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"Where we're from, that's what they do": An Examination of Female Mexican Immigrants' Perceptions of Mental Health and Treatment in Clarkston, Georgia

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An abstract of
A thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
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Abstract

Introduction
Globally, there are billions of people who may not subscribe to the same psychological beliefs as those of Western-based mental health practitioners; millions of those people live in the United States. Many of them have difficulty accessing mental health care, yet few researchers have explored reasons why beyond the policy or stigma levels.

Methods
The purpose of this research is to examine perceptions of mental health and treatment among one such population. In order to do this, the researcher used a mixed methods approach, utilizing a survey and focus group. A systematic literature review was also performed to supplement the small available sample size.

Research
The researcher divided the research question into six themes: definition of a migrant, effects of mental health on physical health, prevalence of mental health issues in the general population, prevalence of mental health issues among immigrants, non-Western views on mental health, mental health stigma, and mental health services available in Mexico and the United States. There has been much research done in each of the areas, however, there is not enough published literature on the intersection of all these themes. For the primary research, the researcher chose a mixed methods study design for this research, using a short quantitative survey and focus groups discussion (FGD). In order to be included, potential participants must have fit each of the following criteria: non-native English speaking women over the age of 18 originating from Mexico who were participating in a social support group at a specific apartment complex located in Clarkston, GA. In total six (6) participants completed the survey, and four (4) participated in the focus group.

Results
The results of the quantitative data found that participants had significantly lower perceived knowledge in the areas of symptoms and treatment (average perceived knowledge in those categories were 66.67% and 61.11%, respectively). Survey participants also unanimously reported that they would never choose to go to a doctor for mental health reasons. The results focus on the eight selected themes identified by the researcher. Six of the themes were inductive, and the other two emerged from the data during analysis. The six inductive themes were: experiences and perceptions with doctors/psychology; promoters and hindrances to help seeking decisions; structural barriers and facilitators to care; mental versus physical health; cause of mental health changes; vocabulary; confidants; and language as a source of isolation.

Discussion
After an examination of the literature and analysis of the primary research, the researcher prioritized potential interventions at each of the socio-ecological model based on emergent data. The researcher recommends the continuation and expansion of social support groups for medically underserved populations in the Clarkston, GA area, as these interventions are relatively low-resource and have high levels of impact.

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Introduction

According to the National Institute of Health, mental health issues impacted approximately 18% of American adults in 2014 (NIMH, 2014). However, these statistics refer to those who can access mental health care and who are being diagnosed primarily by Western-trained medical professionals. Globally, there are billions of people who may not subscribe to the same psychological beliefs as those of Western-based mental health practitioners; millions of those people live in the United States. Many of them have difficulty accessing mental health care, yet few researchers have explored reasons why beyond the policy or stigma levels.

The purpose of this research is to examine perceptions of mental health and treatment among one such population. In order to explore this topic, the following research question was formulated: "What are the perceptions of mental health issues and treatment among immigrant women participating in a social support group in Clarkston, GA?" In order to do this, the researcher used a mixed methods approach, utilizing a survey and focus group. A systematic literature review was also performed to supplement the small available sample size.

This research is significant because it allows an underserved population to express their views on perceptions of mental health in their community. By utilizing members of an underserved community, the researcher is allowing this population to contribute to their own mental health. These contributions may aid mental health practitioners to better serve populations that are traditionally not part of the mental health system in the United States.

Glossary of Terms

For the purposes of this document, the listed terms are defined in the following way:

Immigrant: An individual who is not a U.S. citizen or U.S. national. (Security, 2016)

- Legal immigrant: "An alien who has been granted the right by the USCIS to reside permanently in the United States and to work without restrictions in the United States. Also known as a Lawful Permanent Resident (LPR)." (Service, 2016)
- Illegal immigrant: "Also known as an 'Undocumented Alien,' is an alien who has entered the United States illegally and is deportable if apprehended, or an alien who entered the United States legally but who has fallen "out of status" and is deportable." (Service, 2016)

Mental Health: "Mental health includes our emotional, psychological, and social well-being." (Medicine, 2016)

Literature Review Methodology

Introduction

This section describes the methods used to complete the systematic literature review. The researcher divided the research question into six themes: definition of a migrant, effects of mental health on physical health, prevalence of mental health issues in the general population, prevalence of mental health issues among immigrants, non-Western views on mental health, mental health stigma, and mental health services available in Mexico and the United States. For each theme, the researcher gathered published sources that provided evidence-based information on the topic.

Data Collection and Storage

Several research databases in the fields of: public health, psychology, sociology, law, and anthropology were used. The chosen databases were: PubMed, PsycINFO, EMBASE, Anthropology Plus, Academic Search Complete, SocINDEX, JSTOR, and U.S. Census data. Data sources were considered only if they were available in English. The researcher searched for the following sets of keywords:

- "Immigrant" AND "mental health" AND "Mexico"
- "Non-Western philosophy" AND "mental health"
- "Definition immigrant"
- "Mental health" AND "stigma" AND "Mexico"
- "Mental health issues" AND "prevalence"
- "Mental health" AND "physical health" AND "interaction"
- "Mental health services" AND "Mexico"

- "Mental health services" AND "United States"

Additional resources included: the United Nations (UN), United States Department of Health and Human Services (DHHS), United States Internal Revenue Service (IRS), and the United States Department of Homeland Security (DHS). Examination of references within articles also proved to be fruitful as they provided richer and more specific data. Source relevance was determined by article title, abstract, and keyword(s) in the title or description. The researcher then entered all data into bibliographic software (EndNote X7) for digital storage.

Inclusion and Exclusion Criteria

In order to be included, articles had to meet the following criteria:

- Sources published in the year 2000 or later.
- Peer-reviewed or from a publishing source such as a governing body (the United Nations is one such governing body)
- Priority given to literature specifically about Mexico or Mexican immigrants
- Book chapters from reputable sources, published documents by a governing body, and peer-reviewed journal articles

Sources were excluded if:

- Full text was not publicly available or otherwise available
- Article was not available in English

Results

The researcher completed the review of existing literature between June and December 2015. In total, 606 citations were identified. 49 duplicate citations were eliminated, leaving 557

sources. A further 484 sources were filtered out due to lack of relevance. After these processes, 73 citations were identified as useful and relevant for the literature review.

Conclusion

The utilization of databases from multiple disciplines allowed a more comprehensive review of the research question than research from one database alone. The researcher found many interdisciplinary articles, further helping to explain the interaction between often-disparate subjects. Search methods were sufficient in their ability to provide adequate information pertaining to the research question.

Literature Review

Introduction

A systematic literature review was completed as part of this research. In this section, the researcher will synthesize the results of the literature review on the following topics: definitions of migrants; immigration in Georgia; effects of mental health issues on physical health; non-Western views on mental health; mental health stigma; prevalence of mental health issues in the general public; and mental health services in the United States and in Mexico. Finally, the researcher will identify gaps in currently available literature.

Definitions of "Migrant"

In order to understand the need for culturally relevant mental health care for migrant populations, it is necessary to understand what a migrant is. According to the United Nations definition outlined in the UN Convention on the Rights of Migrants, a migrant is someone, "any person who lives temporarily or permanently in a country where he or she was not born, and has acquired some significant social ties to this country." (United Nations Educational, 2016) However, the definition of a migrant depends heavily the data source and legal system in place. This can have an astounding impact on the rights and protections of a migrant around the world.

The United States has a historically difficult relationship with immigration. Currently, the U.S. Department of Homeland Security (DHS) has the authority to define what a migrant is, not the Department of State, which is common in many other countries. The U.S. DHS definition of a migrant is: "A person who leaves his/her country of origin to seek residence in another country" (United Nations Educational, 2016) A legal immigrant, or permanent legal resident, is, "[a]n alien admitted to the United States as a lawful permanent resident" (United Nations

Educational, 2016). Permanent legal residents are legally afforded rights and the ability to live in the United States permanently. Illegal immigrants are defined by the U.S. Internal Revenue Service (IRS) as someone, "…who has entered the United States illegally and is deportable if apprehended, or an alien who entered the United States legally but who has fallen 'out of status' and is deportable" (Service, 2016).

Although migrants have different rights and protections depending on their legal status, they often experience increased levels of fear and stress due to both physical and environmental conditions in which they live. Therefore, it is necessary to examine the effects of mental health issues on physical health, prevalence of mental health issues in immigrant populations, and non-Western views on mental health.

Immigration in Georgia

According to estimates calculated from 2009 to 2013, Gwinnett County had the most Mexican immigrants in the state of Georgia, followed by Cobb County, Fulton County, and DeKalb County (Institute, 2014). In 2016, the Migration Policy Institute published revised estimates of unauthorized immigrants by county. The most recent calculations maintain almost nearly the same county rankings of where most immigrants live. Table 1 shows the estimates of the number of illegal immigrants by county:

Table 1 Estimates of the number of illegal immigrants by county and country of origin in Georgia, 2016 (Institute, 2016)

County	Estimated Number Illegal Immigrants	Number Illegal Immigrants of Mexican Origin (% of total)
Gwinnett	80,000	38,000 (47%)
Cobb	43,000	21,000 (49%)
Fulton	44,000	23,000 (53%)
DeKalb	51,000	24,000 (46%)

Although the raw numbers of illegal immigrants may seem alarming to some, Georgia has seen a decrease in rates of unauthorized immigrant populations over the last several years (Institute, 2014). There was a decrease in unauthorized immigrants from Mexico in Georgia between 2009 and 2012 (Institute, 2012). In 2012, Mexican immigrants made up approximately 28% of all immigrants to the United States, totaling around 11.6 million (Institute, 2012).

There are a variety of reasons that inspire Mexicans to come to the United States. In a report conducted by the Pew Research Center in 2009, findings showed that Mexican immigrants rated the following topics as "very big" influences on their leaving Mexico: crime (81% of respondents), economic problems (75%), illegal drugs (73%), and corrupt political leaders (68%) (Center, 2009). According to the U.S. Department of State:

> "[The] Mexican government has been engaged in an extensive effort to counter organized criminal groups that engage in narcotics trafficking and other unlawful activities throughout Mexico. The groups themselves are engaged in a violent struggle to control drug trafficking routes and other criminal activity." (State, 2014)

In the Pew report, approximately 33% of Mexicans surveyed stated that they would move to the United States, most of whom believed life to be better in the United States (Center, 2009). More than half of respondents in that study reported that, should they move to the United States, they would consider doing so illegally (Center, 2009).

There are many barriers that Mexicans face upon their arrival in the United States. These barriers include: poverty, lack of access to public services, education, and the ability to get a job. Poverty is arguably the most pressing issue. According to a study done by the Migration Policy

Institute in 2003, approximately one-third of children of Mexican immigrants lived in poverty (Hook, 2003). Another study done in 2010 showed that the average income for Mexican immigrants over the age of 16 earned an average of $20,000 per year, and that 27% of Mexican immigrants live in poverty (Zong & Batalova, 2014). In addition, many Mexican immigrants send money to loved ones and friends back in Mexico (Zong & Batalova, 2014). Although some immigrants can hardly afford it, many say they feel a duty to help those in Mexico who are struggling even more than they are (Zong & Batalova, 2014).

This income level means that, in states that did not expand Medicaid, many Mexican families qualify for neither Medicaid nor the Affordable Care Act (Motel & Patten, 2010). In addition, immigrants who are shown to be in the United States illegally are ineligible to access many services, including Medicaid and the ACA (Motel & Patten, 2010). Before implementation of the ACA, more than one-third of Mexican immigrants do not have health insurance, one of the highest proportions of any group in the United States (Hook, 2003). Immigrants who pay taxes without having health insurance are therefore forced to pay a penalty on their taxes. For the year 2016, the tax penalties for lack of health insurance are as follows: $695 per adult ($347.50 per minor), or 2.5% of household income, with a maximum penalty of $2085 per household (Healthcare.gov, 2016). These penalties are fees that many can hardly afford. Other services are difficult for many immigrants to gain access to, as well. Luckily, federally qualified health centers do not require any identification, although there is often a small fee still attached to a wellness visit that some cannot afford (Services, 2013).

