Latino perspectives of mental health recovery: a grounded theory analysis

Kristin Y. Walstad

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Latino Perspectives of Mental Health Recovery: A Grounded Theory Analysis

by

Kristin Y. Walstad

Submitted to the Graduate Faculty as partial fulfillment of the requirements for the

Master of Arts Degree in Psychology

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May 2015
An Abstract of
Latino Perspectives of Mental Health Recovery: A Grounded Theory Analysis

by

Kristin Y. Walstad

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The University of Toledo
May 2015

The Latino population in U.S. is a rapidly growing demographic, including over 15 million individuals as of the 2010 Census (U.S. Census Bureau, 2010). Symptom distress and mental illness are prevalent among Latinos (Alegría et al., 2007; Alegría et al., 2008; OMH, 2012). However, there are significant differences in prevalence rates of psychiatric diagnoses (Alegría et al., 2007; Alegría et al., 2008) and rates of mental health help-seeking and service utilization (Alegría et al., 2002; OMH, 2012) between Latinos and other demographic groups. Current mental health recovery models emphasize that recovery from serious mental illness (SMI) is a personal journey (Henderson, 2010, SAMHSA, 2012). Consumer narratives have played an important role in identifying key themes of the recovery process (Corrigan et al., 1999; Ridgway, 2001; Young & Ensing, 1999). However, the recovery experiences of Latino consumers are notably absent.

This study sought to deepen the recovery literature by developing a Latino-centered model of mental health recovery. One-on-one interviews were conducted with eight Latino consumers and four family members of Latino consumers regarding their experiences with recovery. Themes were assessed using grounded theory analysis. Primary themes emerging from the analysis include a split between the Latino values of
family unity and caring for family members, and a systematic lack of knowledge of the nature of mental illness and recovery. Overall, the coping strategies described by Latinos in the sample were found to be consistent with those described in other recovery models. However, Latinos in recovery appear to be especially empowered when connected with quality mental health care and community organizational support. A majority of participants also demonstrated a strong desire to self-advocate and give back to the community. Stigma and lack of education on mental illness among Latinos were frequently cited as harmful for Latino consumers living with SMI. Encouragingly, the majority of consumers represented in our sample had not experienced prejudice from their mental health care providers as a function of their ethnicity.
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I would especially like to thank Anita Martinez-Folger and Claudia Annoni. Without their support and guidance, this project would not have been possible. The participants of this study also continue to serve as an inspiration of how to support mental health recovery in a way that celebrates one’s heritage.
Table of Contents

Abstract iii

Acknowledgments v

Table of Contents vi

List of Tables ix

List of Abbreviations x

I. Literature Review 1

A. History of Consumer/Survivor Movement 1

B. History of Recovery Construct 5

C. Defining Mental Health Recovery 9

D. Prevalence of Mental Illness in U.S. Latino Population 10

E. Factors Affecting Latino Mental Health 13

  a. Traditional Values and Beliefs Related to Family and Social Relationships 13

  b. Religiosity/Spirituality 14

  c. Immigration, Acculturation and Acculturative Stress 14

  d. Mental Health Care Utilization and Help-Seeking/Barriers to Care 16

  e. Mental Illness Stigma Among Latinos 19

F. Statement of the Problem 19

G. Purpose of the Study 21

H. Research Questions 21

I. Hypotheses 21
II. Method

A. Participants

B. Measures

   a. Abbreviated Multidimensional Acculturation Scale (AMAS-ZABB)
   b. Semi-Structure Interview Protocol

C. Procedure

D. Data Analysis

   a. Interpretivism in Qualitative Research
   b. Grounded Theory

III. Results

A. Quantitative Results

B. Qualitative Results

   a. Family
   b. Stigma
   c. Ignorance
   d. Mental Health Education and Advocacy
   e. Individual Factors Influencing Latino Mental Health
   f. Mental Health Treatment Experiences
   g. Advocacy for Classes and Services for Latinos

IV. Discussion

A. Implications

B. Limitations

C. Directions for Future Research
References 72

Appendices 81

A. Semi-structured Interview Protocol – English Version 81
B. Semi-structured Interview Protocol – Spanish Version 85
C. Interview Excerpts by Theme 89
List of Tables

Table 1  Descriptive Statistics of Consumer Demographic Variables .........................24
Table 2  Descriptive Statistics of Family Demographic Variables .................................25
Table 3  Descriptive Norms for AMAS-ZABB Community Sample ..............................27
Table 4  AMAS-ZABB Results for Current Study Sample ............................................37
Table 5  Effect Sizes for AMAS-ZABB Results for Study Sample ..............................37
Table 6  Outline of Core Themes: Family ..................................................................38
Table 7  Outline of Core Themes: Stigma ...................................................................42
Table 8  Outline of Core Themes: Ignorance .............................................................44
Table 9  Outline of Core Themes: Mental Health Education and Advocacy ................45
Table 10 Outline of Core Themes: Individual Factors Influencing Latino Mental Health .........................................................................................................................50
Table 11 Outline of Core Themes: Mental Health Treatment Experiences ..................55
Table 12 Outline of Core Themes: Advocacy for Classes and Services for Latinos ......57
List of Abbreviations

AMAS-ZABB .......... Abbreviated Multidimensional Acculturation Scale

BLS ..................... Bureau of Labor Statistics

CMI ....................... Chronic Mental Illness

DSM-5 ..................... Diagnostic and Statistical Manual of Mental Disorders, 5th Edition

MHRM ..................... Mental Health Recovery Measure

NAMI ...................... National Alliance on Mental Illness
NIMH ....................... National Institute of Mental Health

OMH ....................... Office of Minority Health

SAMHSA .................. Substance Abuse and Mental Health Services Administration
SMI ......................... Serious Mental Illness
SPMI ....................... Serious and Persistent Mental Illness

WMR ....................... Wellness Management and Recovery
Chapter One

Literature Review

History of the Consumer/Survivor Movement

The recovery model has become the new standard for mental health care policy and research. It is person-centered and emphasizes that individuals with serious mental illness (SMI) can make meaningful recovery despite their psychiatric disabilities (Anthony, 1993; Corrigan et al., 1999; Henderson, 2010; Jacobson & Greeley, 2001; New Freedom Commission on Mental Health, 2003; SAMHSA, 2011). Psychiatric patients living with SMI have played an important role in the model’s development by actively sharing their experiences (Deegan, 1988; Frese, Knight & Saks, 2009; Ridgway, 2001; Young & Ensing, 1999), which have influenced how recovery is measured (Bullock, 2009; Young & Bullock 2003; 2005) and treated (Dixon et al., 2001; WMR CCOE, 2012). The model diverges significantly from both the rehabilitative and medical models of mental illness that predated it. Both prior models centered interventions on long-lasting the deficits caused by the illness (either through psychiatric care or services, respectively) rather than on client strengths (Anthony, 1993).

It is also important to note that several terms have been used to describe individuals in recovery. Terms such as “ex-patient” and “psychiatric survivor” have a long history in the rights movement for mental health patients (Chamberlin, 1990). More recently, individuals in recovery have been termed “consumers,” reflecting their active role in treatment and a shift to the recovery model mindset (Anthony, 1993). For the purposes of this study, individuals in recovery will be referred to as consumers.
Also, the definition of serious mental illness (SMI) and who it applies to has been debated and commonly interchanged with other terms, such as serious and persistent mental illness (SPMI) and chronic mental illness (CMI) (Torres, 2010). Current governmental policy emphasizes the use of the SMI categorization in place of other definitions, since no established standard has been used for these categorizations (Social Security Administration, 2010). The federal definition of serious mental illness – as defined in the 1992 ADAMHA Reorganization Act (P.L. 102-321) – is very inclusive. According to this legislation, an individual meets the definition of living with SMI if they are: 1) over age 18; 2) have experienced a mental, behavioral or emotional disorder; and 3) have a disorder that meets DSM-III-R criteria. The disorder must also result in functional impairment that interferes with one or more life activities and is recurrent and persistent. The law notes, however, that disorders can vary in severity and disability (NIMH, 2013).

Emphasis on consumers’ voices and their role in treatment and recovery has emerged out of significant historical roots (Chamberlin, 1990; Frese & Davis, 1997; Hervey, 1986). In England, for example, the rights of mental asylum patients and the inhumane care used in asylums were hot topics of public discourse as far back as the early 18\textsuperscript{th} century (Hervey, 1986). These self-defined “ex-patients” played a significant role as advocates during this period, and many formed formal advocacy groups (Chamberlin, 1990; Frese & Davis, 1997; Hervey, 1986). One of the earliest known groups was the Alleged Lunatic’s Friend Society, which was established in England in 1845. The group made many calls for improvements of the mental health care system in England, including promoting more humane treatment, inclusion of patients in treatment
planning, and prohibition of illegal commitments, among many others. Interestingly, one demand the ALFS forwarded was asking local magistrates to put themselves in a patient’s shoes and consider whether they wanted to be treated by the current mainstream methods for even just one week (Hervey, 1986).

