in feelings of self-worth and self-confidence. Additionally, the person often describes not feeling “whole” (Dickerson, Sommerville & Origoni, 2002). Riskind and Wahl (1992) presented participants with vignettes describing profiles of individuals. When identical descriptions of behavior were used, participants tended to be more socially rejecting, more fearful, and had more negative expectations when the vignette contained information indicating that the individual had a psychiatric history.

Studies have indicated that when information regarding a previous psychiatric hospitalization or treatment has been disclosed, the person’s success at being able to obtain housing, employment, as well as school admission has significantly decreased (Oppenheimer & Miller, 1988; Sibicky & Dovidio, 1986; Wahl, 1999). Wahl (1999) conducted a large survey study using clients of mental health services and found approximately one-third of all consumers indicated they had been denied a job for which they were qualified after disclosing their mental health status. Furthermore, Wahl (1999) found that one-fourth of the individuals responding to the survey indicated they were seldom or never supported, by their supervisors or coworkers, after becoming aware of the respondent’s mental health status. Thirty percent reported denial of health insurance because several companies deemed their mental health status or condition as preexisting. In this same study, 60% reported they had been shunned or avoided by others due to their

mental status and 74% indicated they had intentionally avoided telling other's outside their immediate family about their mental health condition. An interesting caveat to this finding is that individuals indicated the avoidance of disclosure assisted them in concealing their mental health condition, and thus receiving some relief from the stigma; but their fear of discovery and being exposed remained (Wahl, 1999). It was also found that 77% of respondents indicated they often encountered hurtful or offensive media portrayals of mental health or mental conditions. Additionally, 70% of the respondents noted they experienced being treated as less competent by others upon the discovery of their illness (Wahl 1999).

Dickerson and colleagues (2002) reported in their study that approximately half of the patients' surveyed reported experiencing stigma in their interactions with the general public. These patients also identified experiencing stigma with family members, peers and coworkers, as well as with healthcare providers. Over half of the respondents indicated they did not feel accepted by the general public and that their condition was misunderstood. Approximately half of the respondents indicated the general public holds the perception of individuals with mental health problems as less capable and competent than others (Dickerson et al., 2002). They also reported a majority of the respondents in the study were worried about being viewed unfavorably due to their psychiatric condition, and often avoided telling others about their condition because of fear of being socially rejected.

Jahoda and Markova (2004) reported a majority of individuals indicated a major concern for them was the lack of social acceptance due to their psychiatric condition.

Respondents in that study indicated they were anxious about being involved in settings with more normative individuals because of the possibility of failure or discrimination. Additionally, a vast majority expressed feelings of hurt and loss regarding the rejection by former friends, and indicated they were embarrassed associating with friends because there might be questions regarding their emotional stability (Jahoda & Markova, 2004).

Similarly, Wahl (1999) reported 80% of the participants in his study had been personally hurt or offended by individuals making derogatory comments regarding mental health problems and half reported they had experienced this type of stigma quite frequently. A study conducted by Sirey, Bruce, Alexopoulos, Perlick, Friedman and Meyers (2001) found both older and younger outpatient mental health clients felt stigmatized for their condition. Yet, younger patients endorsed feeling more stigmatized than older clients. In addition, Wahl and Harman (1989) surveyed family members who had a relative with mental health problems and found a large majority indicated stigma had a negative impact on the relative; specifically, indicating the impact was seen in the individual's self-esteem, their ability to make and keep friends, as well as their ability to secure employment.

Stigma typically leads to negative attitudes and beliefs, as well as discriminatory behavior toward an individual with mental health problems (Corrigan, 1998). This leads the individual with mental health problems to feel ashamed about themselves and their condition. Not only does stigma lead to feelings of shame and inadequacy, but Link et al. (2006) argues that those who are stigmatized are at increased risk of developing other stress-related illnesses, and the stigmatization they feel exacerbates their current

condition. He argues stigma interferes with the ability of individuals to work, as well as have a normative social life (Link et al., 2006).

These studies combined indicate the stigma of mental health directly impacts patients and exacerbates, in some cases, their presenting condition. As clinicians and therapists it is imperative that stigma be address in treatment in order to mitigate the impact stigma has on patients. Otherwise stigma could exacerbate or worsen a patient's condition, even though the primary problem is being effectively treated. Therefore, stigma is relevant to both clinical and counseling psychology directly. And as such, individuals working in these two fields must begin to realize the impact stigma has on the presentation of individuals for treatment, their persistence in treatment, as well as their success post-treatment.

#### *Public Perceptions of People with Mental Health Problems*

Several studies have focused on the general public's opinion regarding individuals with mental health problems. Pescosolido, Monahan, Link, Stueve and Kikuzawa (1999) approached the concept of how the general public views mental health by evaluating the laws pertaining to individual's who have mental health problems. Pescosolido and colleagues (1999) stated that within the United States the law seems to uphold three core assumptions regarding individuals with mental health issues. The first assumption is individuals with mental health problems are not competent to make their own decisions; in other words, they are not free to decide for themselves what they can do. It is true individuals with mental health issues have the right to make decisions regarding treatment and other aspects of their life, as long as they are deemed to be competent. If, in

such a case, they are deemed incompetent, then those rights, and the right to make decisions, are legally withdrawn from the individual. The second assumption is that individuals with mental health issues are at increased risk of physically harming themselves or others. Thus, healthcare professionals have the legal right to involuntarily hospitalize individuals deemed dangerous to themselves or others (Pescosolido et al., 1999). The final assumption is individuals with mental health problems must participate in treatment for their mental condition, and if they do not, a state-sanctioned coercion into treatment is legally acceptable; therefore, coercion is justified and legally sanctioned as a way of forcing individuals with mental health problems to receive treatment.

In general, Pescosolido and colleagues' point is that the general public tends to believe that individuals with mental health issues are dangerous and incompetent. Furthermore, if we have laws which regulate the treatment of mental health and individuals with mental health problems, then those laws are reflective of the general public's perspective of individuals with mental health conditions. In other words, governing laws, especially in the United States and other democracies, are based on the majority of people agreeing about a certain rule or social norm. Laws are developed out of social norms and social beliefs, which are used to guide and regulate the individuals within a society. This is an interesting approach because it highlights and suggests that the general public has a certain negative perception of individuals with mental health conditions, and that this perception is pervasive throughout the culture. In contrast, if this were not the case, we probably would not have laws which regulate the treatment of individuals with mental health problems.

Several studies have documented that the public stereotype of individuals with mental health problems is that they are dull, incompetent, dangerous, unpredictable, strange, worthless, and dirty (Calicchia, 1981; Farina, Holland & Ring, 1966). Sibicky and Dovidio (1986) found participants described individuals with mental health conditions as being more defensive, awkward, cold, sad, insecure, and unsociable than individuals without mental health problems. Pescosolido and colleagues (1999) studied the responses of individuals from the general public on their perspectives of individuals with severe psychiatric conditions. In the study they found that overall the general public viewed individuals with schizophrenia as being more dangerous and unstable than individuals who suffer from alcohol dependence, depression, or even no mental disorder. Similarly, a study conducted by Piner and Kahle (1984) found when participants were paired with individuals pretending to have mental health problems, but not exhibiting symptoms, the participants that were informed that their partner had a history of psychiatric problems tended to view their partners as more unusual and strange than participants who were not informed their partner was pretending to have mental health problems, but symptomatic. This finding is actually quite interesting given that the participants were randomly assigned to each condition, and the only difference was whether or not they were informed their partner had some sort of psychiatric history. This suggests that the labeling of mental health problems or the knowledge of someone having a psychiatric condition, not just the symptoms, changes the perspective of the individual interacting with them. Therefore the label acts as a trigger for activating the negative stereotype and leading to the attribute being devalued and the person being treated

differently. Furthermore, these findings have real-world implications in the lives of individuals who have psychiatric conditions. If the stigma of mental health is pervasive throughout the general population, then individuals who have mental health problems are going to experience stigmatization across settings; at least this is what would be suggestive of the findings regarding the general public.

### *Violence and the Stigma of Mental Health Problems*

Struening, Perlick, Link, Hellman, Herman and Sirey (2001) showed that not only does the general public view patients with mental health conditions as unstable; they also tend to view them as prone to violence. For example, a study involving 1500 adults residing in the United States found 65% identified individuals with mental health problems as being unpredictable. Similarly, 60% agreed it was normal to be afraid of individuals who have mental health problems. Also 70% agreed that individuals with mental health problems are dangerous (Struening et al., 2001). In a study conducted by Link and colleagues (1999), 1400 adults were asked to read several vignettes depicting individuals with varying degrees of psychiatric conditions: a vignette describing an individual with symptoms of schizophrenia, major depression, dependence on alcohol, addiction to cocaine, and a “troubled person”. Of these vignettes, 87% of the sample identified the person as having a dependence on cocaine as being potentially violent; followed by alcohol dependence (71%), schizophrenia (61%), individuals with depression (33%), and 17% identified the individual described as a “troubled person” as being potentially violent. This is an interesting result as none of the vignettes mentioned anything regarding violence, or acts of violence. Furthermore, it supports the idea that

diagnostic labels, as well as behavioral symptoms, trigger powerful negative stereotypes regarding individuals with these disorders.

Surprisingly, and contrary to the stereotype, individuals who have mental health problems are not any more or less violent than individuals who do not have a mental health problem (Struening et al., 2001). Studies that have evaluated violence in individuals with mental health problems have found that only a minority of individuals with mental health problems are actually violent (Struening et al., 2001). However, a study found 57% of the respondents concurred that individuals with mental health problems are significantly dangerous and unpredictable (Struening et al., 2001).

Also notable is the idea that 84% of individuals indicated a majority of the population would look down on someone who has either been hospitalized or has received significant psychiatric treatment (Struening et al., 2001). Pescosolido and colleagues (1999) found respondents viewed individuals with mental health problems as less competent in decision making around treatment, as well as their ability to manage their finances, and this was in relationship to the severity of their condition. So, as severity of condition increased, the respondent's view of the individual's ability to be competent in these two areas decreased. Additionally, respondents indicated a person who has mental health problems had potential for increased violence as the severity of the condition progressed.

#### *Healthcare Providers and the Stigma of Mental Health Problems*

Furthermore, studies looking at specific settings tend to support this view. For example, Lefley (1985) indicated 90% of participants in a survey who were mental health



clinicians reported often overhearing colleagues making negative or derogatory comments regarding mental health patients or their families. Similarly, Dickerson and colleagues (2002) conducted a survey of National Alliance for the Mentally Ill (NAMI) affiliated individuals; 20% endorsed the idea or statement that mental health providers stigmatize individuals with mental health issues. They indicated mental health providers tend to lack understanding and support for them. Lastly, Schnittker (2000) indicated there is evidence supporting the fact that mental health professionals tend to discriminate and stigmatize individuals with mental health issues, especially when they are in an evaluative or assessing role.

Starr, Campbell and Herrick (2002) conducted a study involving the utilization of mental health services in a rural setting and found participants from the community reported they expected the patient-professional relationship to be negative and they described it as distrustful, more disrespectful, and less caring than respondents who lived in metropolitan areas. Overall these studies regarding health professionals seem to indicate individuals with mental health problems also experience stigma by health professionals, and even those who are trained to work with mental health conditions directly. Furthermore, these studies suggest that the stigma of mental health problems is pervasive and occurs across various settings; even in settings where it would be thought least likely.

#### *Families and the Stigma of Mental Health Problems*

Another real-world implication of the stigma of mental health problems is its impact on families of individuals who are identified as having mental health problems.

There appears to be a growing body of evidence suggesting that not only does stigmatization of mental health problems apply to the person who has the mental health issue, but also to the caregivers and family members directly involved with the individual with the mental health condition (Lefley, 1989; Perlick, 2001; Richardson, 2001).

Corrigan and Penn (1999) reported a person diagnosed with a mental condition had lowered self-esteem and strained relationships with other family members because of the stigma (Lefley, 1992; Wahl & Harman, 1989). Hatfield (1981) reported many caregivers of offspring who have mental health problems feel residual and unjustified guilt regarding the mental health of their offspring, and that much of this guilt has been brought about by both the professional community and societal stereotypes regarding mental health problems. Hatfield and Lefley (1989) found family members tended to be critical of themselves and felt shame that one of their family members had a mental health problem. Other studies indicate family members endorse the idea that the general public tends to stigmatize individuals with mental health problems, as well as family members (Perlick, 2001; Starr et al., 2002).

Several studies have found parents to be cautious and reluctant to enter their children into mental health treatment (Richardson, 2001; Starr et al., 2002). For example, Richardson (2001) found parents expressed considerable concern regarding the use of mental health services and these concerns were based on negative attitudes and beliefs regarding mental health.