Access to education over the last several years has undergone some institutionalized change, but many Mexican immigrants have lower access to education. This is due to a variety of reasons. First, higher education can be limited because of lack of proper identification for those

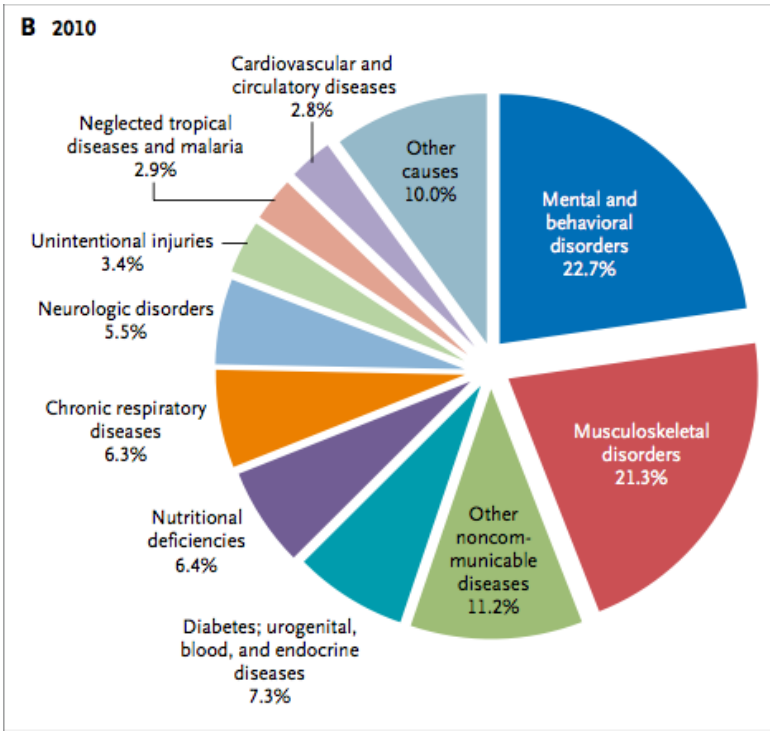
in the United States illegally. This means that, although students may graduate high school, many cannot attend college. In 2013, 6% of Mexican immigrants had a Bachelor's degree or higher, which is much lower than the nation's average (Hook, 2003). Another factor leading to lower education level has to do with poverty. If a family is struggling, children of Mexican immigrants are likely to drop out of high school in order to supplement the household income (Hook, 2003). While this may help in the short term, this lower education level perpetuates poverty (Hook, 2003).

Effects of Mental Health Issues on Physical Health

There has been much research done in both the public health and psychology fields in regard to the effects of mental health issues on physical health. The research focuses on the effects in two general populations: those suffering from mental health problems, and those around them.

A study published in 2013 examined the prevalence of mental health issues and each illness's economic burdens in more than fifteen countries on six continents (Becker, 2013). Data from the Global Burden of Disease completed in 2010 were used. Results indicated that the burdens associated with mental health issues were greater than those of any other non-communicable diseases, including diabetes, cardiovascular diseases, respiratory diseases, and cancer. Major depression had the most economic burden of any mental illness, and was ranked 2nd in years lost due to disability (YLDs) globally (Becker, 2013). The study also found that mental and behavioral disorders account for 22.7% of YLDs worldwide (see Figure 1).

Figure 1. Estimates of YLDs worldwide (Becker, 2013)



Similar findings can be found in regards to the relationship between mental health and Body Mass Index (BMI). One study found that comprehensive mental health treatment among adolescents improved BMI better than did segregated care (Greyber & al, 2013). Another study found that financial and other stressors had direct impacts on mental health of chronic pain patients. Patients reported significantly higher levels of chronic pain during times of mental distress (Skinner & al, 2004).

The effects of mental health on treatment of physical health problems also have strong impacts on treatment effectiveness. First off, those with mental health issues are less likely to have access to adequate medical treatment than are their counterparts (Burns, 2009). For instance, mental illness is associated with higher risk behaviors and poor treatment adherence in

HIV/AIDS and tuberculosis. Considering that control of these two diseases is a global priority, the impact that mental health has on treatment should be of great importance in the international community. Severe mental illness has also been shown to correlate to poor physical health and lifestyle behaviors, decreasing treatment effectiveness among members of that population (D. Scott & Happell, 2011). Overall, desire to focus on mental health issues is not strong, despite the fact that they touch the lives of everyone in the world.

Mental and physical health do not only impact those with a mental health issue; caregivers often experience negative physical and psychological issues as well. Many studies have shown that there are statistically significant changes in the mental and physical health of caregivers over time (See Table 2).

Table 2 Correlation between clinical variables, burden, and quality of life. (Grover & Dutt, 2011)

	Quality of life of caregivers						Burden	
Variables	General	Physical	Psychological	Social	Environment	Total	Subjective burden	Objective burden
Total duration of illness		−0.38**						
Total duration of treatment		−0.31*						0.35*
YBOCS Obsession score	−0.36*			−0.32*	−0.34*	−0.36*	0.58**	0.54**
YBOCS Compulsion score	−0.33*	−0.29*	−0.29*	−0.38*	−0.34*	−0.39*	0.55**	0.44**
YBOCS total score	−0.36*	−0.29*		−0.37**	−0.35*		0.58**	0.5**
Burden								
Financial burden		−0.37*				−0.33*		
Disruption of family leisure	−0.49**	−0.43**	−0.29*	−0.41**	−0.39**	−0.5*		
Disruption of family interaction	−0.45**	−0.33*	−0.45**	−0.42**	−0.31*	−0.48*		
Effect on mental health of others	−0.32*							
Subjective Burden	−0.48**		−0.31*			−0.37*		
Objective burden	−0.45**	−0.41**	−0.31*	−0.39**	−0.33*	−0.48*		

*$P < 0.05$; **$P < 001$.
Quality of life of caregivers and burden were measured with the World Health Organization Quality of Life Scale-BREF and Family Burden Interview Schedule, respectively.
YBOCS, Yale–Brown Obsessive Compulsive Scale.

As Table 2 shows, caregivers of those with mental health issues can experience statistically significant changes in their physical, psychological, social, and environmental health. Similar findings have been explored when caregivers are caring for a person with physical health issues (Alexander & Wilz, 2010; Kenny & al, 2014; Ortega & al, 2006; Stetz & Brown, 2004).

It is important to note that mental and physical health are inexorably linked, not only for those with a mental health issue, but for those responsible for care. This fact is one of many reasons it is necessary to explore perceptions and experiences of mental health in different populations.

Non-Western Views on Mental Health

This section of the literature review focuses on available literature on non-Western views of mental health. The literature is thin on the subject. Many of the published articles are simply calls for further research on the subject with limited primary research.

On the subject of cross-cultural views on psychology, some have discussed the need for a paradigm shift in the mental health care community (Sheikh & Furnham, 2000; Tamasese, Peteru, Waldergrave, & Bush, 2005). One article published in *Transcultural Psychiatry* noted that:

> "It is striking how often published studies of non-Western populations refer to subjects' 'limited knowledge of mental disorders'… Thus non-Western subjects are meant to understand 'us', rather than the other way round, and their own cultural frameworks are likely to be seen as an obstacle to this understanding." (Summerfield, 2012)

This sentiment is counter-intuitive to many current public health education models, which promote increasing knowledge about different health topics.

One strong example of psychology's ability to transform across time and place is China. Confucius established one of the world's first versions of psychology in 500 BCE (Jing & Fu, 2001). Upon the arrival of Jesuit missionaries in the 1600s, many Chinese adapted their views of mental health to incorporate the religious ideology (Jing & Fu, 2001). The spread of Western-centric psychology in the early 1900s again led to a shift in Chinese beliefs about mental health and its treatment (Jing & Fu, 2001). However, the Chinese widely abandoned psychology during the Soviet era as part of a rejection of all ideologies stemming from the West (Jing & Fu, 2001). Currently, many Chinese subscribe to a mix of Confucian and Western-style psychology (Jing & Fu, 2001).

Mental Health Stigma

This section will explore the role of stigma in mental health. First, the researcher will explain how different disciplines define stigma. Then presentations of stigma will be explored in the following categories: personal, social, familial, employment, and media.

Before beginning an exploration of it, it is necessary to understand what is meant by stigma. The Oxford dictionary defines stigma as: "mark of disgrace associated with a particular circumstance, quality, or person" (Dictionary, 2015). Interestingly, that dictionary's example of the word is: "the stigma of mental disorder". Psychologists and sociologists describe stigma in a more nuanced way. They split stigma into two distinct parts: social stigma and self-stigma (also referred to as "perceived stigma") (Davey, 2013). Social stigma is described as: "prejudicial attitudes and discriminating behaviour directed towards individuals with mental health problems as a result of the psychiatric label they have been given" (Davey, 2013). In contrast, self-stigma

is defined as: “the internalizing by the mental health sufferer of their perceptions of discrimination”, which may lead to feelings of shame (Davey, 2013). By splitting the definition of the word in two, it is clear the role that societal factors play in mental health.

Next, the researcher will examine whether those suffering from mental health issues describe feelings of self-stigma. One study identifies three major types of self-stigma that emerged from qualitative research done with British participants in mental health support and leadership groups. The three types identified by participants include: non-recognition, misrecognition, and disrespect (Lewis, 2009). Non-recognition is the feeling of being invisible to others; misrecognition is the feeling of inferiority; and disrespect is feeling disparaged in everyday situations (Lewis, 2009). All of these types of self-stigma can be associated with social stigma, but participants in this study identified these patterns within themselves. One participant claimed that, “’Most genuine people don’t use, they contribute.’” (Lewis, 2009) This indicates that participants had feelings of inadequacy and shame surrounding their own mental illness. Feelings of guilt for not being “normal” were also prevalent in many studies (Davey, 2013; Dingfelder, 2009).

Social stigma is also widely reported among those with mental health issues. Even mental health professionals cannot come up with a universal term for mental health. Vocabulary describing mental health in academic journals includes: mental health, mental illness, mental disorder, mental incapacity, psychiatric disability, mental disability, psychosocial disability, and intellectual disability (Hunt & Mesquita, 2006). Each of these terms has connotations that depict those with mental health issues as either in or out of control of their own minds. But the stigmatizing vocabulary is not limited to mental health professionals. A study done in England with teenagers revealed that young people had more than 250 terms to denote mental illness

(Rose & al, 2007). Popular terms included: nuts, psycho, crazy, weird, and freak. These terms all have a dehumanizing effect, making it easier to ignore or mistreat those with mental health issues.

Unfortunately, it is often those closest to, or having the most influence on, those with mental health issues that exhibit the most stigmatizing behaviors. The two types of relationships examined in this section are familial and professional.

One study examined the level of embarrassment felt by close relatives of people suffering with two types of health issues: general medical condition (GMC) and alcohol, drug, or mental health condition (ADMC) (Ahmedani, 2013). This study showed that approximately twice as many close relatives reported feelings of embarrassment and shame caused by a relative with ADMC as opposed to GMC (49.5% and 24.9%, respectively) (Ahmedani, 2013). The rate of embarrassment amongst a relative with both GMC and ADMC was 36.6% (Ahmedani, 2013). Another study revealed that even the prospect of interacting with someone with mental health issues makes family members uncomfortable. The study showed that 56% of people surveyed would be definitely or probably unwilling to spend an evening socializing with someone with a mental health issue (Dingfelder, 2009). 68% of people on the same survey said they would be unwilling to have someone with a mental health issue marry into their family (Dingfelder, 2009). This shows a significant level of stigma toward mental health, even within close families.

Another group that shows stigma toward those with mental health issues is employers (or potential employers). Dingfelder's study showed that 58% of people were unwilling to work closely with someone with a mental health issue (Dingfelder, 2009). It has also been shown that employers are less likely to hire an applicant if it is known that that person has a mental health issue. For example, studies have shown that half of US employers are hesitant to hire someone

currently being treated for depression, and 70% of them are not comfortable hiring someone with a history of addiction (Stuart, 2006). Another study showed that almost 25% of US employers would terminate the employment of someone who had not disclosed their mental health diagnosis (Stuart, 2006).

