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THE RELATIONSHIP BETWEEN MEXICAN AMERICAN COLLEGE
STUDENTS’ LEVEL OF ACCULTURATION, ATTRIBUTIONS FOR
PSYCHOLOGICAL DISTRESS, AND UTILIZATION OF PROFESSIONAL
MENTAL HEALTH SERVICES

DISSERTATION

Presented in Partial Fulfillment of the Requirements for
the Degree of Doctor of Philosophy in the Graduate
School of the Ohio State University

By

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1995

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To Jessica

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CHAPTER I
INTRODUCTION

The underutilization of mental health services by Mexican Americans has been consistently documented for over 30 years. This pattern has been noted for community mental health centers and hospital settings (Edgerton & Kano, 1971; Jaco, 1959,1960; Kamo & Edgerton, 1969; Padilla, Ruiz, & Alvarez, 1975; Ruiz & Padilla, 1977; Wells, Hough, Golding, Burnam, & Kano, 1987), as well as university counseling centers (Ruiz, Casas, & Padilla, 1977; Ruiz & Padilla, 1977; Sanchez & King, 1986). It should be explained here that “underutilization” refers to a lower rate of mental health service use than would be expected given a groups’ prevalence in the total population. As Acosta (1979a) and Newton (1978) have noted, this underuse of services seems paradoxical given the high degree of stress related to social and economic hardship experienced by many Mexican Americans. When one considers that African Americans, a population with a long history of oppression in this country, have been found to be adequately and even overrepresented as clients in the mental health system (e.g., Acosta, 1979a; Cheung & Snowden, 1990; Yamamoto & Silva, 1987), the state of affairs with regard to Mexican Americans is even more intriguing. Mexican Americans have been forced to endure a hostile, stressful and oppressive environment (e.g., Chapa & Valencia, 1993). Why has this population not sought relief by going to mental health professionals?

Several explanations have been posited to explain Mexican Americans’ underutilization of mental health services. Jaco (1959) suggested that the strong emotional support system provided by the Mexican American family predisposed these individuals to
have fewer emotional problems and psychiatric disorders than might be expected. More recent research, however, suggests that Mexican Americans experience psychological distress at a rate at least comparable to, and sometimes higher than, that of the general population (e.g., Griffith, 1985; Kamo, Burnam, Hough, Escobar, & Golding, 1987; Roberts, 1980).

Rogler, Malgady, and Rodriguez (1989) recently identified two major theories of Mexican American mental health service underutilization: alternative resource theory and barrier theory. According to alternative resource theory, Mexican Americans in need of mental health services seek out culturally familiar sources of help such as family, spiritual leaders, folk healers ("curanderos"), and physicians rather than mental health professionals. Alternatively, proponents of barrier theory view mental health service underutilization as the result of barriers that keep Mexican Americans away from professional mental health services. According to Rogler et al. (1989), cultural and institutional barriers may keep Mexican Americans from seeking services. Cultural barriers are aspects of Mexican culture, such as values and beliefs, which may make it difficult for its members to seek professional psychological help. Institutional barriers refer to characteristics of the mental health service delivery system which keep Mexican Americans from utilizing its services. One example of an institutional barrier is the absence of Spanish-speaking or culturally sensitive mental health professionals.

The above explanations all have some degree of utility in explaining Mexican Americans' underutilization of mental health services. Ultimately, some integration of alternative resource theory and barrier theory may provide a more comprehensive framework for examining this problem (Rogler et al., 1989). Before accepting this premise, however, empirical evidence for each theory must be generated.

Various components of alternative resource theory and barrier theory have been empirically examined. Research on alternative resource theory has identified several
important cultural elements. The extended family generally functions as an important support system for Mexican Americans (Keefe, 1978; Keefe & Casas, 1978, 1980; Keefe, Padilla, & Carlos, 1978); Mexican Americans tend to seek out physicians for help with psychological problems (Acosta, 1979a, 1984; Barerra, 1978; Wells et al., 1987); and the use of “curanderos” in place of formal health care among Mexican Americans is minimal (Acosta, 1979a; Barerra, 1978; Keefe, 1978; Keefe & Casas, 1978, 1980). The abundance of recent research addressing institutional barriers such as a lack of culturally sensitive mental health professionals (e.g., Atkinson, Casas, & Abreu, 1992; López, López, & Fong, 1991; Ponce & Atkinson, 1989) reflects an ongoing interest in this area, as well as a commitment to eliminate these barriers. There is little doubt that institutional barriers exist, which make it difficult for Mexican Americans to seek psychological services. As Rogler et al. (1989) have noted, we cannot expect people to seek help in agencies where they are not understood, and where their culture is not acknowledged and respected.

Knowledge of cultural barriers is less developed than that of institutional barriers and alternative resources. The hypothesis that Mexican Americans share culturally bound attitudes and beliefs about emotional disorder that prevent them from seeking mental health services has received mixed support. Karno and Edgerton (1969) found few differences in the ways that Mexican Americans and Anglos perceive and define mental illness. They concluded that “The underutilization of psychiatric facilities by Mexican Americans . . . is not to be accounted for by the fact that they share a cultural tradition which causes them to perceive and define mental illness in significantly different ways than do Anglos” (p. 237). As Parra and Yiu-Cheong So (1983) noted, the validity of this statement has seldom been questioned. More recent evidence, however, indicates that Mexican Americans may perceive mental illness in a way that inhibits them from seeking professional psychological help (Jenkins, 1988; Keefe, 1978; Newton, 1978). Furthermore, as Acosta (1979a, 1984)
noted, research on Mexican Americans’ perceptions of psychological problems has been concerned primarily with severe psychiatric disorders such as schizophrenia and major depression. According to Acosta, it is not clear how Mexican Americans perceive less severe psychological problems that would not necessarily be classified as “mental illness.”

A number of writers, including Jenkins (1988) and Newton (1978) have discussed the stigma associated with psychological distress in Mexican culture. Jenkins (1988) observed that Mexican Americans often go to great lengths to avoid using potentially stigmatizing labels such as schizophrenia. As, according to these writers, weak or vulnerable individuals are generally considered to be the ones most likely to develop emotional or mental disorders, it is understandable that Mexican Americans may be reluctant to adopt such labels. According to Newton, Mexican culture dictates that people resolve their problems before they become more severe; seeking psychological help is a source of shame for many Mexican Americans, because this signifies weakness and an inability to deal with one’s own problems. Other writers (e.g., Castro, Furth, & Karlow, 1984; Cohen, 1985) have discussed the Latino concept of “controlarse,” or the excercise of control and discipline employed by the individual over negative mood states related to unpleasant environmental stressors.

It seems questionable to presume that Mexican Americans’ underuse of mental health services is not shaped, at least in part, by cultural perceptions and attitudes regarding emotional disorder and its implications for individuals. If Mexican Americans see psychological problems and formal help seeking as signs of personal weakness, reluctance to admit needing help would be understandable.

Atkinson, Thompson, and Grant (1993), writing about roles that counselors can take with racial/ethnic minority clients, discussed a problem etiology continuum ranging from internal to external. According to Atkinson et al., many problems that racial/ethnic minority individuals experience which initially appear to have an internal source (i.e.,
depression, feelings of inadequacy) can be traced to external sources such as societal discrimination and oppression. These authors stated that, for minority individuals who are low in acculturation and who have limited experience dealing with mainstream American culture, such external stressors may not be easily recognized. Applying the thinking of Atkinson et al. to Mexican Americans and their tendency to view psychological disorder as a sign of weakness, it would seem that Mexican Americans (particularly those closely connected to Mexican culture), despite being in a stressful environment, might tend to overlook environmental contributions to their psychological problems. These individuals might instead attribute their problems to internal character flaws such as weakness or inability to effectively deal with life's challenges.

Mexican Americans experience a significant number of environmentally imposed hardships. Mexican American college students are in the unique position of having to endure both the emotional difficulties typically faced by many non-minority college students (e.g., Hammen, 1980; O'Brien & Krames, 1988; Oliver & Burkham, 1979), as well as problems unique to the experience of racial/ethnic minorities in majority-dominated institutions. Mexican American college students experience significantly greater levels of stress than do their Anglo counterparts (Munoz, 1986; Nájera, 1990). The stress experienced by this population appears to be taking its toll, as Mexican Americans are more likely than African Americans or Caucasians to drop out of college (Barón, 1991; Chapa & Valencia, 1993; Pérez & Salazar, 1993). Mexican Americans underutilize mental health services at university counseling centers, as well as in the community at large. Since Mexican American college students are at high risk for psychological distress, their underutilization of psychological services in this setting warrants examination.

The purpose of the present study was to increase our knowledge regarding cultural barriers that Mexican Americans face, which may inhibit them from seeking professional mental health services. Specifically, this study addressed three areas: (a) the degree to
which Mexican American college students attribute psychological problems to internal shortcomings or external stressors; (b) whether such attributional tendencies are related to attitudes toward and use of mental health services; and (c) whether such tendencies are a function of Mexican Americans' degree of cultural affiliation.
CHAPTER II
LITERATURE REVIEW

Ethnic Labels

Throughout the literature, various terms have been employed to refer to the Mexican American population; therefore, a brief discussion of ethnic labels may help to minimize confusion. The terms “Hispanic,” “Latino(a),” “Chicano(a),” and “Mexican American” are the ethnic labels used most frequently to refer to this population. The terms “Hispanic” and “Latino(a)” are generally used to describe persons having ethnic origins in Cuba, Mexico, Puerto Rico, and Central and South America, while “Chicano(a)” and “Mexican American” are more specific terms, used to refer only to people having ethnic origins in Mexico (Barón, 1991). As Barón has noted, ethnic labels tend to vary historically in terms of acceptability; currently, both “Hispanic” and “Latino(a)” are used, although Chapa and Valencia (1993) noted that “Latino(a)” is growing in preference. Barón indicated that “Chicano(a),” previously used pejoratively against Mexican Americans, has been transformed into a positive label. “Chicano(a)” and “Mexican American” tend to be used interchangeably now, although the latter term seems to be employed more frequently.

The Mexican American Population

While the Mexican American population is not the only Latino subgroup known to underutilize mental health services, most knowledge in this area stems from research with this group (Rogler et al., 1989). Research on Mexican Americans rather than other Latino subgroups is due to several factors. First, a large number of Mexican-origin persons now reside in this country. The most recent (1990) U.S. Census figures reported the total
Latino population to exceed 22 million, or 9% of the total U.S. population; this figure represents a 53% increase since 1980 (Chapa & Valencia, 1993). The Mexican American population is the largest subgroup, comprising over 60% of all Latinos. Second, the large geographical distribution of the Mexican American population, which is located predominantly in the southwest and midwest, also makes this a more accessible group to study. Finally, Mexican Americans are the most socially and economically disadvantaged Latinos (Chapa & Valencia, 1993; Pérez & Salazar, 1993). Given the fact that the Latino population as a whole is a group with marginal status in this country (Chapa & Valencia, 1993), it is clear that Mexican Americans are in an extremely disadvantaged position, putting them at high risk for psychological distress. Thus, their underuse of mental health services is a troubling observation.

**Gender Differences and Mental Health Service Utilization**

Women have been found to hold more favorable attitudes toward counseling and mental health services than men (Fischer & Turner, 1970), and to be more likely to seek such services than men (Robertson & Fitzgerald, 1992). Despite Barón's (1991) indication that “help-seeking is contrary to the traditional [Mexican American] male orientation of self-sufficiency and control” (p. 180), gender differences have seldom been explored when examining Mexican Americans' utilization of mental health services. There is evidence, however, that suggests gender to be an important variable to consider when looking at this population's utilization of services. Sanchez and Atkinson (1983) found Mexican American women to hold significantly more favorable attitudes toward using counseling services than Mexican American males. Similarly, Sanchez and King (1986) found that Mexican American women were more willing to use counseling services than their male counterparts. In light of these findings, it is important to take gender into consideration when assessing Mexican Americans' utilization of mental health services.
The central purpose of this study is to examine how Mexican Americans look at psychological problems, whether their views contribute to the utilization of psychological services, and whether their views are related to their degree of cultural affiliation, or acculturation. Thus, one global question is whether or not Mexican Americans’ tendency to use mental health services is indirectly related to their degree of embeddedness within Mexican culture. This question underlies not only cultural barriers, but the other major explanations of Mexican American underutilization of mental health services as well. Presumably, the more Mexican Americans identify with their culture (to the exclusion of the majority culture), the more likely they might be to seek help from family or indigenous folk healers rather than mental health professionals. Similarly, the more Mexican Americans identify with their culture, the more likely they might be to avoid mental health facilities that lack Spanish-speaking professionals. Given the possible importance of acculturation to mental health service utilization, it is surprising that few studies have addressed this relationship.

According to Rogler et al. (1989), acculturation refers to “the complex process whereby the behaviors and attitudes of a migrant [minority] group change toward the dominant group as a result of exposure to a cultural system that is significantly different” (p. 5). Negy and Woods (1992) stated that “those of non-Anglo American backgrounds are said to have become acculturated to the American life-style when they have acquired the language, customs, values, and so on of the Anglo-American culture” (p. 224). Acculturation is a complex, multidimensional process. Casas and Vasquez (1989) noted that the process of acculturation is bidirectional; its direction can be reversed; and its rate can be halted, slowed, or accelerated, depending on numerous factors such as prevailing sociopolitical and economic conditions and access to high-quality education.
Some writers (e.g., Buriel, 1984; Ramirez, 1984) have argued that prevailing models of acculturation are actually nothing more than models of assimilation, where aspects of one's original culture are gradually replaced with aspects of the host culture. Such a model tends to ignore people who are bicultural and, to varying degrees, functional in both cultures. Such a model implicitly assumes that complete assimilation is the ultimate goal of racial/ethnic minorities. While there is little doubt that some degree of familiarity with the host culture is beneficial for racial/ethnic minorities attempting to function in this society, the importance of maintaining some degree of integration with their original culture is recognized (Buriel, 1984; Negy & Woods, 1992; Ramirez, 1984; Rogler, Cortes, & Malgady, 1991). These authors argued that complete assimilation into the dominant society alienates people from their traditional support groups, and at the same time facilitates the internalization of damaging stereotypes and prejudiced attitudes held by the dominant society. While some degree of acculturation is probably functional and necessary for survival, complete assimilation appears to be detrimental.

A central (but frequently unasked) question underlying the major explanations of Mexican Americans' mental health service underutilization is whether unacculturated individuals are less likely to seek professional services than are those who are more acculturated. While recent studies (i.e., Atkinson et al., 1992; López et al., 1991; Ponce & Atkinson, 1989) have linked acculturation to factors believed to influence Mexican Americans' utilization of psychological services, such as perceptions of counselor credibility and competence, few have addressed the more basic issue of whether acculturation is related to use of services.

A few studies have assessed the role of acculturation in Mexican Americans' patterns of mental health service use. Keefe (1978) examined Mexican Americans who had been in contact with mental health services versus those who had not. She hypothesized that those who had been in contact would be less integrated into the ethnic subcommunity,
reflect a lack of cultural conformity, be English speaking and more acculturated. Keefe found only language usage to be significantly related to clinic contact, leading her to conclude that "level of acculturation in general is not associated very strongly with mental health clinic contact" (p. 101). Since Keefe's study, however, use and mastery of the English language have consistently been identified as key components of acculturation (Cuellar, Harris, & Jasso, 1980; Rogler et al., 1991). Thus, her conclusion is questionable, given that a significant indicator of acculturation (knowledge and use of the English language) was related to mental health service contact.