Deane and Todd (1996) reported help-seeking attitudes were directly affected by concerns regarding stigma, and parents who perceived stigma in regards to mental health

were less likely to seek help for themselves or their children. McCune, Richardson, & Powell (1984) found in the study of parents' attitudes toward mental health that many of them were unwilling to have their child or adolescent assessed, or participate in mental health treatment, even if the child had mental health problems because of concerns regarding stigma. Richardson (2001) conducted a study regarding parent's expectations of the outcome of mental health care for their children and found a majority of the parents had several negative expectations regarding mental health treatment. Approximately half the parents who participated in the study indicated they had reservations regarding the mental health professionals' trustworthiness. Twenty-five percent of the parents sampled indicated they were concerned about others finding out that their child was receiving mental health treatment. Furthermore, Richardson (2001) found parents also expected other family members to disapprove of them seeking mental health services for their children or themselves, which suggests that stigma goes beyond the individual and affects family members as well.

Overall these studies suggest that the stigma of mental health impacts families and their decision making around whether to seek services or participate in mental health treatment themselves, or have other family members be treated. Additionally, it appears families who have an individual who has mental health problems also endorse the idea that the general public tends to stigmatize and hold negative beliefs and attitudes regarding those individuals with mental health problems.

### *Mental Disorders and the Stigma of Mental Health Problems*

The stigma of mental health problems has been shown to impact clients in aversive ways. For example, stigma has been shown to impact an individual's participation in therapy, ability to reintegrate socially into society, and their compliance with medications (Dickerson, Sommerville, Origoni, Ringel & Parente, 2002; Perlick, 2001).

Researchers have also focused on the stigma of mental health as it applies to various psychological disorders. Studies have consistently demonstrated that the stigma of mental health is a function of the label and the severity of symptoms presented by the individual (Dickerson et al., 2002b; Perlick, 2001). It has been found that patients with a more severe pathology, and those who evidenced more symptoms and had poorer social skills, tended to be more stigmatized. For example, clients with schizophrenia had markedly higher responses and levels of reported stigma than clients with different disorders (Dickerson et al., 2002; Mechanic et al. 1994).

In a study conducted by Perlick (2001), it was found individuals who suffered from bipolar disorder, and who reported significant concerns about stigma, continued to feel socially stigmatized seven months later. Specifically, it was found that individuals with bipolar disorder, who had increased concerns about stigma also showed greater impairment in their ability to socialize and engage in leisure activities. This was even after controlling for symptom severity, as well as social adaptation and socio-demographic characteristics (Perlick, 2001). Moreover, it was found that these individuals with bipolar disorder had impaired social functioning when it came to

interacting with individuals outside their family unit, but did not show this impairment when interacting with family members (Perlick, 2001).

In another study, Ben-Porath (2002) found that individuals experiencing depression were viewed more negatively than those who experienced, for example, a back injury. Participants in this study rated individuals with depression as more unstable, less interesting, and less competent than those with physical ailments. Out of the group who were identified as having major depression, participants viewed individuals in the depressed group who sought treatment as more unstable and less competent than their counterparts who sought no treatment.

This discovery by Ben-Porath (2002) is disturbing. It suggests that not only are individuals stigmatized for having mental health problems, but they are further stigmatized for seeking treatment for their mental health problems. This implies seeking treatment is indicative of their inability to cope and manage their mental health problems; opposed to their counterparts, who are equally symptomatic, but who do not seek treatment. This suggests that the combination of being depressed and seeking help leads to the greatest stigmatization of individuals with mental health problems and reinforces the decision not to seek help.

### *Medication Compliance*

A recent review of several studies regarding medication compliance among psychiatric patients with psychotic disorders found approximately 40% of the persons receiving antipsychotic medication were noncompliant (Corrigan, 2002; Cramer & Rosenbeck, 1998). Furthermore a study by Wieden & Olfson (1995), reported that

noncompliance to psychiatric medications, specifically antipsychotic, resulted in a significant increase in re-admittance rates for hospitals, as well as costing hundreds of millions of dollars. Corrigan (2002) argues these findings are reflective of an individual's health beliefs, which have been found to influence a person's compliance with medication. Furthermore, Corrigan (2002) posits that health beliefs are influenced by multiple factors, one of them being societal stigma toward mental health problems. The impact that stigma has on medication compliance does not appear to only affect individuals who take antipsychotic medication, but also affects medication compliance among individuals who suffer from depression.

In a study conducted by Sirey and colleagues (2001) involving medication compliance among individuals diagnosed with clinical depression, it was found individuals with less feelings of being stigmatized, combined with higher ratings of condition severity, were more compliant with their medication regimen. It was found individuals who had less interpersonal problems, or in other words, had less difficulty interacting with other people, were more compliant than those who had interpersonal difficulties (Sirey, et al., 2001).

Based on these findings, it is apparent that the stigma of mental health problems has a direct impact on patients participating in treatment, both in terms of pharmacological compliance and psychotherapy.

#### *Socioeconomics and the Stigma of Mental Health Problems*

Another area in which stigma of mental health problems has been studied is in regards to socioeconomic status. Several studies have indicated that stigma directly

impacts clients with mental health problems socioeconomically. Link (1982) suggested that mental health clients can be harmed directly by discrimination, and specifically by employment discrimination. Studies have documented that employers have admitted to being biased in their selection of applicants for positions; specifically, employers would prefer not to hire applicants identified as having mental health problems. Employers have also been shown to be less friendly in interview situations, as well as rate applicants lower who have disclosed a history of mental health problems (Corrigan et al., 1999; Farina & Felner, 1973; Link, 1987; Olshansky, Grob & Malamud, 1958). Wahl (1999) found approximately 70% of a large sample of individuals with mental health problems reported that they often avoided disclosing their mental health issues on applications for jobs, housing, and licenses, and that they did so knowingly because they felt they would be discriminated against.

This last finding brings up an interesting point. Not only do employers engage in conscious or unconscious discriminatory behavior toward individuals with mental health problems, but individuals that have mental health problems internalize those societal beliefs which results in self-limiting behaviors such as avoidance and lower feelings of self-worth and self-confidence. Link (1982) argues that as a result of becoming aware that they are part of a devalued population, individuals with mental health problems then begin to mitigate the impact of rejection from society through avoiding and restricting their societal interactions. As a result this directly impacts their ability to fully participate in society and secure employment. Additionally, it has been found that patients expect to be rejected, often act less confident, tend to be somewhat more defensive, and avoid

contacts that they perceive as threatening. As a result they are not likely to be perceived by employers as being as confident and capable (Link, 1982).

The evidence presented from these studies regarding socioeconomics and the stigma of mental health problems suggests that it does impact clients and their ability to obtain employment, as well as maintain their employment status. Furthermore, it appears to impact the amount of income they are able to generate. These studies also suggest the stigma of mental health problems and its impact on socioeconomic status of clients is a combination of the general public's stigma of mental health and an individual's self-stigma. The general public's stigma impacts employers' decisions and behaviors regarding the employment and retention of individuals with mental health problems in the workforce. The self-stigma experienced by clients as a result of being associated with a devalued population, pushes them to avoid and withdraw from perceived threatening social contacts such as potential employers (Link, 1982).

#### *Ethnic Differences and the Stigma of Mental Health Problems*

As mentioned earlier and highlighted by the Surgeon General (1999), there is an important need within the healthcare professions to understand cultural differences of groups that compose the general population. The rationale behind this is the fact that understanding the differences within and among minority groups, aids us as healthcare professionals, especially in mental health, to provide services that are congruent with cultural beliefs and presented in a fashion that maximizes potential benefit to that minority group. The present study builds on the current literature, as well as extends it by focusing on Mexican Americans and gender differences within and between Mexican



Americans and White non-Hispanic European Americans with regards to the stigma of mental health problems.

The Surgeon General (1999) reported that one of the most fundamental barriers to individuals seeking psychiatric treatment is stigma. Furthermore, the Surgeon General emphasized the importance of having a better understanding of stigma and its impact on individuals with mental health problems, as well as the general public's perception of mental health, but also to understand any cultural, racial, or gender differences within or between different populations that represent the general population.

In general, there is a lack of studies in the literature focusing on racial or ethnic differences in terms of the stigma of mental health problems. It is assumed by many that the stigma of mental health problems is inherent in all cultures and that it is a stigmatized or devalued condition. However, some evidence suggests this is not the case.

It has long been known that a large majority of the population who suffer from mental health problems do not seek treatment for their infirmity (DHHS, 1999; Kessler, McGonagle, Zhao, Nelson, Hughes, Eshleman, Wittchen, & Kendler, 1994). Additionally it has been found that ethnic and racial minorities are significantly underrepresented in participating in mental healthcare treatment (Hough, Landsverk, Karno, Burnam, Timbers, Escobar & Regier, 1987; Sue, Fujino, Hu, Takeuchi, & Zane, 1991). This is interesting given the fact that the prevalence rate of major mental health problems among minorities is the same as what is found in the White non-Hispanic European Americans (Choi & Gonzalez, 2005; DHHS, 1999, 2001). As a matter of fact, it appears there is some evidence to suggest that ethnic and racial minorities are at increased risk for

experiencing mental health problems due to stress associated with minority status. For example, minorities may be at increased risk of experiencing hostility, rejection, and discrimination. These factors combined with possible language barriers and acculturation stress appears to increase their risk of experiencing mental health problems such as depression and anxiety (Jackson, Antonucci, & Gibson, 1995; Kim & Kim, 1992; Mills & Edwards, 2002). Furthermore, studies have indicated that minority under representation in mental healthcare appears to be a function of low rates of access to services, as well as high dropout rates following admittance into treatment and that both of these factors have been associated with stigma (Rogler, 1998).

Several studies looking at minorities accessing mental health services have identified many factors which impact both the access and the participation in therapy. One of the factors that have been identified consistently throughout the literature is stigma. It appears that many minority adults are reluctant to participate in therapy due to the societal stigma toward mental health problems (Currin, Hayslip, Schneider, & Kooken, 1998). Furthermore, there is some research suggesting mental health may be stigmatized more among ethnic minority populations (Alvidrez, 1999). In a study using college students it was found that African-Americans and Latinos held more negative views of mental health problems than their white counterparts (Silva de Crane & Spielberger, 1981). A study conducted by Albrecht, Walker and Levy (1982) found that in several cultures mental health was more stigmatized than physical disabilities.

Interestingly enough, when eligibility for services was controlled for, there still appears to be a significant difference between African Americans, Latinos and their

European American counterparts in terms of accessing mental health services, even when they have similar coverage in insurance (Scheffler & Miller, 1989). A study conducted by Temkin-Greener and Clark (1988) found Medicaid patients who were European-American were more likely than ethnic minorities with Medicaid to utilize outpatient mental health services.

African Americans were significantly less likely to visit outpatient clinics than their white counterparts, even though the two groups do not differ in the prevalence of mental health problems among their populations. Also, African Americans with psychotic disorders were significantly less likely to present at outpatient psychiatric treatment than White non-Hispanic European Americans who had similar psychotic disorders (Choi et al., 2005). Richardson (2001) found White non-Hispanic European American parents tended to experience more positive experiences when seeking mental health treatment than African American parents; and African American parents tended to be less likely to bring their children in for psychiatric treatment than European American parents. This was due to the fact that African-Americans tended to feel mental health was more stigmatized culturally and had increased concerns regarding providers' impression of them as parents, and whether or not providers would provide quality care (Richardson, 2001).

Saetermoe and colleagues (2001) found Asian American participants tended to be more stigmatizing toward physical and mental disabilities than African American, Latin American, or White non-Hispanic European American individuals. Therefore, Asian Americans in the study tended toward increased or greater social distance from

individuals with disabilities than other ethnic groups. Secondly, in the study it was also found that Asian-Americans born in Asia tended to be more stigmatizing than Asian Americans born in the United States. This suggests for Asian Americans the stigma toward physical and mental disabilities may be attenuated to a certain degree by their level of acculturation (Saetermoe et al., 2001). It is believed Asian Americans demonstrate such a strong desire for social distance from individuals with physical and mental disabilities due to the fact that in their culture there is a fear of contagion and a strong emphasis on conformity (Saetermoe et al., 2001). High stigma level among Asian Americans may be driven somewhat by the fact that in collectivist societies there is a strong demand placed upon the individual to fulfill contributory roles within society, and when these roles are not fulfilled, due to some condition, the individual becomes stigmatized. Research also suggests Asians view mental health problems as rising from the deprivation of parental love during childhood. As a result, they tend to be reluctant to disclose any information suggesting they have mental health problems because it confers blame on family members, as well as stigmatizing the family and the individual (Saetermoe et al., 2001). This finding seems to be supported by Zhang, Snowden and Sue (1998) who found that Asian Americans tended to be less willing to talk about mental health problems, as well as to visit mental health centers, than their White non-Hispanic European American counterparts. Furthermore, only 12% of the Asian Americans sampled in the study were willing to talk to friends or family regarding mental health problems. Only 4% of the Asian American sample was willing to speak with a mental

health professional or psychiatrist regarding mental health problems. This was significantly less than their White non-Hispanic European American counterparts.