Similar advocacy work by ex-patients became prominent in the United States after the Civil War (Frese & Davis, 1997). The Anti-Insane Asylum Society in Illinois, an ex-patient advocacy group, was founded by Elizabeth Packard in response to her experience being forcefully committed by her husband. Packard also actively published books and pamphlets about her experiences starting in 1868. Around this time, Elizabeth Stone, who was also committed by her husband, began actively organizing in Massachusetts in support of rights for the “insane” (Chamberlin, 1990). Clifford Beers, another American ex-patient, brought the advocacy fight into the 20th century with the publication of his memoir *A Mind That Found Itself* in 1923 (Frese & Davis, 1997). Beers had been previously hospitalized several times due to bipolar disorder with psychotic features (Chamberlin, 1990). In his book, Beers detailed the inhumane treatment endured by psychiatric patients and advocated for their rights and empowerment. Beers also played an important role in the establishment of what would become the National Mental Health Association (Chamberlin, 1990; Frese & Davis, 1997).

The modern consumer/survivor movement began in earnest around 1970 and developed without an awareness its early roots (Chamberlin, 1990; Frese & Davis, 1997). The guiding principles of the movement emphasize self-definition, self-determination, and commitment towards raising public awareness about patients’ rights and abuse
Early groups in the 1970s included organizations like the Mental Patients’ Liberation Project (founded in New York City in 1971) and Network Against Psychiatric Assault (founded in San Francisco in 1972) (Chamberlin, 1990). National conferences were held by consumers to address patients’ rights. For example, the Conference of Human Rights and Psychiatric Oppression was first organized in 1973 and held annually until 1985 (Frese & Davis, 1997). The movement was also showing up in print. For example, in the San Francisco metro area, a newsletter (titled Madness Network News) was created with the goal of publicizing the movement’s progress (Chamerlin, 1990; Frese & Davis, 1997) and ran from 1972 to 1986 (Frese & Davis, 1997). Through continued political efforts, consumers began to gained seats on health boards, at legislative hearings, and notably in 1976, on the President’s Commission on Mental Health (Chamberlin, 1990; Frese & Davis, 1997).

The success of the consumer/survivor movement in the 21st century has been significant. In 2003, the President’s New Freedom Commission released a report on the U.S. mental health system. The report specifically emphasized the importance of client choice and empowerment in treatment and underscored three key treatment requirements: 1) clients should be able to designate who serves on the care team; 2) clients should share in the decision-making; and 3) clients should be able to agree or disagree with their treatment plan. The report also emphasized two key guidelines for transforming the current mental health system. First, treatments and services should be client and family-focused. Second, care should emphasize facilitating recovery, building resilience, and empowering clients to cope with the challenges they face (New Freedom Commission Report, 2003).
History of Recovery Construct

Recovery as a construct developed out of progressive transformations of beliefs about serious mental illness (SMI) and the ways it should be treated. Prior to the 1980s, the medical model primarily guided treatment. The model emphasized the deficits caused by mental illness and focused on symptom reduction as a near exclusive goal. In the 1980s, the rehabilitation model emerged and sought to address the poor outcomes of individuals with psychiatric disabilities through community services (Anthony, 1993). Deinstitutionalization of patients in the 1960s and 1970s also changed the structure of mental health care (Anthony, 1993) and resulted in notable stories of formerly institutionalized patients living full, satisfying lives outside of the hospital (Harding et al., 1987; Harding, Zubin, & Strauss, 1987). Recovery emerged distinct from the medical and rehabilitative focuses. Rather than being prescriptive, the concept of recovery focuses on clients’ personal experience accepting and moving beyond their disability toward living a full life (Anthony, 1993).

The construct itself is closely tied to the consumer/survivor movement (Frese & Davis, 2009; Henderson, 2010; Young & Ensing, 1999) and is founded in consumers’ personal dialogues (Anthony, 1993; Deegan, 1988; Frese & Davis, 2009; Young & Ensing, 1999). The consumer/survivor movement rebelled against the discriminating idea of “mentalism” – that psychiatric patients were volatile, inept and helpless. It argued for consumer empowerment through protecting consumers’ rights to advocate for their needs and make their own treatment decisions. It also emphasized the concept of self-help, maintaining that consumers should be empowered to think of themselves as
competent and valuable. Advocacy for consumer rights was also a central theme to the movement (Chamberlin, 1990).

These themes have repeatedly emerged in the personal dialogues of consumers (Deegan, 1988; Frese et al., 2009; Ridgway, 2001; Young & Ensing, 1999). Notably, several mental health professionals living with psychiatric disabilities have played important roles advocating for the idea of meaningful recovery (Deegan, 1998; Frese et al., 2009). For example, Dr. Elizabeth Baxter, a working psychiatrist diagnosed with schizoaffective disorder, has openly discussed her psychiatric history and revealed she was once told by doctors that the best career she could hope would be to work on an assembly line. Dr. Frederick Frese, a clinical psychologist diagnosed with schizophrenia, has argued for active collaboration between consumers and their care providers (Frese et al., 2009). Dr. Patricia Deegan, a clinical psychologist living with schizophrenia, published an open narrative of her experiences. She writes that to her, “[r]ecovery refers to the lived or real life experience of people as they accept and overcome the challenges of the disability” (Deegan, 1988, p. 11). Deegan (1988) also argues that the recovery process is no different between psychiatric and physical disabilities and emphasizes that recovery is not synonymous with rehabilitation through services. Instead, it requires a client to find a new identity and direction that focuses them beyond the limits created by their disability.

Similar themes emerged from qualitative interviews of consumers (Corrigan et al., 1999; O’Rourke, 2009; Ridgway, 2001; Young & Ensing, 1999). Generally, Young and Ensing (1999) found that consumers identified with three major stages in recovery: overcoming “stuckness,” recovery from loss and moving forward, and improving quality
of life. Accepting one’s illness, gaining motivation, reengaging in life, and fostering hope are common themes for consumers in earlier stages of recovery (Ridgway, 2001; Young & Ensing, 1999). Factors such as self-esteem, empowerment, social support, and quality of life have been shown to be positively associated with recovery. Most notably, Ridgway (2001) found that consumers viewed recovery as a complex and nonlinear process, which depended on strong social support. For consumers in a psychoeducation program, having a sense of group belonging, equality, and “having fun” were key processes to achieving recovery within this context (O’Rourke, 2009).

The possibility for meaningful recovery has been directly supported by outcome research, most notably for schizophrenia (Harding et al., 1987a; Harding, Zubin, & Strauss, 1987; Harrison et al., 2001). In a 32 year longitudinal study initiated in the 1950s, Harding et al. (1987a) examined outcomes of 262 patients of a Vermont State Hospital. At the time of their inclusion in the study, these patients had an average period of illness of 16 years, had been totally disabled for an average of 10 years and been hospitalized for an average 6 years. In the initial sample group, 79 percent of subjects were given a diagnosis of schizophrenia based on DSM-I criteria. Harding et al. (1987a) later reexamined these diagnoses to match the DSM-III, the current DSM edition at the date the article was published.

The most striking result of the Harding et al. (1987a) study was the heterogeneous courses experienced by patients – most notably that it was not consistently downward. The authors found that for most outcome variables examined (rates of hospitalization, socialization, employment, symptomatology, basic functioning and living a full life) approximately 67 to 80 percent of patients were found to be significantly improved. Of
the patients taking psychotropic medication, 75 percent took low to moderate doses. Around 50 percent of patients weren’t taking medication at all. In response to the Harding et al. (1987a) results, Harding et al. (1987b) emphasized how divergent the heterogeneous outcomes found by Harding et al. (1987a) study were relative to traditional views of schizophrenia. The authors noted that early researchers around the beginning of the 20th century, such as Emil Kraepelin and Emil Bleuer, believed that a diagnosis of schizophrenia led only to deterioration, substantial deficits and poor outcomes.