Perhaps stigma on a more personal level is partially determined by representations of mental health issues in the mess media. Mass media is becoming ever more present in the international community, ranging from films to smart phone applications. Representations of mental health in these formats are able to form and change people's opinions about what it means to have a mental health issue. Overall, the media has struggled to adequately or accurately portray the different experiences of mental health worldwide.

Television and film provide potent examples. As of 2006, only 2-3% of primetime TV characters were identified as having some sort of mental health issue, despite the fact that the prevalence of mental health issues is much higher (Cutcliffe, 2001). There is also a tendency for people with mental health issues to be portrayed as violent—one in four of these characters commit murder, and half of all those portrayed as having a mental health issue hurt someone (Cutcliffe, 2001). These statistics are vastly dramatized and create stigma against this vulnerable population. For instance, the movie "Gone Girl" received praise from the film community, yet only showed the dark, violent, and manipulative parts of mental health (Lombardi, 2014). Characters with mental health issues are also often seen as forms of amusement and "lightening the mood". For instance, in the television show "Monk", the main character's severe Obsessive-Compulsive Disorder is meant to be seen as funny and quirky, as opposed to an often-debilitating illness (Cutcliffe, 2001).

It is not only fictional media that encourages stigma on this topic. Print media can arguably have more impact on the public's views of people with mental health issues. As of 2009, 50% of American newspaper articles about mental health issues mentioned that person committing violence (Dingfelder, 2009). That same study showed that 34% of articles mentioning mental health referred to criminals or criminal behaviors (Dingfelder, 2009). And this trend is not only prevalent in the United States. One study completed in three central European countries (Croatia, Czech Republic, and Slovak Republic) found that people had more negative opinions of those with mental health issues overall when newspaper articles were shorter and if the article did not site a mental health professional (Nawkova, 2012). In contrast, mental health professionals were cited in 61.6% of articles portraying mental health in a positive light (Nawkova, 2012). That statistic in negative articles was 16.3% (Nawkova, 2012). This proves that people are more likely to react positively to those with mental health issues if they are educated about the subject. Ignoring the subject or portraying it negatively has a detrimental effect on the treatment of those with mental health issues.

Prevalence of Mental Health Issues in the General Public

In this section, the discussion will center on the prevalence of mental health issues and the most common mental health problems of the general global population as well as among Mexicans. It is important to note that every person in the world is at risk for mental health issues. While mental health and mental illness can and does impact everyone, there are certain groups that are at higher risk of having mental health issues. Statistics on mental health are all likely to be conservative estimates due to underreporting, particularly in developing nations. The following statistics, therefore, should be regarded with caution.

The World Health Organization completes a world mental health survey approximately once every five years. The survey attempts to determine a wide range of factors that contribute to mental health issues. According to their results, approximately 450 million people worldwide are currently suffering from some sort of mental health issue, 350 million of whom have depression (W. H. Organization, 2001). It further states that the World Health Organization estimates that one in four people will have a mental health issue in their lifetime. The survey has consistently shown that women are at higher risk for many mental health issues, including depression (W. H. Organization, 2001). There has also been research done that shows people of lower social status are more likely to have mental health issues (W. H. Organization, 2001). Underreporting of mental health issues is still common, meaning that many of these statistics are likely to be very conservative.

Globally, women are at particularly high risk for mental health issues. Much of this increased risk is due to women's social status. For instance, women are much more likely to be the victims of violence (Hunt & Mesquita, 2006). Female survivors of violence are four to five times more likely to need mental health treatment, and are five times more likely to attempt suicide (Hunt & Mesquita, 2006). Depression is also prevalent among women; 30% of disability is due to depression, whereas that number is 12.6% for men (Gülçür, 2000). Caretakers still have the ability to force hysterectomies and sterilization upon females with mental health issues in many parts of the world (Roy, 2012). Women with mental health issues are at much higher risk for abuse and sexual violence, which can exacerbate mental health issues (Roy, 2012). These phenomena do not arise out of nowhere; when women are more economically dependent on men, they are more likely to have issues with mental health (Roy, 2012). All of these risk factors make women's mental health an urgent issue that should be addressed on an international scale.

Unfortunately, there is another frightening trend in mental health: inequality is shown to have a negative impact on mental health. Studies have shown that countries with higher levels of income inequality have an increased percentage of the population with reported mental health issues (see Figure 2).

Figure 2. Correlation between mental illness and income inequality. (Pickett, 2010)

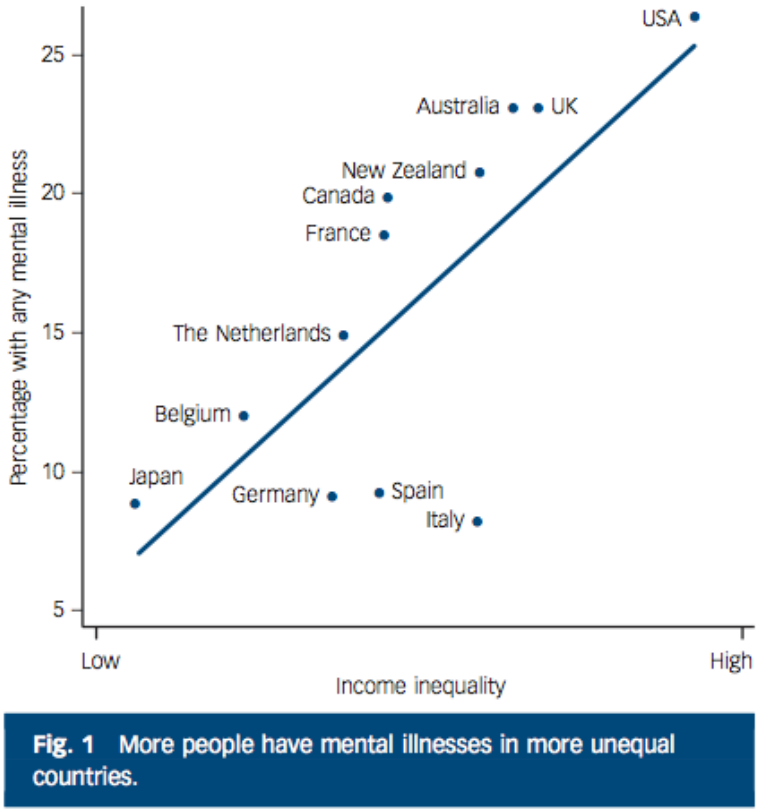


Fig. 1 More people have mental illnesses in more unequal countries.

Income inequality directly relates to education, employment, community violence, and access to services. Yet it is not only objective social status (OSS) that is correlated with mental health issues. How a person feels about their relative position in society, known as subjective social status (SSS), is also related to prevalence of mental health issues. A recent study using World Health Organization data collected in 20 countries revealed that there was an inverse association

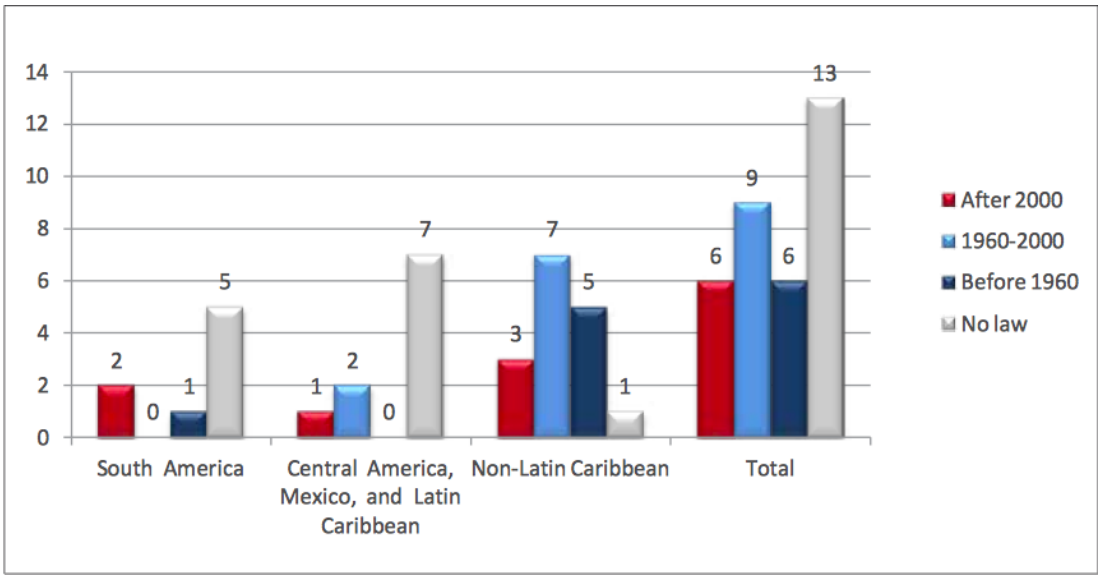
between SSS and mental health (K. Scott, 2014). This relationship was significant in 15 of the 20 countries, with three additional countries showing a similar pattern. Even after adjusting for several objective indicators, the relationship remained. It is important to note that certain countries may be more open about mental health issues than others, but the overarching pattern reveals an interesting phenomenon.

Mental Health Services in Mexico and the United States

It is important to understand the differences between mental health services in Mexico and the United States. An exploration of this topic may aid in understanding conceptions of mental health in both countries. In this section the researcher will examine statistical data on federal budgets and legislation provided by the World Health Organization (WHO), Pan American Health Organization (PAHO), and the Substance Abuse and Mental Health Services Administration (SAMHSA). First, the researcher will examine current rates of mental health legislation and budgeting between the two countries. Then, the researcher will compare mental health staffing and services between Mexico and the United States.

According to extensive research completed by PAHO comparing its member states' current health systems, Mexico is one of two countries in Central America and the Latin Caribbean to have passed mental health legislation before the year 2000 (Figure 3).

Figure 3. Number of countries with mental health legislation, by year in which the law was passed (P. A. H. Organization, 2012)



Mexico passed its legislation, officially titled the Official Mexican Standard NOM-025-SSA2 for the Provision of Health Services in Medical and Psychiatric Units and Comprehensive Hospital Care, in 1994 (Sotelo & al, 2015). While Mexico should be applauded for its relatively early action in regards to mental health, 1994 was the last legislation passed in the country (P. A. H. Organization, 2012). The United States, on the other hand, has passed multiple legislative actions on a federal level, the most recent of which is an amendment to the Mental Health Parity Act. The amendment requires health insurance companies must cover both mental and physical health conditions equally if the insurance policy covers both. The Patient Protection and Affordable Care Act (ACA) passed in 2010 expanded heath insurance coverage for millions of Americans, but had little focus on mental health.

Legislation is not the only source of difference between Mexico and the United States. Mexico devotes much smaller proportion of the federal health budget to be allocated specifically

for mental health. According to a report published by PAHO, Mexico dedicates just 2% of its total health budget to mental health, and 80% of that budget is earmarked for psychiatric hospitals (P. A. H. Organization, 2012). In comparison, the United States allocated 5.9% of its total health budget on mental health in 2014 (Administration, 2015). While that figure is still low, there are much more mental health services available in the United States than in Mexico.

In order to illustrate the differences in services available between the two countries, the researcher will compare staffing and basic services available between the two countries.

Table 3. Rate per 100,000 people of health professionals working in the mental health sector (Administration, 2015; P. A. H. Organization, 2012).

Type of Staff	Mexico	United States
Psychiatrist	1.57	7.79
Psychologist	0.55	29.03
Social Worker	0.33	17.93

Table 3 illustrates differences in mental health staffing rates between countries. The United States has roughly 5 times more psychiatrists per 100,000 people than does Mexico (7.79 and 1.57, respectively). The numbers are even more staggering for psychologists and social workers. The United States boasts almost 53 times more psychologists (29.03 and 0.55, respectively), and 54 times more mental health social workers than does Mexico (17.93 and 0.33, respectively). I Mexico, even primary care physicians have limited mental health training. According to PAHO, only 4% of Mexican primary care physicians receive any training in mental health (P. A. H. Organization, 2012). Of those, only 11% receive any follow-up or refresher courses (P. A. H. Organization, 2012). Similar statistics were not available for the United States.