In a large-scale study of the utilization of health services in Los Angeles, Wells et al. (1987) collected data regarding acculturation, psychological distress, and mental health service utilization from over 3,000 Mexican Americans and Anglo Americans. They found that Mexican Americans, particularly the less acculturated, were significantly less likely to utilize mental health services than were Anglo Americans. This finding held even for those with psychiatric disorders. Wells et al. also found that less acculturated Mexican Americans relied more on medical providers for mental health care than either more acculturated Mexican Americans or Anglo Americans.

Sanchez and Atkinson (1983) indirectly assessed the role of acculturation in mental health service utilization by examining Mexican Americans' attitudes toward the use of professional counseling services. These investigators found that those with a strong commitment to only the Mexican American culture (i.e., those low in acculturation) had less favorable attitudes toward counseling.

Although some support exists for the hypothesis that acculturation is related to mental health service utilization, more research is necessary. As some writers (e.g., Keefe & Casas, 1978; Padilla & Lindholm, 1984) have indicated, much of the research involving Mexican Americans has not attended to the cultural variability that exists within this population. When examining reasons for Mexican Americans' underuse of psychological
services, it is important to ascertain whether cultural variability is a moderating variable affecting underutilization. If Mexican Americans' acculturation (cultural variability) is a factor in mental health service utilization, it should be incorporated into research on this phenomenon.

Acculturation is relevant to the issue of interest in this study—that is, whether Mexican Americans share culturally bound beliefs about psychological distress which inhibit their use of mental health services. If acculturation is related to utilization, then perhaps the existence of such cultural barriers can help to explain this relationship. The following section addresses research that has explored Mexican Americans' perceptions of and attitudes toward psychological disorder.

**Mexican Americans' Perceptions of Psychological Disorder**

Understanding of cultural barriers to the mental health service utilization of Mexican Americans is extremely limited. Current research focuses on identifying aspects of the mental health service delivery system that discourage Mexican American utilization. Examination of the scant research on cultural barriers, however, reveals that cultural values and beliefs may play an important role in how certain Mexican Americans see psychological problems and subsequent help-seeking.

Although Kamo and Edgerton's (1969) study was conducted almost a quarter of a century ago, their conclusions still seem to be accepted without question (e.g., Rogler et al., 1989). Kamo and Edgerton examined Mexican Americans' and Anglos' perceptions of mental illness. They interviewed over 600 individuals regarding their reactions to short vignettes depicting people suffering from various psychiatric disorders. Although the investigators found "remarkably few statistically significant differences between the interview responses of Mexican Americans and Anglos involving perceptions and definitions of mental illness" (p. 237), some interesting differences were noted. In response to the vignettes describing persons with major depression and schizophrenia,
Mexican Americans were more likely than Anglos to state that they were ill, and to recommend the care of a physician. The authors also reported that considerably more Mexican Americans believed that mental disorders begin in childhood.

The conclusion of Kamo and Edgerton (1969) that Mexican Americans' underuse of mental health services is not due to differing perceptions of mental illness seems questionable given the differences that were obtained. Furthermore, stating that "in an introductory report of this kind, it is possible to discuss only a few of our findings" (p. 236), the investigators only reported subjects' responses to vignettes describing people with relatively severe disorders, even though other vignettes (e.g., marital discord, delinquent behavior) were also employed. Given these omissions, Kamo and Edgerton's conclusion seems even more suspect.

Edgerton and Kamo (1971), employing the same data set used in Kamo and Edgerton's (1969) study, examined differences within the Mexican American group. The investigators found that the language spoken during the interview was the variable which best discriminated among the Mexican Americans' responses to the vignettes. With language considered, considerable differences within the sample were noted. Spanish speaking participants considered depression to be more serious, and were more likely to describe the depressed person as suffering from a "nervous" condition (as opposed to "loneliness" for English speakers). When responding to a vignette describing a juvenile delinquent adolescent, English speakers identified the cause as being in the parent-child relationship, whereas Spanish speakers held the child responsible. Spanish speakers were significantly more likely to believe that mental illness is inherited, and that prayer could cure mental illness.

Edgerton and Kamo's (1971) findings regarding language differences within the Mexican American sample illustrate the importance of considering within-group differences
when studying this group's perceptions of mental disorder. Cultural differences that contributed to differing perceptions existed within their sample of Mexican Americans.

Silva de Crane and Spielberger (1981) investigated attitudes toward mental illness among Hispanic, Black and Caucasian college students by administering a scale designed to assess affective and cognitive components of attitudes toward mental illness. Hispanics and Blacks exhibited more negative attitudes toward mental illness than Caucasians, as measured by affective components of attitudes (i.e., how they felt about mental illness and those afflicted). No differences were found between Hispanics and Caucasians on cognitive components of attitudes (i.e., how they perceived and defined mental illness). The authors noted that their findings concerning perceptions and definitions were similar to those of Kamo and Edgerton (1969), whose study of perceptions of mental illness seemed to assess only cognitive components of attitudes. Thus, the consideration of affective, as well as cognitive, components appears to be critical when examining racial/ethnic minorities' attitudes toward mental illness.

Silva de Crane and Spielberger (1981) suggested that their results could account for Hispanic underutilization of mental health services, in that the data obtained from this group indicated a tendency to view people with mental illness as being inferior or abnormal. A limitation of this study, however, is that differences both between and within Hispanic subgroups were not taken into account. Given the heterogeneity of the Hispanic group, such an oversight limits the generalizability of the findings. Silva de Crane and Spielberger's findings do, however, fit into an emerging pattern. Kamo and Edgerton (1969) and Edgerton and Kamo (1971) found that Mexican Americans—particularly those who were interviewed in Spanish—considered people's problems to have originated within themselves; that is, they described the people in the vignettes as being ill or in some other way responsible for their problems. The Spanish-speaking Mexican Americans also tended to believe that mental illness is inherited—another indication that they perceived the
problems of disturbed individuals to originate within themselves. Given the findings obtained by Kamo and Edgerton, Silva de Crane and Spielberger’s suggestion that their sample of Hispanics viewed people with mental illness as inferior is plausible.

Parra and Yiu-Cheong So (1983) investigated the changing perceptions of mental illness in a Mexican American community. Employing telephone interviews generated from random digit dialing, these investigators sought responses to vignettes describing persons suffering from varying degrees of psychiatric disorder. Those subjects that they termed being of the “Chicano generation”—Mexican American persons born and educated in the U.S.—perceived mental illness in a unique way from other (older, less acculturated) Mexican Americans. Specifically, individuals of the Chicano generation had narrower definitions of mental illness, and were more reluctant than others to label certain behavior as mental illness.

Parra and Yiu-Cheong So (1983) explained their results by saying that the Chicanos have “assimilated the American dream of equal opportunity and upward mobility . . . the high aspirations of the Chicano generation, however, fail to be realized” (p. 99). The authors suggested that, since these individuals may experience a higher degree of frustration and alienation, they may be less likely to label certain behavior as reflecting mental illness. Perhaps the highly acculturated Chicanos, being familiar with living in an oppressive society, were willing to attribute disturbed behavior to external rather than internal forces.

Parra (1985) took a different approach in assessing Mexican Americans’ attitudes toward mental illness, and measured social tolerance toward the mentally ill. Using the same telephone interview method employed by Parra and Yiu Cheong-So (1983), Parra questioned respondents about varying degrees of possible interaction with hypothetical persons suffering from mental illness. As with Edgerton and Kamo (1971) and Parra and Yiu-Cheong So (1983), Parra (1985) found differences with respect to indicators of
acculturation. Better educated Mexican Americans were more tolerant than those with less education, and younger respondents were more tolerant than older respondents. A gender effect was also found. Women were less tolerant of the mentally ill than were men, and women with less education were the least tolerant of all. Again, there were indications that Mexican Americans might view psychological disturbance in different ways, depending on their level of acculturation.

Jenkins (1988), exploring Mexican Americans' and Anglo Americans' conceptions of psychosis within families, interviewed relatives of patients who had returned home following psychiatric hospitalization for an acute psychotic episode. The relatives were interviewed to ascertain their interpretations of the patients' illnesses. The Mexican Americans, who obtained relatively low scores on an acculturation rating scale, conceptualized the problem as one of nerves, or "nervios," while the majority of the Anglo American relatives characterized the problem as being some type of mental or psychiatric disorder. Jenkins suggested that "Mexican American notions of mental illness are often too extreme for families to consider them appropriate for their relatives" (p. 1240). "Nervios," the investigator explained, is a less threatening and stigmatizing label than is a term like "mental illness" or "schizophrenia," as it is often used broadly to refer to persons who are distressed over difficult life circumstances. Jenkins' findings lend further support to the hypothesis that Mexican Americans low in acculturation tend to attach stigma to psychological disturbance.

In summary, Mexican Americans low in acculturation tend to see psychological problems as originating within and being the responsibility of the person (Edgerton & Kamo, 1971; Kamo & Edgerton, 1969), perhaps leading them to consider those afflicted as being abnormal (Silva de Crane & Spielberger, 1981) and therefore less tolerable and more stigmatized (Jenkins, 1988; Parra, 1985). More highly acculturated Mexican Americans seem less likely to attribute responsibility to and think negatively about a person
exhibiting deviant behavior (Parra & Yiu-Cheong So, 1983), and more likely to see that behavior as reflecting something more temporary and changeable—such as an aversive reaction to stressful or difficult life circumstances.

A study by Newton (1978) may illuminate the above findings, and how this type of thinking may contribute to Mexican Americans’ underutilization of mental health services. Using a qualitative research approach, Newton investigated the Mexican American emic system of mental illness and its effect on attitudes concerning the utilization of mental health services. Twenty-three first through fourth (primarily first and second) generation Mexican Americans were asked open-ended questions about various aspects of their beliefs, primarily focusing on their perceptions, definitions and feelings about psychological disorder, and attitudes about potential sources of help for psychological distress. A modal analysis in response to the questions was employed. Regarding perceptions of psychological disorder, all respondents mentioned two factors: emotional problems versus mental problems, and strong versus weak. Emotional problems were considered to be less serious, representing the initial stage on the continuum of severity which eventually lead to mental problems. Emotional problems were thought to be amenable to “talking it out with someone” while the problem was at this stage. If the problem was not resolved, the person was in danger of developing a mental problem. Inability to cope, loss of self-control, and loss of contact with reality were the principle defining features of a mental problem. The concept of strong versus weak occupied a central and critical position in the respondents’ emic system of psychological distress. Newton stated: “All respondents considered the binary concept of strong-weak to be a principle factor in the etiology and prognosis of mental disorders. That is, the strength of a person’s character directly influences the probability of developing a mental problem” (p. 78). According to this belief system, weak individuals are more susceptible to developing emotional problems which progress to mental disorders. Strong individuals, on the other hand, are more likely to be able to
effectively deal with their problems before they develop into emotional problems; when emotional problems do develop, however, strong individuals are thought to be more capable of controlling the problem before it becomes serious.

The concepts of emotional-mental and strong-weak also figured prominently in Newton's (1978) exploration of the respondents' help-seeking attitudes. Generally, the "proper" response to an emotional problem was to deal with it on one's own. If self-help failed to resolve the problem, talking with a family member or friend was recommended. Seeking professional help was endorsed as the problem moved along the severity continuum. Physicians were the first professionals recommended, progressing through psychotherapists and ending with institutionalization. According to Newton, pride was an important variable in the strong-weak conceptualization of character. Seeking professional help was viewed as admitting inability to deal with problems. These respondents indicated that pride often prevented the seeking of professional help.

Newton's (1978) study illuminates the thinking processes of Mexican Americans regarding how they perceive those suffering from psychological distress. A consistent finding in this literature—that certain Mexican Americans (particularly those low in acculturation) tend to hold individuals responsible for their distress—is illustrated in a quote from Newton:

The critical point is that the respondents tend to conceive of the individual as being largely responsible for his own psychological state. They recognize that life presents many difficult problems and stresses . . . . The respondents consistently expressed the belief that, although emotional problems are understandable and to be expected, given the nature of life, it is primarily up to individuals to deal with these problems and to maintain control of their emotions and mental functioning. (p. 80)
The above quote suggests why many Mexican Americans might avoid professional help. The Latino concept of “controlarse” (Castro et al., 1984; Cohen, 1985) appears to be an important motivational force in Mexican culture. Any indication of weakness or inability to live up to one’s expectations—as a visit to a mental health professional seems to imply—might be perceived as shameful and thus avoided.

In conclusion, the research examined in this review counters Karno and Edgerton’s (1969) discounting of cultural barriers on Mexican Americans’ underutilization of mental health services. Some evidence suggests the existence of cultural beliefs which may inhibit Mexican Americans’ use of psychological services.

**Objectives of the Study**

The purpose of this study was to further our understanding of Mexican American cultural beliefs and norms that may keep segments of this population from utilizing potentially helpful professional resources. Over the past 25 years, research in this area has been sparse; the available evidence, however, justifies further empirical investigation.

Research suggests that perceived locus of problem etiology is an important dimension in Mexican Americans’ attitudes toward psychological distress and mental health service utilization. Coupled with the observation that Mexican Americans experience severe stress and environmental hardship in this society, it seems logical to conceptualize Mexican Americans’ perceptions of psychological disorder along an internal-external continuum. Thus, the central questions of interest are: (a) Do Mexican Americans who are relatively embedded within their culture tend to attribute psychological problems to internal (i.e., weakness of character, inability to deal with life’s problems) rather than external (i.e., environmental stress, racism/discrimination) factors? And, (b) Do such attributions have an impact on their decision to seek or avoid professional mental health services? Mexican American college students are especially at risk to develop emotional difficulties—those typically faced by college students in general and those faced by ethnic minorities in
majority-dominated institutions. Thus, the Mexican American college student population warrants attention with regard to mental health service underutilization.

As far as this investigator is aware, the impact of Mexican Americans’ attributional tendencies for psychological problems on their willingness to utilize professional mental health services has not previously been studied. This study also addresses several shortcomings of previous research. As Acosta (1979a, 1984) indicated, much of the research conducted on Mexican Americans’ perceptions of psychological problems has been concerned with severe forms of distress. “Mental illness” is a term frequently employed by these studies. As Newton (1978) reported, however, Mexican Americans attribute different meanings to terms such as “mental” and “emotional” (see also Acosta, 1979b). Furthermore, many Mexican Americans who are not utilizing mental health services (such as university students) may experience problems in the less severe range, or problems that would not necessarily be considered “mental illness.” In the present study, although Mexican Americans’ attributions were assessed for psychological problems of differing severity, the problems were validated by university counseling center clinicians to ensure that they reflected concerns typical of Mexican American college students.