More recent longitudinal studies of the course of psychotic illness have corroborated with the results found and discussed by Harding et al. (1987a) and Harding et al. (1987b). In a 15 and 25 year follow up study, Harrison et al. (2001) examined outcomes of 1,633 participants diagnosed with a range of psychotic disorders over 15 year and 25 year spans at 19 locations throughout the world. The authors found that between 56 and 60 percent of participants were rated “recovered” and had not had psychotic episodes in the last 2 years prior to the assessment. A small percentage of participants had spent the majority of the last year hospitalized (3.4 percent for other psychosis, 11.6 percent for schizophrenia). Nearly 57 percent of individuals with a schizophrenia diagnosis and 69 percent diagnosed with other psychosis had spent the majority of the last two years before follow-up working. Similar to the studies by Harding and her colleagues, Harrison et al. (2001) emphasized the heterogeneous range of outcomes experienced by individuals with psychosis. Moreover, they emphasized that the negative prognoses given to patients has not been substantiated in their study and that their results offered a strong case for optimism.
Defining Mental Health Recovery

Out of the growing body of evidence supporting the possibility of meaningful recovery for SMI individuals, formalized models of recovery and its components have since emerged (Anthony, 1993; Henderson, 2010; Jacobson & Greenley, 2001, SAMHSA, 2012). Anthony (1993) provided an early model of recovery and defined it as an idiographic process where an individual adjusts their attitudes, values, feelings, goals, skills and/or roles to live a satisfying life despite the limitations of their illness. Anthony emphasizes that recovery for individuals with SMI does not mean they return to premorbid functioning. Rather, recovery means the individual adapts to a new way of living. More recently, the United States Substance Abuse and Mental Health Services (SAMHSA) of the U.S. Department of Health and Human Services has supported the recovery model and publically promoted its own model. SAMHSA’s current working definition of recovery states that mental health recovery is “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential” (SAMHSA, 2012).

Important foundational components and stages of recovery have also been researched and promoted. Anthony (1993) cites several key assumptions inherent to the recovery model, including 1) recovery does not require professional intervention, 2) personal support helps drive recovery, 3) recovery isn’t a derivative of the believed cause of the illness, 4) recovery can occur even with recurrent symptoms, 5) recovery changes occurrence of symptoms, 6) recovery is not a linear process, 7) recovering from the consequences of mental illness can be more difficult than the illness itself and 8) successful recovery from mental illness doesn’t mean the illness isn’t real. Similar to
Young and Ensing (1999), Jacobson and Greenley (2001) argue for three basic stages of recovery: recuperation, moving forward and getting back from loss. SAMHSA (2012) cites ten key features of mental health recovery, including: self-direction, individualization, empowerment, strengths-focus, peer support, respect from community and social groups, personal responsibility, hope, and an understanding that recovery is non-linear.

Also of note, the recovery model has been shown to align with other current treatment models (Barber, 2012; Borrell-Carrió, Suchman, & Epstein, 2004). For example, Barber (2012) argues that the recovery model serves a natural extension of the medical model. Here, recovery model practices of person-centered care, information sharing and shared decision making are incorporated. The biopsychosocial model also seeks to humanize medical care and is relationship-centered. It emphasizes on the interaction between mind and body in treatment, which connects well with the holistic focus of the recovery model. The biopsychosocial model also emphasizes similar practices, such as mutual trust, informed choice of treatment, support of patient autonomy, and shared decision making (Borell-Carrió et al., 2004). Lastly, SAMHSA emphasizes the integrated care model along with the recovery model. SAMHSA cites that many individuals in recovery also deal with comorbid health conditions, and that creating an alliance with a consumer’s treatment providers can help to promote holistic care of the individual (SAMHSA, 2014).

Prevalence of Mental Illness in the U.S. Latino Population

The Latino population in the United States is a rapidly growing demographic. According to the 2010 U.S. Census, 15.2 million individuals identified themselves as of
Latino or Hispanic origin. The number of self-identified Latinos/Hispanics increased 43 percent between 2000 and 2010. The Latino/Hispanic demographic also accounted for 16.4 percent of the U.S. population and was the largest minority group in the country as of the 2010 Census. Among Latino/Hispanic individuals in the 2010 Census, approximately 59 percent were Mexican, 10 percent were Puerto Rican, 5 percent were Central American, 4 percent were South American, and 4 percent were Cuban. Approximately 17 percent of Hispanics/Latinos had no designated a country of origin on the 2010 Census (U.S. Census Bureau, 2011).

Symptom distress and mental illness are prevalent among the Latino demographic (Alegría et al., 2008; Alegría et al., 2008; OMH, 2012). The Office of Minority Health (OMH) of the U.S. Department of Health and Human Services found that nearly four percent of Hispanics experienced severe psychological distress between 2009 and 2010. The estimation was based the reported frequency of feelings of sadness, nervousness, restlessness, hopelessness, worthlessness, fatigue and lack of motivation (OMH, 2012). The lifetime prevalence of depressive, anxiety and substance use disorders has been estimated to total around 30 percent for Latino men and women based on DSM-IV criteria (Alegría et al. 2007). Prevalence rates of psychiatric disorders among Latinos do differ relative to other demographics. Notably, Alegría et al. (2008) found that lifetime prevalence rates of psychiatric disorders are substantially lower among Latinos (30%) relative to non-Latino whites (43%). The significantly lower prevalence rates among Latinos were found for major depressive episode, panic disorder, generalized anxiety disorder, social phobia, alcohol abuse and dependence, drug abuse and dependence. No
significant difference was found in the prevalence rates of dysthymia or agoraphobia without panic.

Some of the disparity in prevalence rates of psychiatric disorders between Latino and non-Latino whites can be explained by complexities within Latino subgroups (Alegría et al., 2007; Alegría et al., 2008). Mental illness prevalence rates tend to be higher among U.S born Latinos (Alegría et al, 2007; Alegría et al., 2008), Latinos proficient in English (Alegría et al, 2007) and Latinos of Puerto Rican origin (Alegría et al., 2007; Alegría et al., 2008). Years of acculturation and integration into U.S. culture (Puerto Ricans being the most integrated on average) are also associated with higher rates of psychiatric disorders that more closely match rates for non-Latino whites (Alegría et al., 2007; Alegría et al., 2008).

Regarding the prevalence of specific disorders, immigrant Latinos have been shown to have significantly lower prevalence rates for major depressive episodes, social phobia, post-traumatic stress disorder, anxiety disorders, alcohol abuse and dependence, and drug abuse and dependence relative to U.S. born Latinos. Alegría et al. (2008) argue that immigrant status and lack of acculturation may serve as a protective mechanism against adopting societal norms (e.g., tendency to self-medicate leading to substance use). In the case of Puerto Ricans, it’s been suggested that their higher prevalence rates may be due in part to the stress and stigma they face migrating to the U.S. for work and being perceived as only coming to live on Welfare (Alegría et al., 2007; Alegría et al., 2008). Alegría et al. (2007) suggest that English proficiency may also cause acculturative stress from negotiating between two cultures or the disruption of traditional family and social relationships.
Factors Impacting Latino Mental Health

Traditional Values and Beliefs Related to Family and Social Relationships.

When exploring personal narratives by Latinos, there are several traditional values that are important to note. Regarding the family, gender roles – especially among less acculturated groups – tend to be defined traditionally (Organista, 2007). *Machismo*, a traditional value incorporated into how Latino men are raised, encourages suppression of emotion and projection of strength and self-reliance (Organista, 2007), as well as assumption of the role of provider and protector of the family (Abdullah & Brown, 2011). Conversely, *mariansimo* is a traditional value incorporated into the rearing of Latina women that encourages being accommodating, obedient, and centered toward family (Abdullah & Brown, 2011; Organista, 2007). Mariansimo also encourages women to assume the suffering of the family with dignity (Abdullah & Brown, 2011; Organista, 2007), which can often include taking on the role of caretaker for disabled or ill relatives (Organista, 2007). More generally, family closeness and loyalty or *familismo* is highly valued and Latino-American families tend to be much more collectivistic than Caucasian-American families (Abdullah & Brown, 2011; Organista, 2007). Latino families are traditionally patriarchal and respect of elders is emphasized. Children who adhere to traditional Latino values are termed *bien educado* (raised properly) versus *mal criado* (poorly raised) (Organista, 2007).

There are also several common cultural values tied to interpersonal relationships and interpersonal effectiveness which are also important to note. On a general level, traditional Latino culture emphasizes *personalismo* or the importance of building relationships and being sociable. Accordingly, social relationships should be approached...
with *simpatía* or a congenial politeness (Abdullah & Brown, 2011; Organista, 2007) that avoids conflict and confrontation (Organista, 2007). A certain amount of polite self-disclosure or *plática* is also expected, and building good rapport or *confianza* is also emphasized. Dignity and respect of others (*dignidad y respeto*) are strongly valued with regard to empathy, connectedness to others, and respect of others’ equality (Abdullah & Brown, 2011).