It is not only staffing that is lacking in Mexico. Mental health facilities in the country are minimal, as illustrated in Table 4.

Table 4. Number and rate per 100,000 of mental health facilities in Mexico (P. A. H. Organization, 2012).

Type of Facility	Number	Rate per 100,000
Psychiatric hospitals	46	0.040
Outpatient Care Units	544	0.500
Day Centers	3	0.000
Psychiatric Units in General Hospitals	13	0.010
Community Residences	8	0.007
Beds for Mental Health in General Hospital	-	0.120

Psychiatric hospitals receive 80% of the federal health budget allocated to mental health, yet there are only 46 of that type of facility in all of Mexico (rate of 0.04 per 100,000 people) (P. A. H. Organization, 2012). The other types of facilities include: outpatient care units (544 total), day centers (3 total), psychiatric units in general hospitals (13 total), and community residences (8 total) (P. A. H. Organization, 2012). There are also limited beds in general hospitals allocated to mental health (rate of 0.12 per 100,000 people) (P. A. H. Organization, 2012). All of these facilities split the other 20% of the miniscule mental health budget allocated to mental health in the country. In the United States, the situation is slightly different. For instance, in the Atlanta, Georgia area there are several state-run mental health facilities (24 in the city of Atlanta, 12 in the city of Decatur, and 1 in Stone Mountain) (Administration, 2008). It is important to note that

there are no state-run mental health facilities in Clarkston, Georgia, the area where this study took place.

It is clear that there is a difference between Mexico and the United States in terms of availability of mental health services and care. The United States is not a paragon of mental health, yet may provide hope for Mexican immigrants moving to the United States.

Researcher-Identified Gaps in the Literature

There has been much research done in each of the areas above. However, there is not enough published literature on the intersection of all these themes. One of the goals of this research project is to explore the relationship between culture, vocabulary, stigma, and treatment in populations that may benefit greatly from increased access to and utilization of mental health treatment services. By utilizing actual representatives of one such immigrant population in this study, this community gains power and voice to contribute to the discussion of mental health.

Case Study Research Methodology

Introduction

This section describes the methods used to complete the case study including: the overall study design, instrument design, study population, participant recruitment, and study location. Next, data collection, data management and analysis, and ethical considerations are described. Finally, the chapter details data quality and limitations.

Study Design

The researcher chose a mixed methods study design for this research, using a short quantitative survey and focus groups discussion (FGD). The researcher created a survey in order to obtain basic information about participants and their views on mental health topics. 50 Cents. Period. will use these baseline data in order to monitor and evaluate future social support group programs. The Emory Institutional Review Board (IRB) considered this study to be non-human research, and was therefore exempt from the IRB review process.

Research Instrument Development

The researcher began to develop the data collection instruments after finalizing the study design. Concurrent design of study instruments allowed the researcher to ensure that all research topic areas were adequately covered. The researcher sought to obtain information on the following topics:

- Common ways that the study population talks about mental health (and the associated language/vocabulary);
- Perceived types of mental/ psychological issues among the study population;

- Changes in mental health among the study population before/after arrival in the United States; and
- Sources of support available to the study in the community (pros, cons, suggestions, facilitators, and barriers).

The survey focused on quantitative data in two areas: demographic information and health information. The researcher included demographic information for the purpose of determining potential differences in participant perspectives (ie: age, insurance status). The researcher also aimed to investigate knowledge of vocabulary and basic health access information; the researcher addressed these questions in the health information section of the survey. The quantitative survey was not translated into Spanish due to literacy concerns.

Grey literature was the primary source for design of the focus group instrument. Information from the World Mental Health Survey and the Harvard Trauma Center provided valuable insight into the instrument's design (W. H. Organization, 2002; Trauma, 2006). The researcher also consulted published literature about immigrant mental health in order to best word survey questions (RAND, 2015). The researcher and program partners designed some study questions because of the lack of published or grey literature on the subject. The instrument design process was iterative. After receiving feedback from implementing partners and participants, the researcher made changes to the instruments. The researcher also reviewed the survey questions with the certified translator before data collection began. The researcher ensured that no probes for specific, personal experiences of trauma or mental health issues were brought up while conducting the focus group. The researcher made this decision in order to maintain participant comfort and participation. See Appendices 1 and 2 for study instruments.

Study Population

After the finalization of the study instruments, the researcher focused on the targeted study population. The study population had inclusion and exclusion criteria. In order to participate, the following identifiers were used as inclusion criteria:

- Women;
- At least 18 years of age;
- Lived in the United States less than ten years from the date of first contact with researchers;
- Non-native English speaker;
- Past or present participant in the Mexican women's support group offered by Willow Wellness; and
- Originally from Mexico.

The following identifiers were used as exclusion criteria:

- Men;
- Not a participant in past or present women's support groups;
- Resident of the United States ten years or more;
- Under age 18;
- Native English speaker; and
- Not originally from Mexico.

Incorporation of these criteria was critical in order to maintain consistency and cohesion within the group.

Participant Recruitment

An existing wellness program at Willow Branch Apartments in Clarkston, Georgia, served as a recruiting ground for participants. The researcher conducted an informational session during which study goals and basic subject matter were explained to all potential participants. Although the goal of the study was to obtain 100% participation of support group members, the researcher stated clearly that participation in the study was not a prerequisite for continued participation in the support group.

For women who decided to participate in the study, the researcher then informed participants about specific dates and locations of data collection activities. All study activities took place in Clarkton, Georgia. Clarkston is part of unincorporated DeKalb County, which has the highest concentration of immigrant and refugee populations in Georgia. The regular group meeting room-- a classroom attached to the complex's leasing office-- served as the space to conduct the focus group and survey.

Data Collection

The researcher conducted the focus group in January 2016 in order to contextualize and expand upon topics covered in the survey. Only the researcher had access to sensitive participant information. Pseudonyms and other tools for de-identification were used in all products of the research. The researcher maintained participant confidentiality by keeping all information about the study in a locked room to which only the researcher had access. In the case of digital files, the researcher used password-protected accounts.

The researcher clarified questions about vocabulary or terminology with a certified translator before any interaction with participants. During data collection the translator, speaking

in the participant's' native language of Spanish, administered surveys face-to-face and marked each participant's response. Participants had the option to work one-on-one with the certified translator in a private or semi-private area in order to reduce influence from other participants or research staff. Surveys took an average ten minutes to complete.

A certified translator was present as an aid for intermediary translation during the focus group. The researcher received verbal assent from all participants after a reminder of the terms of consent. The entirety of the focus group was recorded using a digital recording device provided by Emory University. Participants sat in chairs set up in a circle in order to promote participant comfort and participation. The researcher provided culturally appropriate drinks and food during the focus group. The researcher conducting the focus group posed questions and probes in English, using the translator as an intermediary line of communication with participants. The focus group took approximately 100 minutes to complete.

Data Management and Analysis

The researcher implemented a double data entry policy for this project. Excel was used for all quantitative data collected. The researcher then completed data cleaning, and verified data with a 5% check. Due to sample size, some quantitative data response options were collapsed in order to account for lack of variation. The researcher used Excel to analyze quantitative data due to the small sample size.

After completion of the focus group, the researcher sent a copy of the audio file to a certified transcription and translation service. That service transcribed all of the English spoken in the focus group. In order to ensure accurate translation, a separate person transcribed and translated all of the Spanish spoken during the focus group. The transcription passed 95%

accuracy tests, and was then uploaded to MAX QDA for analysis after merging the transcriptions into one document. The researcher used memos to initially identify important characteristics of the data, after which the researcher identified codes and themes. The results of the quantitative survey provided insight into important variables in the analysis of the qualitative data. The researcher destroyed all sensitive or identifiable products of the research after completion of the research project.

Limitations

As with any study, this project had some limitations. This section discusses some study limitations and an analysis of the study's overall quality. The limitations discussed are: potential selection bias, number and gender of participants, reliance on translators, and lack of saturation.

Selection bias is often a potential confounder in studies; this study is no different. It is possible that the women who participated in this study have observable and/or unobservable characteristics that are different from other community members. Those who volunteered to be part of a social support group might, for instance, be more acculturated, trusting, or be more ready to talk about mental health issues.

The small number of participants is also a limitation. Because of limited time and funding, researchers chose to focus on one ethnic and language group in the Clarkston area. The study is not generalizable to all Mexican immigrants or other immigrant populations. For instance, researchers also may have found different themes had men been included in the study population.

Another limitation was researcher reliance on translators to complete surveys and translate in the focus group. The researcher and partner organizations decided to not translate

surveys into the participants' native language because of literacy concerns. This meant that the translator had to be trained about survey administration and study goals. The focus group offered a slightly different limitation. The researcher's ability to build rapport may have suffered because of participants' need to speak through a translator. It is also possible that nuances of focus group conversations that may have led to richer data were missed in the moment. However, it was impossible for the researcher to learn Spanish in a short period of time, and funding was unavailable for adequate focus group facilitation training for translators.

The final major limitation is that researchers were unable to reach saturation. Due to time and budgetary concerns, only one focus group was completed. This meant that crucial themes may have been missed because of the inability to include more participants and, therefore, more opinions.

Overall, this case study offers a different perspective on previous research efforts in immigrant mental health. The results presented in case this study may help improve future programming efforts.

Quantitative Data Analysis

Introduction

This chapter describes the results of the quantitative survey completed by study participants. The results include basic demographic characteristics, health information statistics, and mental health knowledge.

Quantitative Results

Six participants completed the survey. Only one participant in the social support group did not complete the survey, and that was a result of the fact that that person was unable to attend the day of survey administration. The researcher calculated basic descriptive statistics for the demographics section, as well as part of the health information section (See Table 5).

Table 5. Participant Demographics

Female Mexican Participants	
Mean age (median)	39.5 (37)
Completed high school education	4 (66.7%)
Currently in US illegally	5 (83.3%)
Live with husband	6 (100%)
Has 1-2 children	3 (50%)
Has 3 or more children	3 (50%)
Currently has health insurance	3 (50%)
Currently has a PCP	3 (50%)
Ever had mental health concern	3 (50%)
Ever sought help for mental health concerns	3 (50%)

The mean age of participants was 39.5 years, with a median age of 37 (range: 29-43). Four of six participants reported completing high school, while the other two reported completing less than secondary school. All participants were currently married, had at least one child, and had some family in the United States. Four participants identified as Catholic, one identified as Jehovah's

Witness, and one did not respond. All participants reported residing in the United States for at least three years. Five participants reported being in the United States illegally; one participant did not respond to this question. Due to the small number of participants, more detailed analyses were impossible.

Three of the six participants reported having health insurance coverage. These participants also reported that they currently had a primary care physician and had attended an appointment with that physician within the last 30 days. Two of these three participants had chronic illnesses, and one participant was pregnant at the time of data collection. Two other participants reported not having health insurance coverage. Those two participants (and one participant who did not respond to the health insurance question) reported not having a primary care physician, and reported not going the doctor in the past year.

The next section of survey questions inquired as to why participants would choose to go to a doctor (See Table 6).

Table 6. Reported Reasons to Go to a Doctor

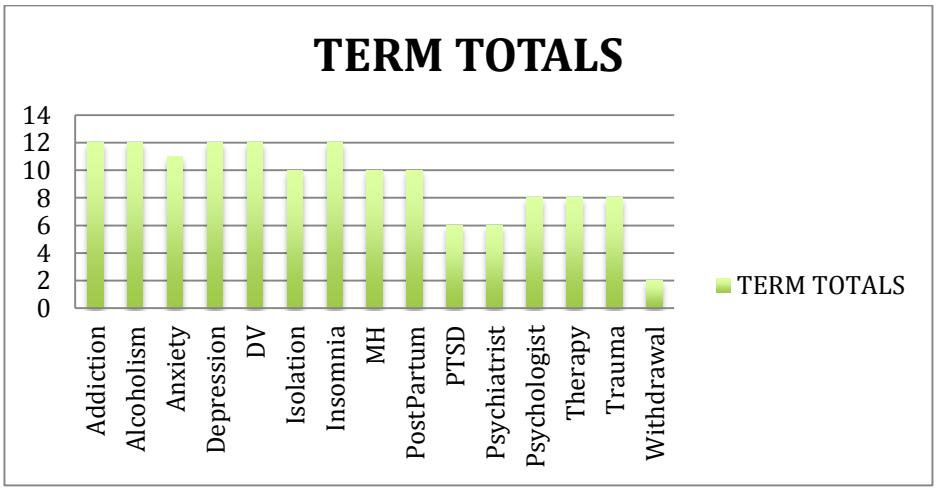
Reported Reasons to Go to a Doctor (%)	
Prevention (example: women's annual exam, check-up, vaccines)	6 (100%)
Emergency	5 (83.3%)
Chronic Illness (example: diabetes, high blood pressure)	4 (66.7%)
Temporary Illness (example: flu, eye infection)	1 (16.7%)
Mental Health (example: feeling sad or afraid all the time)	0 (0%)
I would never go to the doctor	0 (0%)

Responses from that survey question were as follows: prevention (N=6), emergency (N=5), chronic illness (N=4), and temporary illness (N=1). No participants reported going to the doctor for any other reason, including for a mental health concern.