The existing research on Mexican Americans’ perceptions of psychological disorder imposes etic concepts onto a culture in which such concepts have not been validated (see Kleinman & Good, 1985; Rogler et al., 1991). For example, vignettes depicting people suffering from a psychiatric disorder as defined by the majority culture have been utilized. There is no way of knowing how much meaning these vignettes have for respondents of another culture. In the present study, the imposition of etic concepts was avoided by having the participants respond to hypothetical Mexican Americans experiencing problems that Mexican Americans have reported experiencing.

Finally, whereas most research has speculated about the relationship between cultural beliefs and attitudes regarding psychological disorder and help-seeking tendencies,
the present study directly tested this relationship. Thus, this study integrates the research on Mexican Americans' perceptions of and attitudes toward mental illness with research examining this population's underuse of psychological services.

**Hypotheses**

The literature suggests (a) the existence of a relationship between the acculturation level of Mexican Americans and their use of professional mental health services; and (b) the existence of a relationship between the acculturation level of Mexican Americans and their tendency to attach stigma to psychological problems, and to attribute such problems to internal, rather than external, factors. Based on these findings and this study's purpose of improving our understanding of cultural barriers to the mental health utilization of Mexican Americans, the following hypotheses were proposed:

1. Participants scoring higher in acculturation will:
   a. be more likely to have had previous mental health service contact
   b. have more favorable attitudes toward seeking professional mental health services
   c. be more likely to endorse professional mental health services for persons experiencing psychological distress than will participants scoring lower in acculturation.

2. Participants scoring higher in acculturation will tend to attribute psychological problems to external factors, while participants scoring lower in acculturation will tend to attribute problems to internal factors.

3. Participants who have had previous mental health service contact will tend to attribute psychological problems to external factors, while participants who have not had mental health service contact will tend to attribute psychological problems to internal factors.

4. Participants who attribute psychological problems to external factors will:
   a. have more favorable attitudes toward seeking professional mental health services
b. be more likely to endorse professional mental health services for persons experiencing psychological distress than will participants who attribute problems to internal factors.

5. Mexican American women will be more likely than men to:
   a. have had previous mental health service contact
   b. have favorable attitudes toward seeking professional mental health services
   c. endorse professional mental health services for persons experiencing psychological distress.

While no directional hypotheses were proposed, differences as a function of (a) gender of the person experiencing the problem, and (b) severity of the problem, were examined with respect to internal and external attributions and endorsement of professional mental health services.

There are a variety of reasons for Mexican Americans' underutilization of mental health services. Ultimately, some integration of the major theories of underutilization is probably going to provide us with the most comprehensive explanation for this problem. Current knowledge and understanding of cultural barriers to Mexican Americans' utilization of services is poor. This study attempted to examine cultural beliefs and perceptions about psychological distress, and the relationship of such beliefs and perceptions to Mexican Americans' attitudes toward and use of professional mental health services. Given the undeveloped state of the knowledge in this area, any enlightenment provided by this study would be of substantial value.
CHAPTER III

METHOD

Participants

The participants were Mexican American college students attending two universities in central Texas. A total of 137 students were recruited, 50 male and 87 female. Fifty percent of the participants came from each institution. Participants were recruited from Hispanic and Mexican American student organizations. In order to limit the sample to Mexican Americans, only students having ethnic origins in Mexico were recruited. There were no generational restrictions. As an incentive, participants were entered into a lottery to win one of two $50 U.S. Savings Bonds. An estimated 60-70% of the students who were solicited agreed to participate in the study.

Instruments and Materials

Solicitation statement. Participants were given a written solicitation (Appendix A) which briefly explained the nature of the study and what they were asked to do. They were informed that their participation was voluntary, that they were free to stop at any time, and that they were free to skip questions they did not wish to answer. Participants were also informed that they were assured only of a chance to win a $50 Savings Bond. The investigator communicated the same information verbally.

Demographic sheet. Participants completed a single page requesting the following demographic information: age, gender, year in college, marital status, religious preference, current living arrangements (i.e., on own, with parents, etc.), and marital status of parents (Appendix B). In order to obtain a thorough description of the sample, the participants
were asked to indicate their father’s and mother’s occupation, and the highest level of
education attained by each parent. Based on the description provided by the participant, the
occupation was coded into one of the following six categories: (a) unskilled/semiskilled,
(b) clerical, (c) technical, (d) administrative, (e) managerial, and (f) executive/professional.
This classification system is based on Hollingshead and Redlich’s (1958) Occupational
Scale, a status-based system of classifying occupations. As noted by Negy and Woods
(1992b), the Hollingshead scale is somewhat outdated due to the shift in status ascribed to
some occupations over the years; therefore, for purposes of this study the scale was
adjusted to more appropriately reflect the current economic status of some occupations (for
example, ‘technical’ was separated from ‘clerical’ and given a higher status ranking).

Acculturation Rating Scale for Mexican Americans (ARSMA). The ARSMA
(Cuellar, Harris, & Jasso, 1980) was developed to measure acculturation in both normal
and clinical populations of Mexican Americans. The ARSMA consists of 20 questions,
each rated on a 5-point Likert scale ranging from extremely Mexican-oriented (1) to
extremely Anglo-oriented (5) (Appendix C). Higher total scores on the scale represent
higher degrees of acculturation. Because missing responses could artificially lower a
participant’s score (Atkinson et al., 1992), an item average score is also computed for each
participant. Based on level of acculturation, the scale differentiates five distinct types of
Mexican Americans: Type 1, very Mexican; Type 2, Mexican-oriented bicultural; Type 3,
“true” bicultural; Type 4, Anglo-oriented bicultural; and Type 5, very Anglicized. For this
study, ARSMA scores were categorized into three levels to reflect differing degrees of
acculturation (low = 1 - 2.3; medium = 2.4 - 3.6; high = 3.7 - 5). Factor analysis yielded
four factors in the ARSMA: (a) Language familiarity, usage, and preference; (b) Ethnic
identity and generation; (c) Reading, writing, and cultural exposure; and (d) Ethnic
interaction. Cuellar et al. (1980) reported a coefficient alpha of .88 for normal
(unhospitalized) subjects, and a test-retest reliability (one month apart) of .80.
Montgomery and Orozco (1984) cross-validated the ARSMA on a sample of Mexican American and Anglo college students in south Texas, and obtained a coefficient alpha of .92. In addition, factor analysis revealed the same four factors identified in the original normative data. Montgomery and Orozco (1984) obtained a relatively normal distribution of ARSMA scores from their Mexican American sample. The ARSMA differentiates between Mexican, Mexican American, and Anglo subjects, as well as between generational level of Mexican Americans. Furthermore, Cuellar et al. (1980) found the ARSMA to demonstrate concurrent validity with the Bicultural Inventory (BI; Ramirez, Cox, & Castaneda, 1977, cited in Cuellar et al., 1980; rho = .81, p < .001) and the Behavioral Acculturation Scale (BAS; Szapocznik, Scopetta, Kurtines, & Arnalde, 1978, cited in Cuellar et al., 1980; rho = .76, p < .001). The ARSMA has been widely used and published in acculturation research with Mexican Americans (Negy & Woods, 1992b).

Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS). The ATSPPHS (Fischer & Turner, 1970) was developed to assess people's attitudes toward seeking professional psychological services. The scale contains 29 items (Appendix D) and includes four subscales: (a) Need (recognition of personal need for professional help); (b) Stigma (tolerance of stigma associated with psychological help); (c) Openness (interpersonal openness regarding one's problems); and (d) Confidence (confidence in the ability of the mental health professional to be of assistance). Each item is rated on a 4-point Likert scale ranging from strongly disagree (1) to strongly agree (4). The ATSPPHS has been found to have internal consistency of .86 and test-retest reliability of .82 (one month apart), and to distinguish mental health facility users from nonusers. In this study, to make the scale more appropriate for a college student population, the words "counselor," "psychological," and "counseling center" have been substituted for "psychiatrist," "psychiatric," and "mental health center" or "clinic," respectively. Thus, the item "I would feel uneasy going to a psychiatrist because of what some people would
think” was changed to “I would feel uneasy going to a counselor because of what some people would think.” This modified version of the ATSPPHS has been used previously with Mexican American college students (Sanchez & Atkinson, 1983) and Asian American college students (Atkinson & Gim, 1989; Atkinson, Ponterotto, & Sanchez, 1984).

**Vignettes.** Assessment of participants’ causal attributions for emotional distress and endorsement of sources of help involved the use of brief written vignettes. This method has been used in previous research examining Mexican American and Japanese American perceptions of and attributions for mental illness (see Edgerton & Kamo, 1971; Kamo & Edgerton, 1969; Narikiyo & Kameoka, 1992; Parra & Yiu-Cheong So, 1983). The present methodology concerning the vignettes was influenced by Narikiyo and Kameoka (1992).

The vignettes that were employed depicted traditionally-aged Mexican American college students in differing degrees of distress. A brief set of instructions (Appendix E) preceded the vignettes. Vignette A (Appendix F) described a student who is experiencing a great deal of environmental stress, and who has begun to experience symptoms of emotional distress such as low self-esteem, depression and anxiety. Vignette B (Appendix G) described a student who is experiencing a great deal of environmental stress, and who has developed more serious symptoms of emotional distress such as severe depression, anxiety and hopelessness. The vignettes were identical, differing only with regard to problem severity. Ruiz et al. (1977) indicated that depression and anxiety tend to be the problems most frequently reported by Chicanos, both in community and university settings; therefore, these two problems were chosen as the primary presenting concerns depicted in the vignettes. In order to examine possible differences as a function of the gender of the person experiencing the problems, half of the vignettes depicted a male, and half depicted a female. Although the vignettes were the authors’ creation, they were based on existing descriptions of Mexican American clients in distress found in the literature.
The content validity of the vignettes was assessed to ensure that they were believable and reflected concerns typical of Mexican American college students. Twenty-four members of the counseling staff at the University of Texas Counseling and Mental Health Center read the vignettes and rated their plausibility on a scale from 1 (not plausible at all) to 5 (highly plausible). To ensure that the vignettes appropriately reflected differing degrees of severity, the counselors were also asked to rate the severity of each vignette on a scale ranging from 1 (not severe at all) to 5 (highly severe). The sample consisted of 10 psychologists, 3 social workers, 3 doctoral-level psychology interns, 1 social work intern, 1 professional counselor, 2 counseling specialists, 2 contract staff members, 1 psychiatrist, and 1 participant who did not indicate his or her professional identity. These professionals had an average of 8.14 years of experience working at a university counseling center, ranging from less than 1 year to 25 years. Staff members individually read vignettes A and B in counterbalanced order to minimize carryover effects between the vignettes. Half of the staff received vignettes depicting a male, and half received vignettes depicting a female. Overall, the participants rated the vignettes as being plausible. For the male vignette, vignette A received a mean rating of 5.0 (SD = 0), while vignette B received a mean of 4.83 (SD = .39). The mean ratings for the female vignette were identical, with vignette A receiving a mean of 5.0 (SD = 0) and vignette B receiving a mean of 4.83 (SD = .58). As might be expected, the vignette describing the more serious (and potentially less frequently encountered) problems was rated as slightly less plausible. With regard to the perceived severity of the vignettes, the staff participants rated the vignettes as differing in the expected direction. For the male vignettes, vignette B was rated significantly more severe (M = 4.25, SD = .62) than was vignette A (M = 3.33, SD = .65), t = 3.68, p < .01. For the female vignettes, vignette B was also rated significantly more severe (M = 4.09, SD = .70) than was vignette A (M = 3.58, SD = .51), t = 2.04, p < .05. Combining the male and
female vignettes, vignette B was rated significantly more severe (M = 4.17, SD = .65) than was vignette A (M = 3.46, SD = .59), t = 4.18, p < .01.

Based on the results obtained with a relatively experienced professional counseling center staff, it was determined that the content validity of the vignettes was satisfactory, that the vignettes were acceptable for use with Mexican American college students, and that vignettes A and B differed in severity in the appropriate direction.

To assess the extent to which the student participants perceived the vignettes to differ in severity, they were asked to rate the vignette that they read on a scale from 1 (not severe at all) to 5 (highly severe). Following the vignette, participants were also asked to rate the likelihood of eight possible attributions for the distress that the person in the vignette was experiencing (Appendix H). Attributions were classified as primarily internal and due to the person (hereditary, physical illness, negative thinking, weakness of character) or external and due to the environment (problems with others, major life changes, school or work-related stress, discrimination or unfair treatment). Participants were asked to rate the likelihood of each possible attribution on scales ranging from 1 (not a cause at all) to 5 (definitely a cause). Following the list of possible attributions, participants were given an opportunity to write down anything that was not mentioned that they felt might have contributed to the distress of the person in the vignette. Following the vignette, participants also rated the potential helpfulness of seven sources of help on scales ranging from 1 (not helpful at all) to 5 (definitely helpful) (Appendix I). The sources of help were self, family, friends, physician, religious leader, faith healer ("curandero"), and mental health professional—resources that the literature (e.g., Keefe & Casas, 1978; Rogler, 1989) suggests Mexican American individuals have traditionally turned to in times of crises and distress. Participants were asked to rate the helpfulness of each source. Participants were again asked to write down any additional sources of help that were not mentioned.
**Assessment of professional mental health contact.** Participants were asked whether they, any member of their immediate family, or any of their friends, were currently in counseling or had ever received counseling or used mental health services in the past (Appendix J).