**Religiousity/Spirituality.** A large percentage of Latinos in the U.S. identify themselves as religious (Organista, 2007; Gallup, 2012). Gallup recently estimated in 2012 that approximately 85 percent of Latinos identified with some kind of religious affiliation, with Catholics comprising the largest group (54%) (Gallup, 2012). Religious milestones (e.g., baptisms and first communions in the Catholic Church), are celebrated within the broader church community and their significance and value is transmitted through generations (Organista, 2007).

Religious involvement has been shown to be a protective factor for low-income and immigrant Latinos. Involvement in religious organizations can provide Latinos the opportunity to integrate into a positive social support structure. Some evidence also suggests that involvement in church can act as a form of social control that limits bad behavior, such as substance use (Alegría & Woo, 2009). Organista (2007) also argues that religiosity can be counterproductive to Latino mental health when religious beliefs undercut an individual sense of self-efficacy (e.g., praying for God to solve one’s problems).

**Immigration, Acculturation and Acculturative Stress.** Despite speaking the same language, Latinos vary significantly in their experiences with immigration and
acculturating in the U.S. Latino subgroups vary in the level of U.S. governmental support, “outsider status,” and discrimination experienced upon immigrating to the U.S. Mexican Americans have historically resided in the U.S. the longest, including prior to the ratifications of western U.S. states like Texas, Colorado and California when the territory was controlled by Mexico. Puerto Rico became a U.S. territory in 1898 as a consequence of the Spanish American War, and Puerto Ricans were later granted U.S. citizenship in 1917. Cuban emigration began following the Castro Revolution in the 1950s. The migration was initially considered to be only a temporary exile by Cuban refugees, with most Cubans staying in isolated communities the Miami, Florida area to remain close to the island. Central American immigrants have historically sought U.S. residency due to civil war in their country of origin, but U.S. policies have made it difficult for many to obtain refugee status (Organista, 2007).

Each of these historical trajectories has resulted in very different “point of exit/point of entry” experiences for these groups. Cuban Americans, especially early immigrants, tended to be white Cubans and included licensed professionals and business leaders well-connected to the U.S. government. Fitting with the political motives of the U.S. at the time, Cubans received substantial aid from the U.S. government. As a result, Cuban immigrants have had a relatively easier adjustment into the U.S. compared to other Latino groups. The opposite is true for Puerto Ricans, despite their status as U.S. citizens. Historically, the U.S. government and multinational corporations have severely depressed the Puerto Rican economy by abusing resources and underpaying labor. Also, emigrating Puerto Ricans have been more racially diverse (including black Puerto Ricans) than Cubans, for example, and thus have faced more “out group” discrimination.
and segregation in the U.S. Mexicans continue to serve as a key manual labor workforce. The presence of Mexicans, especially documented workers, has varied over time depending on the U.S. economy and economic policies. Both Mexicans and Central Americans also remain relatively segregated from other ethnic groups (Organista, 2007).

Personal factors that have been shown to promote or reduce acculturative stress, including retention of cultural traditions, retention of native language, and age at immigration. Notably, research related to age suggests that living in one’s country of origin past the late teens and early twenties when psychiatric disorders typically develop can be a protective factor (Fuligni & Perreira, 2009). Low socioeconomic status has not been shown to be consistently associated with psychological stress among Mexicans, Puerto Ricans and Cubans. Research suggests that perceived net wealth has protective effects against psychological stress for these groups. Increased education, especially when it includes a degree for Puerto Ricans, can also protect against psychological distress (Xu, 2011).

**Mental Health Service Utilization and Help-seeking/Barriers to Care.**

Notable inequalities are present in the utilization of mental health services by Latinos relative to non-Latino whites and other demographic groups. For example, in 2008, the U.S. Office of Minority Health found that non-Hispanic whites received mental health treatment twice as often as Hispanics (OMH, 2012). When diagnosed with a psychiatric disorder or comorbid psychiatric disorders, Latino individuals have been shown to be the least likely to use specialty mental health care (e.g., treatment from psychiatrist, psychologist or psychotherapy) relative to non-Latino whites and African Americans (Alegria et al., 2002).
Several factors have been examined for their influence on the level of services used or sought by Latinos (Berdahl & Torres Stone, 2009; Ishikawa, Cardemil & Falmange, 2010; Chan, Natsuaki, & Chen, 2013; Hansen & Aranda, 2012; Moreno & Caremdmil, 2012; Organista, 2007). Related to service choice, Latinos have been shown to be more likely to seek specialty mental health services (e.g., psychiatrist, psychologist) when they feel they face a severe mental health problem; have had favorable experience with treatment in the past; expect to be satisfied by future treatment; feel similar to their care provider or have good rapport with their care provider (Ishikawa et al., 2010). Having an attitude of medical self-reliance (e.g., “I can overcome illness without help from a medically trained person.”) has not been consistently shown to play an important role in lowering service utilization rates among Latinos relative to other groups (Berdahl & Torres Stone, 2009).

Concerning differences within the Latino demographic, Latino immigrants (especially recent immigrants) are less likely to use services relative to U.S. born Latinos. Latinos who are more proficient in English are more likely to use services than those who are not. Country of origin also influences service utilization. Puerto Ricans tend to use services at higher rates than any other Latino subgroup, while Mexicans have the lowest rates of use. The differences in utilization rates based on country of origin are also reflective of acculturation factors (e.g., English proficiency, time living in the U.S.) (Berdahl & Torres Stone, 2009). Latinos living in poverty have been shown to be less likely to use services due to poor accessibility (Alegría et al., 2002).

Several personal characteristics and beliefs have also been shown to influence service utilization by Latinos. For example, older Latinos tend to be less likely to use or
seek services as they age (Hansen & Aranda, 2012). Latinos reporting higher levels of family cohesion (highest among first and third-generation Latinos) are also less likely to use mental health services (Chang et al., 2013). Related, the belief that one should not confide personal information to family outsiders is recurrent among Latinos (Ishikawa et al., 2010). Research has also shown that Latinos (especially female and less acculturated Latinos) are more likely to somaticize mental health problems. As a result, somaticizing Latinos are often more likely to seek medical rather than mental health care (Organista, 2007). Religious Latinos have been shown to prefer religious mental health services over professional mental health services for treatment, unless treatment is sought for severe mental health problems of perceived biological origin (Moreno & Cardemil, 2013). It’s been suggested that Latinos frequently turn to folk healers (e.g., curanderos) to treat mental health problems; however, this has not been consistently supported in the literature (Organista, 2007).

Latinos face a number of potential barriers to obtaining mental health care. Low socioeconomic status can act as a significant barrier to care in numerous areas, including being able to afford care or health insurance, having time to seek care, and having sufficient transportation to reach care (Cabassa, Zayas & Hansen, 2006; Kouyoumdjian, Zamboanga & Hansen, 2003). Low socioeconomic status as it relates to care access is particularly relevant for Latinos, given that approximately 25 percent of Latinos live below the poverty line as of 2011 (U.S. Census, 2011) with rates typically even higher among Latino immigrants (Kouyoumdjian et al., 2003). Moreover, Latinos have the second highest unemployment rate of all U.S. ethnic groups, second to African-Americans. As of September 2013, the average unemployment rate for Latinos was 8.5%
(BLS, 2013) relative to 6.1% for non-Latino whites (BLS, 2013). Notably, research has shown that care providers are more likely to take on clients from high socioeconomic backgrounds (Kouyoumdjian et al., 2003). Lack of knowledge of where to seek treatment and unfamiliarity with the treatment process also serve as barriers to care for Latinos (Cabassa et al., 2006). Lastly, living in rural settings has been shown to restrict Latinos access to care (Cabassa et al., 2006; Kouyoumdjian et al., 2003).

**Mental Illness Stigma amongst Latinos.** Latinos have been shown to place greater stigma on psychiatric disorders and their treatment compared to non-Latino whites (Kouyoumdjian et al., 2003). Some of this stigma has been attributed to traditional Latino gender roles and gender-based styles of coping (Applewhite, Biggs, & Herrera, 2009; Kouyoumdjian et al., 2003). For example, severe psychiatric symptoms may be considered a sign of weakness for men, while women may be pressured to cope with severe symptoms within the family rather than receive outside treatment (Applewhite et al., 2009). In a related subject, limited research is available with regard to the mental health effects of stigma placed on gay and lesbian Latinos. In a study of gay and bisexual Latino men, Diaz et al. (2001) found social isolation to be a mediating factor of psychological distress for participants and that experiences with homophobia, racism and poverty negatively influenced participants’ self-esteem.