Four participants reported concerns about their mental health at some point in their lives. Of those four positive responses, three participants reported previously seeking help for their mental health. Interestingly, this may imply that these participants would seek help from someone other than a health professional for mental health concerns, or that they do not consider a social support group to be a help-seeking behavior.

For the final section of the survey, the researcher tallied knowledge of mental health terminology per participant, as well as per term. Each term was then split into the following categories: general (1 term), events (2 terms), symptoms (3 terms), diagnoses (6 terms), and treatment (3 terms). The researcher calculated averages for knowledge of terminology in raw scores and percentages. Each participant received a knowledge score, and scores ranged from 17 to 29 out of 30 possible points (mean: 23.17). There appeared to be no clear pattern between age and knowledge score. The researcher also calculated total knowledge for each term, and these scores ranged from 2 to 12 points out of 12 possible points (see Figure 4).

Figure 4. Total term scores amongst all participants (Max score= 12).



Terms were then split into one of five categories: General, Events, Symptoms, Diseases/Diagnoses, and Treatment; the researcher then calculated average raw scores for each category. Percent average knowledge calculations were also completed (See Table 7.) Overall, knowledge was lowest in the categories of "symptoms" and "treatment". Participants reported highest scores in the category of "diseases/diagnoses", followed closely by "general" and "events".

Table 7. Raw scores and percent average knowledge of mental health terminology.

Category	*General*	*Events*	*Symptoms*	*Diseases/Diagnoses*	*Treatment*
Terminology	- Mental Health	- Domestic Violence - Trauma	- Insomnia - Isolation - Withdrawal	- Addiction - Anxiety - Alcoholism - Depression - Post Partum Depression - Post Traumatic Stress Disorder	- Psychiatrist - Psychologist - Therapy
Average Knowledge (Raw Score, out of 12)	10.0	10.0	8.0	10.5	7.33
Average Knowledge (%)	83.33	83.33	66.67	87.50	61.11

Conclusion

The quantitative survey data allowed researchers to gain insight into beliefs about participants' mental health and factors that may contribute to these beliefs. This survey also may offer some insight into the qualitative data collected in January 2016.

Qualitative Data Analysis

Introduction

After completion of the quantitative analysis, the researcher then turned to the qualitative analysis. This chapter describes the results of the focus group completed by the researcher in January 2016. All names have been changed in order to protect the anonymity of the participants. The results focus on the eight selected themes identified by the researcher. Six of the themes were inductive, and the other two emerged from the data during analysis. The six inductive themes were: experiences and perceptions with doctors/psychology; promoters and hindrances to help seeking decisions; barriers and facilitators to care; cause of mental health changes; vocabulary; and confidants. The two deductive themes were: mental versus physical health and language as a source of isolation.

Table 8. Themes, number of segmented codes per theme, and justification for inclusion in analysis

Theme	Total number of segmented codes per theme	Justification
Experiences and Perceptions with Doctors/Psychology	13	To establish background
Promoters and Hindrances to Help Seeking Decisions	19	To establish background
Structural Barriers/Facilitators to Care	8	To establish background
Mental vs. Physical Health	1	Emergent Theme
Cause of Mental Health Change	7	To establish background
Vocabulary	5	To establish background
Confidants	7	To establish background
Language as a Source of Isolation	2	Emergent Theme

Experiences and Perceptions with Doctors and Psychology

Receiving care for physical and mental health is very important in order to maintain a successful and productive life. Experiences with doctors can have an enormous impact on the reception of care. In this section, the researcher will discuss the theme of previous experiences with doctors and psychologists, and how that may impact the decision to seek care.

In the focus group, participants expressed a paradoxical idea about the decision to see a doctor: if you decide to go to a psychologist, then you're sane. However, if you do not believe you need to seek out mental health care, then you are not sane. Yet participants also expressed that it is very offensive should someone recommend that you see a psychologist.

> *"If someone goes to the psychologist it's not because they're bad off. Where we're from, if someone says, 'You need to go to the psychologist,' you would say, 'I'm not crazy.' It's offensive." –Dolores, 43*

This paradox limits the amount of mental health care that this community accesses. When asked whether a person who is deemed violent may need to see a psychologist or doctor, one participant (Dora, 27) stated: "They would have to." However, someone viewed to be violent or dangerous is less likely to be willing to seek treatment.

Another important point brought up by participants was that seeing a psychologist is viewed to be the last option. Participants expressed that they would much prefer to seek out mental health care from a primary care physician rather than from a mental health professional. Despite this, three participants discussed past frustrations with medical care options in Mexico and the United States. One participant (Carmen, 61) stated emphatically in regards to the importance of seeking mental health care in Mexico: "Sometimes in Mexico you don't have that option of going to see a psychologist. People don't even have money to eat." All other

participants agreed, stating that they would much prefer to eat than to deal with potential mental health issues.

Promoters and Hindrances to Help-Seeking Decisions

The researcher explored the theme of ways that mental health can be promoted or hindered in their community. This theme has three subthemes: communication about mental health, treatability, and mental health literacy.

Communication About Mental Health

The participants addressed three major types of communication about mental health: the news, television shows, and in their local community. First, it was imperative to examine how those issues are portrayed in the news. Participants admitted that the news in Mexico rarely mentioned mental health, except when a violent or strange crime was committed. One participant recalled a news story in Mexico in which a girl killed her mother and sister by slitting their throats. The news reported that the perpetrator was on drugs and that she had voices in her head. Asked if the media addressed mental health more generally in light of that incident, one participant stated that the news mentioned doing testing to ensure that the girl "was okay". This incident was the only time participants could recall the news ever addressing mental health in any capacity.

Mainstream news sources are not the only mode of mass communication. Participants noticed a trend toward acceptance of mental health over the last ten years, mentioning a popular Mexican soap opera (*telenovela*). The researcher identified the show as "What Women Don't Say" (*Lo que Callamos Las Mujeres*), which has received widespread praise from the Latin

American mental health community for its portrayal of issues such as domestic violence, sexual abuse, and mental illness while maintaining appeal for a large audience [1]. Participants stated that the show has provided information about mental health to a wide audience, and that it encourages discussion amongst friends and family. When asked how "What Women Don't Say" has impacted stigma toward mental health, one participant (Maribel, 38) stated, "It helps a little bit. It helps you see and think about it in a different way." They did note a correlation between the show and an increase in overall communication about mental health issues.

The researcher aimed to explore whether mental health left the home and was discussed within the wider community. Participants' answers were significantly different when they spoke about mental health stigma in Mexico and in the United States. All four participants noted a much higher degree of stigma in Mexico than what they perceived in the United States.

Dolores, 43, stated that, partially as a result of "What Women Don't Say", there have been significant health changes in Mexico over the last decade. She noted that there has been a greater effort to disseminate health information to the masses, and to improve access to health services. These improvements have not changed the level of stigma surrounding mental health, particularly in more rural areas of Mexico. Carmen, 61, described a disturbing situation regarding a neighbor in her hometown: a man with an undiagnosed mental health issue lived in a terrible situation with his sister and brother-in-law.

> *"They never take him outside. They go out walking, he'll take his clothes off, so they have him tied up. They have chains on his feet… [T]hey kept him locked up in a room, closed up in a room. He'd scream. It feels really bad. It was someone who is our age, and he was locked up."*

When asked by the researcher whether that was common behavior when caring for someone with a mental health issue, Carmen stated: “Where we're from, that's what they do.”

Participants noted a significant difference in how mental health is dealt with in the United States, however. Maribel, 38, noted:

> *“I see that things are different here. Let's say that somebody has a disability or something, they can still take care of themselves, they can still fend for themselves here.”*

All of the participants believed that those with mental illnesses in the United States were better able to receive care and to participate in “normal” society. Carmen, 61, emphatically declared, “Who's going to help you in Mexico? Nobody. You don't have help from anybody there. We do here.” Dolores, 43, noted that in rural Mexico, those who have mental health issues are often isolated from the community and that they are considered to be useless. She and others felt that in the United States those with mental health issues are considered to be more valuable than are those in Mexico.

The participants noticed stigma against mental health in their current community. None of them could recall a time when mental health was mentioned in their churches or in other popular community gathering locations. Participants also noted the desire to seem “normal” to those outside of the immediate family. As defined by participants, “normal” is considered to be someone who is able to work and take care of his or her family. The inability to do so means the loss of “privileges” such as having a family or participating in common activities with those outside of one’s immediate family.

Participants noted that many people in their community feel shame about their mental health due to the fact that many want to be perceived as "normal". Dora, 29, shared a story about a family member:

> *"My mother-in-law goes to a doctor. It's always come up that she needs to go see a psychologist. She's never gone. She's never wanted to say why, either. She doesn't say why she doesn't want to go or what the problem is."*

This shame is particularly prevalent amongst older generations, who have not been exposed to as many of the health changes in Mexico or in the United States.

Maribel, 38, had a very specific experience with seeking mental health care. After the birth of one of her children, she experienced severe post-partum depression. She reported that during that period she had strong urges to hit or to yell at her baby. She also stated that she had very negative feelings about her body. Maribel recalled the following incident:

> *"One time I hit my little girl, and I felt bad about it. My mom saw it, and she felt bad about it too. Then little by little I started promising myself that I wasn't going to hit my kids anymore. It's been a long time now. I do yell still, but I don't want to hit them anymore. Just a little. It's fine."*

After this incident, Maribel reported that her mother encouraged her to see a doctor for treatment. The doctor recommended a holistic treatment that minimized her dependence on medications. This positive experience led Maribel to have a more positive view of doctors.

Mental Health Literacy

Participants were very willing to speak with the researcher about their experiences with mental health issues, but they did not seem to have a clear understanding of what the term mental

health means. The following are examples brought up by participants: (the aftermath of) rape, Alzheimer's, autism, learning disorders, post-partum depression, suicide, Down's Syndrome, and schizophrenia. Participants also mentioned more than one instance when someone not acting "normally" was considered to be mentally ill in their culture. Dora, 29, gave the following definition of mental health: "It's something has to do with emotions, with feelings. If you can't process a problem." This lack of clarity among participants may imply a lack of mental health literacy among this population, which can be a hindrance to seeking health care.

Participants in the focus group also had a limited understanding of who can be impacted by mental health issues. Carmen, 61, stated:

> *"There's some people that even when they're young, they're born with problems like that. Two stages. Sometimes it can be when you're young. Sometimes it can be when you're older, like in your seventies."*

Maribel was the only participant who had a clear understanding that mental health issues could also manifest in adulthood. Dora and Dolores had a vague notion that mental health could impact someone who experienced a traumatic event, but could not identify a specific example.

Treatability

All participants placed an emphasis on the treatment of mental health when making a decision about seeking care. The researcher noted three basic stages of treatment capacity: improving mental health on one's own, receiving medication for mental health, and being unable to improve one's mental health. Two participants, Dolores and Maribel, stated that they were able to treat their mental health problems on their own with time. They referred to this process as "going away", as if it required no support from their families or community.