**Procedure**

The demographic sheet, ARSMA, ATSPPHS, vignette and rating scales for attributions and sources of help, and assessment of professional mental health contact were combined into questionnaire booklets. Since participants' acculturation level was the key independent variable in the primary hypotheses, the ARSMA was placed first in the booklet, immediately following the demographic sheet. Carryover effects between the materials and participant fatigue were predicted to be minimal; therefore, the materials were not counterbalanced. Participants were randomly assigned to read one of four vignettes: male vignette A (less severe), female vignette A, male vignette B (more severe), or female vignette B. Participants were given the written and oral solicitation statements, provided with a questionnaire booklet, and given a debriefing statement (Appendix K) upon completion of the materials.
CHAPTER IV
RESULTS

Demographic Characteristics of the Participants

One hundred thirty-seven students participated in the study; four incomplete data sets were eliminated, leaving a total sample of 133. Eighty-five (63.9%) of the participants were female, and 48 (36.1%) were male. Participants ranged in age from 17 to 28, with a mean of 20.1 years. A relatively large proportion (39.8%) of the participants were first-year students; please refer to Table 1 for a complete summary of participants' class levels. The vast majority of students self-identified as single (97.7%) and living on their own in an apartment or dormitory (89.5%). Eighty-four percent of the participants identified themselves as Catholic, while the remaining 15% used labels such as “Christian,” “Protestant,” “atheist” and “agnostic” to describe their religious identities. The participants in this study came from families with a wide range of occupational and educational backgrounds. Tables 2, 3, 4 and 5 refer to the occupational and educational levels of the participants’ parents.
Table 1

Class Levels of the Participants

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<tr>
<th>Year in College</th>
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<td>1st</td>
<td>53</td>
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<tr>
<td>2nd</td>
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<tr>
<td>3rd</td>
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<tr>
<td>4th</td>
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<tr>
<td>5th</td>
<td>17</td>
<td>12.8</td>
</tr>
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<td>6th</td>
<td>2</td>
<td>1.5</td>
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Table 2

Occupational Classification of Participants' Fathers

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<tr>
<th>Classification</th>
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<tbody>
<tr>
<td>Unskilled/semiskilled</td>
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<td>Administrative/secretarial</td>
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<tr>
<td>Managerial</td>
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<td>.8</td>
</tr>
<tr>
<td>Executive/professional</td>
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<tr>
<td>Did not report</td>
<td>15</td>
<td>11.3</td>
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Table 3

Educational Attainment of Participants' Fathers

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<th>Level of Education</th>
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<tr>
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<td>Left before entering high school</td>
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<td>High school diploma</td>
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<td>5.3</td>
</tr>
<tr>
<td>Four-year college degree</td>
<td>9</td>
<td>6.8</td>
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<tr>
<td>Some graduate or professional school</td>
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<td>5.3</td>
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<tr>
<td>Graduate or professional degree</td>
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<tr>
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Table 4

**Occupational Classification of Participants’ Mothers**

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<th>Classification</th>
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<tr>
<td>Unskilled/semiskilled</td>
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<td>Skilled/technical</td>
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<td>12.8</td>
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<tr>
<td>Administrative/secretarial</td>
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<td>6.8</td>
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<td>4.5</td>
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</table>
Table 5

Educational Attainment of Participants' Mothers

<table>
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<th>Level of Education</th>
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<th>%</th>
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</thead>
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<td>9.0</td>
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<td>Left before entering high school</td>
<td>43</td>
<td>32.3</td>
</tr>
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<td>Some high school</td>
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<td>6.8</td>
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<td>High school diploma</td>
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<td>19.5</td>
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<tr>
<td>Some college</td>
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<tr>
<td>Two-year college degree</td>
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<td>9.0</td>
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<td>Four-year college degree</td>
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<td>6.8</td>
</tr>
<tr>
<td>Some graduate or professional school</td>
<td>2</td>
<td>1.5</td>
</tr>
<tr>
<td>Graduate or professional degree</td>
<td>5</td>
<td>3.8</td>
</tr>
</tbody>
</table>
Descriptive Data on the Measures

Descriptive statistics were computed for the measures representing the variables of interest in this study; participants' scores on the Acculturation Rating Scale for Mexican Americans (ARSMA) and Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS), as well as their ratings on the eight attributions for the problems of the person in the vignette, and their ratings on the seven sources of help for the person in the vignette. In addition, frequency data were obtained for each of the three (yes/no) items in the assessment of professional mental health contact.

Table 6 contains the descriptive statistics for the ARSMA and ATSPPHS. A mean total score of 59.76 was obtained for the ARSMA, with a standard deviation of 12.06. Cuellar et al. (1980) reported a similar mean of 60.20 on the ARSMA. The possible range for this instrument is from 20 to 100; scores obtained from the current sample ranged from 32 to 90. Item average scores were also computed for the ARSMA, by totaling the participants' scores and dividing by the number of completed items. A mean item average score of 2.99 was obtained, with a standard deviation of .60. Item averages ranged from 1.6 to 4.5. Cronbach's alpha (internal consistency reliability) was computed at .92. This is slightly higher than the alpha of .88 reported by Cuellar et al. (1980), and equal to that obtained by Montgomery and Orozco (1984). For purposes of this study, the item range was divided into three equal parts to reflect three levels of acculturation (low = 1 - 2.3; medium = 2.4 - 3.6; high = 3.7 - 5). Previous investigators (e.g., Atkinson et al., 1992; Ponce & Atkinson, 1989) have used identical or similar methods to derive three categories from the ARSMA. Fifteen percent of the participants fell into the low acculturation category, 69% were identified as medium, and 16% were identified as high in acculturation. This is approximately the same distribution as that obtained by Atkinson et al. (1992), who used the same range division on the ARSMA.
For the ATSPPHS, a mean total score of 80.90 was obtained, with a standard deviation of 11.09. Although Sanchez and Atkinson (1983) also used the ATSPPHS with Mexican American college students, they did not report their descriptive statistics; a direct comparison, therefore, is not possible. Atkinson and Gim (1989), using Asian American college students, reported a total mean score of 77.87. The possible range for this instrument is from 29 to 116; scores obtained from the current sample ranged from 44 to 109. Item average scores were also computed for the ATSPPHS. The mean item average score was 2.79, with a standard deviation of .38. Item averages ranged from 1.52 to 3.76. Cronbach’s alpha was .86 for this instrument; this is identical to the alpha reported by Fisher and Turner (1970).

Tables 7 and 8 list the eight attributions and seven sources of help that were rated by the participants, along with the descriptive data for each. Each potential cause of the problems of the person in the vignette was rated on a 5-point scale ranging from 1 (not a cause at all) to 5 (definitely a cause). Participants also rated the potential helpfulness of seven sources of help on scales ranging from 1 (not helpful at all) to 5 (definitely helpful).

Table 9 summarizes the results of the frequency data obtained for each of the three items in the assessment of professional mental health contact. Participants were asked whether they, any member of their family, or any of their friends were currently in counseling or had ever received counseling in the past. Thirty-seven (27.8%) of the participants indicated that they were currently in counseling or had received mental health services at some point in their lives, while 94 (70.7%) indicated that they had not received any type of mental health services. Two (1.5%) of the participants did not respond to this item. Fifty-one (38.3%) of the participants indicated that they knew of a family member who had been in counseling, while 80 (60.2%) indicated that they knew of no one in their family who had ever sought mental health services. Two (1.5%) of the participants did not respond to this item. Seventy-five (56.4%) of the participants indicated that they knew of
at least one friend who had sought counseling, while 54 (40.6%) indicated that, to their knowledge, none of their friends had ever sought mental health services. Four (3.0%) of the participants did not respond to this item.

Table 6
Descriptive Statistics for the ARSMA and ATSPPHS

<table>
<thead>
<tr>
<th>Measure</th>
<th>M</th>
<th>SD</th>
<th>Min</th>
<th>Max</th>
<th>Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARSMA Total</td>
<td>59.76</td>
<td>12.06</td>
<td>32.0</td>
<td>90.0</td>
<td>.92</td>
</tr>
<tr>
<td>ARSMA Item avg.</td>
<td>2.99</td>
<td>.60</td>
<td>1.6</td>
<td>4.5</td>
<td></td>
</tr>
<tr>
<td>ATSPPHS Total</td>
<td>80.90</td>
<td>11.09</td>
<td>44.0</td>
<td>109.0</td>
<td>.86</td>
</tr>
<tr>
<td>ATSPPHS Item avg.</td>
<td>2.79</td>
<td>.38</td>
<td>1.52</td>
<td>3.76</td>
<td></td>
</tr>
</tbody>
</table>
### Table 7

**Participants’ Attributional Ratings**

<table>
<thead>
<tr>
<th>Cause</th>
<th>M</th>
<th>SD</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hereditary</td>
<td>2.02</td>
<td>.96</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Physical Problem</td>
<td>2.34</td>
<td>1.07</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Negative Thinking</td>
<td>3.77</td>
<td>1.07</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Weakness of Character</td>
<td>2.98</td>
<td>1.18</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Problems with Other People</td>
<td>2.95</td>
<td>1.05</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Major Life Changes</td>
<td>4.43</td>
<td>.78</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>School or Work Stress</td>
<td>4.53</td>
<td>.79</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Discrimination</td>
<td>2.83</td>
<td>1.20</td>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>
Table 8

Participants' Ratings of Sources of Help

<table>
<thead>
<tr>
<th>Source of Help</th>
<th>M</th>
<th>SD</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self</td>
<td>3.68</td>
<td>1.18</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Family</td>
<td>4.12</td>
<td>1.02</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Friends</td>
<td>4.11</td>
<td>0.83</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Clergy</td>
<td>3.74</td>
<td>1.00</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Faith Healer</td>
<td>2.05</td>
<td>1.03</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Physician</td>
<td>2.79</td>
<td>0.96</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Mental Health Professional</td>
<td>3.80</td>
<td>1.06</td>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>

Table 9

Assessment of Professional Mental Health Contact

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Did not Respond</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self</td>
<td>37 (27.8%)</td>
<td>94 (70.7%)</td>
<td>2 (1.5%)</td>
</tr>
<tr>
<td>Family</td>
<td>51 (38.3%)</td>
<td>80 (60.2%)</td>
<td>2 (1.5%)</td>
</tr>
<tr>
<td>Friends</td>
<td>75 (56.4%)</td>
<td>54 (40.6%)</td>
<td>4 (3.0%)</td>
</tr>
</tbody>
</table>
Creation of the Internal and External Variables

The list of possible attributions for the problems of the person in the vignette was comprised of eight items; four that were considered primarily internal and attributable to the person (hereditary, physical illness, negative thinking, and weakness of character), and four that were considered external and attributable to the environment (problems with other people, major life changes, school or work-related stress, and discrimination or unfair treatment). In order to create one scale representing internal attributions and one scale representing external attributions, Cronbach's alpha was computed separately for the four internal and four external items. An acceptably high reliability (> .60) for the internal and external items would justify combining them into two measures. An alpha of .53 was obtained for the four internal items, and an alpha of .31 was obtained for the four external items. Neither of the obtained alpha values met the predetermined criteria of .60; therefore, it was decided to combine the two highest correlated internal items to create the Internal measure and the two highest correlated external items to create the External measure. The internal items with the highest correlation were Negative thinking and Weakness of character (r = .46); the highest correlating external items were Major life changes and School or work-related stress (r = .49). Thus, these two internal and external items were summed to represent the Internal and External measures, respectively. Tables 10 and 11 show the correlations among the internal and external items, respectively.
**Table 10**

**Correlations among Internal items**

<table>
<thead>
<tr>
<th>Attribution</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Hereditary</td>
<td>--</td>
<td>.36*</td>
<td>.14</td>
<td>.11</td>
</tr>
<tr>
<td>3. Negative thinking</td>
<td>--</td>
<td></td>
<td></td>
<td>.46*</td>
</tr>
<tr>
<td>4. Weak character</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* p < .01.

**Table 11**

**Correlations among External items**

<table>
<thead>
<tr>
<th>Attribution</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Probs. w/ others</td>
<td>--</td>
<td>-.14</td>
<td>.04</td>
<td>.26*</td>
</tr>
<tr>
<td>2. Major life chgs.</td>
<td>--</td>
<td></td>
<td>.49*</td>
<td>-.05</td>
</tr>
<tr>
<td>3. Stress</td>
<td></td>
<td>--</td>
<td>-.01</td>
<td></td>
</tr>
<tr>
<td>4. Discrimination</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* p < .01.
Correlations among the Variables

Correlations were obtained among the main variables of interest in this study: scores on the ARSMA and ATSPHHS, ratings on internal and external attributions, ratings on the helpfulness of professional mental health services (MH Prof.), assessment of professional mental health contact (MHSC), and participant gender. The correlations are presented in Table 12. It should be noted that although participants rated seven sources of help for the person in the vignette, the primary hypotheses involved the potential helpfulness of a mental health professional; therefore, only this item is presented in the correlation matrix and is involved in the primary analyses of this study. Similarly, the item assessing prior mental health service contact of most importance is that which assesses the participant’s experience; the correlation matrix and analyses assessing the primary hypotheses of this study, therefore, utilize only the item assessing the participant’s experience.

It should also be noted that correlations involving variables measured on a nominal scale (MHSC, gender) are either point-biserial (when being correlated with variables measured on an interval scale) or phi coefficients (when being correlated with each other). These types of correlation coefficients tend to underestimate the true degree of the relationship when the number of participants in each category is unequal (see Bordens & Abbott, 1988). The restriction of range inherent in dichotomous variables also tends to attenuate the magnitude of point-biserial and phi coefficients. Thus, correlation coefficients involving MHSC and gender should be interpreted with caution.
Table 12

Correlations among the Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ARSMA</td>
<td>-</td>
<td>-.09</td>
<td>-.12</td>
<td>.13</td>
<td>-.13</td>
<td>.11</td>
<td>-.06</td>
</tr>
<tr>
<td>2. ATSPPHS</td>
<td>-</td>
<td>-.17</td>
<td>.22*</td>
<td>.48**</td>
<td>-.22*</td>
<td>.23*</td>
<td></td>
</tr>
<tr>
<td>3. Internal</td>
<td>-</td>
<td>-.04</td>
<td>.01</td>
<td>.01</td>
<td>-.07</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. External</td>
<td>-</td>
<td></td>
<td>.28**</td>
<td>-.02</td>
<td>.26**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. MH Prof.</td>
<td>-</td>
<td>-.17*</td>
<td>.21*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. MHSC</td>
<td>-</td>
<td></td>
<td>-.01</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Gender</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* p < .05.  ** p < .01.

Manipulation Check

In order to ensure that the participants perceived the severity of the vignettes to differ, and that perceived severity was not affected by vignette gender, a 2 (vignette severity) X 2 (vignette gender) analysis of variance (ANOVA) was employed, with participants' severity rating as the dependent variable. The results of this analysis are presented in Table 13. A significant main effect was found only for vignette severity, $F(1, 129) = 6.70, p < .01$, with high severity having a higher score ($M = 4.09$) than low severity ($M = 3.69$). The effect due to vignette gender was nonsignificant. The significant finding for vignette severity supports the validity of the independent variable manipulation (i.e., that participants perceived the more severe vignette to be significantly more severe than the less severe vignette).
Preliminary Analyses

Preliminary analyses were run in order to determine whether the factors of participant gender, vignette gender, and vignette severity had significant effects on the dependent variables in this study: professional mental health service contact (MHSC), ATSPPHS scores, MH Prof. scores, and Internal and External attribution scores.

Since the mental health service contact item assessed the participants' own previous experience, this would theoretically be unaffected by the vignette that they read; therefore, only participant gender was tested for this particular dependent variable. A chi-square analysis was computed to determine whether participant gender and mental health service contact were related. The result was nonsignificant, $\chi^2 (1, N = 131) = .01, p < .91$;
therefore, participant gender was dropped from further analyses with mental health service contact as the dependent variable.

Separate 2 (participant gender) X 2 (vignette gender) X 2 (vignette severity) ANOVAs were performed for each of the remaining dependent variables (ATSPPHS, MH Prof., Internal and External attribution scores). The results of the ANOVAs for the preliminary analyses are presented in Tables 14 through 17. For ATSPPHS scores, only participant gender was significant, \( F (1, 125) = 6.42, p < .01 \), with women having a higher score (\( M = 2.85 \)) than men (\( M = 2.67 \)). Participant gender, therefore, was retained as a significant factor in subsequent analyses involving ATSPPHS scores as the dependent variable. For MH Prof. scores, participant gender was again the only significant factor, \( F (1, 132) = 5.91, p < .02 \), with women having a higher average score (\( M = 3.96 \)) than men (\( M = 3.50 \)). Participant gender was also retained as a significant factor in subsequent analyses involving MH Prof. scores. For Internal attribution scores, vignette severity was the only significant factor, \( F (1, 132) = 4.83, p < .03 \), with the more severe vignette having a higher internal attribution score (\( M = 7.10 \)) than the less severe vignette (\( M = 6.38 \)). For External attribution scores, participant gender was the only significant factor, \( F (1, 131) = 9.62, p < .002 \), with women having higher external attribution scores (\( M = 9.25 \)) than men (\( M = 8.53 \)). Therefore, for analyses involving Internal and External attribution scores as the dependent variables, participant gender and vignette severity were retained as significant factors.