**Statement of the Problem**

Based on the previous literature review, personal narratives of Latino mental health consumers regarding their experiences with recovery are noticeably absent. While there is substantial literature available on the various factors affecting Latino mental health, prevalence of mental health disorders, and service use rates, little information is
available on what it means to a Latino consumer to recover. Studies exploring aspects of mental health from the perspectives of Latinos are available, such as the life satisfaction of day laborers (Ojeda & Piña-Watson, 2013), immigrants’ perspectives on depression (Martinez Pincay & Guarnaccia, 2007) or caregivers’ narratives of treatment use by SMI relatives (Marquez & García, 2013). However, these studies do not address the experience of recovery from a psychiatric illness directly.

Much of the literature on Latino mental health focuses on the mechanics of what helps or hinders mental health and care use. While this information may help interpret a Latino consumer’s illness from an outsider perspective, it does not provide information on how the various factors are weighted by the consumer themselves. Recovery research has shown that persons in recovery define their situation very differently relative to traditional medical interpretations (Deegan, 1988; Frese et al., 2009; Ridgway, 2001; Young & Ensing, 1999) and that substantial recovery can be made despite the ongoing presence of psychiatric symptoms (Harding et al., 1987a; Harding et al., 1987b; Harrison et al., 2001).

Exploring the narratives of Latino mental health consumers is an important step in making the recovery literature more culturally competent. Recovery outcome measures, such as the Mental Health Recovery Measure (Armstrong et al., 2014; Bullock, 2009; Young & Bullock, 2003; 2005), are based on consumer recovery narratives and are commonly used to assess outcomes of consumer participants in psychoeducation programs. Given the various cultural factors discussed above that can be at play for a Latino consumer, their view of recovery might have substantial differences relative to
other consumer groups. Building a base of qualitative research of Latino recovery stories is an important starting point to address this cultural gap.

**Purpose of the Study**

The purpose of the present study was to address the existing gap in the recovery literature regarding Latino perspectives of mental health recovery. The central goal of the present study was to identify salient recovery themes in narratives of Latino consumers and identify possible unique beliefs Latino consumers may have regarding recovery and mental illness. The present study is the first study that specifically focused on the recovery narratives of Latino consumers.

**Research Questions**

This study focused on Latino consumers’ perspectives of mental health recovery and asked the following questions: 1) How do participants define recovery or identify with the current recovery construct? 2) What have been participants’ experiences with recovery? 3) What has hindered or supported participants’ recovery? 4) What are participants’ recovery goals? 5) How has being Latino affected participants’ recovery experiences? 6) How has being Latino affected participants’ or their families’ views of mental illness? 7) How has being Latino affected how they’ve been treated by mental health care providers? These questions were also asked from a family member’s point of view, who were also included in this study’s sample.

**Hypotheses**

Given that the current study is qualitative in methodology, no hypotheses were generated prior to data collection. Rather, concepts and potential theories were developed as and after data were collected and analyzed. It was expected that consumers
and family members would talk about their experiences with their own recovery or their relative’s recovery, and how the recovery process is influenced by being Latino. It was also expected that a range of factors affecting recovery would be discussed.
Chapter Two

Method

Participants

A total of N=12 Latino consumers or family members of consumers took part in a semi-structured interview (n=4 Male, n=8 Female). Study participants were recruited through a local agency, the National Alliance on Mental Illness (NAMI) of Greater Toledo, which provides support services for Latino consumers and Latino family members living in Toledo, Ohio. Participants included 8 mental health consumers (67%) and 4 family members of consumers (33%). None of the family participants were related to any of the participants who were mental health consumers. Participant demographics for consumers and family members are summarized in Table 1 and 2, respectively.

The mean age for consumers was 43 (SD=11.23) with a range of 28-58. The mean age for family members was 49 (SD=18.45) with a range of 24-67. When the consumers represented by family are counted, the current study reviewed the experiences of n=8 male consumers and n=4 female consumers. The ethnic makeup of the participants who were mental health consumers included one Mexican national, five Mexican-Americans, one Puerto Rican and one participant of both Mexican and Spanish origin. The family members included one Mexican national and three Mexican-Americans.

Several additional demographic factors were assessed. Regarding participant’s relationship status, five participants had never married; five were married; and two were divorced. For housing, 11 participants lived in their own home or apartment and one lived in a relative’s home. The employment status of participants varied: four were
employed full-time; three were employed part-time; two were homemakers; two were disabled; and one was retired. Participants reported living in the U.S. an average of 34 years (SD=20.33), with a range of 1 to 63 years. Participants also reported completing an average of 14 years (SD=3.70) of schooling, with a range of 7-20 years.

Table 1

*Descriptive Statistics of Consumer Demographic Variables (N=8)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>M</th>
<th>SD</th>
<th>Min.</th>
<th>Max</th>
</tr>
</thead>
<tbody>
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<td>11.23</td>
<td>28</td>
<td>58</td>
</tr>
<tr>
<td>Years living in U.S.</td>
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<td>15.41</td>
<td>13</td>
<td>58</td>
</tr>
<tr>
<td>Years in school</td>
<td>13.63</td>
<td>4.07</td>
<td>7</td>
<td>20</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>4</td>
<td>50.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>4</td>
<td>50.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Country of Origin</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mexico</td>
<td>7</td>
<td>87.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Puerto Rico</td>
<td>1</td>
<td>12.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spain*</td>
<td>1</td>
<td>12.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employment Status</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed full-time</td>
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<td>50.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed part-time</td>
<td>1</td>
<td>12.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homemaker</td>
<td>1</td>
<td>12.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retired</td>
<td>0</td>
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<tr>
<td>Disabled</td>
<td>2</td>
<td>25.0</td>
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<td></td>
</tr>
<tr>
<td>Marital Status</td>
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<td></td>
</tr>
<tr>
<td>Never Married</td>
<td>5</td>
<td>62.5</td>
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<td>Married</td>
<td>2</td>
<td>25.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Separated/Divorced</td>
<td>1</td>
<td>12.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living situation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Own home/apartment</td>
<td>7</td>
<td>87.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A friend/relative’s home</td>
<td>1</td>
<td>12.5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
*Note: One participant endorsed Mexican and Spanish heritage.

Table 2

**Descriptive Statistics of Family Demographic Variables (N=4)**

<table>
<thead>
<tr>
<th>Variable</th>
<th>M</th>
<th>SD</th>
<th>Min.</th>
<th>Max.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>49.25</td>
<td>18.45</td>
<td>24</td>
<td>63</td>
</tr>
<tr>
<td>Years living in U.S.</td>
<td>37.75</td>
<td>30.63</td>
<td>1</td>
<td>63</td>
</tr>
<tr>
<td>Years in school</td>
<td>13.75</td>
<td>3.40</td>
<td>9</td>
<td>17</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Female</td>
<td>4</td>
<td>100.0</td>
</tr>
<tr>
<td>Country of Origin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mexico</td>
<td>4</td>
<td>100.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employment status</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed full-time</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Employed part-time</td>
<td>2</td>
<td>50.0</td>
</tr>
<tr>
<td>Homemaker</td>
<td>1</td>
<td>25.0</td>
</tr>
<tr>
<td>Retired</td>
<td>1</td>
<td>25.0</td>
</tr>
<tr>
<td>Disabled</td>
<td>0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Martial Status</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Never married</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Married</td>
<td>3</td>
<td>75.0</td>
</tr>
<tr>
<td>Separated/Divorced</td>
<td>1</td>
<td>25.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Living situation</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Own home/apartment</td>
<td>4</td>
<td>100.0</td>
</tr>
<tr>
<td>A friend/relative’s home</td>
<td>0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

The participants who were mental health consumers were not formally assessed to determine whether or not they met DSM-5 criteria for a particular disorder. Rather, participants typically provided their diagnosis or related symptoms. Family members also typically provided the consumer’s diagnosis or symptoms. Based on these reports,
consumers represented in this study presented with diagnoses of alcohol dependence 
\((n=1)\); depression \((n=7)\); obsessive-compulsive disorder \((n=1)\); panic disorder \((n=1)\), 
post-traumatic stress disorder \((n=1)\); schizoaffective disorder \((n=1)\), schizophrenia \((n=1)\); 
social anxiety disorder \((n=1)\); and substance dependence \((n=1)\). Two participants 
reported symptoms consistent with comorbid disorders and these numbers are reflected in 
the totals above. One participant reported being diagnosed with comorbid panic disorder 
and social anxiety disorder. The other participant reported being diagnosed with 
comorbid depression, alcohol dependence, and substance dependence.