In another study conducted by Atkinson and Gim (1989), it was found Chinese, Japanese and Korean American participants viewed mental health services as negative and held negative attitudes toward individuals with mental health problems. However, interestingly enough this study also found the level of stigma toward mental health problems was a function of acculturation levels, with less acculturated Chinese, Japanese and Korean American participants holding more stigmatized views of mental health problems than their more acculturated counterparts (Atkinson & Gim, 1989).

Overall these studies suggest Asian-Americans tend to stigmatize mental health problems. It appears the level of stigma is considerably more than what is found in other ethnic groups that make up the U.S. population. Furthermore these studies tend to demonstrate that the stigma of mental health may be a function of acculturation level. However, these studies, with the exception of Atkinson and Gim (1989), tended to group all Asian participants, regardless of culture into the Asian American category. This is a methodological problem which ends up suggesting that all Asian American cultures are as stigmatizing toward mental health. At the same time, it makes the sample unrepresentative of any specific Asian American culture.

With this said, not all ethnic minority groups appear to stigmatize mental health to the same degree. For instance, one study looking at stigma of the mental health problems and disabilities among Native Americans found that Native Americans tend to view an individual's disability as being minor in light of the individual's social identity, and

tended to focus less on the disability and more on the contribution the person makes to the overall society (Groce & Zola, 1993). Other data regarding the stigma of mental health problems among ethnic groups has been found to be mixed. One study found Hispanics who have a disabled child, either physically or mentally, view themselves as chosen by God to raise that child because they would be able to care for that child (Mardiros, 1989). Others have found that Hispanics tended to stigmatize mental health more than severe physical disabilities, as compared to other ethnic groups (Saetermoe et al., 2001). While other studies have indicated that Hispanic individuals will acknowledge their symptoms and problems, they tend not to seek treatment due to cultural shame and strong beliefs regarding self-reliance (Starrett, Rogers, & Decker, 1992). Other studies have found Hispanics view mental health problems as shameful and a sign of weakness, and this belief tends to be pervasive (Choi & Gonzalez, 2005). Furthermore, Choi and Gonzalez (2005) found Hispanics tended to drop out of treatment for several reasons; one of them being the fact that they perceive a sense of shame and stigma related to mental health problems, and a fear of mental health treatment. Lastly, Alvidrez (1999) initially found Hispanic women did not identify stigma as being an obstacle to them for presenting or participating in mental health treatment. However, in a follow-up study she found stigma was a significant obstacle to Hispanics presenting for mental health treatment. Alvidrez attributed a lack of finding in the first study to the stigma questions not being specific enough to elicit the information needed to measure stigma (Alvidrez, 1999). Overall these studies suggest, similar to Asian American studies, Hispanics tend to stigmatize mental health problems and services; even though, there is some data to the

contrary. The overwhelming majority of studies measuring attitudes toward mental health services and the stigma of mental health problems among Hispanics have found mental health problems and services are stigmatized.

With that said many of the studies such as those mentioned previously, have several methodological flaws. Many of them, similar to the Asian American studies, tend to group all Hispanic ethnicities into one category or group, which then becomes non-representative of any specific group and masks any possible differences between the ethnic groups that make up the Hispanic category.

Similar to previous studies, this study looks at differences among ethnic groups with regards to level of stigma, but takes it a step further by filling in the void by specifically looking at Mexican Americans. This is warranted by the fact that Mexican Americans make up approximately 60% of the Hispanic population in the United States and no previous study has had a representative sample consisting predominantly of Mexican-Americans, focusing on the stigma of mental health problems. Another short coming for several of these studies is they tend to be qualitative as opposed to quantitative and as a result their generalizability to the larger population is limited.

The present study attempted to quantitatively measure the stigma of mental health problems among Mexican Americans and compare it to the level of stigma toward mental health problems of White non-Hispanic European Americans. Previous studies have not included monolingual Spanish-speaking individuals in their research; therefore, the majority of their Hispanic samples consisted of English-speaking individuals. This study differed in that it used measures both in English and Spanish to measure the level of

stigma toward mental health problems among Mexican Americans and White non-Hispanic European Americans.

### *Gender and the Stigma of Mental Health Problems*

Generally speaking, studies seem to indicate that the general public tends to view and be less stigmatizing toward female patients with mental health problems. This is driven by perceptions of decreased dangerousness and volatility. Furthermore, studies of health professionals have mirrored the findings reported by the general public in that there appears to be a gender difference in perceptions of evaluators of mental health patients based on the gender of the patient (Waisberg & Page, 1988). Additionally, it was found men and women who suffered from mental health issues, and exhibited symptoms that did not match gender norms, were stigmatized more severely by evaluators than if their symptoms were congruent with gender norms (Prout & Fredrickson, 1991; Rabinowitz & Lukoff, 1995).

A study using a nationally represented sample found that respondents have a greater willingness and openness to interact with female clients with mental health problems than with males who were identified as having mental health problems (Schnittker, 2000). Furthermore, respondents' willingness and openness to interact with female clients over male clients was attributed to females being viewed as less dangerous than males (Schnittker, 2000). Additionally, it was found that female respondents were less tolerant of male patients with psychiatric problems (Schnittker, 2000).

Overall there are few studies that have looked at gender differences within racial and ethnic minority groups regarding stigmatization of mental health problems. Of the



studies that have been conducted regarding the stigma of mental health problems among racial minority groups, differences in gender have contradicted what has been found in the general population. For example, Atkinson and Gim (1989) surveyed Asian American students, both male and female, regarding their attitudes toward mental health problems and treatment. They found that there were no gender differences between Chinese, Japanese and Korean American students. This finding was consistent with a similar study conducted by Atkinson, Ponterotto and Sanchez (1984) which found no gender differences among Vietnamese American males and females toward mental health problems and services.

In a qualitative study conducted by Alvidrez (1999), which interviewed a sample of minority women who were African American, Hispanic and White non-Hispanic European American, regarding their perceptions and attitudes toward mental health problems and treatment, it initially found that stigma did not appear to be an obstacle for these women. Nevertheless, in a follow-up study conducted by the same author, using focus groups involving European American and minority women, (African American and Hispanic) it was found stigma was a significant barrier and obstacle to them participating in mental health services. Lack of findings in the former study was attributed to the wording of questions asked during the previous interviews, which did not appear to tap the respondents' perceptions and attitudes toward mental health problems and treatment. The study found that Hispanic females endorsed stronger beliefs that mental health problems should not be discussed or dealt with outside the family, but also found that Hispanic females were less likely to endorse beliefs that mental health problems or

psychological problems carry a stigma. White non-Hispanic European American females were much more likely to make and attend psychiatric appointments and participate in therapy more than African American or Hispanic females. According to the author, the Hispanic females exhibited particularly low rates of service use than the other two groups. Lastly, Alvidrez found African Americans were one-third less likely than European-Americans to make a mental health visit, and Hispanic females were one-tenth as likely to participate in therapy. Although Alvidrez's (1999) study only looks at females of different ethnic groups and their perceptions of stigma, it does support the idea that there may be gender differences within ethnic groups regarding the stigma of mental health. Furthermore, because Alvidrez's study is qualitative, it does not necessarily lend itself easily to being generalized across the population. Similar to previous studies, Alvidrez's sample is an amalgamation of several different Hispanic nationalities and cultures; therefore, it is not necessarily representative of all Hispanics or any particular Hispanic group.

## CHAPTER THREE

### Methodology

This chapter describes the participants, procedures, measures, and data analyses used in this study. This study examined the differences in the stigma of mental health problems between Mexican American and White non-Hispanic European American males and females. The possible relationships between Mexican American acculturation level and the stigma of mental health as well as attitudes toward seeking help were also explored. Select demographic variables such as age, years of education, participation in counseling and/or mental health services and perceived ethnic discrimination among Mexican Americans were explored for possible associations with mental health stigma and attitudes toward seeking help.

The data for this study were obtained from self-administered questionnaires. A survey research design was used because it is a practical and efficient method of measuring individual's attitudes and opinions. It also provides researchers with the ability to collect data from a large number of individuals (Evans, 1985; Nardi, 2003).

### Participants

A power analysis was conducted in order to determine the number of participants needed to find a medium effect size when comparing two sample groups on three variables. This was done by setting alpha at .05 and power at .80, which are common

criteria used in a priori research studies (Murphy & Myers, 2004). Since this was a factorial design, the number of factors and levels were also incorporated into the analysis in order to estimate the number of participants. A software program titled “One Stop F Calculator” was used to compute the power analysis. Results from the power analysis were  $F(1, 298) = 7.85$ ,  $PV = .026$  which is calculated using power value of .80. This F value is true for both main effects and interactions. Results from the power analysis indicated that approximately 75 individuals were needed in each group with a total of 450 individuals participating in the study overall. According to Murphy and Myers (2004) power increases with multi-factorial designs therefore this is a conservative estimate of sample size.

A total of 550 individuals completed and returned the survey. Of the 550 surveys returned, 507 met the original criteria for the study: 18 years of age and older, self-identified as Mexican\Mexican American or White non-Hispanic European American and living in one of two cities in the southern part of the state of Idaho. Tables 1 through 5 summarize the sample demographics.

Table 1

*Number of Participants by Ethnicity and Race*

Ethnicity/Race	N	%
Asian American	6	1.1
African American	4	.7
Mexican	129	23.5
Mexican American	115	20.9
White non-Hispanic European American	263	47.8
Native American	7	1.3
Total	524	95.3

Table 2

*Number of Participants by Ethnicity, Language and Gender*

Ethnicity/Race	English		Spanish		Total	
	Female	Male	Female	Male	N	%
Asian American	4	2	-	-	6	1.1
African American	2	2	-	-	4	.8
Mexican	21	11	42	40	114	21
Mexican American	63	28	15	6	112	20
White non-Hispanic European American	171	89	-	-	260	47
Native American	6	1	-	-	7	1.2
Total	267	133	57	46	503	91

Table 3

*Number of Participants by Ethnicity and Generation Level*

Ethnicity/Generation	Generation Level						Total
	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>	5 <sup>th</sup>	Unknown	
Asian American	1	-	3	1	-	1	6
African American	-	-	-	-	4	-	4
Mexican	87	12	5	-	2	11	117
Mexican American	20	39	11	21	6	8	105
White non-Hispanic European American	7	5	25	48	151	16	252
Native American	-	-	3	1	2	1	7
Total	115	56	47	71	165	37	491

Table 4

*Number of Participants who have had Counseling and/or Mental Health Services (MHS)*

*by Ethnicity and Gender*

Ethnicity/Race	Counseling			MHS		
	Female	Male	Total	Female	Male	Total
Asian American	4	2	6	1	1	2
African American	2	1	3	-	-	0
Mexican	14	11	25	5	2	7
Mexican American	28	12	40	12	6	18
White non-Hispanic European American	105	52	157	46	22	68
Native American	4	-	4	3	-	3
<b>Total</b>	<b>157</b>	<b>78</b>	<b>235</b>	<b>67</b>	<b>31</b>	<b>93</b>



Table 5

*Mean and Median Age and Years of Education by Ethnic Group*

Ethnicity/Race	Age			Education		
	Mean	Median	SD	Mean	Median	SD
Asian American	41.2	35.5	13.2	13.6	13	1.9
African American	27.8	22.5	13.7	11.5	11.5	.58
Mexican	34.7	33	11.4	10	10	3.7
Mexican American	37.3	35	14.1	12.3	12	3.5
White non-Hispanic European American	41.6	40	13.6	15	16	3.3
Native American	31.9	30	9.4	13.3	12	2.4
Total	39	37	13.7	13.2	13	4.0

## Procedures

The researcher obtained approval from the University of Denver Institutional Review Board (IRB) to conduct this study. Participants for this study were recruited from two moderate-sized cities located in the southern part of the state of Idaho. A convenience sampling technique was used to identify participants and have them complete the survey. The researcher identified and invited 10 research assistants to assist in identifying participants as well as disseminating and collecting surveys. The research assistants consisted of three White non-Hispanic European American, one Asian-American and six individuals of Mexican descent who were bilingual. There was at least one White non-Hispanic European American and one Mexican American research assistant in each city to collect disseminated surveys from individuals. The research assistants were instructed to visit public locations such as community events (i.e. folkloric celebrations, health fairs, public athletic events, etc.) and public areas (parks, community recreations centers, community cultural centers, public eateries, churches, etc.) in order to identify potential participants and ask them to participate in the study. In order to protect the participants' anonymity from the researcher, the research assistants facilitated the distribution and collection of the surveys. Participants were asked by the research assistants at the various community locations to complete the survey and return it to them directly. Upon completion of the survey, participants were given the opportunity to participate in a raffle as reimbursement for their time and effort. Participants were given the opportunity to voluntarily provide their name and address for the raffle, which consisted of two \$50.00 gift certificates to two local restaurants and one

\$50.00 gift certificate to a local shopping center. Participation in the raffle was voluntary and participants were able to remain anonymous by completing the raffle information and detaching it from their survey form and placing it in a secured drop box and returning the completed survey to the research assistant. Surveys were disseminated and collected over an eight-week period; from the middle of March to the middle of May 2008. When the surveys were collected the research assistants returned the surveys to the primary investigator.