Results obtained from the preliminary analyses indicated that participant gender and vignette severity each had significant effects on at least one of the dependent variables of interest. Participant gender was a significant factor for ATSPPHS and MH Prof. scores, as well as for External attribution scores; for subsequent analyses involving these dependent variables, participant gender was included as an independent variable. Vignette severity was significant for Internal attribution scores; for analyses involving Internal
attribution scores as the dependent variable, vignette severity was included as an independent variable. Vignette gender was not a significant factor for any of the variables and was dropped from further analyses.

Table 14
ANOVA for ATSPPHS by Participant Gender, Vignette Gender, and Vignette Severity

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>VG</td>
<td>1</td>
<td>.09</td>
</tr>
<tr>
<td>VS</td>
<td>1</td>
<td>.12</td>
</tr>
<tr>
<td>PG</td>
<td>1</td>
<td>6.42*</td>
</tr>
<tr>
<td>VG X VS</td>
<td>1</td>
<td>1.38</td>
</tr>
<tr>
<td>VG X PG</td>
<td>1</td>
<td>.19</td>
</tr>
<tr>
<td>VS X PG</td>
<td>1</td>
<td>.15</td>
</tr>
<tr>
<td>VG X VS X PG</td>
<td>1</td>
<td>.68</td>
</tr>
<tr>
<td>Residual</td>
<td>118</td>
<td>(.14)</td>
</tr>
</tbody>
</table>

Note. Value enclosed in parentheses represents mean square error. VG = vignette gender; VS = vignette severity; PG = participant gender.

*p < .01.
Table 15

ANOVA for MH Prof. by Participant Gender, Vignette Gender, and Vignette Severity

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>VG</td>
<td>1</td>
<td>.34</td>
</tr>
<tr>
<td>VS</td>
<td>1</td>
<td>.13</td>
</tr>
<tr>
<td>PG</td>
<td>1</td>
<td>5.91*</td>
</tr>
<tr>
<td>VG X VS</td>
<td>1</td>
<td>.96</td>
</tr>
<tr>
<td>VG X PG</td>
<td>1</td>
<td>.10</td>
</tr>
<tr>
<td>VS X PG</td>
<td>1</td>
<td>1.03</td>
</tr>
<tr>
<td>VG X VS X PG</td>
<td>1</td>
<td>1.26</td>
</tr>
<tr>
<td>Residual</td>
<td>125</td>
<td>(1.11)</td>
</tr>
</tbody>
</table>

*Note. Value enclosed in parentheses represents mean square error. VG = vignette gender; VS = vignette severity; PG = participant gender.

*p < .02.*
Table 16

ANOVA for Internal by Participant Gender, Vignette Gender, and Vignette Severity

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>VG</td>
<td>1</td>
<td>.06</td>
</tr>
<tr>
<td>VS</td>
<td>1</td>
<td>4.83*</td>
</tr>
<tr>
<td>PG</td>
<td>1</td>
<td>.72</td>
</tr>
<tr>
<td>VG X VS</td>
<td>1</td>
<td>.08</td>
</tr>
<tr>
<td>VG X PG</td>
<td>1</td>
<td>.04</td>
</tr>
<tr>
<td>VS X PG</td>
<td>1</td>
<td>.29</td>
</tr>
<tr>
<td>VG X VS X PG</td>
<td>1</td>
<td>.004</td>
</tr>
<tr>
<td>Residual</td>
<td>125</td>
<td>(3.76)</td>
</tr>
</tbody>
</table>

*Note. Value enclosed in parentheses represents mean square error. VG = vignette gender; VS = vignette severity; PG = participant gender.*

*P < .03.
Table 17

ANOVA for External by Participant Gender, Vignette Gender, and Vignette Severity

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>VG</td>
<td>1</td>
<td>2.98</td>
</tr>
<tr>
<td>VS</td>
<td>1</td>
<td>.01</td>
</tr>
<tr>
<td>PG</td>
<td>1</td>
<td>9.62*</td>
</tr>
<tr>
<td>VG X VS</td>
<td>1</td>
<td>.06</td>
</tr>
<tr>
<td>VG X PG</td>
<td>1</td>
<td>1.20</td>
</tr>
<tr>
<td>VS X PG</td>
<td>1</td>
<td>.11</td>
</tr>
<tr>
<td>VG X VS X PG</td>
<td>1</td>
<td>1.50</td>
</tr>
<tr>
<td>Residual</td>
<td>124</td>
<td>(1.61)</td>
</tr>
</tbody>
</table>

*Note.* Value enclosed in parentheses represents mean square error. VG = vignette gender; VS = vignette severity; PG = participant gender.

*p < .002.*
Hypothesis 1

To test the first hypothesis, separate analyses were computed to determine the relationship of acculturation level (ARSMA scores; low, medium, high) to (a) previous mental health service contact (MHSC), (b) attitudes toward seeking professional psychological help (ATSPPHS scores), and (c) the tendency to endorse professional mental health services for persons experiencing psychological distress (MH Prof. scores).

To determine the relationship between ARSMA level and MHSC, a 3 (ARSMA level) X 2 (MHSC; yes/no) chi-square analysis was computed. The cell frequencies for this analysis are presented in Table 18. The result was nonsignificant, $\chi^2 (2, N = 129) = 4.20, p < .12$, indicating that acculturation level was unrelated to previous mental health service contact.

To determine the relationship between ARSMA level and (a) ATSPPHS scores, and (b) MH Prof. scores, two 3 (ARSMA level) X 2 (gender) ANOVAs were computed, with gender retained as a significant factor for each dependent variable. The results from these analyses are presented in Tables 19 and 20. Results indicated that only gender was significant for ATSPPHS scores, $F (2, 124) = 6.14, p < .02$, with ARSMA level showing no significant effect. The interaction of ARSMA level by gender was also nonsignificant. For MH Prof. scores, results indicated significant main effects for both ARSMA level, $F (2, 130) = 3.37, p < .04$, and gender, $F (1, 130) = 5.30, p < .02$. The interaction of ARSMA level by gender was nonsignificant. To isolate the means which significantly differed across ARSMA level, a Tukey HSD multiple range procedure was employed. This test indicated that participants in the medium acculturation category obtained higher MH Prof. scores ($M = 3.91$) than participants in the high acculturation category ($M = 3.24$), $p < .05$. Participants low in acculturation ($M = 3.79$) did not significantly differ from either of the other two groups.
Results obtained above did not support Hypothesis 1; acculturation level was unrelated to previous mental health service contact and ATSPPHS scores. Although ARSMA level was significant for MH Prof. scores, the direction of this effect ran counter to the hypothesis (i.e., participants medium in acculturation scored higher than those high in acculturation). Although the effect was not significant, participants low in acculturation obtained higher MH Prof. scores than participants high in acculturation; this is opposite to what was predicted.

Table 18

Cell Frequencies for Chi-Square Analysis — ARSMA level by MHSC

<table>
<thead>
<tr>
<th>MHSC</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
<th>Row total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>9</td>
<td>22</td>
<td>5</td>
<td>36 (27.9%)</td>
</tr>
<tr>
<td>No</td>
<td>10</td>
<td>67</td>
<td>16</td>
<td>93 (72.1%)</td>
</tr>
<tr>
<td>Column total</td>
<td>19 (14.7%)</td>
<td>89 (69.0%)</td>
<td>21 (16.3%)</td>
<td>129 (100.0%)</td>
</tr>
</tbody>
</table>

Note. MHSC = mental health service contact.
Table 19

ANOVA for ATSPPHS scores by ARSMA level and Participant Gender

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARSMA</td>
<td>2</td>
<td>2.29</td>
</tr>
<tr>
<td>PG</td>
<td>1</td>
<td>6.14*</td>
</tr>
<tr>
<td>ARSMA X PG</td>
<td>2</td>
<td>1.08</td>
</tr>
<tr>
<td>Residual</td>
<td>119</td>
<td>(.14)</td>
</tr>
</tbody>
</table>

Note. Value enclosed in parentheses represents mean square error. PG = participant gender.

*p < .02.
Table 20

ANOVA for MH Prof. scores by ARSMA level and Participant Gender

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARSMA</td>
<td>2</td>
<td>3.37*</td>
</tr>
<tr>
<td>PG</td>
<td>1</td>
<td>5.30**</td>
</tr>
<tr>
<td>ARSMA X PG</td>
<td>2</td>
<td>.13</td>
</tr>
<tr>
<td>Residual</td>
<td>125</td>
<td>(1.07)</td>
</tr>
</tbody>
</table>

Note. Value enclosed in parentheses represents mean square error. PG = participant gender.

*p < .04. **p < .02.
Hypothesis 2

To test the second hypothesis, separate analyses were computed to determine the relationship of acculturation level (ARSMA scores; low, medium, high) to (a) Internal attribution scores, and (b) External attribution scores. Two 3 (ARSMA level) X 2 (vignette severity) X 2 (participant gender) ANOVAs were computed, with vignette severity and participant gender retained as significant factors. The results from the ANOVAs for Internal and External attributions by ARSMA level, vignette severity, and participant gender are presented in Tables 21 and 22. For Internal attribution scores, results obtained indicated only a significant main effect for vignette severity, \( F (1, 130) = 4.57, p < .04 \); neither ARSMA level nor participant gender was significant. None of the interactions involving ARSMA level, vignette severity, and participant gender were significant (all \( p \)’s > .15). For External attribution scores, a significant main effect was obtained only for participant gender, \( F (1, 129) = 9.48, p < .003 \). The effects for ARSMA level and vignette severity were both nonsignificant. None of the interactions involving ARSMA level, vignette severity, and participant gender were significant (all \( p \)’s > .30).

Hypothesis 2 was not supported by the above results; acculturation level was related to neither Internal nor External attribution scores. Significant effects were obtained only for vignette severity (Internal) and participant gender (External), factors which were shown to be significant in the preliminary analyses.
Table 21
ANOVA for Internal by ARSMA level, Vignette Severity, and Participant gender

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARSMA</td>
<td>2</td>
<td>.11</td>
</tr>
<tr>
<td>VS</td>
<td>1</td>
<td>4.57*</td>
</tr>
<tr>
<td>PG</td>
<td>1</td>
<td>1.19</td>
</tr>
<tr>
<td>ARSMA X VS</td>
<td>2</td>
<td>.50</td>
</tr>
<tr>
<td>ARSMA X PG</td>
<td>2</td>
<td>.05</td>
</tr>
<tr>
<td>VS X PG</td>
<td>1</td>
<td>.35</td>
</tr>
<tr>
<td>ARSMA X VS X PG</td>
<td>2</td>
<td>1.68</td>
</tr>
<tr>
<td>Residual</td>
<td>119</td>
<td>(3.67)</td>
</tr>
</tbody>
</table>

Note. Value enclosed in parentheses represents mean square error. VS = vignette severity; PG = participant gender.

*_{p < .04}.}
Table 22

ANOVA for External by ARSMA level, Vignette Severity, and Participant gender

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARSMA</td>
<td>2</td>
<td>.73</td>
</tr>
<tr>
<td>VS</td>
<td>1</td>
<td>.10</td>
</tr>
<tr>
<td>PG</td>
<td>1</td>
<td>9.48*</td>
</tr>
<tr>
<td>ARSMA X VS</td>
<td>2</td>
<td>.92</td>
</tr>
<tr>
<td>ARSMA X PG</td>
<td>2</td>
<td>.52</td>
</tr>
<tr>
<td>VS X PG</td>
<td>1</td>
<td>.08</td>
</tr>
<tr>
<td>ARSMA X VS X PG</td>
<td>2</td>
<td>1.06</td>
</tr>
<tr>
<td>Residual</td>
<td>118</td>
<td>(1.67)</td>
</tr>
</tbody>
</table>

Note. Value enclosed in parentheses represents mean square error. VS = vignette severity; PG = participant gender.

*p < .003.
Hypothesis 3

To test the third hypothesis, separate analyses were computed to determine the relationship of mental health service contact (MHSC) to (a) Internal attribution scores, and (b) External attribution scores. Two 2 (MHSC) X 2 (vignette severity) X 2 (participant gender) ANOVAs were computed, with vignette severity and participant gender retained as significant factors. The results from these analyses are presented in Tables 23 and 24. For Internal attribution scores, only vignette severity attained significance, $F (1, 130) = 4.14$, $p < .04$. Neither MHSC nor participant gender was significant. None of the interactions involving MHSC, vignette severity, and participant gender were significant (all $p$’s > .30).

For External attribution scores, only a significant main effect was obtained for participant gender, $F (1, 129) = 8.52$, $p < .004$. The effects for MHSC and vignette severity were both nonsignificant. None of the interactions involving MHSC, vignette severity, and participant gender were significant (all $p$’s > .25).

Hypothesis 3 was not supported by the above results; mental health service contact was significant for neither Internal nor External attribution scores. Significant effects were obtained only for vignette severity (Internal) and participant gender (External), factors which were shown to be significant in the preliminary analyses.
Table 23

ANOVA for Internal by MHSC, Vignette Severity, and Participant gender

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHSC</td>
<td>1</td>
<td>.03</td>
</tr>
<tr>
<td>VS</td>
<td>1</td>
<td>4.14*</td>
</tr>
<tr>
<td>PG</td>
<td>1</td>
<td>.96</td>
</tr>
<tr>
<td>MHSC x VS</td>
<td>1</td>
<td>.01</td>
</tr>
<tr>
<td>MHSC x PG</td>
<td>1</td>
<td>1.07</td>
</tr>
<tr>
<td>VS x PG</td>
<td>1</td>
<td>.18</td>
</tr>
<tr>
<td>MHSC x VS x PG</td>
<td>1</td>
<td>.01</td>
</tr>
<tr>
<td>Residual</td>
<td>123</td>
<td>(3.71)</td>
</tr>
</tbody>
</table>

**Note.** Value enclosed in parentheses represents mean square error. VS = vignette severity; PG = participant gender.

*_{p} < .04.
Table 24

ANOVA for External by MHSC, Vignette Severity, and Participant gender

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHSC</td>
<td>1</td>
<td>.03</td>
</tr>
<tr>
<td>VS</td>
<td>1</td>
<td>.001</td>
</tr>
<tr>
<td>PG</td>
<td>1</td>
<td>8.52*</td>
</tr>
<tr>
<td>MHSC x VS</td>
<td>1</td>
<td>.18</td>
</tr>
<tr>
<td>MHSC x PG</td>
<td>1</td>
<td>1.23</td>
</tr>
<tr>
<td>VS x PG</td>
<td>1</td>
<td>.05</td>
</tr>
<tr>
<td>MHSC x VS x PG</td>
<td>1</td>
<td>.59</td>
</tr>
<tr>
<td>Residual</td>
<td>122</td>
<td>(1.68)</td>
</tr>
</tbody>
</table>

Note. Value enclosed in parentheses represents mean square error. VS = vignette severity; PG = participant gender.