The second stage of treatment capacity was receiving medication for the improvement of one's mental health. Dora, 29, stated:

> *"I think it's when you get to the point that you can't hide symptoms anymore that there's a problem happening. I think that's when someone recognizes okay, I need to go to the doctor, I need to go to the psychologist."*

Participants also noted that there are treatments for certain types of mental health issues (ie: schizophrenia). Participants did not seem to differentiate between regulating symptoms and eliminating a mental health issue so that medication was not necessary.

The final stage of treatment capacity was the inability to improve one's mental health status. Participants mentioned "crazy clinics" (*clinicas de loceros*) where people with no hope of improvements to their mental health go in Mexico. Carmen, for instance, admitted to the group that she does not believe that her sister can improve her mental health and that she is simply crazy. These people with no hope for improvement are the people deemed necessary to be locked away or isolated from the community.

Structural Barriers and Facilitators to Care

This section focuses on structural barriers and facilitators to seeking mental health care services. Participants brought up the following topics: physical health care costs, gender, and lack of services.

The participants reflected on their reluctance to seek mental health care as a result of struggles receiving physical health care. Dolores, 43, stated that she once had to take her young son to the emergency room because two pediatricians missed a severe health issue. This was a huge expense for her family, and seemed to erode her trust in the American healthcare system.

Maribel, 38, stated that she had to pay $1000 for basic health evaluations for herself and her husband. These evaluations were required for immigration. Carmen, 61, needed to have a colonoscopy, and had to pay $700 out of pocket after insurance. The participants therefore assumed that mental health care would be even more expensive, leading to their reluctance to seeking care from a doctor.

Another barrier to care discussed by participants was gender. Dolores, 43, noted that it is much easier for women to admit they require aid for their mental health issues than it is for men. She cited *machismo* as the cause. "There are some programs that will go to that area and offer help. The people that always go to those things are women." Participants noted that men prefer to be viewed as the provider of the family and that they are infallible. Women are viewed are caretakers, and therefore more susceptible to mental health issues.

Near the close of the focus group, the researcher inquired as to whether the participants knew of any mental health services in their community of Clarkston, Georgia. None of the participants were aware of any such services, making it difficult to receive care. When asked if they thought anyone from their community would utilize such services should they be available, all participants agreed that members of their community would be interested if the services offered were culturally and topically appropriate.

Mental versus Physical Health

This section discusses the theme of prioritization of physical over mental health. Dolores, in particular, explained how many in her community make decisions about prioritizing health. Dolores served as her mother's caretaker for several years. Dolores disclosed that her mother died from cancer, although she did not share what type of cancer it was.

> *"I think if someone has the hope that their loved one might get better, they would do up to the impossible, they would do even the impossible. But my mother was different. They said two years of life for her only. They said there's no solution for the problem that she has."*

The prospect of treatability seemed to be very important to the participants. Their preference to go to a primary care physician also points toward the tendency to prioritize physical over mental health.

Causes of Change in Mental Health

The researcher also explored participants' ideas about what can cause a change in someone's mental health. Reported causes were: economic concerns, family problems, and voices.

Economic concerns were the most common among participants. The husbands of the participants often work seasonal jobs, or are at high risk for their hours being dramatically decreased with no notice. This can put stress on the husband, as well as the rest of the family. This was of particular concern to those with young children. According to participants, family problems also can cause changes to mental health status. This was particularly true for Carmen, 61, whose sister caused Carmen much distress. She reported feeling physical ails after interacting with her sister, and Carmen's daughter (Maribel) noted that seeing her sister impacted Carmen's mental health as well.

The other potential cause for change in mental health status was mentioned briefly by one participant, who stated: "A lot of times there's suicide because of depression. The people that kill other people because they have the voices that say, 'Kill them. Kill them.'" This potential cause

for change seemed to be shared by each of the participants, but they did not expand further on the subject.

Vocabulary

The final theme identified by the researcher was in regards to the vocabulary used by participants when speaking about mental health. In order to provide culturally competent healthcare to different populations, mental health care providers must understand the way in which the population speaks about the issue. This may be because vocabulary often provides deeper meaning about how that population connotes a topic.

During the activity conducted at the beginning of the focus group, the researcher provided the following definition of mental health: "[It] includes our emotional, psychological and social well being." Participants were then asked to provide words or phrases that they associated with the mental health. The following is a list of vocabulary provided by participants in the order in which they were provided:

- Crazy (*loco*)
- Crazy (*demente*)
- Cuckoo
- Not thinking well
- Missing a screw
- Screw loose
- Contagious
- Psychologist
- Schizophrenic

Participants later used the term “crazy clinic” (*clinica des loceros*) to describe a place where someone goes for mental health treatment. When asked by the researcher to identify positive and negative words from the generated list, all participants immediately stated that all of the words and phrases have a negative connotation in their culture. Interestingly, the word *loco* was used nineteen times in regards to people from the Mexican community over the course of the focus group, making it the most common adjective to describe a person.

Confidants

In order to discover how participants define culturally appropriate mental health care, the researcher explored with whom participants currently talk about their mental health. The qualities discussed by participants are mentioned here, as well as participants’ negative experiences with confiding in someone about their mental health.

Participants uniformly believed that women are easier to talk to than are men. They reported feeling that women are more accepting and less judgmental. Examples of women participants felt comfortable speaking to were: sisters, mothers, friends, and cousins. Husbands were viewed to be the second best confidants in regards to mental health. This was because spouses are privy to all family dynamics and can understand the stresses of parenting. However, participants noted that husbands were only helpful if they already tended to be supportive of their wives.

Outside of the immediate family, it is much more difficult to establish confidence in people. Carmen, 61, stated that, when she tried to speak with an acquaintance about her own mental health concerns, she was written off as a gossip. Participants stated that this may be

because their community puts pride into seeming “normal” and successful in front of others. This desire does not lead to open communication and expression about mental health.

Even amongst more distant relatives, participants reported feeling uncomfortable speaking about mental health. For instance, Dolores, 43, expressed her concern for her sister and nephews due to the fact that Dolores’s brother-in-law is an alcoholic. She intimated that he is psychologically and verbally abusive to his family. Dolores, however, stated: “[B]ecause he's not your family you don't say anything.” All participants agreed that it is offensive to confront someone about their mental health if that person is not in your immediate family, even if that person directly impacts the mental health of someone in your immediate family.

Participants seemed to be open about expanding mental health support in their community. All of the participants reported enjoying the social support group. Dora, 29, stated: “I like doing things in a group because I see other points of view.” She also added that having individual support available on an as-needed basis would be ideal in case someone is not yet comfortable speaking about mental health in a group environment.

Language as a Source of Isolation

Limited English language ability seemed to be a source of isolation for participants. In this section, the researcher will explore how language may lead to isolation. Receiving a driver’s license, finding employment, and communicating with doctors and others are made more difficult when one is unable to speak the language. Such impairments may freedom of movement and increase feelings of incompetence as a productive member of society, which can impact mental health. Dolores, 43, stated:

> *"To the gynecologist that I go to, they don't speak any Spanish. Sometimes we have to just gesture. Sometimes they ask if everything is okay. Not everything is okay. You have to speak with gestures to make yourself understood."*

Participants also reported language being a barrier when attempting to receive support within their communities. The inability to communicate about help seeking behavior can result in frustration. Maribel, 38, recalled having some of those feelings upon her arrival in the United States. She was unable to communicate with any of her American neighbors due to the language barrier, and recalled that the inability to communicate with her neighbors led her to withdraw and only speak to her immediate family. Dolores agreed, saying:

> *"I feel limited. I feel bad not knowing English well… [I feel] frustrated, but just with myself. Sometimes I think I've been here ten years and I still can't. I learned Spanish, so how am I not going to be able to do this?"*

Encouragingly, all of the participants reported feeling proud that their children were able to speak English, as they saw this as a sign of success. Perhaps that optimism is due to the perception that their children will not need to experience the same level of isolation as do their parents.

It is important to note that all of the participants in the focus group were a part of an existing social support group for Mexican women in Clarkston, Georgia. As a result of this, the participants are less likely to experience shame when seeking help for mental health issues. However, all four women noted that shame is still an important barrier to care in their community. This is especially true amongst the older population who hold more traditional Mexican values.

Conclusion

Overall the focus group provided key information that contextualized information gathers in the quantitative survey. Though the number of participants was small, the quality of the data was rich. This may be a result of the fact that the researcher required little time to build rapport among participants due to their involvement in the support group.

Discussion

Introduction

The combination of established literature and the research completed in this study allow for a more complete picture of immigrant mental health. This section will explore the broader findings of the research and contextualize those findings within the realm of existing literature. In order to do this, the researcher will utilize a socio-ecological model to demonstrate at which level an intervention should take place. After, the researcher will discuss recommendations for further research.

Synthesis of Findings

As anticipated, several themes from existing literature manifested in this study. For instance, participants' previous experiences with healthcare professionals influenced perceived reasons to go to a doctor. Another example is that participants views on the acceptability of certain mental health issues correlated with a participant's previous experience with mental health. Previous experience also tended to lead to a higher perceived knowledge of mental health terminology. The last finding discovered in this study that the researcher noticed in existing literature was that participants used more medically accurate vocabulary when their knowledge of the term was higher. For example, two participants accurately used the term post-partum depression. This may be because one of the participants had personal experience with that mental health issue. However, areas where the participants had lower knowledge (ie: symptoms and treatment) in the quantitative data correlated to more colloquial and inaccurate terminology usage during the focus group. An example of this was the participant use of the term "crazy clinic" to describe a mental health treatment facility.

Despite the fact that the same participants who completed the survey also participated in the focus group, the researcher observed two major discrepancies between information provided in the survey and the focus group. The first of these discrepancies was that participants did not specifically identify having health insurance as a facilitator to receiving healthcare, nor the lack of health insurance as a barrier. Health insurance and access to care are commonly linked in the literature, so it is interesting that the participants did not mention this. Participants did, however, address the link between cost and the decision to go to the doctor in the focus group. That link was not brought up in the survey, and is related to the second discrepancy found between the quantitative and qualitative data in this study. Participants never made an association between insurance status and views of the worth of seeing a psychologist or other healthcare provider about a mental health issue. This discrepancy may be due to the fact that the participants prioritized other barriers before health insurance.

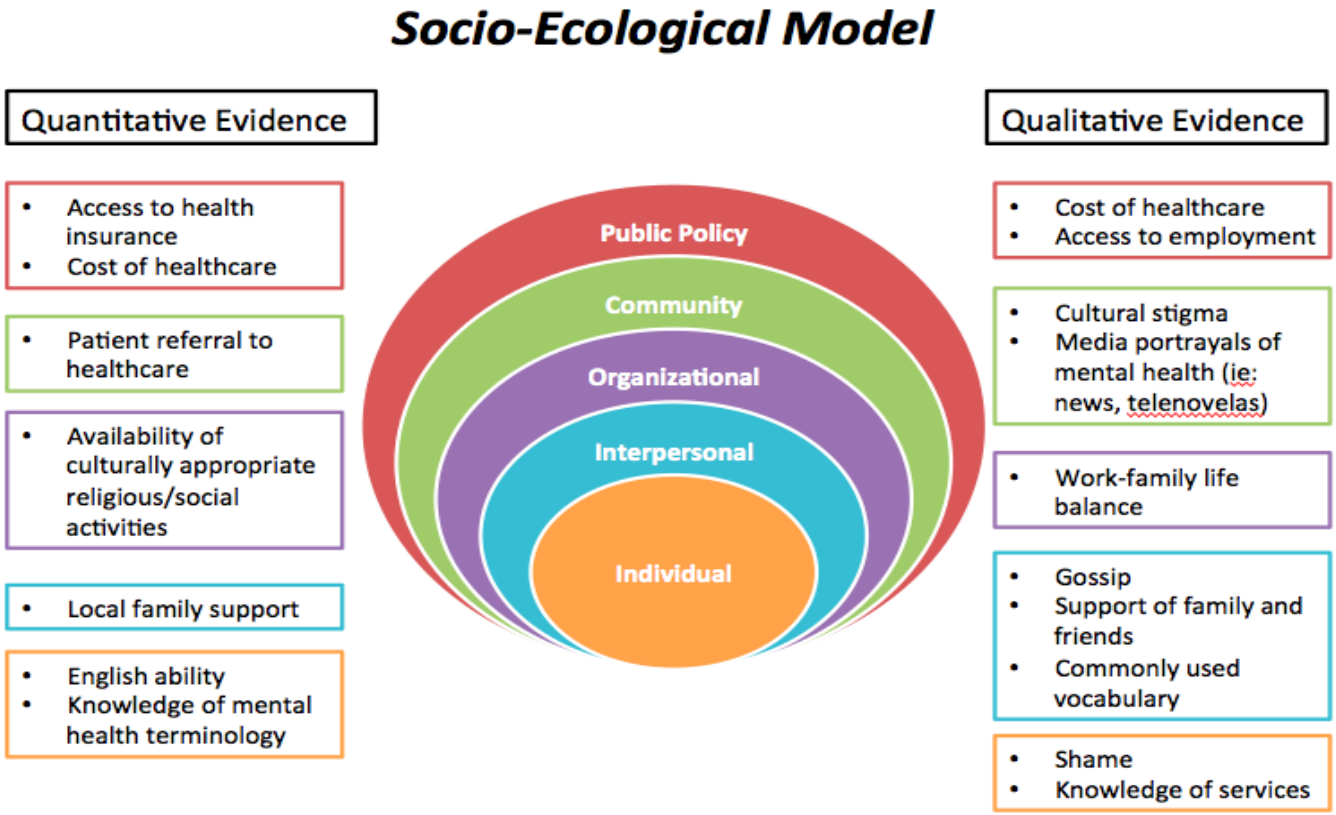
Two new findings emerged from this research. First, the participants more readily identified mental health issues as being present in their daily lives if the participant felt they had a greater understanding of the term. One example of this phenomenon was the relatively high estimated knowledge of the term schizophrenia because participants had viewed a news story about a girl with that specific that mental health issue. The second new finding emerging from this research was that a participant's self-reported understanding of mental health terms did not necessarily correlate to medically or psychologically accurate understandings of those terms. The researcher intentionally labeled the possible responses on the survey in order to measure participants' comfort level with a term (see Methods section for more information). While participants reported that they had an understanding of a term on the survey, all of them at some point described mental health terms inaccurately in the focus group. However, simply