### Measures

The survey was pilot tested with ten individuals, five White non-Hispanic European Americans and five bilingual individuals of Mexican descent. They were recruited from personal contacts and all of them resided in the communities under study. These individuals were directed to check for ambiguity, confusion, and poorly prepared survey items. They were instructed to write their comments on the margin of the survey as they read and answered the questions. In addition, they were instructed to provide additional comments on the back page of the survey. They were given two weeks to complete their survey and return the survey to the researcher. Their suggestions were used to revise and finalize the survey.

The survey included a project information sheet (see Appendix A) which invited participants to voluntarily take part in the study by completing the five measures. Participants were instructed to refrain from writing their name anywhere on the survey in order to protect their anonymity. The six instruments in this study included a demographic form, a help-seeking measure, a social distance measure, a perceived ethnic

discrimination measure, an ethnic identity measure and an acculturation measure. The demographic form and all measures were translated into Spanish using the process of forward and backward translation to ensure accuracy.

### *Variables*

For the purposes of this study mental health stigma was measured using instruments that measure openness to seeking help and social distance. In addition, a measure of perceived ethnic/racial discrimination was used and acculturation was measured using measures of language proficiency, ethnic identity and self-reported generation level.

*Help-Seeking.* The Self-Stigma of Seeking Help scale (SSOSH, see Appendix C) was used to measure participants' willingness to seek psychological help (Vogel, Wade & Haake, 2006). The SSOSH consists of 10 items which measure self-stigma and the likelihood a person would be willing to seek psychological help. Items are rated on a five-point scale, ranging from 1 (strongly disagree) to 5 (strongly agree). Higher scores reflect greater self-stigma and less likelihood of seeking help. Estimates of the internal consistency range from 0.86 to 0.90, and the two-week test-retest reliability was reported to be 0.72 in ethnically diverse college student samples (Vogel et al., 2006). Validity of the SSOSH has been shown through correlation with attitudes toward seeking professional help and intention to seek counseling (Vogel et al. 2006).

*Social Distance.* Measures of social distance are often used in stigma research to indicate the amount of social distance a person desires to be from individuals with some stigmatized attribute. For the purposes of this study, the Social Distance Scale (SDS, see

Appendix D) was used to measure social distance. This scale contains eight items that participants rate on a scale of 0 to 3, where 0 indicates “definitely willing” and 3 indicates “definitely unwilling.” Possible scores range from 0 to 24, with higher scores indicating a greater desire for distance from individuals with mental health issues. The Social Distance Scale has good reliability and validity. The reliability coefficient for this measure was found to be .92 in previous studies (Corrigan, Green, Lundin, Kubiak & Penn, 2001; Link et. al, 1987).

*Perceived Ethnic Discrimination.* The Brief Perceived Ethnic Discrimination Questionnaire – Community Version (Brief PEDQ-CV, See Appendix F) was utilized in this study. The Brief PEDQ-CV is a 17 item measure that was developed from the Lifetime Exposure scale of the full PEDQ-CV and consists of a five-point Likert scale ranging from 1 indicating “never happened” to 5 indicating “happened very often”(Brondolo, Kelly, Coakley, Gordon, Thompson, & Levy, 2005). The Brief PEDQ-CV measures a person’s exposure to ethnic discrimination from different sources and over different time periods. Specifically, this measure assesses ethnicity - related social distancing, ethnic stigmatization, workplace discrimination, and harassment with higher scores indicating increased perceptions of ethnic discrimination (Brondolo et. al, 2005). The internal consistency reliability was .70 to .87 in previous research (Brondolo et. al, 2005)

The purpose of this study was to better understand how mental health problems are stigmatized in Mexican-American culture, and as such, this study investigated the relationship between acculturation and the stigma of mental health problems. The subject

of acculturation has been a controversial topic and researchers continue to debate what constitutes the construct of acculturation. However, from the research that has been done on acculturation two factors which consistently correlate with acculturation are language proficiency and ethnic identity. For the purposes of this study, measures of language proficiency, ethnic identity and self-reported generation level were used to assess level of acculturation. It was anticipated that an individual's lower language proficiency would be indicative of being less acculturated. Similarly, an individual who strongly identifies with their ethnic group was viewed as exemplifying the values and beliefs held by the individuals of that culture, rather than those of the majority culture.

*Demographic Section.* A demographic section (See Appendix B) asked participants to identify their age, gender, ethnicity, parents ethnicity, age at immigration, generational level, number of years of education, whether they have participated in counseling and/or mental health services, and both individual and family annual income.

*Language Proficiency.* The Language Proficiency Subscale (LPS, see Appendix G) from the Bidimensional Acculturation Scale for Hispanics (BAS) was used to measure language proficiency. This subscale of the BAS consists of 12 items which are scaled from 1 to 4, where 4 indicates "very well" and 1 indicates "very poorly." The Language Proficiency Subscale measures a person's language ability in English and Spanish languages. A high score on the items regarding English or Spanish indicate greater proficiency in that language. A low score on items regarding English or Spanish indicate lower proficiency in that language. The Linguistic Proficiency Subscale of the BAS has

good reliability and validity. The internal consistency reliability has been estimated to be .97 (Marin & Gamba, 1996).

*Ethnic Identity.* The Multigroup Ethnic Identity Measure – Revised (MEIM-R, see Appendix E) was used to assess ethnic identity. The MEIM-R is a 6 item measure developed to assess ethnic identity across diverse ethnic groups. The MEIM-R 6 items are scaled from 1 to 5 where 1 indicates “strongly disagree” and 5 indicates “strongly agree.” The MEIM-R assesses ethnic identity by measuring a person’s willingness to learn more about their ethnic group and participating in ethnic cultural practices (Phinney & Ong, 2007). It also assesses ethnic identity by measuring a person’s feeling toward their ethnic group and commitment to their ethnic group (Phinney & Ong, 2007). The psychometric properties of the MEIM-R are sound and it has good validity and reliability; Cronbach’s alpha .83 for exploration and .89 for commitment (Phinney & Ong, 2007).

#### Data Analysis

Descriptive statistics of the items were computed. The researcher used SPSS, a statistical computer package that is used to analyze the data. A test for Cronbach’s alpha was conducted to estimate the internal consistency of the SSOSH, SDS, Brief PEDQ-CV, LPS and MEIM-R. A two-way analysis of variance (ANOVA) was conducted to determine if there were any statistically significant differences between Mexican American and White non-Hispanic European American males and females on the amount of social distance desired from individuals with mental health problems. Attitude toward help-seeking was another variable under study; however, the Self Stigma of Seeking Help

Scale (SSOSH) resulted in low reliability coefficients for the Mexican American sample, which is further discussed in the Fourth Chapter. Therefore, comparative analyses between Mexican Americans and White non-Hispanic European Americans on help-seeking were not conducted. Factor analyses of the SSOSH for both the White non-Hispanic European American and Mexican American samples were conducted in order to better understand the low reliability coefficient for the Mexican American sample.

Because the SSOSH was found to be reliable with the White non-Hispanic European American sample a t-test was conducted in regards to gender differences among White non-Hispanic European American males and females. No correlational analyses with the SSOSH were conducted using the Mexican American sample because of the low reliability coefficient with that group. Lastly, a series of correlation analyses were conducted to determine if there were statistically significant relationships between Mexican American acculturation level as well as select demographic variables and the stigma of mental health.

The following hypotheses were created for the present study:

- (1) Mexican Americans and White non-Hispanic European Americans would differ in the amount of social distance desired from individuals with mental health problems.
- (2) Males and females would differ in the amount of social distance desired from individuals with mental health problems and differ in their attitudes toward seeking help.



- (3) There would be significant interaction between gender and ethnicity with Mexican American males desiring significantly more social distance from individuals with mental health problems when compared with Mexican American females and White non-Hispanic European American males and females.
- (4) Mexican Americans' language proficiency would be associated with the amount of social distance desired from individuals with mental health problems.
- (5) Mexican Americans' level of ethnic identity would be related to the amount of social distance desired from individuals with mental health problems.
- (6) Mexican Americans' generation level would be associated with the amount of social distance desired from individuals with mental health problems.
- (7) Mexican Americans' age would be related to the amount of social distance desired from individuals with mental health problems.
- (8) Mexican Americans' level of education would be associated with the amount of social distance desired from individuals with mental health problems.
- (9) Mexican Americans' participation in counseling would be related to the amount of social distance desired from individuals with mental health problems.
- (10) Mexican Americans' participation in mental health services would be associated with the amount of social distance desired from individuals with mental health problems.

(11) Mexican Americans' level of perceived ethnic discrimination would be related to the amount of social distance desired from individuals with mental health problems.

### Summary

This chapter described the participants, procedures, measures, and data analyses used in the study. Data analyses included a test for Cronbach's alpha on all five instruments to determine internal consistency reliability. A two-way analysis of variance (ANOVA) and a t-test were conducted to determine gender and ethnicity differences. Correlational analyses were conducted to determine the relationships between Mexican American acculturation level, selected demographic variables, mental health stigma and attitudes toward seeking help. The succeeding fourth and fifth chapters will provide the results of the data collected from the participants and a discussion of the overall results.

## CHAPTER FOUR

### Results

A total of 550 surveys were returned by the participants. Of the 550 surveys returned, 507 met the original criteria for the study: 18 years of age and older, self-identified as Mexican\Mexican American or White non-Hispanic European American and participating in one of two cities in southern Idaho. All 507 surveys were included in the final data analysis, however it was noted that not all participants completed the entire survey, which appeared to be due to non-response by the participant.

Prior to analyzing the data, it was observed that many individuals self-identified as Mexican and Mexican American even if their parents' ethnicity was not necessarily consistent with how they identified. For example, on several cases individuals self-identified as Mexican, even though they indicated that their parents were Mexican Americans. Conversely, some individuals identified as Mexican American even though their parents were Mexican and they were born in Mexico. As a result it was decided that the Mexican and Mexican American groups would be combined into the Mexican American group for statistical purposes because there did not appear to be clear demarcation between the two groups. However, prior to combining the groups, a analysis of variance (ANOVA) was conducted to determine if the Mexican sample differed significantly from the Mexican American sample on any of the dependent measures.

Statistically the groups did not differ and it was decided that the two groups were more homogenous than heterogeneous.

*Internal Consistency of Survey Measures*

Cronbach's alpha was calculated to estimate the internal consistency (reliability) of the responses to the SSOSH, SDS, Brief PEDQ-CV, LPS, and MEIM-R for this sample. Tables 6 and 7 summarize the reliability coefficients and descriptive statistics for each of the five survey measures by ethnic group.

Table 6

*Reliability Coefficients and Descriptive Statistics for Survey Measures with Mexican Americans*

Measures	# of Items	Cronbach's Alpha	<i>M (SD)</i>	Min. – Max.
Self-Stigma of Seeking Help scale <sup>a</sup>	10	.63	2.55(.26)	2.15 – 2.97
Social Distance Scale <sup>b</sup>	8	.82	1.28(.28)	.962 – 1.69
Brief Perceived Ethnic Discrimination Questionnaire – Community Version <sup>c</sup>	17	.90	1.99(.38)	1.42 – 2.74
Language Proficiency Subscale <sup>d</sup>	12	.85	3.10(.25)	2.75 – 3.45
Multigroup Ethnic Identity Measure – Revised <sup>e</sup>	6	.91	3.50(.18)	3.19 – 3.69

Note. <sup>a</sup> The Self-Stigma of Seeking Help Scale was coded on a 1-5 scale with higher scores indicating less positive help-seeking attitudes of counseling services. <sup>b</sup> The Social Distance Scale was coded on a 0-3 scale with higher scores indicating greater social distance from individuals with mental health problems. <sup>c</sup> The Brief Perceived Ethnic Discrimination Questionnaire – Community Version was coded on a 1-5 scale with higher scores indicating increased perceptions of ethnic discrimination. <sup>d</sup> The Language Proficiency Subscale of the Bidimensional Acculturation Scale for Hispanics was coded on a 1-4 scale with higher positive scores associated with greater proficiency in English and higher negative scores associated with greater proficiency in Spanish. <sup>e</sup> The Multigroup Ethnic Identity Measure – Revised was coded on a 1-5 scale with higher scores indicating greater sense of ethnic identity.