*p < .004.
Hypothesis 4

Multiple regression analyses were employed to determine the relationship of participants' Internal and External attribution scores to ATSPPHS and MH Prof. scores. Internal and External scores were used as predictors for each of the dependent variables (ATSPPHS and MH Prof. scores). Due to the results of the preliminary analyses, participant gender was retained as a significant factor for ATSPPHS and MH Prof. scores and used as a third predictor variable; dummy coding was used to transform gender into a continuous variable. The analytic strategy of choice was stepwise multiple regression; this decision was made due to several factors. First, it was deemed important to assess the significance, if any, of each of the predictor variables separately. Second, the research questions being addressed in the fourth hypothesis were not framed by a specific theory or model suggesting specific causal priority of the predictors; indeed, the exploratory nature of this study is in line with Cohen and Cohen's (1983) suggestion that stepwise analyses be used only when the research goal is primarily predictive, rather than explanatory. Finally, the relatively small number of predictor variables in proportion to the total N minimized the chances that entry order of the variables would be determined purely by chance (see Cohen & Cohen, 1983).

For the following stepwise multiple regression procedures, the computer was programmed to select from the group of predictor variables (Internal scores, External scores, participant gender) that which accounted for the most variance in the dependent measure (see Bordens & Abbott, 1988). Subsequent variables were entered into the equations based on their ability to add significantly to the regression models. Once the predetermined significance level of .05 was reached, the program terminated the analyses.

The results from the regression equations for ATSPPHS scores by participant gender, Internal, and External attributions are presented in Tables 25 and 26. Participant gender was the first variable entered into the regression equation, $F(1, 124) = 6.72, p <$
gender accounted for 5% of the variability in ATSPPHS scores ($R^2 = .05$). With participant gender in the equation, External was next to be entered ($R^2 = .03$, $p < .05$), followed by Internal ($R^2 = .02$, $p < .09$); neither External nor Internal, however, attained the necessary significance to be included in the equation. Because Hypothesis 4 was primarily concerned with the predictive ability of Internal and External attributions for ATSPPHS scores, a stepwise analysis was run with Internal and External as the only predictor variables. External was entered first, $F(1, 124) = 6.54$, $p < .01$, accounting for 5% of the variability in ATSPPHS scores ($R^2 = .05$). Inspection of the beta weight revealed that higher scores on the External scale predicted higher ATSPPHS scores, ($\beta = .22$), $t(124) = 2.56$, $p < .01$. Internal did not add significantly to the model ($R^2 = .02$, $p < .09$), and was not included in the equation.

The results from the regression equation for MH Prof. scores by participant gender, Internal, and External attributions are presented in Table 27. External was the first variable entered into the regression equation, $F(1, 130) = 10.98$, $p < .001$; External attribution scores accounted for 8% of the variability in MH Prof. scores ($R^2 = .08$). The beta weight for this equation revealed that higher scores on the External scale predicted higher MH Prof. scores, ($\beta = .28$), $t(130) = 3.31$, $p < .001$. Participant gender was next to be entered ($R^2 = .02$, $p < .15$), followed by Internal ($R^2 = .00$, $p < .89$); neither participant gender nor Internal attained the necessary significance to be included in the equation.

Results obtained above partially supported Hypothesis 4. Without gender in the equation, External scores accounted for a small but significant (5%) portion of the variability in ATSPPHS scores. As predicted, higher External scores predicted higher ATSPPHS scores. Internal scores, however, did not contribute significantly to the regression model. Results also indicated that, as predicted, higher External scores significantly predicted higher MH Prof. scores, with External scores accounting for 8% of...
the variability in MH Prof. scores. Internal scores, however, did not significantly contribute to the regression model for MH Prof. scores.

Table 25

**Stepwise Regression for ATSPPHS scores by Participant Gender, Internal, and External**

<table>
<thead>
<tr>
<th>Variable</th>
<th>R</th>
<th>R²</th>
<th>β</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>.23</td>
<td>.05</td>
<td>.23*</td>
</tr>
</tbody>
</table>

*Note. External (R² = .03; β = .17, ps < .05) and Internal (R² = .02; β = -.15, ps < .09) were not entered into the regression equation.*

*P < .01.

Table 26

**Stepwise Regression for ATSPPHS scores by Internal and External**

<table>
<thead>
<tr>
<th>Variable</th>
<th>R</th>
<th>R²</th>
<th>β</th>
</tr>
</thead>
<tbody>
<tr>
<td>External</td>
<td>.22</td>
<td>.05</td>
<td>.22*</td>
</tr>
</tbody>
</table>

*Note. Internal (R² = .02; β = -.15, ps < .09) was not entered into the regression equation.*

*P < .01.
Table 27

Stepwise Regression for MH Prof. scores by Participant Gender, Internal, and External

<table>
<thead>
<tr>
<th>Variable</th>
<th>R</th>
<th>$R^2$</th>
<th>$\beta$</th>
</tr>
</thead>
<tbody>
<tr>
<td>External</td>
<td>.28</td>
<td>.08</td>
<td>.28*</td>
</tr>
</tbody>
</table>

Note. Gender ($R^2 = .02; \beta = .13, ps < .15$) and Internal ($R^2 = .00; \beta = -.01, ps < .89$) were not entered into the regression equation.

Hypothesis 5

The fifth hypothesis proposed gender differences with regard to mental health service contact (MHSC), ATSPPHS scores, and MH Prof. scores; results of the analyses for participant gender have already been reported in the Preliminary Analyses section, and will be briefly reviewed here. A chi-square analysis was computed to determine whether participant gender and mental health service contact were related. Table 28 presents the cell frequencies for this analysis. The result was nonsignificant, $\chi^2 (1, N = 131) = .01, p < .91$, indicating that women were no more likely than men to have had previous mental health service contact. The results from the analyses for ATSPPHS and MH Prof. scores by gender are contained in Tables 14 and 15. Participant gender had a significant effect on ATSPPHS scores, $F (1, 125) = 6.42, p < .01$, with women having a higher score ($M = 2.85$) than men ($M = 2.67$). Participant gender was also a significant factor for MH Prof. scores, $F (1, 132) = 5.91, p < .02$, with women having a higher average score on this scale ($M = 3.96$) than men ($M = 3.50$).
The results obtained indicated partial support for Hypothesis 5. Although gender was unrelated to previous mental health service contact, the women in this sample did obtain significantly higher ATSPPHS and MH Prof. scores than did the men.

Table 28
Cell Frequencies for Chi-Square Analysis -- Participant Gender by MHSC

<table>
<thead>
<tr>
<th>MHSC</th>
<th>M</th>
<th>F</th>
<th>Row total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>13</td>
<td>24</td>
<td>37 (28.2%)</td>
</tr>
<tr>
<td>No</td>
<td>34</td>
<td>60</td>
<td>94 (71.8%)</td>
</tr>
<tr>
<td>Column total</td>
<td>47 (35.9%)</td>
<td>84 (64.1%)</td>
<td>131 (100.0%)</td>
</tr>
</tbody>
</table>

Note. MHSC = mental health service contact.

Additional Hypotheses

Differences as a function of (a) vignette gender, and (b) vignette severity, were examined with regard to Internal and External attribution scores and MH Prof. scores. These results were also discussed in the Preliminary Analyses section and will be briefly reviewed here. Please refer back to Tables 15, 16, and 17 for the complete results from these analyses. For Internal attribution scores, vignette severity was the only significant factor, \( F(1, 132) = 4.83, p < .03 \), with the more severe vignette having a higher internal attribution score \( (M = 7.10) \) than the less severe vignette \( (M = 6.38) \). Vignette gender was not significant. For External attribution scores, neither vignette gender nor vignette
severity was significant. For MH Prof. scores, neither vignette gender nor vignette severity was significant.

**Analyses of Qualitative Data**

Following their ratings of problem attributions and sources of help, participants had an opportunity to write down additional things that they felt (a) may have caused or contributed to the person’s distress, and (b) may have helped the person to deal with his or her distress. Fifty (36%) of the participants responded to at least one of these items. The procedure used to analyze these data was content analysis, as described by Patton (1990). For responses to both causes and sources of help, primary themes expressed by the participants were identified, and responses were categorized accordingly.

Twenty-seven (20%) of the participants responded to the item that asked them if there was anything not mentioned that they felt may have caused or contributed to the distress of the person in the vignette. Table 29 lists the themes that emerged for this item, along with the number and percentage of participants expressing ideas categorized into each theme. As indicated by Table 29, the themes accounting for most of the responses were (a) isolation from other Mexican American students (41%), (b) loneliness and homesickness (19%), and (c) pressure from being the first in one’s family to attend college (19%). It should be noted that all of the themes but one (weak character, mentioned by 1 participant) tend to acknowledge a source of the distress external to the person. The results suggest that these participants considered isolation an important factor in the lives of Mexican American students experiencing distress.

Thirty-four (25%) of the participants responded to the item that asked them if there was any source of help not mentioned that they felt may have helped the person in the vignette deal with his or her distress. Table 30 lists the themes that emerged for this item, along with the number and percentage of participants expressing ideas categorized into each theme. The themes accounting for most of the responses were (a) additional social support
such as friends, significant others, etc. (38%) and (b) staff or faculty members serving in a supportive capacity (18%). These results mirror those obtained for the first item, in that they suggest isolation and loneliness to be important factors to consider in the etiology of psychological distress for Mexican American students.

Table 29

Attributional Themes

<table>
<thead>
<tr>
<th>Theme</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isolation from other MA’s</td>
<td>11</td>
<td>41</td>
</tr>
<tr>
<td>Lonely, homesick</td>
<td>5</td>
<td>19</td>
</tr>
<tr>
<td>Pressure of being 1st to attend college</td>
<td>5</td>
<td>19</td>
</tr>
<tr>
<td>Financial concerns</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Inadequately prepared for college</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Stress from school</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Weak character</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>
## Table 30

**Themes for Sources of Help**

<table>
<thead>
<tr>
<th>Theme</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional social support</td>
<td>13</td>
<td>38</td>
</tr>
<tr>
<td>Staff/faculty support</td>
<td>6</td>
<td>18</td>
</tr>
<tr>
<td>Peer support groups</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Alone time, relaxation</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Involvement in extra-curricular activities</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Self-help material</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Tutoring</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Stress mgmt. workshops</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Minority support services</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>God</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>
CHAPTER V
DISCUSSION

Objectives of the Study

The purpose of this study was to improve our understanding of cultural barriers that may prevent Mexican Americans from utilizing professional mental health services. The existing literature suggested a relationship between Mexican Americans’ level of acculturation and (a) their attitudes toward and utilization of mental health services, and (b) their tendency to attribute psychological distress to either internal shortcomings or external stressors.

The primary hypotheses in this study predicted a positive relationship between acculturation level and (a) previous mental health service contact, (b) attitudes toward seeking professional mental health services, (c) the endorsement of professional mental health services for persons experiencing psychological distress, and (d) a tendency to attribute psychological distress to external, rather than internal, factors. In addition, it was predicted that participants who attributed psychological problems to external factors would (a) hold more favorable attitudes toward seeking professional mental health services, and (b) be more likely to endorse professional mental health services for persons experiencing psychological distress, than participants who attributed problems to internal factors. It was also predicted that participants with previous mental health service contact would be more likely to attribute distress to external factors, while those with no previous contact would be more likely to attribute distress to internal factors. Finally, it was hypothesized that women
would be more likely than men to (a) have had previous mental health service contact, (b) hold favorable attitudes toward seeking mental health services, and (c) endorse professional mental health services for persons experiencing psychological distress.

This study also explored whether participants tended to differ in their views of psychological distress as a function of (a) gender of the person experiencing the distress, and (b) severity of the distress.

**Findings of the Study**

The primary hypotheses in this study were not supported; acculturation level was unrelated to previous mental health service contact, attitudes toward seeking mental health services, and attributional tendencies among Mexican American college students. Although a significant relationship between acculturation and the tendency to endorse mental health professionals was found, it was not in the expected direction. Less acculturated participants endorsed mental health professionals more highly than those high in acculturation. Although the reasons for this finding are unclear, they may be a function of (a) limitations of the instrument used to measure acculturation, or (b) unequal cell sizes. These issues will be addressed shortly.

The lack of support for acculturation as a predictor variable runs contrary to previous research. Results have suggested that acculturation is related to Mexican Americans’ (a) use of mental health services (e.g., Keefe, 1978; Wells et al., 1987), (b) attitudes toward seeking such help (e.g., Sanchez & Atkinson, 1983), and (c) tendencies to view the etiology of psychological distress in different ways (e.g., Edgerton & Karno, 1971; Jenkins, 1988; Newton, 1978; Parra, 1985; Parra & Yiu-Cheong So, 1983; Silva de Crane & Spielberger, 1981). One explanation for this study’s discrepant findings may be the small percentage of participants who were identified as either low (15%) or high (16%) in acculturation, thus attenuating the power of the statistical tests. Given that a relatively normal distribution was obtained for the acculturation measure, it seems logical to infer that
a larger sample size would have resulted in more participants falling in the high and low
categories. It is also possible that the lack of significant findings regarding acculturation is
at least partially due to limitations of the acculturation measure that was utilized. This issue
will be discussed shortly.

The secondary hypotheses received mixed support. Previous mental health service
contact was not related to external or internal attributional tendencies. Neither external nor
internal attributional tendencies were powerful predictors for attitudes toward seeking
services or endorsement of mental health professionals. External attributional tendencies,
however, were found to have a small but significant effect on participants’ endorsement of
mental health professionals, with higher external ratings predicting more favorable ratings
for mental health professionals. Internal attributional tendencies were not significant
predictors for attitudes toward seeking services or endorsement of mental health
professionals.

As far as this investigator is aware, this study is the first to examine Mexican
Americans’ attributional tendencies for psychological distress along an internal-external
dimension. Thus, it is not possible to place these findings within the context of previous
research. Previous work has, however, suggested that certain aspects of Mexican
American culture may encourage people to place the burden of responsibility for
psychological distress on the person experiencing the distress—and that this may inhibit
their willingness to utilize professional mental health services (e.g., Newton, 1978; Silva
de Crane & Spielberger, 1981). Thus, the relatively weak findings for the hypotheses
involving internal and external attributions are somewhat surprising. It may be that other,
more compelling attributions exist than those that were provided for the participants. It is
also possible that the method used to operationalize attributional tendencies failed to provide
the most powerful measures of attribution. The original intent was to separately combine
the four internal and four external items to create the attributional measures. The internal
consistency of each of the measures, however, was not high enough to justify this procedure. It was then decided to utilize only the two highest correlated internal and external items. Although the coefficients for the two internal and external items were significant, they were not high. Therefore, the resulting internal and external measures were less powerful than they might have been had the individual items been more highly correlated. Future research involving this attributional construct would benefit from a larger pool of items. This would likely yield a higher internal consistency for the internal and external measures, and more powerful attributional measures, than were obtained in this study.

The most significant findings in this study were those involving gender differences. While gender was unrelated to previous mental health service contact, Mexican American women were more likely than men to (a) hold favorable attitudes toward seeking help, and (b) endorse the services of mental health professionals. Gender differences with respect to attitudes toward seeking mental health services and utilization of such services have long been noted by investigators working with both European Americans (e.g., Fischer & Turner, 1970; Robertson & Fitzgerald, 1992) and Mexican Americans (e.g., Sanchez & Atkinson, 1983; Sanchez & King, 1986). Women have consistently been found to hold more favorable attitudes toward counseling and mental health services, and to be more likely to seek such services, than men. It is interesting to note that in this study gender was unrelated to prior mental health service contact. This finding may be due to the characteristics of the college student sample, a population which is relatively young and presumably has had limited opportunities to seek professional mental health services. Future research utilizing an older, more experienced sample might yield results more consistent with what was expected.