understanding a mental health term will not lead underserved populations to care. It is imperative that Western-trained medical professionals be aware of different connotations of commonly-used mental health terminology. Potential patients are more likely to seek care if they feel assured that they will be understood linguistically and culturally by their doctor.

Intervention Recommendations Using the Socio-Ecological Model

Participants indicated several potential areas of intervention in this study, all of which can be categorized using the socio-ecological model (See Figure 5).

Figure 5. Elements participants brought up in the study in relation to the Socio-ecological model.



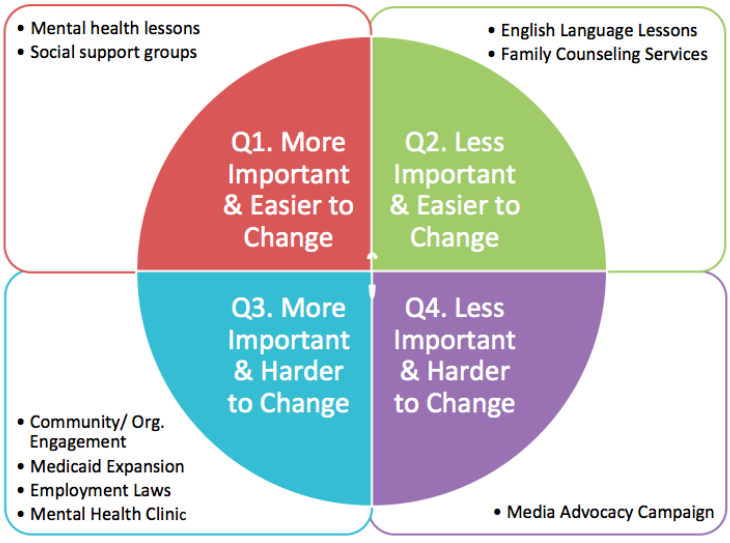
In this section, the researcher will explore each level of the socio-ecological model in relation to this study, and will make a recommendation for targeting future interventions in this community.

The first unit of this model is individual factors. Participants noted limited English language ability, knowledge of mental health terminology, shame, and lack of knowledge of available services as barriers to mental health care in their community. Example interventions to address these issues are: providing English language classes and mental health lessons. At the interpersonal level of the model, factors participants noted as barriers or facilitators to care were: local family support, gossip, and commonly used mental health vocabulary. In order to address these barriers, an intervention could be to expand the availability of culturally and linguistically appropriate support groups such as the one the participants are involved in, or to provide family counseling services. Within local organizations such as churches and community centers, participants brought up the difficulty of balancing work and family life, as well as limited availability of culturally and linguistically appropriate health services. This was particularly true in the realm of mental health. In order to improve this situation, one suggested intervention could be to engage local community leaders to incorporate mental health education into their programming. The next level of the socio-ecological model refers to the community. At this level participants noted cultural stigma, media portrayals of mental health, and obstacles to making doctors appointments or being referred to doctors which participants could not afford. Interventions at this level could involve an advocacy campaigns for changing media portrayals of mental health, or to expand mental health services for low-income populations by advocating for a new mental health clinic in the community. Under policy, the final level of the model, participants mentioned lack of access to health insurance, cost of healthcare, and limited

employment as barriers to care. Interventions at this level could include advocating for Georgia to expand Medicaid, or to change policies toward employment regarding illegal immigrants.

Each level of the socio-ecological model presents intervention options. For instance, changes at the policy level could impact the most people. However, policy level changes are much more difficult to instate than are interventions at the individual or personal level. The researcher recommends intervening at the interpersonal level for this population. An intervention at this level is most economically feasible, has a high level of impact, and has the potential to address mental health literacy levels at the individual and organizational levels as well. Figure 6 is the researcher's intervention prioritization matrix that stems from the primary research and pre-existing literature. Quadrant 1 (Q1) includes interventions that have both high impact and are the most feasible. Quadrant 2 (Q2) includes interventions that are not as urgent, yet are fairly feasible. The third quadrant (Q3) includes interventions that are very important, but will require more time and resources in order to be effective. Finally, Quadrant 4 (Q4) represents interventions that are not as urgent, and require significant time and resources.

Figure 6. Prioritization matrix based on primary research and existing literature.



Interventions in Quadrant 1 should be of highest priority to any local institution looking to improve mental health in this population. This includes social support groups, which fall under the interpersonal level of the socio-ecological model. Social support groups require little staffing (ie: a certified counselor and a translator), making them cost-effective. Linguistically and culturally appropriate support groups also allow for stigma reduction and community outreach. Participants in social support groups are likely to spread their knowledge of mental health and support services to others in their communities, which impacts other quadrants of the prioritization matrix that are of lower priority. For these reasons, the researcher highly recommends expanding culturally and linguistically appropriate support groups in this community.

Recommendations for Future Research

Due to the sample size limitations of this study, the first recommendation for future research is to replicate this study with a greater number of participants. Further research should also include men, as men often experience even more stigma in regards to receiving mental health services than do women. A replication of this study with a larger sample size and other language groups may allow for a more nuanced analysis, as well as reveal more potential groups to target.

Another recommendation for future research would be to conduct a similar study with other populations. Examples of potential study populations are: immigrants not from Mexico, refugee populations, and American-born adults. Findings from these studies may highlight mental health knowledge gaps, and provide a foundation for educational campaigns. It is also possible that conducting more studies with Mexican immigrant populations with Affordable Care

Act Medicaid expansion. The same can be said for states with more or less strict immigration policies than Georgia.

Above all, more research must be done in the area of non-Western views of mental health. As discussed in the literature review, there is a gap in research in this area. In fact, views on psychology from non-Western perspectives are not even currently considered to be psychology; they are considered to be philosophy. This difference in terminology diminishes the cultural relativity of mental health, implying that other points of view are not even science. In order to best treat non-Western patients, it is necessary to conduct more research in the subjectivity of mental health. Although some underserved populations may choose to seek care, it is important to explore the differences in connotation of mental health terminology and services for non-Western patients so that mental health and medical professionals can best treat these populations.

Conclusion

This study took an initial look into non-Western views of mental health as well as its impact on perfection and utilization of mental health care in this country. Even this study has wider public health implications. The following section describes some of these implications.

With the aid of further research, the gap in knowledge on the intersection of non-Western psychology and the American healthcare system can decrease in size. In the focus group, participants compared and contrasted their beliefs about mental health in Mexico and the United States. This information will provide context to future researchers.

Participants revealed much information about their views on mental health and the decision to seek mental health care. This research may improve mental health care providers'

interactions with patients from this population. In addition, mental health care providers who wish to expand their patient-base to include this population may consult this research in order to understand what services will best suit this population.

This research also effectively demonstrates that there is a need for mental health services among Mexican immigrant populations. Participants discussed some of the various mental health needs within their social networks, and these needs are likely to be mirrored in the rest of the community. Further research and expansion of services to this area will decrease mental health stigma and encourage others from the community to seek care.

Another public health implication is that this study shows there is an interest in mental health care in Clarkston. The participants in this study believed that, should services be available, people from their community would seek care. Because of the lack of mental health care facilities in the area, mental health programs looking to begin in the Atlanta area should strongly consider Clarkston as a base of operations.

Findings from this study also support the need for mental health literacy in this population. Participants demonstrated limited mental health literacy, and they themselves admitted that they are likely to be more educated about health than are others in their community due to their participation in a health-focused support group. Educating this vulnerable population on health, mental health in particular, may improve overall health status in the community.

Finally, this research explored the barriers and facilitators to care on each level of the socio-ecological model. In order to impact mental health in this community, programs should utilize this research to determine which activities may be the most effective and feasible.

References

Administration, S. A. a. M. H. S. (2008). *Projections of National Expenditures for Mental Health and Substance Abuse Treatment 2004-2014*.

Administration, S. A. a. M. H. S. (2015). *National Directory of Mental Health Treatment Facilities 2015*. Retrieved from http://www.samhsa.gov/data/sites/default/files/2015_National_Directory_of_Mental_Health_Treatment_Facilities.pdf.

Ahmedani, B. K. (2013). Embarrassment when illness strikes a close relative: a World Mental Health Survey Consortium Multi-Site Study. *Psychological Medicine, 43*, 2191-2202.

Alexander, T., & Wilz, G. (2010). Family Caregivers: Gender Differences in Adjustment to Stroke Survivors' Mental Changes. *Rehabilitation Psychology, 55*(2).

Becker, A. (2013). Mental Health and the Global Agenda. *The New England Journal of Medicine, 369*(1).

Burns, J. (2009). Mental Health and Inequity: A Human Rights Approach to Inequality, Discrimination, and Mental Disability. *Health and Human Rights, 11*(2).

Center, P. R. (2009). Most Mexicans See Better Life in U.S.-- One in Three Would Migrate.

Cutcliffe, J. R. (2001). Mass media, 'monsters' and mental health clients: the need for increased lobbying. *Journal of Psychiatric and Mental Health Nursing, 8*, 315-321.

Davey, G. C. L. (2013). Mental Health & Stigma. Retrieved from https://www.psychologytoday.com/blog/why-we-worry/201308/mental-health-stigma

Dictionary, O. E. (2015). Definition: stigma. Retrieved from http://www.oxforddictionaries.com/us/definition/american_english/stigma

Dingfelder, S. F. (2009). Stigma: Alive and Well. Retrieved from http://www.apa.org/monitor/2009/06/stigma.aspx

Greyber, L., & al, e. (2013). A Pilot Examination of Outcomes From an Adolescent Residential Treatment Facility Health and Wellness Intervention on Body Mass Index. *Residential Treatment for Children and Youth, 30*.

Grover, S., & Dutt, A. (2011). Perceived burden and quality of life of caregivers in obsessive–compulsive disorder. *Psychiatry and Clinical Neurosciences, 65*.

Gülçür. (2000). Evaluating the Role of Gender Inequalities and Rights Violations in Women's Mental Health. *François-Xavier Bagnoud Center for Health and Human Rights*.

Healthcare.gov. (2016). *The Fee for not having health insurance. If you don't have health insurance: How much you'll pay*. healthcare.gov Retrieved from https://www.healthcare.gov/fees/fee-for-not-being-covered/.