Table 7

*Reliability Coefficients and Descriptive Statistics for Survey Measures with White non-Hispanic European Americans*

Measures	# of Items	Cronbach's Alpha	<i>M (SD)</i>	Min. – Max.
Self-Stigma of Seeking Help scale <sup>a</sup>	10	.87	2.45(.25)	1.99 – 2.82
Social Distance Scale <sup>b</sup>	8	.85	1.22(.51)	.686 – 2.04
Brief Perceived Ethnic Discrimination Questionnaire – Community Version <sup>c</sup>	17	.94	1.62(.28)	1.20 – 2.36
Language Proficiency Subscale <sup>d</sup>	12	.82	2.65(1.31)	1.32 – 3.93
Multigroup Ethnic Identity Measure – Revised <sup>e</sup>	6	.90	3.20(.15)	3.07 – 3.48

<sup>a</sup> The Self-Stigma of Seeking Help Scale was coded on a 1-5 scale with higher scores indicating less positive help-seeking attitudes of counseling services. <sup>b</sup> The Social Distance Scale was coded on a 0-3 scale with higher scores indicating greater social distance from individuals with mental health problems. <sup>c</sup> The Brief Perceived Ethnic Discrimination Questionnaire – Community Version was coded on a 1-5 scale with higher scores indicating increased perceptions of ethnic discrimination. <sup>d</sup> The Language Proficiency Subscale of the Bidimensional Acculturation Scale for Hispanics was coded on a 1-4 scale with higher positive scores associated with greater proficiency in English and higher negative scores associated with greater proficiency in Spanish. <sup>e</sup> The Multigroup Ethnic Identity Measure – Revised was coded on a 1-5 scale with higher scores indicating greater sense of ethnic identity.

In the two tables, the Self-Stigma of Seeking Help scale (SSOSH) obtained a reliability coefficient below .70 in the Mexican American group, but obtained a reliability coefficient above .70 in the White non-Hispanic European American group. DeVellis (1991) indicated that a reliability coefficient below .70 falls within the unacceptable range for the internal consistency of a measure. A weak reliability suggests that the instrument is poorly measuring a specific construct. As a result of this finding, a principle components analysis was conducted and unrotated to assess the underlying structure for the ten items of the SSOSH. The assumptions of independence, normality and linearity were checked. Tables 8 and 9 summarize the results of the factor analyses for the White non-Hispanic European American and the Mexican American samples respectively.

Table 8

*First Two Factor Loadings for the White non-Hispanic European American Sample on the Self-Stigma of Seeking Help Scale (SSOSH) (N = 263)*

Item	Factor Loading		Communality
	1	2	
I would feel inadequate if I went to a therapist for psychological help.	.75	-.40	.73
My self-confidence would NOT be threatened if I sought professional help.	.66	.43	.62
Seeking psychological help would make me feel less intelligent.	.75	-	.68
My self-esteem would increase if I talked to a therapist.	-	.42	.26
My view of myself would not change just because I made the choice to see a therapist.	.65	-	.55
It would make me feel inferior to ask a therapist for help.	.81	-	.72
I would feel okay about myself if I made the choice to seek professional help.	.75	-	.71
If I went to a therapist, I would be less satisfied with myself.	.78	-	.67
My self-confidence would remain the same if I sought professional help for a problem I could not solve.	.57	.53	.60
I would feel worse about myself if I could not solve my own problems.	.74	-	.67
Eigen values	4.78	1.43	
% of Variance	47.79	14.25	

*Note.* Loadings < .40 are omitted



Table 9

*First Three Factor Loadings for the Mexican American Sample on the Self-Stigma of Seeking Help Scale (SSOSH) (N = 263)*

Item	Factor Loading			Communality
	1	2	3	
I would feel inadequate if I went to a therapist for psychological help.	.43	-	-	.32
My self-confidence would NOT be threatened if I sought professional help.	-	.57	.57	.73
Seeking psychological help would make me feel less intelligent.	.61	-	-	.54
My self-esteem would increase if I talked to a therapist.	-	.62	-	.51
My view of myself would not change just because I made the choice to see a therapist.	-	.49	.46	.50
It would make me feel inferior to ask a therapist for help.	.78	-	-	.68
I would feel okay about myself if I made the choice to seek professional help.	.59	.55	-	.69
If I went to a therapist, I would be less satisfied with myself.	.75	-	-	.65
My self-confidence would remain the same if I sought professional help for a problem I could not solve.	-	.57	-.52	.65
I would feel worse about myself if I could not solve my own problems.	.46	-	-	.43
Eigen values	2.56	2.11	1.03	
% of Variance	25.57	21.07	10.29	

*Note.* Loadings < .40 are omitted

The results regarding the White non-Hispanic European American sample indicated that there were two factors. The first factor, which seemed to index feelings toward the self as it pertains to seeking help, had the strongest loadings. The second factor, which seemed to index self-confidence, had high loadings, but had three cross-loadings over .40 on the feelings toward self factor. This may indicate that those questions are tapping both underlying constructs, which is undesirable in a measure because ideally only one factor should predict each item.

In regard to the Mexican American sample, results indicated that there were three factors. The first factor seemed to index feelings toward the self as it pertains to seeking help; which was similar to the White non-Hispanic European American sample. The first factor had strong loadings on six out of the ten items with only a single cross-loading over .40 on the second factor. The second factor, which seemed to index self-esteem, had high loadings on five out of the ten items with three cross-loadings on the third factor and one cross-loading on the first factor. The third factor seemed to index self-confidence with high loadings on three out of the ten items with cross-loadings on all three with the self-esteem factor.

The results for the Mexican American sample were unusual in that the factor analysis revealed three factors instead of two like in the White non-Hispanic European American sample. This was problematic because it suggested that the Mexican Americans who participated in this study viewed the items on the SSOSH differently than their White non-Hispanic European American counterparts. Furthermore, this difference between the two groups was independent of language. Both Spanish and English

speaking Mexican Americans viewed the items similarly and answered them in a similar fashion. This suggested that the items, in some way, might be illuminating a subtle cultural distinction between self-esteem and self-confidence as it pertains to seeking help; hence three factors instead of two.

As a result of these findings and the low reliability coefficient for the SSOSH, analyses that included the variable of help-seeking were not performed in order to avoid erroneous interpretations. However, within the White non-Hispanic European American group, a t-test was conducted with regard to gender differences on help-seeking because the Self-Stigma of Seeking Help Scale (SSOSH) was found to have an acceptable reliability coefficient.

#### *Differences between Sample Groups*

In analyzing the data in regards to ethnic differences, it was identified that the research question regarding ethnic differences (research question #1) and its subsequent hypotheses (hypotheses #1 & 3) was subsumed in the research question and hypotheses regarding gender (research question #2, hypotheses #2 & 3). Therefore, it was decided that the most parsimonious way to analyze these research questions and hypotheses without exploiting alpha through repeated analyses was to use a single analysis incorporating social distance, gender and ethnicity.

A two-way analysis of variance (ANOVA) for social distance as a function of ethnicity and gender was conducted. Prior to conducting the two-way analysis of variance (ANOVA) examining social distance, the assumptions of independence, homogeneity of variances and normality for each group were checked. Results of the statistical analysis

on the main effect of ethnicity did not support the hypotheses that there would be a difference between Mexican Americans ( $M = 10.06, SD = 4.80$ ) and White non-Hispanic European Americans ( $M = 9.72, SD = 4.06$ ) on the amount of social distance desired from individuals with mental health problems,  $F(1,476) = .158, p = .692$ . Similarly, for the main effect of gender, the statistical analysis did not support the predication that there would be a difference between males ( $M = 9.87, SD = 4.73$ ) and females ( $M = 9.88, SD = 4.42$ ) on the amount of social distance desired from individuals with mental health problems,  $F(1,476) = .017, p = .896$ .

Hypothesis #3 stated that there would be a statistically significant interaction between gender and ethnicity with Mexican American males ( $M = 9.62, SD = 4.73$ ) desiring significantly more social distance from individuals with mental health problems than Mexican American females ( $M = 10.34, SD = 4.84$ ), White non-Hispanic European American females ( $M = 9.51, SD = 4.03$ ) and White non-Hispanic European American males ( $M = 10.11, SD = 4.09$ ). Results of the statistical analysis did not support this hypothesis,  $F(1,476) = 2.44, p = .119$ .

An independent samples t-test was used to test for gender differences on attitudes toward seeking help within the White non-Hispanic European American group. Prior to conducting the t-test examining attitudes toward help-seeking, the assumptions of normality and equal variances were tested and met. Results of the statistical analysis supported the hypothesis that there would be a gender difference between White non-Hispanic European males ( $M = 26.00, SD = 6.89$ ) and females ( $M = 23.44, SD = 7.32$ ) on attitudes toward seeking help,  $t(256) = 2.72, p = .007$ .

### *Acculturation Influence on Social Distance and Help-seeking*

A series of correlation analyses were conducted in order to explore the relationship between Mexican Americans' level of acculturation and desire for social distance from individuals with mental health problems (research question #3). Acculturation was measured by language proficiency, ethnic identity and generational level. Correlation analyses regarding seeking help were not conducted because the measure was found to have a low reliability coefficient for the Mexican American group. The level of statistical significance was set at .017 for correlation tests in order to account for the possibility of conducting a Type I error. The original level of statistical significance was set at .05, two-tailed, and was divided by three because three correlation analyses were conducted. Table 10 summarizes the results of the correlational analyses regarding Mexican Americans' level of acculturation and amount of social distance they desire from individuals with mental health problems.

Table 10

Correlations between Mexican American Acculturation Level and Social Distance

Variables	1	2	3	4
1. Social Distance Scale <sup>a</sup>	–			
2. Language Proficiency Subscale <sup>b</sup>	-.04	–		
3. Multigroup Ethnic Identity Measure – Revised <sup>c</sup>	.07	-.07	–	
4. Generational Level <sup>d</sup>	-.06	.481**	.031	–
<i>M</i>	10.06	19.78	3.47	2.23
<i>SD</i>	4.80	5.18	.93	1.60

<sup>a</sup> The Social Distance Scale was coded on a 0-3 scale with higher scores indicating greater social distance from individuals with mental health problems. <sup>b</sup> The Language Proficiency Subscale of the Bidimensional Acculturation Scale for Hispanics was coded on a 1-4 scale with higher positive scores associated with greater proficiency in English and higher negative scores associated with greater proficiency in Spanish. <sup>c</sup> The Multigroup Ethnic Identity Measure – Revised was coded on a 1-5 scale with higher scores indicating greater sense of ethnic identity. <sup>d</sup> Generational Level was categorized as 1 = 1<sup>st</sup> generation, 2 = 2<sup>nd</sup> generation, 3 = 3<sup>rd</sup> generation, 4 = 4<sup>th</sup> generation, 5 = 5<sup>th</sup> generation and 6 = generation unknown.

\* $p < .05$ . \*\* $p < .01$ . \*\*\* $p < .001$ .

In order to determine if there was a statistically significant association between language proficiency and the amount of social distance desired toward individuals with mental health problems among Mexican Americans (hypothesis #4), a Pearson correlation was computed. Assumptions for normality and linearity were tested and met. Results indicated that there was no statistically significant correlation between language proficiency and the amount of social distance desired from individuals with mental health problems for Mexican Americans.

To investigate if there was a statistically significant association between level of ethnic identity and the amount of social distance desired toward individuals with mental health problems for Mexican Americans (hypothesis #5), a Pearson correlation was computed. Assumptions for normality and linearity were tested and met. Results indicated that there was no statistically significant relationship between level of ethnic identity and the amount of social distance desired from individuals with mental health problems.

In order to determine if there was a statistically significant association between Mexican Americans' generational level and amount of social distance desired from individuals with mental health problems (hypothesis #6), a Kendall's Tau-b correlation was computed because generational level was an ordinal variable. Assumptions for normality and linearity were tested and met. Results indicated that there was no statistically significant correlation between generational level and the amount of social distance from individuals with mental health problems.

### *Select Demographic Variables Influence on Social Distance and Help-seeking*

Select demographic variables of the Mexican American sample, such as age, years of education, participation in counseling and mental health services and level of perceived ethnic discrimination, were explored in terms of their relationship to the amount of social distance desired from individuals with mental health problems and attitudes toward seeking help (research question #4). A series of correlation analyses were conducted in order to explore these demographic variables and desire for social distance. Correlation analyses regarding seeking help were not conducted because the measure was found to have a low reliability coefficient for the Mexican American sample. The level of statistical significance was set at .01 for correlation tests in order to account for the possibility of conducting a Type I error. The original level of statistical significance was set at .05, two-tailed, and was divided by five because five correlation analyses were conducted. Table 11 summarizes the results of the correlational analyses regarding the relationship between select demographic variables of the Mexican American sample and the desire for social distance from individuals with mental health problems.



Table 11

## Correlations between Mexican American Demographic Variables and Social Distance

Variables	1	2	3	4	5	6
1. Social Distance Scale <sup>a</sup>	–					
2. Brief Perceived Ethnic Discrimination Questionnaire – Community Version <sup>b</sup>	-.05	–				
3. Age	.17**	-.081	–			
4. Education Level	-.04	.11	.09	–		
5. Counseling <sup>c</sup>	.034	-.21**	-.11	-.19**	–	
6. Mental Health Services <sup>d</sup>	.066	-.061	-.022	-.14*	.42**	–
<i>M</i>	10.06	1.99	35.9	11.1	1.71	1.9
<i>SD</i>	4.80	.69	12.92	3.75	.50	.31

<sup>a</sup> The Social Distance Scale was coded on a 0-3 scale with higher scores indicating greater social distance from individuals with mental health problems. <sup>b</sup> The Brief Perceived Ethnic Discrimination Questionnaire – Community Version was coded on a 1-5 scale with higher scores indicating increased perceptions of ethnic discrimination. <sup>c</sup> Participation in counseling was a dichotomous variable with Yes = 1 and No = 2. <sup>d</sup> Mental health services was a dichotomous variable with Yes = 1 and No = 2.