An unexpected gender finding was that women were more likely than men to attribute psychological distress to external factors. One explanation may be that women, by
virtue of their oppressed status in society, may have an enhanced sense of being vulnerable to external forces, and may be more able or willing to acknowledge the power of the environment. This may be especially true for Mexican American women, who are members of two oppressed groups—women and ethnic minorities. Alternatively, Mexican American men, by virtue of their culture’s traditional emphasis on male autonomy and self-sufficiency, may be more conditioned to see adversity as being the responsibility of the person. It is interesting to note that, although men had higher scores on the internal measure than did women, the difference was not significant. This may be attributable to limitations of the attributional measures discussed previously. Future research is necessary to test the stability of these findings. Much attention has recently been given to gender roles and their effect on men’s levels of psychological distress and subsequent help-seeking tendencies—both within the European American (Good et al., 1995; Heppner, 1995) and Hispanic (Casas, Wagenheim, Banchero, & Mendoza-Romero, 1994) communities. The findings regarding gender in this study bolster the available evidence that Mexican American men have less favorable attitudes toward mental health services than do Mexican American women. They also suggest attitudinal differences regarding psychological distress between Mexican American men and women.

An unexpected but interesting finding was that participants who were presented with the more severe problem had a tendency to make more internal attributions. This finding suggests that the more serious the problem was perceived to be, the more likely the participants were to place responsibility on the person experiencing the distress. This finding is consistent with previous research (e.g., Jenkins, 1988), which has suggested that more serious psychological problems may be more stigmatized by the Mexican American community and viewed as the result of an internal flaw rather than difficult life circumstances.
Limitations of the Study

There are several inherent limitations in the ARSMA, which was utilized to operationalize acculturation. The ARSMA consists of a number of multiple-choice items which assess participants’ attitudes, primarily toward specific behaviors. For example, several items assessed participants’ preferences for food, music, television, and movies, as well as language preference and choice of self-label. As Casas and Vasquez (1989) and Rogler et al. (1989) have noted, acculturation is a complex construct that operates on many different levels. A person’s behavioral tendencies may not necessarily reflect her or his actual values; for example, a person’s preference to listen to music only in English may or may not actually be reflective of a more acculturated orientation. The second limitation of the ARSMA concerns its status as a self-report instrument. Negy and Woods (1992a) suggested that the assessment of acculturation by self-report can be problematic, in that individuals are often unable to objectively represent themselves. These authors suggested that, in order to obtain a more accurate portrayal of a person’s true acculturation level, investigators collect information from other sources regarding that person’s behavior, attitudes, and identity.

The method in which acculturation level was determined may constitute another limitation of this study. The item range of the ARSMA was divided into three equal parts and participants were classified according to their item-average scores. Negy and Woods (1992) noted that when such a method is used to classify individuals on an acculturation scale, conflicting results may occur due to artificially imposed category levels. For example, in this study the cutoff between the low and medium categories was 2.3 and 2.4. Although participants with these two scores would be classified into different categories, their actual level of acculturation would be practically the same. One way to avoid this in future research would be to eliminate the medium acculturation category and utilize only the
low and high categories. This would, however, necessitate a substantially larger sample than was obtained for this study.

Finally, the ARSMA may be a conceptually flawed instrument. It is based on a one-dimensional model of acculturation where participants must, in essence, choose between one culture or the other. It does not assume that an individual can be highly acculturated to both the American and Mexican cultures. As mentioned earlier, more recent models of acculturation have recognized that many individuals are highly functional in both cultures (e.g., Buriel, 1984; Ramirez, 1984; Rogler et al., 1991). Future research utilizing this construct would benefit from a measure based on a two-dimensional model of acculturation which allows for a true “bicultural” orientation.

The issue of sample size was raised earlier. It is possible that the lack of significant findings for acculturation was at least in part due to the relatively small number of participants who were categorized as either low or high. Whether future research in this area uses a similar method to categorize participants, or whether only extreme groups are utilized as suggested above, a larger sample size is indicated. This becomes a potentially troublesome issue when conducting research with an underrepresented group, as large numbers of individuals are often difficult to target.

This study utilized only one measure to represent each construct. According to Cook and Campbell (1979), such “mono-operation bias” is a threat to the internal validity of a study. These authors recommend utilizing multiple measures to assess any given construct. Furthermore, they recommend avoiding “mono-method bias” by utilizing different methods of collecting data (also see Bordens & Abbott, 1988). Thus, in addition to paper and pencil measures such as those used in this study, alternative methods such as verbal recording and/or behavioral observation might also be utilized. Since self-report information regarding an individual’s acculturation level may be unreliable (e.g., Negy &
Woods, 1992), future research involving this construct might benefit from a second type of assessment tool such as a verbal interview procedure.

The use of a college student sample was both a strength and a limitation of this study. As has been discussed previously, Mexican American college students experience significantly greater levels of stress than do their Anglo counterparts (Munoz, 1986; Nájera, 1990; Saldaña, 1994; Solberg et al., 1994), and are at greater risk for dropping out of college prematurely (Báron, 1991; Chapa & Valencia, 1993; Pérez & Salazar, 1993). Therefore, examination of this populations' attitudes toward and utilization of mental health services seems warranted. However, the relatively young age of most college students makes this a relatively inexperienced population—at least in terms of attitudes toward and experience with the mental health system. As was mentioned earlier, the participants in this sample may have had limited opportunities to seek out mental health services. It is also possible that at this point in their lives these students' attitudes were more a reflection of their parents' or families' beliefs than their own. Given the hardships that continue to be experienced by Mexican American college students, continued research with this population is necessary. It is, however, important to acknowledge the difficulties and limitations that this type of sample brings.

Finally, it should be noted that a true random sample of Mexican American college students was not utilized in this study. The participants were solicited from Hispanic and Mexican American student organizations, and therefore may not have been representative of all Mexican American college students. In fact, the majority of Mexican American college students may not belong to such organizations. Given the difficulties inherent in targeting large numbers of individuals from underrepresented groups, such "convenience" sampling is sometimes necessary. It is important, however, to recognize the limitations of such sampling procedures.
Directions for Future Research

Given the discrepancy between the findings of this study and those of previous research regarding acculturation, continued work in this area seems warranted. A number of explanations for the lack of significant findings have been posited, including limited sample size, methodological issues, and limitations of the acculturation measure. Future research that addresses these shortcomings might provide valuable information about the relationship between acculturation and Mexican Americans' (a) attitudes toward and utilization of mental health services, and (b) attributional tendencies for psychological distress. Specifically, research utilizing a larger sample size and a more powerful index of acculturation might elucidate findings that were obscured in this study and yield results more consistent with previous work.

Despite the relatively weak findings obtained for attributional tendencies, this construct may still hold promise for further exploration. Although potential methodological flaws which have been discussed may have obscured the results, external attributional tendencies did emerge as a significant predictor for participants' endorsement of professional mental health services. It will be important to test the significance of this variable using a more powerful measure of attribution. In addition, future research is necessary to gain clarity on the utility of the internal attribution variable, and to determine whether the lack of significant findings is due to methodological limitations or a more basic problem with the construct. Existing research on Mexican Americans' attitudes toward psychological distress (e.g., Edgerton & Kano, 1971; Jenkins, 1988; Newton, 1978; Parra, 1985; Parra & Yiu-Cheong So, 1983; Silva de Crane & Spielberger, 1981) suggests the internal-external dimension to be one worth continued pursuit.

An interesting finding regarding gender was that women were more likely than men to attribute psychological distress to external factors. Future research is necessary to determine the stability of these findings; confirmatory support might help to explain the
consistent finding that Mexican American men hold less favorable attitudes toward seeking psychological help and are less likely to actually seek help than women. If men are less prone to attributing psychological distress to environmental stressors, they may be more likely to attribute such distress to internal shortcomings and more likely to experience some degree of shame about experiencing distress.

Participants who read the vignette depicting the more severe problem tended to make more internal attributions. If this finding holds for future studies, we will gain important information about Mexican Americans' tendencies to stigmatize individuals who are experiencing severe levels of distress. It should be noted that even the severe vignette depicted a student experiencing problems that are not atypical for college students to experience. Further research in this area might assess Mexican Americans' attributional tendencies for problems on the more severe end of the continuum; if this study's findings are reliable, perhaps participants would endorse internal attributions to an even greater degree.

Finally, results of the qualitative data gathered in this study have suggested several potentially rich areas for further research. For the most part, these data suggested that external factors such as isolation from other Mexican American students, homesickness and the pressure of attending college were more important variables than internal factors in accounting for the distress of the person in the vignette. Social support was most often mentioned as the source of help they would recommend for the person in the vignette. These data could inform future research in three different ways. First, more powerful attributional measures could be created by examining the qualitative responses and constructing attributional measures around these. Second, responses provided by the participants suggest that social support is a source of help valued highly by Mexican American college students. Future quantitative research might confirm this finding. Third, the data obtained could provide the basis for further qualitative work. This is an area that
may be particularly well suited to qualitative inquiry, as demonstrated by Newton’s (1978) investigation of Mexican Americans’ attitudes about mental illness and mental health services. The rich responses obtained by Newton gave substance to concepts which may be too complex to assess by solely quantitative means.

**Implications for Counseling**

Although the primary hypotheses in this study were not supported, the findings that were obtained have potentially important implications for counseling. Investigators are becoming increasingly aware of and concerned with gender differences with respect to attitudes toward and utilization of mental health services. For the Mexican American community, the tendency for men to avoid such services may be exaggerated due to that culture’s traditional emphasis on male autonomy and self-sufficiency (e.g., Casas et al., 1994). As Good et al. (1995) have noted, however, there may be a strong link between the traditional male gender role and psychological distress. Therefore, one could infer that many males—particularly many Mexican American males—may be in the position of having a great need for mental health services but a low probability of obtaining them. Counseling psychologists at college campuses may be in a unique position to deal with this problem. Robertson and Fitzgerald (1992) found that alternative, non-traditional modes of intervention such as outreach efforts and seminars were rated more favorably by men with traditional male gender role values. Thus, those working in college or university counseling centers have a unique opportunity to reach out to males that might otherwise never receive intervention.

Findings obtained in this study suggest that Mexican American men may be less attuned to environmental factors which contribute to psychological distress than Mexican American women, and that Mexican American students in general tend to stigmatize people with more severe problems. Therefore, it is important for mental health providers working with this population to be able to provide basic education regarding the etiology of
psychological distress. It is important to be able to “normalize” distress by framing it as an ordinary reaction to an aversive situation rather than as a dysfunction or pathology. The findings obtained in this study suggest that individuals who are able to attribute distress to external sources are more likely to be open to seeking the services of a mental health professional.

Conclusion

Chapa and Valencia (1993) estimated that the Latino population in this country could exceed 30 million by the beginning of the next century. The vast majority of these individuals will be Mexican Americans. In spite of their burgeoning numbers, however, this is a population that continues to fare poorly in the educational and labor arenas. Chapa and Valencia noted that in 1990 only 5% of all Mexican Americans over the age of 25 had completed four years of college. The college completion rate was 9% for the entire Hispanic population, and 22% for non-Hispanics. The participants in this study indicated that only 7% of their parents had completed a college degree; the vast majority of the parents never reached high school. The lack of success for Mexican Americans in higher education is reflected in labor statistics, which indicate that this group is concentrated in low-skill, low-paying jobs (Pérez & Salazar, 1993). This is also reflected in the sample obtained for this study. Twenty-nine percent of the participants’ fathers, and over 50% of their mothers, were classified as unskilled or semiskilled laborers. Chapa and Valencia (1993) reported that over 28% of all Mexican Americans in this country live below the poverty level.

Pérez and Salazar (1993) argued that education is the most important issue to consider when examining Latino demographic trends. These authors suggested that “it is critical to understand the factors associated with their [Latinos] low educational attainment and limited success in U.S. schools . . .” (Pérez & Salazar, 1993, p. 197). It was noted earlier that Mexican American college students experience greater levels of stress than do
Anglo students. These students must deal with the traditional stresses faced by most college students, as well as the additional burdens faced by underrepresented groups in majority-dominated institutions. This idea was illuminated by several of the participants, who cited the pressure of being the first in one’s family to attend college as a primary cause of psychological distress.

It is clear that Mexican American college students are, for several reasons, at risk for developing adjustment difficulties. Therefore, it seems vital to have a better understanding of their underuse of mental health services. This was an exploratory study designed to illuminate cultural barriers that may prevent Mexican Americans from seeking needed mental health services. Despite the lack of significant findings for the major hypotheses, several interesting and potentially important areas for future research and counseling practice did emerge. Thus, a substantial gap in our knowledge has been narrowed, if not eliminated. Mexican Americans comprise a large and rapidly increasing portion of our population. For the vast majority of these individuals, things that many Americans take for granted remain unattainable. If we do not work to understand and change this state of affairs, we all stand to lose.
REFERENCES


This is a study about Mexican American culture, psychological distress and help-seeking. In addition to being asked to provide some information about yourself and your family, you will also be asked to respond to two questionnaires. In addition, you will be asked to read a brief story and respond to some questions based on the story. Your participation is completely voluntary; you may stop now or at any time during your participation. Although you are encouraged to respond to every question, you may skip questions that you do not wish to answer. Please be aware that all of your responses are completely confidential and anonymous. Upon completion of your participation, your name will be entered into a drawing for one of two $50 U.S. Savings Bonds. Please note that the only thing you are guaranteed is a chance at winning one of the Savings Bonds. Please turn the page and begin.
APPENDIX B

DEMOGRAPHIC SHEET
Please answer the following questions.

1. Sex (circle one)  M  F

2. Age ______

3. What year of college are you currently in? (i.e., 1st, 2nd, 3rd, etc.) ___________

4. What is your marital status? (circle one) single  married  divorced  separated

5. What is your religious preference? ____________________________

6. What are your current living arrangements? (i.e., living on own, with parents, etc.) ____________________________

7. What is the marital status of your parents? (circle one) married  divorced  separated

8. What is your father’s occupation? ____________________________

9. What is the highest level of education attained by your father? (circle one letter)
   a. None
   b. Left school before completing high school
   c. Some high school
   d. High school diploma
   e. Some college
   f. Two-year college degree (AA)
   g. Four-year college degree (BA, BS, etc.)
   h. Some graduate or professional school
   i. Graduate or professional degree (MA, MS, MBA, PhD, JD, MD)

10. What is your mother’s occupation? ____________________________

11. What is the highest level of education attained by your mother? (circle one letter)
   a. None
   b. Left school before completing high school
   c. Some high school
   d. High school diploma
   e. Some college
   f. Two-year college degree (AA)
   g. Four-year college degree (BA, BS, etc.)
   h. Some graduate or professional school
   i. Graduate or professional degree (MA, MS, MBA, PhD, JD, MD)
APPENDIX C

ACCULTURATION RATING SCALE FOR MEXICAN AMERICANS
Please circle the letter next to the answer that most applies to you, in most situations.