Hook, J. V. (2003). Poverty Grows Among Children of Immigrants in U.S.: Migration Policy Institute.

Hunt, P., & Mesquita, J. (2006). Mental Disabilities and the Human Right to the Highest Atainable Standard of Health. *Johns Hopkins University Press, 28*(2).

Institute, M. P. (2012). Mexican-Born Population Over Time, 1850-Present.

Institute, M. P. (2014). U.S. Immigrant Population by State and County.

Institute, M. P. (2016). Unauthorized Immigrant Population Profiles. http://www.migrationpolicy.org/programs/us-immigration-policy-program-data-hub/unauthorized-immigrant-population-profiles

Jing, Q., & Fu, X. (2001). Modern Chinese psychology: Its indigenous roots and international in□fuences. *International Journal of Psychology, 36*(6), 408-418.

Kenny, P., & al, e. (2014). The physical functioning and mental health of informal carers: evidence of care-giving impacts from an Australian population-based cohort. *Health and Social Care in the Community, 22*(6).

Lewis, L. (2009). Politics of Recognition: What Can a Human Rights Perspective Contribute to Understanding Users' Experiences of Involvement in Mental Health Services? *Social Policy and Society, 8*(2).

Lombardi, K. (2014). David Fincher's "Gone Girl" finds praise from critics. Retrieved from http://www.cbsnews.com/news/gone-girl-ben-affleck-critics-reviews/

Medicine, U. S. N. L. o. (2016). *Mental Health*. Retrieved from https://www.nlm.nih.gov/medlineplus/mentalhealth.html.

Motel, S., & Patten, E. (2010). Hispanics of Mexican Origin in the United States, 2010.

Nawkova, L. (2012). The Picture of Mental Health/Illness in the Printed Media in Three Central European Countries. *Journal of Health Communication, 17*(1), 22-40.

NIMH. (2014). Prevalence of Any Mental Illness Among U.S. Adults (2014).

Organization, P. A. H. (2012). *WHO Aims: Report on Mental Health Systems in Latin America and the Caribbean*. Retrieved from http://www.paho.org/hq/index.php?option=com_docman&task=doc_view&gid=21325&Itemid.

Organization, W. H. (2001). Mental Disorder Affect One in Four People. Retrieved from http://www.who.int/whr/2001/media_centre/press_release/en/

Organization, W. H. (2002). World Health Survey Individual Questionnaire. http://www.who.int/healthinfo/survey/whslongindividuala.pdf

Ortega, A., & al, e. (2006). Co-occurence of mental and physical illness in US Latinos. *Social Psychiatry and Psychiatric Epidemiology, 41*.

Pickett, K. E. (2010). Inequality: an underacknowledged source of menal illness and distress. *The British Journal of Psychiatry*.

RAND. (2015). Social Support Survey: RAND Medical Outcomes Study. Retrieved from http://www.rand.org/health/surveys_tools/mos/mos_socialsupport.html

Rose, D., & al, e. (2007). 250 labels used to stigmatise people with mental illness. *BMC Health Services Research, 7*(97).

Roy, A. (2012). The Human Rights of Women with Intellectual Disability. *Journal of Royal Society of Medicine, 105*, 384-389.

Scott, D., & Happell, B. (2011). The High Prevalence of Poor Physical Health and Unhealthy Lifestyle Behaviours in Individuals with Severe Mental Illness. *Issues in Mental Health Nursing, 32*.

Scott, K. (2014). Associations Between Subjective Social Status and DSM-IV Mental Disorders: Results from the World Mental Health Surveys. *JAMA Psychiatry, 71*(12).

Security, D. o. H. (2016). *Definition of Terms*. Retrieved from https://www.dhs.gov/definition-terms - 12.

Service, I. R. (2016). *Immigration Terms and Definitions Involving Aliens*. Retrieved from https://www.irs.gov/Individuals/International-Taxpayers/Immigration-Terms-and-Definitions-Involving-Aliens.

Services, C. f. M. a. M. (2013). *Federally Qualified Health Center*. http://www.cms.gov Retrieved from https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/fqhcfactsheet.pdf.

Sheikh, S., & Furnham, A. (2000). A cross-cultural study of mental health beliefs and attitudes towards seeking professional help. *Social Psychiatry and Psychiatric Epidemiology, 35*(7), 326-334.

Skinner, M. A., & al, e. (2004). Financial Stress Predictors and the Emotional and Physical Health of Chronic Pain Patients. *Cognitive Therapy and Research, 28*(5).

Sotelo, G., & al, e. (2015). Analysis of the Mental Health Legislation in Mexico. *International Journal of Mental Health, 43*(4), 1-19.

State, U. S. D. o. (2014). *Mexico Travel Warning*. Retrieved from http://travel.state.gov/content/passports/english/alertswarnings/mexico-travel-warning.html.

Stetz, K., & Brown, M.-A. (2004). Physical and Psychosocial Health in Family Caregiving: A Comparison of AIDS and Cancer Caregivers. *Public Health Nursing, 21*(6).

Stuart, H. (2006). Mental Illness and Employment Discrimination. *Current Opinions in Psychiatry, 19*, 522-526.

Summerfield, D. (2012). Afterword: Against "global mental health". *Transcultural Psychiatry*.

Tamasese, K., Peteru, C., Waldergrave, C., & Bush, A. (2005). Ole Taeao Afua, the new morning: a qualitative investigation into Samoan perspectives on mental health and culturally appropriate services. *Australian and New Zealand Journal of Psychiatry, 39*(4), 300-309.

Trauma, H. P. i. R. (2006). *Harvard Trauma Questionnaire Iraqi Version*.

United Nations Educational, S., and Cultural Organization. (2016). *Migrant/Migration*. Retrieved from http://www.unesco.org/new/en/social-and-human-sciences/themes/international-migration/glossary/migrant/.

Zong, J., & Batalova, J. (2014). Mexican Immigrants in the United States.

Appendix 1- Survey Tool

Demographics

1) How old are you?

   _____

2) What language(s) do you speak?
   Please list all, and write which is your native language.

   _____
   _____
   _____

3) What is your country of origin?

   _____

4) Which countries, other than the U.S., have you lived in?
   Please list all. If refugee camp, please list camp name and country.

   _____
   _____
   _____
   _____

5) How long have you lived in the U.S.?
   _____ Less than one month
   _____ One to three months
   _____ Four to six months
   _____ Six months to one year
   _____ One to three years
   _____ More than three years

7) What is your current legal status?
   _____ American citizen
   _____ Permanent resident (green card)
   _____ Legal migrant (work or student visa)
   _____ Refugee or asylee
   _____ Pending
   _____ Illegal or undocumented migrant
   _____ Other: _____

8) If applicable, to which refugee resettlement agency were you designated? *Choose one.*
   _____ Catholic Charities (CC)

____ International Rescue Committee (IRC)
____ Lutheran Services of Georgia (LSG)
____ New American Pathways (NAP)
____ World Relief (WR)

9) What is your religion? *Choose one.*
____ Christian (non Catholic)
____ Catholic
____ Muslim
____ Buddhist
____ Jewish
____ Atheist
____ Other: _____

10) What is the highest level of education you have reached? *Choose one.*
____ None (never attended formal schooling)
____ Some primary school
____ Completed primary (at least four years)
____ Some secondary
____ Completed secondary (at least eight years)
____ Some university
____ Completed university
____ More than university

11) How many children do you have?
Please list gender and age of all children. Example: girl age 7

_____
_____
_____
_____
_____
_____
_____

12) Do you have any other family members with you in the U.S.? Please list all.
Includes: husband, parents, uncles, aunts, cousins, grandparents, etc.

_____
_____
_____
_____

Health Information

13) Do you currently have health insurance?

____ Yes
____ No
____ I don't know

14) Do you have a primary care doctor?

____ Yes
____ No
____ A family member does, but not me
____ I don't know

15) When was the last time you went to the doctor?

____ Less than one month ago
____ Between one and three months ago
____ Less than six months ago
____ Less than one year ago
____ More than one year ago
____ Never
____ I don't remember
____ Other _____

16) Why would you go to the doctor?

____ Illness (example: flu, eye infection)
____ Chronic illness (example: diabetes, high blood pressure)
____ Mental health (example: feeling sad or afraid all the time)
____ Prevention (example: women's annual exam, check-up, vaccines)
____ Emergency
____ I would never go to the doctor
____ Other _____

17) Have you ever had any concerns about your mental health?

For the purposes of this question, use this definition of mental health: "emotional, psychological, and social well-being."

____ Yes
____ No

a) If yes, have you ever tried to get help for these concerns?

____ Yes
____ No

18) Have you heard of the following terms?

Put an X in the box that best fits your answer.

	Yes, and I think I understand what it means	Yes, but I don't understand it	No
Addiction			
Alcoholism			
Anxiety			
Avoidance			
Depression			
Detachment			
Domestic violence			
Flashback			
Hyperarousal			
Isolation			
Insomnia			
Mental health			
Post-Partum Depression			
Post Traumatic Stress Disorder (PTSD)			
Psychiatrist			
Psychologist			
Shame			
Therapy			
Trauma			
Withdrawal			

Appendix 2- Focus Group Guide

Introduction:

My name is Ana, and I'm a Global Health student at Emory University. I want to thank you for taking the time to talk to me today, and for sharing your views. Before we get started, I just wanted to go over some things about what we're doing. I am doing a study on how immigrant and refugee women think about mental health issues and treatment in Clarkston. The goal of the study is to help 50 Cents. Period. understand how to best help you. We really want to get your perspective. There aren't any "right" or "wrong" answers, but if you feel uncomfortable answering a question, you can feel free to not participate for that portion of the focus group. Also, if you want to take a break or leave the focus group at any time, feel free to tell me that. I'm hoping to spend about two hours with you today. We will take a short break in the middle of the focus group for you to get a snack or to use the restroom. I'm also hoping to record this interview. I'm doing that so that I can better remember what we're talking about today. Anything you tell me won't be directly linked to you, and the recording will be deleted in May at the end of the school year. Do I have your consent to record?

I would like to quickly set some ground rules for this focus group. Feel free to speak openly here, but please be respectful of others' opinions. Also, there should be one person speaking at a time. I encourage you to discuss the questions with other members of the group, but please don't have any side conversations. On another note, if you have a cell phone or another device that might make noises, please ensure that it is turned off and put away so that we can have the best discussion possible. Are there any other ground rules that anyone would like to suggest?

Do you have any other questions for me before we start?

Warm-Up Question:

1) Let's start by going around the room and saying our name, age, where we're from, and how long we have lived in the United States.

Activity:

Here is a definition of mental health: "Mental health includes our emotional, psychological, and social well-being."

List all words/phrases they use to talk about mental health in their culture (native language)

-- Sort into "positive" and "negative" words/phrases

1) How do people in your culture talk about mental health?

Probes: open discussion, not at all, rumors, etc

2) What can cause changes in your mental health? (free listing)

Probes: language, employment, family/children, isolation, etc; changes post resettlement

3) Who do you think you can talk to about your problems?

Probe: "go-to" person; types of people (women, men, family, inside/outside culture)

4) Why/When would a person in your culture talk to someone about their mental health?

Probes: a doctor, friend, caseworker, etc

5) What prevents people from talking to someone about their mental health?

Probes: general barriers (cost, language, stigma, etc)

6) What mental health supports are currently available in your community?
Probes: usage, perception (individual and community), pros, cons, suggestions, etc

7) What kinds of mental health supports would you like to be available for you?
Probes: groups, culturally appropriate therapy, other recommendations, etc

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Directions for activity: Facilitator provides a definition of mental health ("Mental health includes our emotional, psychological, and social well-being.") The facilitator then asks participants to list all words or phrases that their culture uses to talk about mental health. This should be done in their native language (with English translation written on board via translator). Once a list is established, participants sort the words/phrases into "positive" and "negative" in terms of connotation in their culture. (Example: "crazy" might be negative, while "support" might be positive).

Materials needed: white board/large sheet of paper; marker/pen; camera for researcher to take pictures of final product.

Time required: 20 minutes