\* $p < .05$ . \*\* $p < .01$ . \*\*\* $p < .001$ .

In order to determine if there was a statistically significant association between age and the amount of social distance desired toward individuals with mental health problems among Mexican Americans, a Pearson correlation was computed. Assumptions for normality and linearity were tested and met. Results indicated that there was a statistically significant correlation between age and the amount of social distance desired from individuals with mental health problems for Mexican Americans. This suggested that the amount of social distance desired from individuals with mental health problems increased as participant's age increased.

To investigate if there was a statistically significant association between level of education and the amount of social distance desired toward individuals with mental health problems for Mexican Americans, a Pearson correlation was computed. Assumptions for normality and linearity were tested and met. Results indicated that there was no statistically significant relationship between level of education and the amount of social distance desired from individuals with mental health problems for Mexican Americans.

In order to determine if there was a statistically significant association between Mexican Americans' participation in counseling and amount of social distance desired from individuals with mental health problems, a Point-biserial correlation was computed because participation in counseling was a dichotomous variable and social distance was an interval variable. Assumptions for normality and linearity were tested and met. Results indicated that there was no statistically significant correlation between participation in

counseling and the amount of social distance from individuals with mental health problems for Mexican Americans.

Similarly, to investigate if there was a statistically significant association between Mexican Americans' participation in mental health services and the amount of social distance desired from individuals with mental health problems, a Point-biserial correlation was computed because participation in mental health services was a dichotomous variable and social distance was an interval variable. Assumptions for normality and linearity were tested and met. Results indicated that there was no statistically significant correlation between participation in mental health services and the amount of social distance from individuals with mental health problems for Mexican Americans.

In order to determine if there was a statistically significant association between level of perceived ethnic discrimination and the amount of social distance desired toward individuals with mental health problems among Mexican Americans, a Pearson correlation was computed. Assumptions for normality and linearity were tested and met. Results indicated that there was not a statistically significant correlation between perceived ethnic discrimination and the amount of social distance desired from individuals with mental health problems for Mexican Americans.

### Summary

This chapter described the results of the data collected from the participants (N = 507). It was decided to combine the participants who self-identified as Mexican with those who self-identified as Mexican American because it appeared that there was no

distinction statistically between the groups and they appeared more homogenous than heterogeneous. The Self-Stigma of Seeking Help scale (SSOSH) had a low reliability coefficient with the Mexican American sample. Therefore, no analyses were conducted on the seeking help variable among Mexican Americans. However, a satisfactory reliability coefficient for the White non-Hispanic European American group was found on the measure. Therefore, an analysis of gender differences within the White non-Hispanic European American group on the variable of help-seeking was conducted. In order to account for the possibility of a Type I error when conducting multiple correlations, the level of statistical significance of .05 was adjusted and set at .017 for correlations regarding acculturation and .01 for correlations regarding selected demographic variables. Results indicated that there was no difference between Mexican Americans and White non-Hispanic European Americans on the amount of social distance desired from individuals with mental health problems. Similarly, the results indicated that there was no difference between males and females on the amount of social distance desired from individuals with mental health problems. Furthermore, results did not support the hypothesis related to a significant interaction between ethnicity and gender. No significant correlations were found between Mexican American's level of acculturation, as measured by language proficiency, level of ethnic identity and generational level, and amount of social distance desired from individuals with mental health problems. In regards to selected demographic variables, there was a positive correlation between Mexican Americans' age and the amount of social distance desired from individuals with mental health problems. However, there were no statistically

significant correlations between Mexican Americans' level of education, participation in counseling and mental health services as well as level of perceived ethnic discrimination. The Fifth Chapter will provide a discussion of the overall results, including implications for the study, limitations of the study, and areas for future research.

## CHAPTER FIVE

### Discussion

This study examined the stigma of mental health problems and discrimination between Mexican Americans and White non-Hispanic European Americans. Out of 550 participants who completed the survey, which consisted of a project information sheet, a demographic form, and five measures, a total of 507 participant surveys met the criteria to be included in the data analysis. A convenience sampling technique was used in order to recruit participants for the study.

This study examined four major questions with respect to stigma of mental health problems and Mexican Americans:

*Research Question #1:* Do Mexican Americans and White non-Hispanic European Americans differ in regard to the amount of mental health stigma, as measured by the amount of social distance they desire from individuals with mental health problems and their own attitudes toward seeking help?

*Research Question #2:* Do Mexican American and White non-Hispanic European American males and females differ in regard to the amount of mental health stigma, as measured by the amount of social distance they desire from individuals with mental health problems and their own attitudes toward seeking help?

*Research Question #3:* Is Mexican American acculturation level, as measured by language proficiency, ethnic identity and generation level, related to the stigma of mental health as measured by help-seeking attitudes and the amount of social distance from individuals with mental health problems?

*Research Question #4:* Is Mexican American age, years of education, participation in counseling and/or mental health services, and level of perceived ethnic discrimination related to the stigma of mental health, as measured by help-seeking attitudes and the amount of social distance from individuals with mental health problems?

It was hypothesized that Mexican Americans and White non-Hispanic European Americans would differ in the amount of social distance desired towards individuals with mental health problems as well as differ in their attitudes towards seeking help. No difference was found between Mexican Americans and White non-Hispanic European Americans in the amount of social distance desired from individuals with mental health problems. With a possible range of 0 – 24, the scores of both Mexican Americans ( $M = 10.06$ ,  $SD = 4.80$ ) and White non-Hispanic European Americans ( $M = 9.72$ ,  $SD = 4.06$ ) scores were in the moderate range in the amount of social distance they desired. This suggested that both Mexican Americans and White non-Hispanic European Americans tended to be similar in regard the amount of social distance desired from individuals with mental health problems. These scores suggests that when both Mexican Americans and White non-Hispanic European Americans, when confronted with interacting with someone with a mental health problem, prefer to have a moderate amount of social distance from that individual. This finding did not support previous research which

suggested that minority groups tended to be more stigmatizing toward mental health problems (DHHS, 1999). Similarly, Narrow, Regier, Norquist, Rae, Kennedy & Arons (2001) found that White non-Hispanic European Americans were more likely to use psychiatric services than African American and Hispanics; and that stigma was a contributing factor to lower use of services. However, this result did support Mardiros (1989) finding that Mexican Americans may not stigmatize mental health problems to the same degree as other minority groups. Overall, the findings of this study suggested that Mexican Americans do not want more social distance from individuals with mental health problems than White non-Hispanic European American individuals.

It was hypothesized that males and females would differ in the amount of social distance desired from individuals with mental health problems as well as their attitudes towards seeking help. With a possible range of 0 – 24 on the Social Distance Scale males ( $M = 9.87, SD = 4.73$ ) and females ( $M = 9.88, SD = 4.42$ ) did not significantly differ in the amount of social distance desired from individuals with mental health problems. Scores of males and females were in the moderate range in terms of the amount of social distance desired from individuals with mental health problems. This appeared to be consistent with some previous studies in which it was found that males and females tended to both stigmatize mental health problems to the same degree (Albizu-Garcia, Alegria, Freeman, & Vera, 2001; Schnittker, 2000). However, other studies had found that females tend to desire more social distance from individuals with mental health problems than males (Parra, 1985).



It was also hypothesized that Mexican American males and females would differ from White non-Hispanic European American males and females in the amount of social distance desired from individuals with mental health problems and their attitudes toward seeking help. Furthermore, it was hypothesized that there would be significant interaction between gender and ethnicity with Mexican American males desiring significantly more social distance from individuals with mental health problems and least likely to seek help than Mexican American females and White non-Hispanic European American males and female. Results of this study did not support this hypothesis and found that there was no significant interaction between ethnicity and gender in terms of social distance. This suggests that Mexican American males ( $M = 9.62$ ,  $SD = 4.73$ ) did not differ from Mexican American females ( $M = 10.34$ ,  $SD = 4.84$ ) or White non-Hispanic European American males ( $M = 10.11$ ,  $SD = 4.08$ ) and females ( $M = 9.51$ ,  $SD = 4.03$ ) with regards to social distance from individuals with mental health problems. As can be seen, the means were approximately the same and the groups desired a moderate amount of social distance from individuals with mental health problems. These results suggest that participants tended to be moderately tolerant of individuals with mental health problems. This finding was not consistent with what was found in previous studies. Parra (1985) reported that older Mexican American females were the least tolerant of individuals with mental health problems as compared to younger Mexican American females and Mexican American males as well as White non-Hispanic European American males and females. Alvidrez (1999) found that Hispanic females held stronger beliefs that mental health problems should not be discussed or dealt with outside the family and they were less

likely to participate in mental health treatment. Similarly, Saetermoe et al. (2001) found that Hispanics tended to stigmatize mental health problems more severely than physical disabilities when compared to other ethnic groups.

Since the help-seeking measure was found to be reliable for the White non-Hispanic European American sample, the hypothesis that there would be a gender difference regarding help-seeking was tested. Results supported this hypothesis and found that females ( $M = 23.44$ ,  $SD = 7.32$ ) were found to be significantly more likely to seek help for mental health problems than were males ( $M = 26.00$ ,  $SD = 6.90$ ). This finding was consistent with previous research studies which demonstrated that males are significantly less likely than females to seek help for a variety of problems such as depression, substance abuse, stressful life events and physical disabilities (Husanini, Moore, & Cain, 1994; McKay, Rutherford, Caccicola & Kabasakalian-McKay, 1996).

In order to explore the relationship between Mexican American acculturation level and the amount of social distance desired from individuals with mental health problems as well as attitudes towards seeking help, a series of correlations were conducted. For the purposes of this study, acculturation was measured using language proficiency, ethnic identity and self-reported generation level. It was hypothesized Mexican Americans' language proficiency would be associated with the amount of social distance desired from individuals with mental health problems as well as be associated with their attitudes towards seeking help. With a range of 6 – 24 on both the English subscale and the Spanish subscale of the Language Proficiency Subscale, Mexican Americans' ( $M = 16.98$ ,  $SD = 6.65$ ) score on the English language subscale was in the

moderate range in terms of proficiency. As for the Spanish subscale Mexican Americans ( $M = 19.78$ ,  $SD = 5.18$ ) score was in the high range in terms of language proficiency in Spanish. Results from statistical analysis did not support the hypothesis that language proficiency would be associated with social distance. This was interesting given the fact that regardless of language proficiency, which is only one measure of acculturation, Mexican Americans desired a moderate amount of social distance from individuals with mental health problems. However, there is also the possibility that since language proficiency was self-reported and not measured using standardized language tests, that it was not accurate. It is clearly difficult to determine whether or not participants' self-reporting of language proficiency was accurate or even reflective of their actual proficiency by self-report.

In addition to language proficiency, an ethnic identity measure was also used to assess acculturation level. It was hypothesized that the Mexican Americans' degree of ethnic identity would be associated with the amount of social distance desired from individuals with mental health problems. With a range of 1 to 5, Mexican Americans' ( $M = 3.47$ ,  $SD = .93$ ) score indicated that they moderately identified with their ethnic group. Statistical analyses did not support the hypothesis that Mexican Americans level of ethnic identity would be related to the amount of social distance they desired from individuals with mental health problems. This finding did not support previous studies which have found that more traditional (less acculturated) Mexican Americans tend to hold more negative views of mental health problems and tend to avoid interacting with individuals with mental health problems (Gonzales, 1976; Parra, 1983). It could be that the lack of

significance in this study between these two variables may be attributable to the fact that the majority of Mexican American participants rated themselves as identifying with their ethnic group only moderately, rather than highly, which would reflect a more traditional (less acculturated) orientation.

Lastly, self-reported generation level was used as a measure of acculturation. It was hypothesized that Mexican Americans generation level would be associated with the amount of social distance desired from individuals with mental health problems. With a possible range varying from first generation to fifth generation, the majority for Mexican Americans self-identified as first or second generation, which accounted for 71% of the total sample of Mexican Americans. Individuals who identify as first or second generation usually are less acculturated than individuals from higher generational levels. Results did not support the hypothesis that there would be a relationship between generational level and amount of social distance desired by Mexican Americans from individuals with mental health problems. One explanation for the lack of a significant relationship between generation level and amount of social distance was due to the possible restricted range of the sample (71% of sample self-identified as first or second generation), which appeared to constrict the variance.

Overall, the stereotypic view of Mexican Americans regarding mental health is that less acculturated Mexican Americans tend to stigmatize mental health problems more than higher acculturated Mexican Americans. The results of this study do not support this stereotypic view. Furthermore, previous research suggested that less acculturated Mexican Americans hold more negative perceptions of individuals with

mental health problems than higher acculturated Mexican Americans (Parra, 1983). This study does not support those findings; rather it indicates that acculturation does not appear to be related to the stigma of mental health problems as measured by social distance.