**Measures**

**Abbreviated Multidimensional Acculturation Scale (AMAS-ZABB).** The 
Abbreviated Multidimensional Acculturation Scale (Zea, Asner-Self, Birdman, & Buki, 
2003) or AMAS-ZABB is a 42-item measure rated on a 4 point Likert scale. It is a 
bilinear process measure that assesses acculturation retained from one’s culture of origin 
and from one’s current culture of residence (in this case, the United States).

The scale is intended to assess a participant’s level of acculturation in the United 
States and their Latino country of origin. Three key areas are assessed within the United 
States and “culture of origin” groups, including: cultural identity, language competence 
(English and Spanish), and cultural competence. For items assessing cultural identity, the 
answers range from 1 (strongly disagree) to 4 (strongly agree). Answers range from 1 
(not at all) to 4 (extremely well) for language and cultural competence questions. 
Acculturation scores for the U.S. and culture of origin groups are calculated by taking the 
average of the scale subgroups. For the U.S. grouping, the scores for cultural identity 
(items 1-6), English language (items 13-21), and cultural competence (items 31-36) are
averaged. For the “culture of origin” group, the scores for cultural identity (items 7-12), Spanish language (items 22-30), and cultural competence (items 37-42) are averaged. Together, these scores provide a comparison of a participant’s relative cultural competence in the U.S. or Latino country of origin. The AMAS-ZABB was available to participants in either English or Spanish.

The AMAS-ZABB was validated by Zea et al. (2003) using two samples of 156 college students from four mid-Atlantic universities and community colleges and 90 Central American Latino/Latina community members living in the Washington, DC area. In these studies, alpha coefficients ranged from 0.90 to 0.97 for the college sample and 0.83 to 0.97 for the community sample, indicating adequate internal consistencies for the measure subscales. Convergent and discriminant validity of the AMAS-ZABB were also successfully established relative to two other acculturation questionnaires, including the Bicultural Inventory Questionnaire (BIQ-B) (study 1) and the Multigroup Ethnic Identity Measure (MEIM) (study 2). Construct validity of the AMAS-ZABB was also demonstrated through a factor analysis of the two sample groups. Of the two samples used to validate the AMAS-ZABB, the community group is most comparable to the current study’s sample. Table 3 summarizes the normative scores for the AMAS-ZABB community sample group.

Table 3

<table>
<thead>
<tr>
<th>Scale</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. Acculturation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural Identity</td>
<td>2.60</td>
<td>0.71</td>
</tr>
</tbody>
</table>
Semi-Structured Interview Protocol. A semi-structured interview was used to collect qualitative responses from participants (see Appendix C and Appendix D). The protocol included an initial demographic questionnaire, followed by a recovery-related portion. The recovery-related questions for the interview protocol were adapted from questions developed by Young and Ensing (1999) in their study of consumers’ recovery narratives. The protocol was available to participants in English and Spanish. The Spanish version was translated by the researcher and proofed by two professional colleagues of the researcher who are Spanish-speaking Latinos with graduate-levels of education.

Procedure

Prior to initiating data collection, this research project was approved by a University Institutional Review Board for research with human participants. The study interview protocols and measures were also approved for use in both Spanish and English. Interviews for the study were conducted either at the home of the participant (n=6), at NAMI of Greater Toledo (n=3), a satellite site operated by NAMI of Greater Toledo (n=2), or at a local business chosen by one participant (n=1). All components of the interview session were delivered in either English (n=10) or Spanish (n=2),
depending on the participant’s preference. Participants’ language preference was asked prior to obtaining consent. Given the possibility that providing personally identifying information might be particularly sensitive for this sample group, consent was obtained orally. This method helped maintain confidentiality and reduced the likelihood of unintended disclosure by obtaining written consent. The consent form was read orally by the researcher to the participant. The participant was provided a copy of the consent form as a reference. After oral consent was obtained, the interview portion was conducted. Interviews lasted between 30 to 50 minutes. The interview sessions were audio recorded, with participants’ permission. Permission to record was obtained at the time of consent. At the conclusion of the interview, participants were given time to ask questions and thanked for their time.

Data Analysis

**Interpretivism in Qualitative Research.** Qualitative and quantitative research are both distinct in how they approach the observable world. Quantitative research follows the positivist scientific paradigm that focuses on what is observable and measurable. Qualitative research takes an interpretivistic stance that emphasizes that the world is complex, dynamic and socially defined. This distinction is important because it ultimately results in divergent goals and methodologies.

Qualitative research – including the Grounded Theory methodologies used in this study – explores phenomenological events that cannot easily be divided into discrete, quantifiable variables. Qualitative research emphasizes that understanding a participant in their environment from multiple perspectives is essential and involves an in-depth interaction between the participant and the researcher. Unlike quantitative research,
qualitative research does not begin with building hypotheses from theory. Rather, the
subject matter researched dictates the hypotheses to be tested and grounded theories are
constructed as and after data collection is completed. The methods used in qualitative
research are also flexible and can shift as the study progresses.

The goals of these two research styles ultimately differ in an important way. In
quantitative research, experimental techniques are used to test hypotheses with the goal
of finding generalizable results. For qualitative research, the ultimate goal of any
analysis is to capture the important meanings of the situation studied (Glesne & Peshkin,

Grounded Theory. The method of analysis for this study was guided by
Grounded Theory analysis and focused on analyzing phenomenon present in one-on-one
interviews with Latino consumers or their family members regarding how they recover
from mental illness. Grounded theory was originally developed by Glaser and Strauss
(1967) to provide a systematic, rigorous framework by which to analyze qualitative data.
Strauss and Corbin (1998) define the grounded theory method as the process of
developing theory “derived from data, systematically gathered and analyzed through the
research process” (p. 12). Strauss and Corbin note that “[a] researcher does not begin a
project with a preconceived notion in mind… Rather, the researcher begins with an area
of study and allows the theory to emerge from the data” (p.12). Thus, a priori
hypotheses are not made or considered appropriate since the theory is determined while
or after data is collected.

Initial interviews for this study were completed and transcribed by the lead
researcher. Each transcript was micro-analyzed and coded “line-by-line” to assess for
meaning. This process is called “open coding” or “open reading” (Glaser & Strauss, 1967; Wertz et al., 2011). Wertz et al. (2011) describe open coding as “holistic reading” or initial analysis that “involves no judgment, no selectivity, and an openness to all details” (p.131). Data was separated into “meaning units” or segments of interview data that contain a unified idea or concept. In this study, these units ranged from one or two words up to several sentences. Coding was completed by both the lead researcher and a faculty member to assess for reliability, as suggested by Elliot, Fischer, and Rennie (1999). Both coders had regular meetings across the data collection and analysis process. Both coders compared open and axial codings of each transcript and discussed emergent themes. Particular attention was paid to new themes that were not a part of established models of the mental health recovery process or recovery themes that appeared unique to Latino culture.

Prior to initiating the coding process, both coders completed a “bracketing” exercise (Wertz et al., 2011). Bracketing involves setting aside personal assumptions, meanings, and values related to the research subject. Specifically, each coder completed a Microsoft Word document and detailed their expectations of the study results based on the previous research. Starks and Trinidad (2007) argue that bracketing is intended to ensure that the researcher stays “honest and vigilant about her own perspective, pre-existing thoughts and beliefs, and developing hypotheses.” Moreover, the authors argue qualitative researchers should “recognize and set aside (but do not abandon) their a priori knowledge and assumptions, with the analytic goal of attending to the participants’ accounts with an open mind’” (p. 1376). In this sense, a key goal of the bracketing exercise was to ensure that both coders maintained “theoretical sensitivity” or a keen
awareness of the themes and categories emerging from data itself (Glaser & Strauss, 1967). The bracketing exercise was intended to reduce the possibility of confirmation bias, or the likelihood that the researchers would only evaluate the data in a way that confirms their own expectations and biases (Mays & Pope, 1995; Oswald & Grosjean, 2004). The bracketing and literature review processes were conducted to target the analysis on Latino themes. Research on general recovery processes was reviewed prior to the study, but was not set aside in the bracketing exercise. Rather, these themes were still available to researchers during the coding process, and only Latino factors were initially bracketed to facilitate fresh analysis of the topic area.