1. What language do you speak?
   a. Spanish only
   b. Mostly Spanish, some English
   c. Spanish and English about equally (bilingual)
   d. Mostly English, some Spanish
   e. English only

2. What language do you prefer?
   a. Spanish only
   b. Mostly Spanish, some English
   c. Spanish and English about equally (bilingual)
   d. Mostly English, some Spanish
   e. English only

3. How do you identify yourself?
   a. Mexican
   b. Chicano(a)
   c. Mexican American
   d. Spanish American, Latin American, Hispanic American, American
   e. Anglo American or other

4. Which ethnic identification does (did) your mother use?
   a. Mexican
   b. Chicana
   c. Mexican American
   d. Spanish American, Latin American, Hispanic American, American
   e. Anglo American or other

5. Which ethnic identification does (did) your father use?
   a. Mexican
   b. Chicano
   c. Mexican American
   d. Spanish American, Latin American, Hispanic American, American
   e. Anglo American or other

6. What was the ethnic origin of the friends and peers you had as a child up to age 6?
   a. Almost exclusively Mexicans, Chicanos, Mexican Americans (La Raza)
   b. Mostly Mexicans, Chicanos, Mexican Americans
   c. About equally Raza (Mexicans, Chicanos, or Mexican Americans) and Anglos or other ethnic groups
   d. Mostly Anglos, Blacks, or other ethnic groups
   e. Almost exclusively Anglos, Blacks, or other ethnic groups

7. What was the ethnic origin of the friends and peers you had as a child from age 6 to 18?
   a. Almost exclusively Mexicans, Chicanos, Mexican Americans (La Raza)
   b. Mostly Mexicans, Chicanos, Mexican Americans
   c. About equally Raza (Mexicans, Chicanos, or Mexican Americans) and Anglos or other ethnic groups
   d. Mostly Anglos, Blacks, or other ethnic groups
   e. Almost exclusively Anglos, Blacks, or other ethnic groups
8. Whom do you now associate with in the outside community?
   a. Almost exclusively Mexicans, Chicanos, Mexican Americans (La Raza)
   b. Mostly Mexicans, Chicanos, Mexican Americans
   c. About equally Raza (Mexicans, Chicanos, or Mexican Americans) and Anglos or other ethnic groups
   d. Mostly Anglos, Blacks, or other ethnic groups
   e. Almost exclusively Anglos, Blacks, or other ethnic groups

9. What is your music preference?
   a. Only Spanish
   b. Mostly Spanish
   c. Equally Spanish and English
   d. Mostly English
   e. English only

10. What is your TV viewing preference?
    a. Only programs in Spanish
    b. Mostly programs in Spanish
    c. Equally Spanish and English programs
    d. Mostly programs in English
    e. Only programs in English

11. What is your movie preference?
    a. Spanish-language movies only
    b. Spanish-language movies mostly
    c. Equally English/Spanish
    d. English-language movies mostly
    e. English-language movies only

12. Where were you born?
    __ Mexico ___ U.S. ___ Other
    Where was your father born?
    __ Mexico ___ U.S. ___ Other
    Where was your mother born?
    __ Mexico ___ U.S. ___ Other
    Where was your father's mother born?
    __ Mexico ___ U.S. ___ Other
    Where was your father's father born?
    __ Mexico ___ U.S. ___ Other
    Where was your mother's mother born?
    __ Mexico ___ U.S. ___ Other
    Where was your mother's father born?
    __ Mexico ___ U.S. ___ Other

On the basis of the above answers, circle the generation that best applies.
   a. 1st generation = subject born in Mexico or other
   b. 2nd generation = subject born in U.S., either parent born in Mexico or other
   c. 3rd generation = subject born in U.S., both parents born in U.S., and all grandparents born in Mexico or other
   d. 4th generation = subject and parents born in U.S. and at least one grandparent born in Mexico or other, with remainder born in U.S.
   e. 5th generation = subject and parents born in U.S., and all grandparents born in U.S.
13. Where were you raised?
   a. In Mexico only
   b. Mostly in Mexico, some in U.S.
   c. Equally in U.S. and Mexico
   d. Mostly in U.S., some in Mexico
   e. In U.S. only

14. What contact have you had with Mexico?
   a. Raised for 1 year or more in Mexico
   b. Lived for less than 1 year in Mexico
   c. Occasional visits to Mexico
   d. Occasional communications (letters, phone calls, etc.) with people in Mexico
   e. No exposure or communications with people in Mexico

15. What is your food preference?
   a. Exclusively Mexican food
   b. Mostly Mexican food, some American
   c. About equally Mexican and American
   d. Mostly American food
   e. Exclusively American food

16. In what language do you think?
   a. Only in Spanish
   b. Mostly in Spanish
   c. Equally in English and Spanish
   d. Mostly in English
   e. Only in English

17. Can you read Spanish? ___ yes ___ no
   Can you read English? ___ yes ___ no

   Which do you read better?
   a. Read only in Spanish
   b. Read Spanish better than English
   c. Read both Spanish and English equally well
   d. Read English better than Spanish
   e. Read only English

18. Can you write in Spanish? ___ yes ___ no
   Can you write in English? ___ yes ___ no

   Which do you write better?
   a. Write only in Spanish
   b. Write Spanish better than English
   c. Write both Spanish and English equally well
   d. Write English better than Spanish
   e. Write only in English
19. If you consider yourself a Mexican, Chicano(a), Mexican American, member of La Raza, or however you identify this group, how much pride do you have in this group?
   a. Extremely proud
   b. Moderately proud
   c. Little pride
   d. No pride but do not feel negative toward group
   e. No pride and feel negative toward La Raza

20. How would you rate yourself?
   a. Very Mexican
   b. Mostly Mexican
   c. Bicultural
   d. Mostly Anglicized
   e. Very Anglicized
APPENDIX D

ATTITUDES TOWARD SEEKING PROFESSIONAL PSYCHOLOGICAL HELP SCALE
Please read each statement and indicate how much you agree or disagree, using the following scale:

   strongly disagree (1) ... disagree (2) ... agree (3) ... strongly agree (4)

Please express your frank opinion in rating the statements. There are no right or wrong answers. Please rate every statement.

1. Although there are counseling centers for people with psychological troubles, I would not have much faith in them.

2. If a good friend asked my advice about a psychological problem, I might recommend that s/he see a counselor.

3. I would feel uneasy going to a counselor because of what some people would think.

4. A person with a strong character can get over psychological conflicts by him/herself, and would have little need of a counselor.

5. There are times when I have felt completely lost and would have welcomed professional advice for a personal or emotional problem.

6. Considering the time and expense involved in counseling, it would have doubtful value for a person like me.

7. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.

8. I would rather live with certain psychological conflicts than go through the ordeal of getting counseling.

9. Emotional difficulties, like many things, tend to work out by themselves.

10. There are certain problems which should not be discussed outside of one’s immediate family.

11. A person with a serious emotional disturbance would probably feel most secure in a good counseling center.

12. If I believed I was having a psychological breakdown, my first inclination would be to get professional attention.

13. Keeping one’s mind on a job is a good solution for avoiding personal worries and concerns.

14. Having been a counseling center client is a blot on a person’s life.

15. I would rather be advised by a close friend than by a counselor, even for an emotional problem.

16. A person with an emotional problem is not likely to solve it alone; s/he is likely to solve it with professional help.
17. I resent a person - professionally trained or not - who wants to know about my personal difficulties.

18. I would want to get psychological attention if I was worried or upset for a long period of time.

19. The idea of talking about problems with a counselor strikes me as a poor way to get rid of emotional conflicts.

20. Having had psychological problems carries with it a burden of shame.

21. There are experiences in my life I would not discuss with anyone.

22. It is probably best not to know everything about oneself.

23. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in counseling.

24. There is something admirable in the attitude of a person who is willing to cope with his/her conflicts and fears without resorting to professional help.

25. At some future time I might want to have psychological counseling.

26. A person should work out his/her own problems; getting psychological counseling would be a last resort.

27. Had I received treatment in a counseling center, I would not feel that it ought to be "covered up."

28. If I thought I needed psychological help, I would get it no matter who knew about it.

29. It is difficult to talk about personal affairs with highly educated people such as doctors, teachers, and clergymen.
APPENDIX E

INSTRUCTIONS FOR VIGNETTES
Following is a description of a student who is experiencing various difficulties. Following the description are several questions. Please answer the questions according to your opinion. You are not expected to have any expert knowledge, and there are no right or wrong answers.
Roberto is an 18 year old first-year Chicano college student. He is the first in his family to attend college, and his parents are very proud of this. Roberto lives at the university, and has never been away from home for an extended period of time. He has been at school for about two months now, and mainly for financial reasons, has not been able to return home for a visit. He feels different and “out of place” at the university, and “not as smart” as other students. Roberto’s family does not have much money, so he works 20 hours per week at a local restaurant to help make ends meet. As a result, he often stays up late into the night to get his studying done. Midterm exams are coming up, and Roberto is worried that he will not do well. For about the first month, he had been feeling sad and down, and somewhat anxious. Lately, though, Roberto has been feeling worse; he feels depressed more days than not, has been sleeping more than usual, and doesn’t have much of an appetite anymore. He is unable to concentrate on anything for more than a few minutes at a time, and even the simplest decisions have become difficult and time-consuming. He has been arriving late to work, and is worried that he might lose his job. Roberto has become frustrated with himself, and wonders why he doesn’t just “snap out of it.” He has met other Mexican American students, and they appear to be doing OK. Roberto has some friends at the university, but generally feels alone and isolated. He does not want to tell his parents about his problems for fear of “letting them down.” Roberto feels concerned and unsure of what to do about his problems.

In your opinion, how severe are Roberto’s problems? (circle one)

1 2 3 4 5
not severe at all moderately severe highly severe
APPENDIX G

VIGNETTE B
Julia is an 18 year old first-year Chicana college student. She is the first in her family to attend college, and her parents are very proud of this. Julia lives at the university, and has never been away from home for an extended period of time. She has been at school for about two months now, and mainly for financial reasons, has not been able to return home for a visit. She feels different and “out of place” at the university, and “not as smart” as other students. Julia’s family does not have much money, so she works 20 hours per week at a local restaurant to help make ends meet. As a result, she often stays up late into the night to get her studying done. Midterm exams are coming up, and Julia is worried that she will not do well. For the first month or so, she had been feeling sad and down, and somewhat anxious. Lately, though, Julia has been feeling much worse; she feels depressed most of the time, often cries uncontrollably, and sometimes cannot bring herself to get out of bed. On two occasions in class, Julia suddenly felt very strange; her heart started beating rapidly, she felt lightheaded and disoriented, and had an almost uncontrollable urge to run out of the room. These episodes were extremely frightening to Julia, and she fears that it might happen again. She has missed classes and work, and is almost certain that she will lose her job. Julia feels ashamed of herself and her inability to “snap out of it.” She has met other Mexican American students, and they appear to be doing OK. Julia does not have many friends at the university, and feels alone and isolated. She does not want to tell her parents about her problems for fear of “letting them down.” She feels hopeless about things ever getting better.

In your opinion, how severe are Julia’s problems? (circle one)

1  2  3  4  5
not severe at all moderately severe highly severe
APPENDIX H
ATTRIBUTIONAL RATINGS
Please indicate, in your opinion, the likelihood of each of the following potential causes of Roberto's/Julia's problems by circling the appropriate number. Please circle only one number for each potential cause.

1. **Hereditary**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>not a cause at all</td>
<td>possibly a cause</td>
<td>definitely a cause</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. **Physical problem**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>not a cause at all</td>
<td>possibly a cause</td>
<td>definitely a cause</td>
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</tbody>
</table>

3. **Negative thinking**

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<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<tbody>
<tr>
<td>not a cause at all</td>
<td>possibly a cause</td>
<td>definitely a cause</td>
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</tbody>
</table>

4. **Weakness of character, personality flaw**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<tbody>
<tr>
<td>not a cause at all</td>
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<td>definitely a cause</td>
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</tbody>
</table>

5. **Problems with other people**

<table>
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<th>1</th>
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<th>3</th>
<th>4</th>
<th>5</th>
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<tbody>
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6. **Major life changes**

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<tr>
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<th>3</th>
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<td>definitely a cause</td>
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</table>

7. **School or work-related stress, pressures**

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<th>4</th>
<th>5</th>
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<td>definitely a cause</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
8. Discrimination or unfair treatment

1  2  3  4  5
not a cause at all    possibly a cause    definitely a cause

In the space below, please list anything not mentioned above that you think may have caused or contributed to Roberto's/Julia's distress.
APPENDIX I

RATINGS FOR SOURCES OF HELP
Please indicate, in your opinion, how helpful each of the following potential sources of help would be in helping Julia/Roberto deal with her/his problems. Again, please circle only one number for each potential source of help.

1. **Herself/Himself**

   1. 2. 3. 4. 5.
   
   not helpful at all possibly helpful definitely helpful

2. **Family**

   1. 2. 3. 4. 5.
   
   not helpful at all possibly helpful definitely helpful

3. **Friends**

   1. 2. 3. 4. 5.
   
   not helpful at all possibly helpful definitely helpful

4. **Clergy or religious leader**

   1. 2. 3. 4. 5.
   
   not helpful at all possibly helpful definitely helpful

5. **Faith healer ("curandero")**

   1. 2. 3. 4. 5.
   
   not helpful at all possibly helpful definitely helpful

6. **Medical doctor or physician**

   1. 2. 3. 4. 5.
   
   not helpful at all possibly helpful definitely helpful

7. **Mental health professional (counselor, psychologist, psychiatrist, social worker)**

   1. 2. 3. 4. 5.
   
   not helpful at all possibly helpful definitely helpful
In the space below, please list any source of help not mentioned above that you think may help Julia/Roberto to deal with her/his distress.
APPENDIX J

ASSESSMENT OF PROFESSIONAL MENTAL HEALTH CONTACT
Please answer the following questions to the best of your ability.

1. Have you ever received, or are you currently receiving, professional counseling or mental health services? ___ yes ___ no

2. Has any member of your family ever received, or are they currently receiving, professional counseling or mental health services? ___ yes ___ no

3. Have any of your friends ever received, or are they currently receiving, professional counseling or mental health services? ___ yes ___ no
APPENDIX K
DEBRIEFING
The purpose of the study that you have just participated in is to investigate how some Mexican American college students view psychological distress, and how these views are related to their attitudes toward seeking professional psychological help. It is hoped that this study will help us learn more about cultural differences in how psychological problems are seen and dealt with. This study is being conducted by Juan Riker under the supervision of Dr. Pamela Highlen, as partial fulfillment of the requirements for the doctoral degree in the Department of Psychology at The Ohio State University. If you would like more information or have any questions, please call Juan Riker at (409) 845-4427, ext.134, or (512) 448-2618. If the process of participating in this study has led you to think about counseling for yourself, this service is available to you at the University Counseling Center/Student Counseling Services. The number there is 448-8538/845-4427, and counseling is available to all students at St. Edward's University/Texas A&M University. The drawing for the two $50 U.S. Savings Bonds will take place later this semester, at which time the winners will be notified. Thank you very much for your participation; it is greatly appreciated.