In addition to acculturation, a number of select demographic variables of Mexican Americans were explored in regards to their possible relationship with the stigma of mental health problems. These variables included Mexican Americans' age, education level, participation in counseling and/or mental health services and level of perceived ethnic discrimination. In order to explore these variables and their possible relationship with the stigma of mental health problems, a series of correlation analyses were conducted.

It was hypothesized that Mexican American's age would be associated with the amount of social distance desired from individuals with mental health problems as well as attitudes toward seeking help. The Mexican American sample's average age was 35.9 years ( $SD = 12.92$ ). Results indicated that there was a statistically significant correlation between Mexican Americans' age and amount of social distance desired from individuals with mental health problems. Results further indicated that as age increased, the amount of social distance desired from individuals with mental health problems increased. This suggested that younger Mexican Americans have less stigmatized views about mental health problems than older Mexican Americans. Furthermore, it suggested that younger Mexican Americans may be more tolerant of individuals with mental health problems than older Mexican Americans. This result also suggests there may be a change in

attitudes toward mental health problems between older generations and younger generations. This finding supported previous research which suggested that younger Mexican Americans have more tolerance for individuals with mental health problems than do older Mexican Americans (Parra, 1985). This was also reflected in the research regarding perceptions of mental health problems, with younger Mexican Americans being more reluctant than older Mexican Americans to label certain behaviors as mental health problems (Parra, 1983).

In addition to age, education level was explored in relation to the stigma of mental health problems. It was hypothesized that Mexican Americans' education level would be associated with the amount of social distance desired from individuals with mental health problems as well as with their attitudes toward seeking help. The average years of education amongst the Mexican American sample was 11.1 ( $SD = 3.75$ ). Statistical analysis did not support the hypothesis and indicated there was no significant relationship between the number of years of education and the amount of social distance from individuals with mental health problems. This finding suggested that education may not be related to the amount of stigma an individual may or may not feel toward individuals with mental health problems. Moreover, this finding did not support previous findings which suggested that the level of stigma toward mental health problems was related to education level; with individuals with higher levels of education having less stigmatized attitudes toward mental health problems (Corrigan & Watson, 2007). However, the fact that this study did not support previous studies should be taken with caution. The

majority of participants in this study had educational background consisting of primary and secondary educations and only a few individuals had higher levels of education.

In addition to age and education, Mexican Americans' participation in counseling and mental health services was investigated. Specifically it was hypothesized that there would be an association between Mexican American's participation in counseling and mental health services and the amount of social distance desired from individuals with mental health problems. Correlational analyses indicated there were no significant relationships between counseling or mental health services and the amount of social distance desired from individuals with mental health problems. Out of the 244 Mexican Americans included in the study, 67 indicated that they had participated in counseling, which was approximately 27.5% of the total Mexican American sample. Additionally, out of the 244, 26 indicated that they had participated in mental health services, which was approximately 10.7% of the total Mexican American sample. However, out of the 26 that had participated in mental health services, 23 also indicated that they had participated in counseling. It appeared from the data that the Mexican American sample seemed to make a distinction between counseling and mental health services, rather than viewing counseling as part of mental health services. Another interesting finding was that the Mexican American group utilized mental health services less than the White non-Hispanic European American group, which had approximately 60% indicating that they had participated in counseling and 26% indicated that they had received mental health services. This finding was consistent with other studies which found that Mexican

Americans access counseling and mental health services at significantly lower rates than other ethnic and racial groups (Alvidrez, 1999, DHHS, 1999).

Lastly, ethnic discrimination impacts minority individuals' lives and this may affect how they view mental health problems. This study asked participants to answer questions regarding ethnic discrimination. It was hypothesized that there would be a significant relationship between the level of ethnic discrimination and the amount of social distance desired from individuals with mental health problems. With a range from 1 to 5, Mexican Americans ( $M = 1.99$ ,  $SD = .69$ ) indicated that they experience little to no ethnic discrimination. Statistical analysis did not support the hypothesis that there would be a significant relationship between perceived ethnic discrimination and the amount of social distance desired from individuals with mental health problems. This finding was surprising given the fact that most ethnic minorities report moderate to high level of ethnic discrimination (Brondolo et al., 2005). In fact, this finding suggests that Mexican Americans experience very little ethnic discrimination. In order to better understand this finding, Spanish and English speaking Mexican Americans were separated out and the analysis was replicated. It was found that Spanish and English speaking Mexican Americans experienced approximately the same amount of ethnic discrimination, which was very little. For the Mexican American sample, no mean score on any given item was above three, which would have been a moderate range score.



## Implications of the Study

The focus and emphasis of this study was on gaining a greater understanding of mental health stigma among Mexican Americans. Specifically, the study was developed to look at Mexican Americans within a community sample, and moreover, Mexican Americans who were Spanish-speaking. This study was able to achieve this objective by collecting approximately half of the Mexican American sample from Spanish speakers. The findings from this study, although not statistically significant, raise questions regarding Mexican Americans and the stigma of mental health problems, at least in this sample collected in Idaho.

This study suggested that the Mexican Americans in this sample did not stigmatize mental health problems any more or less than White non-Hispanic European Americans. This argues against the stereotypic belief and some previous research that Mexican Americans tend to be more reluctant to interact with individuals with mental health issues. Furthermore, stereotypes suggest that Mexican American males, in particular, were the likeliest group to want the most distance between themselves and individuals with mental health problems. This was based on previous research which had shown that Mexican American males tended to seek mental health treatment at significantly lower rates than Mexican American females which was indirectly indicative of Mexican American males wanting increased distance from issues involving mental health (Vega, Kolody, Aguilar-Gaxiola & Catalano, 1999). This study does not support that research; rather it suggests that Mexican American males are no more likely to want increased distance between themselves and individuals with mental health problems than

Mexican American females and White non-Hispanic European American male and females.

On a similar note, this study found a significant difference between White non-Hispanic European American males and females in their attitudes toward seeking help. Results indicated that females had significantly less self-stigma and were more likely to seek help for psychological problems than males. Although this was not a novel finding, it did add to the body of literature regarding gender, self-stigma and help-seeking.

Another finding in the study, which was quite interesting, was that Mexican Americans' age was significantly correlated with the amount to social distance from individuals with mental health problems. The positive correlation between social distance and age for the Mexican American population suggests that as age increased the desired amount of social distance from individuals with mental health problems increased. This was believed to reflect a generational shift in attitudes and beliefs regarding mental health problems; with older Mexican Americans viewing mental health problems more negatively and reporting a desire for greater social distance from individuals with mental health problems. Conversely, the younger Mexican Americans appear to be tolerant and may have different beliefs and values regarding mental health problems, resulting in a desire for less social distance from individuals with mental health problems. This finding was consistent with Parra (1983) who found that younger Mexican Americans tended to be more reluctant to label individuals' behaviors as representing a mental health problem.

Additionally, this study supported previous studies regarding Mexican Americans underutilization of mental health and counseling services. A recent study by Vega et al.,

(1999) found that Mexican Americans, in general, underutilize healthcare across the board. Although, Mexican American females were more likely to access mental healthcare significantly more than Mexican American males, both genders utilized mental healthcare significantly less than White non-Hispanic European American males and females (Vega et al., 1999). This study supported this finding. Results indicated that the Mexican American sample accessed counseling and mental health services at approximately half the rate of White non-Hispanic European Americans.

Lastly, this study explored the use of existing measures of social distance and help-seeking attitudes on Spanish and English speaking Mexican Americans. From the literature, it appeared that neither measure had been used with Mexican Americans specifically and had not been translated into Spanish. This study was unique in that it translated all measures into Spanish and administered them specifically to Spanish speaking Mexican Americans. Results indicated that the majority of the measures used were reliable, with the exception of the Self-Stigma of Seeking Help scale (SSOSH); which had low reliability coefficients with the Mexican American sample. This was important because it suggested that the SSOSH, in its current form, is unreliable and may not be a good measure of help-seeking with Mexican Americans. Furthermore, the low reliability of the measure did not appear to be due to the translation of the measure because low reliability coefficients were found in both the English and Spanish speaking Mexican American samples. Furthermore, factor analyses suggested that for the White non-Hispanic European sample and the Mexican American sample the SSOSH was measuring different constructs. The items of SSOSH were found to load on two factors

with the White non-Hispanic European American sample; whereas with the Mexican American sample the items of the SSOSH loaded on three factors. A closer examination seemed to suggest that for the Mexican American sample there may have been a distinction between feelings regarding the self and help seeking, self-esteem and self-confidence. Future research should focus on understanding this discrepancy and improving the measure.

### Limitations

There were a number of limitations to this study. First, this study was limited in looking at Mexican Americans and White non-Hispanic European Americans in a small geographical area consisting of two cities in the southern part of the state of Idaho. Therefore, generalizability of these findings is limited and may not be representative of the Mexican American population.

Another limitation of this study was the possibility of gender bias in terms of participating in the study. Research has suggested that females are more likely than males to participate in survey research studies. The sample for this study consisted of approximately 66% females and 34% males. Based on this, it was felt that the results may better reflect females' attitudes toward individuals with mental health problems and may not have been fully representative of the male population of the geographical area under study.

This study was also limited in the fact that multiple correlation analyses were done on the data when actually another more sophisticated statistical analyses which would have controlled better for alpha or Type I error could have been performed, such

as multiple regression. However, in order to answer the questions which were posed in this study, the multiple correlation analyses needed to be conducted in order to explore these relationships. Future research may want to look at predictive models or regression models in terms of these variables and their association, or lack thereof, within the Mexican American community.

This study was also limited by the sampling technique. This study used a convenience sampling technique which included collecting surveys from the community at various locales within both cities. This was not a randomized study so caution should be used when interpreting the findings of this study. Nevertheless, preliminary statistical analyses indicated that the data set was normally distributed.

Another limitation to this study was the fact that this study included only participants who self-identified as Mexican American or Mexican. It did not take into account individuals who might identify themselves as Chicano or Latino or some other ethnicity that was similar to Mexican American. Therefore, the sample could be somewhat selectively biased due to the fact that self-selection would be made of individuals who identify as Mexican American, but excluded individuals who identify as some other ethnic identity that was closely related to Mexican American.

Additionally, this study was limited in the fact that the measures used in the study had never been used specifically with Mexican Americans, especially Spanish speaking Mexican Americans. Although the majority of the instruments were reliable, that does not always insure they are valid for the groups under study. It is difficult to determine whether or not these instruments are actually valid. It does appear that all the measures

have face validity, but as witnessed with the SSOSH, a measure may actually be measuring more than one construct on any given ethnic group. Therefore, the results of this exploratory study should be interpreted with caution. Further research studies need to be conducted using these measures to validate them as well as make them reliable with the Mexican American ethnic group.

Lastly, one of the limitations of any survey study, especially regarding how individuals view others, is the potential for responding in a socially or politically correct manner as opposed to how the individual truly feels regarding the subject matter. This study is no different. It is possible that the lack of significant findings with the Social Distance Scale may be the result of socially appropriate responding by both Mexican Americans and White non-Hispanic European Americans.

#### Areas for Future Research

Future research can begin looking at the stigma of mental health amongst Mexican Americans by further analyzing the data already collected in this study. It may be useful to look at differences according to other demographic variables such as economic status, help-seeking with controls for age, education level and language. There also is a need for future research to focus on validating and developing more reliable and valid measures to be used with Mexican Americans as well as with Spanish speakers. Although the measures for this study appear to be face valid, it may be that some of them are not measuring the construct of stigma of mental health as defined by Mexican American culture. Therefore, qualitative approaches should be used to illuminate the concept of stigma as defined in Mexican American culture. The measures in this study

assumed that the stigma of mental health problems was conceptually the same in Mexican American culture as it is in White non-Hispanic European American culture. This may not be the case and so qualitative studies may aid in helping better define the concept. As the concept becomes more defined and understood in Mexican American culture, then quantitative measures can be developed or existing measures can be adapted to be used with Mexican Americans.

Additionally, this study used a measure of social distance as a means of measuring mental health stigma. Social distance is only one of many ways to measure mental health stigma, which is a multifaceted and complex phenomenon. Future research may want to use other survey methods such as vignettes, measures of help-seeking or more experimental research paradigms to measure mental health stigma with Mexican Americans. Future research may want to consider adapting present paradigms for studying mental health stigma with Mexican Americans.

As mentioned earlier, an area of future research would be to further study the correlation between age and social distance. Such research would aid in having a better understanding of what exactly that relationship is and if it is reflecting a shift in Mexican American attitudes and tolerance for individuals with mental health problems.

Beyond this study, other areas of future research should be focused on barriers to mental health services and treatment for Mexican Americans. For example, research suggests that Mexican Americans underutilize mental health services. Future research should focus on why Mexican Americans underutilize services and to what extent does stigma play a role in limiting Mexican Americans from accessing mental health services.