Upon the completion of open coding, both coders continued to code the interview data using an “axial coding” framework. Axial coding expanded categories developed through the open coding process and delineated dimensions of the categories and interrelationships between them. Charmaz (2006) specifically notes, “[a] major purpose of axial coding is to bring the data back together again into a coherent whole” (p. 186). Moreover, Strauss and Corbin (1998) note that axial coding delves into the “when, where, why, who, how, and with what consequences, thus giving the concept greater explanatory power.” (p. 90). Axial coding also allowed the coders to differentiate which concepts expanded to categories or reduced to subcategories. Open coding and later stages of the coding process were completed using a “constant comparison” method, as outlined by Glaser and Strauss (1967). To meet the requirements of constant comparison, all concepts, themes, and meaning units contained in the interviews were continually compared to each other. These comparisons allowed both coders to identify broader meaning and themes and ultimately join into an overall theory structure. Each unit was
compared for similarities and dissimilarities, as well as dimensions, defining
c Characteristics, and key features. A key part of the coding process is “memoing” or
detailing notes of each stage of analysis. Charmaz (1996) notes that, “Memo-making
leads directly to theoretical sampling, that is, collecting more data to clarify your ideas
and to plan how to fit them together. Here, you go back and sample for the purpose of
developing your emerging theory, not for increasing the generalizability of your results”
(p. 45).

Sampling and coding analysis for this study were considered complete once
“thematic saturation” was reached. Theoretical sampling dictates that participants are
sequentially added to the study as long as they continue to provide unique information
that augments the emerging theory structure. Once no new information emerges from
new interviews, “thematic saturation” is reached. Thematic saturation indicates that an
appropriate number of participants have been interviewed to outline the topic’s theory
structure. No new participants are recruited after thematic saturation is reached (Glaser
& Strauss, 1967). There is wide variation in guidelines regarding the minimum number
of interviews required for thematic saturation in grounded theory analysis (Guest, Bunce,
& Johnson, 2006). Guest et al. (2006) specifically examined this issue and found that
“saturation occurred within the first twelve interviews, although basic elements for
metathemes were present as early as six interviews” (p. 1). Thematic saturation in this
study was reached after interviewing 12 participants. Overall, the coding process allowed
the researchers to outline a theory of mental health recovery for Latinos that highlights
family, stigma, mental health education, advocacy and other unique factors that impact
Latinos. Treatment experiences and proposed classes and services also resulted from the analysis.
Chapter 3

Results

The goal of the present study was to understand mental health recovery from the perspective of Latino consumers. The resulting theory that emerged from the data indicated seven key themes or categories of recovery unique to Latinos and several subcategories within these overarching themes. The following discussion of the results first focuses on outlining the overall themes themselves and then the subcategories in detail. Connections between different categories and subcategories within a category itself are also fully elaborated. Together, these discussions provide an outline of the unique factors the Latinos in our sample experience when in recovery from mental illness.

The grounded theory analysis discussed here focuses only on those factors that emerged from the data that were clearly unique to the Latino consumers. All the consumers, and family members of consumers, discussed many facets of the mental health recovery process established by previous research in the area and discussed earlier in the literature review. Pursuant to the goals of the current study, the results outlined here do not review these previously well-established themes and, instead, focuses on the Latino-specific results. To ensure that the resulting themes are grounded in the data, passages from the interview data are included with each key category and related subcategories to highlight the themes as they emerged from the words of the interviewees themselves. Also, interviewees’ level of acculturation will be discussed to assess the extent to which they identified as Latino and serve as a good representation for the demographic of interest for this study.
Quantitative Results

Participants were assessed for their level of acculturation for both U.S. culture and their culture of origin using the AMAS-ZABB (Zea et al., 2003). Participants in the study either identified as being of Mexican heritage \((n=11)\); Puerto Rican heritage \((n=1)\), or Spanish heritage \((n=1)\). One participant included in these totals identified as having both Mexican and Spanish heritage. Acculturation scores for this participant were averaged to determine the overall for the sample \((N=12)\). The average AMAS-ZABB scores for the current study’s sample are summarized in Table 4.

The individuals in the sample included a range of backgrounds both in immigrant versus citizen status, country of origin, and relative identification with both U.S. American and Latino country of origin identities. Overall, participants’ cultural identity levels were strong for both the U.S. (U.S. identity \(M=3.23; SD=0.78\)) and culture of origin (Culture of origin identity \(M=2.93; SD=0.54\)). There were no significant differences between participants overall cultural identity levels, \(t(11)=-.922, p=.376\). Likewise, participants strongly identified with both U.S. (U.S. acculturation \(M=3.28; SD=0.91\)) and culture of origin (Culture of origin \(M=3.69; SD=0.33\)) identities. The level of identification between the two countries did not differ significantly, \(t(11)=1.631, p=.131\). Participants also identified themselves as strongly bilingual (English Language \(M=3.46; SD=0.78\); Spanish Language \(M=3.08; SD=0.94\)), with no significant differences in reported language ability, \(t(11)=.841, p=.418\). Finally, participants endorsed greater cultural competence for the U.S. (U.S. competence \(M=2.96; SD=0.87\)) than for their culture of origin (Culture of origin competence \(M=2.01; SD=0.79\)), \(t(11)=2.646, p=.023\).
Table 4

*AMAS-ZABB results for current study sample (N=12)*

<table>
<thead>
<tr>
<th>Scale</th>
<th>M</th>
<th>SD</th>
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<td>Cultural Identity</td>
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<tr>
<td>English language</td>
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<tr>
<td>Cultural competence</td>
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<tr>
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<tr>
<td>Latino/Latina acculturation</td>
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<td></td>
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<tr>
<td>Cultural identity</td>
<td>2.93</td>
<td>0.54</td>
</tr>
<tr>
<td>Spanish language</td>
<td>3.08</td>
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<tr>
<td>Cultural competence</td>
<td>2.01</td>
<td>0.79</td>
</tr>
<tr>
<td>Total Latino/Latina acculturation</td>
<td>3.69</td>
<td>0.33</td>
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</tbody>
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Effect sizes were calculated to assess the magnitude of differences between the study sample and the community norm sample for the AMAS-ZABB. These results are summarized in Table 5. Overall, the study sample was significantly more Americanized and less acculturated to their culture of origin than the AMAS-ZABB community sample norm.

Table 5

*Effect Sizes for AMAS-ZABB results for study sample (N=12)*

<table>
<thead>
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<th>Scale</th>
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<tr>
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<td>Cultural Identity</td>
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<td>English language</td>
<td>1.31</td>
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<td>0.47</td>
</tr>
<tr>
<td>Total U.S. acculturation</td>
<td>1.31</td>
</tr>
</tbody>
</table>
Latino/Latina acculturation
Cultural identity 0.98
Spanish language 2.28
Cultural competence 1.35
Total Latino/Latina acculturation 0.61

Qualitative Results

From their responses to the semi-structured interview, seven key themes or overarching categories emerged: 1) Family, 2) Stigma, 3) Ignorance, 4) Mental Health Education and Advocacy, 5) Individual Factors Influencing Mental Health, 6) Mental Health Treatment Experiences, and 7) Advocacy for Classes and Services for Latinos. For each theme or subtheme, representative quotations are provided. Please see Appendix E for a complete list of the interview quotes on which these themes are grounded.

Family. Table 6 illustrates the category of FAMILY and its structure of influence on our Latino sample. Family was shown to have positive influences, represented by the following subthemes: 1) Family Involvement and 2) Caring for Mentally Ill Family Members within the Household. It also includes a negative subtheme of 3) Lack of Family Support for Mental Illness. Participants frequently endorsed experiences consistent with the FAMILY category themes. For each theme, at least half of all participants endorsed a relatable experience.

Table 6
Outline of Core Themes: Family

A) Positive Family Factors
   a. Family Involvement (n=6)
   b. Caring for Mentally Ill Family Members (n=7)
B) Negative Family Factors
   a. Lack of Understanding of Mental Illness and Recovery (n=5)

The first subcategory, *Family Involvement*, highlights how positively participating in the family unit provides meaningful support to Latino consumers in recovery. Embedded in the representative quotations below are subthemes in this broader theme that outline an array of positive family activities. They include activities like spending time with family, having family come to visit, caring for family members’ needs, promoting the success of other family members, and being motivated by family to stay healthy. Each of the activities reported served as a positive coping skill for the consumer and as a source of community and support.