Other barriers such as language and cultural competency should be investigated in relation to the stigma of mental health; especially as it pertains to Mexican Americans.

### Summary

This chapter provided a discussion on the research study of Mexican Americans and the stigma of mental health problems. Excluding one factor, help-seeking, from the analyses because of low reliability coefficients on the measure, the variables of gender, ethnicity, age, educational level, participation in counseling and mental health services, as well as perceived ethnic discrimination and acculturation level were all explored in relation to social distance. Overall, there were no differences between Mexican Americans and White non-Hispanic European Americans in this sample regarding the amount of social distance desired from individuals with mental health problems. Similarly, there were no gender differences between the ethnic groups. However, there was a significant difference between White non-Hispanic European American males and females on the variable of help-seeking. Also, there was a significant correlation between age and the amount of social distance desired in the Mexican American sample, but not on any of the other variables under study. Even though the results of this investigation are limited due to its exploratory nature and its generalizability to the Mexican American population, it provides some insight into the stigma of mental health problems among this ethnic group. It also helps identify areas of future research that may be conducted with Mexican Americans.



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## APPENDIX A

### **Project Information Sheet**

You are invited to participate in a study investigating people's attitudes and perceptions toward mental health. The survey is **ANONYMOUS** and **NO IDENTIFYING INFORMATION WILL BE COLLECTED.**

This study is a research project that is part of a doctoral dissertation, a requirement for graduation from the University of Denver's Doctoral Program in Counseling Psychology. The purpose of the current research is to gain a deeper understanding of the cultural, ethnic and gender differences people have toward mental health. You will be asked to complete questions regarding your demographics (**NON-IDENTIFYING INFORMATION**), ethnic experiences, thoughts about mental health, and attitude toward mental health services. Findings may be presented to professional organizations and or possibly published. At the completion of this study, results will be available by contacting the researcher.

Jeff Wright, M.A. ([jwright@du.edu](mailto:jwright@du.edu); [wright@lifecounselingcenter.net](mailto:wright@lifecounselingcenter.net); 208-250-4642) will be conducting the research in this study. He is a doctoral candidate at the University of Denver. Jesse N. Valdez, Ph.D. ([jvaldez@du.edu](mailto:jvaldez@du.edu); 303-871-2482) is the supervising faculty member and dissertation chair.

Participation in this study should take about 5-10 minutes of your time. Participation involves responding to 64 questions about your background, ethnic experiences, thoughts about mental health, and attitude toward mental health services. It is important to note that participation in this study is strictly **VOLUNTARY AND ANONYMOUS.** The risks associated with the project are minimal. If you do experience discomfort you may discontinue your participation at any time. We respect your right to choose not to answer any questions that may make you feel uncomfortable. Refusal to participate or withdrawal from participation will involve no penalty or loss of benefits to which you are otherwise entitled. However, for your participation in the study you do have the opportunity to participate in a raffle for a gift certificate at this specific location. **Your return of the questionnaire will serve as your consent to participate in this study.** Results from this study will be posted for you on the following website: [www.lifecounselingcenter.net](http://www.lifecounselingcenter.net).

**Please DO NOT write your name anywhere on the survey.** If you wish to enter the raffle please complete the raffle form and place it in the raffle box.

If you have any concerns or complaints about the questionnaire or how you were treated during the research process, please contact Dennis Wittmer, Chair, Institutional Review Board for the Protection of Human Subjects, at 303-871-2431, Sylk Sotto-Santiago, Office of Sponsored Programs at (303) 871-4052 or write to either at the University of Denver, Office of Sponsored Programs, 2199 S. University Blvd., Denver, CO 80208-2121.

**You may keep this page for your records.**

## APPENDIX B

### Demographic Information

The following items refer to your demographic information. Please fill in each item.

1. Gender (please circle)    Female    Male
2. Age \_\_\_\_\_
3. My ethnicity is (***Please choose one of the following***)
  - (1) Asian, Asian-American, or Oriental
  - (2) Black or African American
  - (3) Mexican
  - (4) Mexican-American
  - (5) White, Caucasian, European American, White non-Hispanic
  - (6) American Indian or Native American
  - (7) Other (write in): \_\_\_\_\_
4. My father's ethnicity is (use numbers above in question 3): \_\_\_\_\_
5. My mother's ethnicity is (use numbers above in question 3): \_\_\_\_\_
6. In what country were you born? \_\_\_\_\_
7. If you were born outside of the U. S., at what age did you immigrate to the U.S.? \_\_\_\_\_
8. What generation are you? (Please circle the one that represents you)
  - 1        1st Generation = I was born in another country other than U.S.
  - 2        2nd Generation = I was born in U.S., either parent was born in another country other than U.S.
  - 3        3rd Generation = I was born in U.S., both parents were born in U.S, and all grandparents were born in another country other than U.S.

- 4 4th Generation = I was born in U.S., both parents were born in U.S, and at least one grandparent born in another country other than U.S. and one grandparent was born in U.S.
- 5 5th Generation = I was born in U.S., both parents were born in U.S., and all grandparents also born in U.S.
- 6 Don't know what generation best fits since I lack some information.

9. How many years of education have you completed? \_\_\_\_\_

10. Have you ever participated in counseling?                      Yes      No

11. Have you ever received mental health services?              Yes      No

12. What is your approximate INDIVIDUAL annual income? \_\_\_\_\_

13. What is your approximate ANNUAL household income? \_\_\_\_\_

## Appendix C

### Self-Stigma of Seeking Help Scale (SSOSH)

**People at times find that they face problems that they consider seeking help for. This can bring up reactions about what seeking help would mean. Please use the 5-point scale to rate the degree to which each item describes how you might react in this situation. Circle each answer.**

	Strongly Disagree	Disagree	Equally Agree & Disagree	Agree	Strongly Agree
1. I would feel inadequate if I went to a therapist for psychological help.	1	2	3	4	5
2. My self-confidence would NOT be threatened if I sought professional help.	1	2	3	4	5
3. Seeking psychological help would make me feel less intelligent.	1	2	3	4	5
4. My self-esteem would increase if I talked to a therapist.	1	2	3	4	5
5. My view of myself would not change just because I made the choice to see a therapist.	1	2	3	4	5

- |     |   |   |   |   |   |   |
|-----|---|---|---|---|---|---|
| 6.  | It would make me feel inferior to ask a therapist for help.   | 1 | 2 | 3 | 4 | 5 |
| 7.  | I would feel okay about myself if I made the choice to seek professional help.                          | 1 | 2 | 3 | 4 | 5 |
| 8.  | If I went to a therapist, I would be less satisfied with myself.  | 1 | 2 | 3 | 4 | 5 |
| 9.  | My self-confidence would remain the same if I sought professional help for a problem I could not solve. | 1 | 2 | 3 | 4 | 5 |
| 10. | I would feel worse about myself if I could not solve my own problems.                                   | 1 | 2 | 3 | 4 | 5 |

APPENDIX D

Social Distance Scale (SDS)

**The following is a series of questions regarding your feelings toward interacting with individuals with mental health problems. People differ in their attitudes toward mental health problems, and there is no right or wrong answer. You will probably be willing on some items and unwilling on others. I am interested in your views. First impressions are usually best in such matters.**

**Use the numbers given below to indicate how much you agree or disagree with each statement. Circle each answer.**

---

	Definitely Willing	Probably Willing	Probably Unwilling	Definitely Unwilling
1. How would you feel about renting a room in your home to a person with a mental health problem?	0	1	2	3
2. How about as a worker on the same job as a person with a mental health problem?	0	1	2	3
3. How would you feel having a person with a mental health problem as a neighbor?	0	1	2	3
4. How about as the caretaker of your children for a couple of hours?	0	1	2	3



- |   |   |   |   |   |
|---|---|---|---|---|
| 5. How about having your children marry a person with a mental health problem?  | 0 | 1 | 2 | 3 |
|   |   |   |   |   |
| 6. How would you feel about introducing a person with a mental health problem to someone you are friends with?          | 0 | 1 | 2 | 3 |
|   |   |   |   |   |
| 7. How would you feel about recommending a person with a mental health problem for a job working for a friend of yours? | 0 | 1 | 2 | 3 |
|   |   |   |   |   |
| 8. How would you feel about renting an apartment to a person with a mental health problem?                              | 0 | 1 | 2 | 3 |

APPENDIX E

The Multigroup Ethnic Identity Measure - Revised (MEIM-R)

**In this country, people come from a lot of different cultures and there are many different words to describe the different backgrounds or *ethnic groups* that people come from. Some examples of the names of ethnic groups are African-American, Anglo-American, Asian-American, European-American, Hispanic and Native-American. Every person is born into an ethnic group, or sometimes two groups. However, people differ on how important their ethnicity is to them, how they feel about it, and how much their behavior is affected by it. These questions are about your ethnicity or your ethnic group and how you feel about it or react to it.**

**Please fill in:**

**In terms of ethnic group, I consider myself to be:**

**Use the numbers given below to indicate how much you agree or disagree with each statement. Circle each answer.**

	Strongly Disagree	Disagree	Equally Agree & Disagree	Agree	Strongly Agree
1 I have spent time trying · to find out more about my ethnic group, such as its history, traditions, and customs.	1	2	3	4	5
2 I have a strong sense of · belonging to my own ethnic group.	1	2	3	4	5
3 I understand pretty well · what my ethnic group membership means to me.	1	2	3	4	5

- |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|
| 4 | I have often done<br>. things that will help me<br>understand my ethnic<br>background better. | 1 | 2 | 3 | 4 | 5 |
| 5 | I have often talked to<br>. other people in order to<br>learn more about my<br>ethnic group.  | 1 | 2 | 3 | 4 | 5 |
| 6 | I feel a strong<br>. attachment towards my<br>own ethnic group.                               | 1 | 2 | 3 | 4 | 5 |

APPENDIX F

Brief-Perceived Ethnic Discrimination Questionnaire-Community Version  
(Brief PEDQ-CV)

**How often have any of the things listed below happened to you, because of your ethnicity?**

**BECAUSE OF YOUR ETHNICITY/RACE ...**

<b>How often.....</b>	<b>Never</b>		<b>Sometimes</b>		<b>Very Often</b>
1. Have you been treated unfairly by teachers, principals, or other staff at school?	1	2	3	4	5
2. Have others thought you couldn't do things or handle a job?	1	2	3	4	5
3. Have others <b>threatened</b> to hurt you (ex: said they would hit you)?	1	2	3	4	5
4. Have others <b>actually</b> hurt you or tried to hurt you (ex: kicked or hit you)?	1	2	3	4	5
5. Have policemen or security officers been unfair to you?	1	2	3	4	5
6. Have others <b>threatened</b> to damage your property?	1	2	3	4	5
7. Have others <b>actually</b> damaged your property?	1	2	3	4	5

- |     |  |   |   |   |   |   |
|-----|--|---|---|---|---|---|
| 8.  | Have others made you feel like an outsider who doesn't fit in because of your dress, speech, or other characteristics related to your ethnicity? | 1 | 2 | 3 | 4 | 5 |
| 9.  | Have you been treated unfairly by co-workers or classmates?  | 1 | 2 | 3 | 4 | 5 |
| 10. | Have others hinted that you are dishonest or can't be trusted?   | 1 | 2 | 3 | 4 | 5 |
| 11. | Have people been nice to you to your face, but said bad things about you behind your back?   | 1 | 2 | 3 | 4 | 5 |
| 12. | Have people who speak a different language made you feel like an outsider?   | 1 | 2 | 3 | 4 | 5 |
| 13. | Have others ignored you or not paid attention to you?  | 1 | 2 | 3 | 4 | 5 |
| 14. | Has your boss or supervisor been unfair to you?  | 1 | 2 | 3 | 4 | 5 |
| 15. | Have others hinted that you must not be clean?   | 1 | 2 | 3 | 4 | 5 |
| 16. | Have people not trusted you?   | 1 | 2 | 3 | 4 | 5 |
| 17. | Has it been hinted that you must be lazy?  | 1 | 2 | 3 | 4 | 5 |

APPENDIX G

Linguistic Proficiency Subscale  
(from the Bidimensional Acculturation Scale for Hispanics BAS)

**Please read the following questions regarding your language ability. Circle each answer.**

	Very Poorly	Poorly	Well	Very Well
1. How well do you speak English?	1	2	3	4
2. How well do you read English?	1	2	3	4
3. How well do you understand television programs in English?	1	2	3	4
4. How well do you understand radio programs in English?	1	2	3	4
5. How well do you write in English?	1	2	3	4
6. How well do you understand music in English?	1	2	3	4
7. How well do you speak Spanish?	1	2	3	4
8. How well do you read in Spanish?	1	2	3	4
9. How well do you understand television programs in Spanish?	1	2	3	4
10. How well do you understand radio programs in Spanish?	1	2	3	4
11. How well do you write in Spanish?	1	2	3	4
12. How well do you understand music in Spanish?	1	2	3	4