*Family involvement*

[ID-1]:   My children have a great influence on my recovery.
[ID-4]:   Well, if his siblings come over, he feels good, I think.
[ID-5]:   I’m the first one that broke the door open.  Yup.  I think at first I scared my family, because I was pulling out things they could relate with but were afraid.  And now they’re not afraid anymore because everyone is getting some type of education.
[ID-6]:   And I have to say that my in-laws have been fantastic.  When we came back up here, they all were just like, “Hey [consumer’s name]!  How you doing?”  And made him...that’s why I think he feels so much better here.  Cause our family here has made him feel like, “Okay.  This is [consumer’s name].  Come on.  No problem.”
[ID-7]:   My mom helped a lot.  Because she saw him as a person first and not the illness.  And they would have been married for a long time.  And he did have a good relationship with my mom.  And I think the fact that they had that support with each other.  That even though he was feeling sad, that he had to be there for my mom too.  So they kind of supported each other.
[ID-8]:   What helps me a lot are my kids and my grandkids.  Because, to me, they are my world.
The second broad theme related to FAMILY was *Caring for Mentally Ill Family Members within the Household*. Again, this theme centers on positive interactions between family members. Consistent throughout the interviews was a strong dedication by Latino families to care for ill family members, even when mental illness is involved. As a part of the caretaking process, mentally ill family members were all cared for within the home. Participants reported families taking pride in caring for mentally ill family members at home, rather than leaving them at a facility.

*Caring for Mentally Ill Family Members*

(ID-4): I wanted to bring him home because in the hospital I thought he was going to be okay. And now in the house, already watching me, being with us. And it’s better, he’s better. Spending time helping. That he gains confidence again. That he stops being afraid. That he’s talking.

(ID-5): Once again, having that relationship with my mom and my daughter. Which was very influential in every way. We learned to deal, we learned to cope. We were all dealing with the same type of anxiety, the same type of depression. And teaching each other how to cope. And to this day, I’m still teaching my mom how to cope with it. She’s giving me breathing lessons and I’m teaching her coping lessons.

(ID-6): When he was in the assisted living facility… The director one day she told me, “You’re such a good mother.” She says, “You come visit him all the time.” I looked at her like, “What are you talking about? This is my son. Why wouldn’t I do that?” She goes, “Oh you wouldn’t know how many people come and they drop their family member off and they never see them again.” And that to me was just unthinkable. You know…you can’t do that. You just – that’s your family. You take care of them.

(ID-7): But he had a lot of support from the family. And I think that is something that is very necessary. You know, to be able to have family support and people that really understand what he’s going through. And actually my mom was his care giver. And she and I, we spoke a lot together. Cause we shared a lot of intimate feelings about dealing with a person that has mental illness.

(ID-8): But it took a while for me to start getting out of the house because the way I felt and the way I hurt. Because, like I said, if it wasn’t for my kids being on me and after me and that, I don’t know – I probably would have already been in the nut house a long time ago.
(ID-11): My mother, she also took the Family-to-Family course. So she knows a little bit more about it. And I was amazed when she would tell me, “Yes, I know what you’re going through. I know this is what you’re going through.” It was amazing.

(ID-12): I feel like the Latin culture especially, we tend to head towards family and look for family support. Just to be able to – “Hey, let’s get together and have dinner.” It’s just…I mean, my Latin culture if anything has taught me “Family’s family.” We have our differences, but we’re always there.

The final theme within the FAMILY category is *Lack of Understanding of Mental Illness and Recovery*. Within this theme, there are several facets to how Latino family members can be unsupportive to consumer relatives. Generally, there was an overarching subtheme of family members being unwilling to accept that a consumer had a chronic mental illness. This lack of acceptance included at times an unwillingness by the family to educate themselves about the consumer’s illness. It was also very common for consumers to report their family telling them to “Just get over it!” (ID-10) and actively insinuating that the consumer’s mental illness was a minor, transitory problem. Lastly, believing the consumer to be an embarrassment to the family was another subtheme. Here, the consumer’s mental illness is considered a shame upon the family, and the consumer is forced or strongly encouraged to stay insulated away from the public.

*Lack of Understanding of Mental Illness and Recovery*

(ID-02): What my dad says about him…He’s kind of mean. Like he doesn’t think it’s like a mental illness. Like he’s depressed or anything. Or anxious. But he’ll be more like “Why would he be anxious anyways?” when I tell him. “He’s stupid anyways…not crazy… I don’t know why he’s thinking that he’s crazy. He’s not anxious.” And things like that. And he’ll be like “Snap out of it.”

(ID-03): I read as much as I can because no one else will help me. My parents, they understand, but they don’t understand, if that makes any sense. They know I’m sick, they wanna…they’re still grieving about it. And they don’t want to believe it. And it’s been 20 years. And they’re still grieving about it.
(ID-06): In the beginning, yeah, I was embarrassed to even tell anybody. It was very, very traumatic for me when he first got sick, and I was embarrassed to even tell anybody. And it’s just because in the Latino community, you just don’t bring this kind of stuff out into the public, in the open.

(ID-10): I think they – because it’s a lot in my family. They look at it as, “Just get over it! There’s nothing wrong. Just get over it.” Like there’s nothing wrong with you emotionally. It’s just you wanting attention or something, instead of realizing it’s a real problem.

(ID-11): So they’ll tell you, “Slip out of it!” “You’re not like this, you’re a happy person.” “You could be yourself.” Especially one of my cousins. Well, he’s not here right now. He’s in another part of Ohio. He would say, “Your problem is you’re depressed. But you could slip out of it.” I mean he knows that I was depressed. But he thought that it was like, yeah, flip a switch – bam!

(ID-12): Coming from a Latino family? Like I said before, I think they just kind of – “Well. He’ll get over it. He’ll handle it.” Or “Oh, let’s take him to the bar and let him have some beers.” And again, that’s where I feel like they aren’t educated the way it needs to be. Or they don’t know how to…prime example was… I don’t think they realize…Latin culture realizes that there’s help out there. And their sources.

**Stigma.** Table 7 outlines the key theme of *STIGMA* and its key category 1)

*Mental Stigma Unique to Latinos.* Cultural stigma toward mental illness was one of the most pervasively reported negative factors impacting mental health recovery for Latino consumers.

Table 7

**Outline of Core Themes: Stigma**

| A) Mental Health Stigma Unique to Latinos (n=10) |

*Mental Health Stigma Unique to Latinos* includes a number of facets of prejudice and pressure to deny weakness. A common subtheme was denying that a consumer’s mental illness was a problem at all or one requiring medical and therapeutic treatment. Consumers in the sample indicated that they have commonly been labeled as “crazy” by
other Latinos and family. Others note a cultural norm of considering mental illness a
curse or religious affliction. Pressure on consumers to avoid disclosing their mental
illness publically was another recurrent subtheme. Also notably, one Latino family
member reported being embarrassed by their mentally ill relative and stated that it was
common for Latinos to hide mentally ill relatives from the community.

*Mental Health Stigma Unique to Latinos*

(ID-02): Latinos tend to believe when you have a mental illness, you’re crazy.
(ID-03): My family or a lot of people think it’s a curse or something religious.
(ID-05): Because of the stigma. We don’t talk about mental health.
(ID-06): When I finally came to realize it wasn’t anything I could do anything
about, you know. I look at it now as no different than someone who has
diabetes. It’s an illness. But at first, it was hard. It was very hard to get
past that point. I mean, I had breast cancer. And his becoming
schizophrenic was harder than getting my diagnosis of having cancer.
(ID-07): I know that she did mention it to some people but not to everybody.
Because she used to say some people didn’t understand. So maybe that
might have been something was a little bit…there must have been some
stigma there.

(ID-08): But, like I said, a lot of Hispanics don’t talk about it. You know,
because I think it was only a couple of us there that were Hispanic. The
rest were more Caucasian and all that. Because they’re not as open.
They’re more private. And they’re always…well my mom used to
say…or my aunt would say, “What are the people gonna say?” You
know, like being embarrassed. Like, “Oh my god! What are they going
to think about us now?” Or…they’re more private. They won’t say
anything.

(ID-09): Because we’re a culture that doesn’t like to talk about this at all. We’re
very…kind of like…just don’t talk about it. You know what I’m saying.
They don’t try to address it. They don’t like to…especially they don’t
like to contact for help.

(ID-10): Latinos, if something’s wrong, they like to sweep things under the rug.
And that’s big in the culture because they don’t want to share it with
anybody else. They’re very private.

(ID-11): I don’t know how they’d be able to help. Most often they’re not
educated. So they’ll have the stigmatism.

(ID-12): I don’t think I’d be one of those people that I can call my parents and
say this. Cause I think in the Latin culture there’s a whole different way
of handling situations. And I don’t think, you know, you can just call
up….I mean, I think the Latin culture tends…. Does a little blind eye to it.

Ignorance. Table 8 outlines the key theme of IGNORANCE and its key category

1) Lack of Education on Mental Illness among Latinos. Ignorance about mental illness was another one of the most pervasively reported negative factors impacting mental health recovery for Latino consumers.

Table 8

Outline of Core Themes: Ignorance

A) Lack of Education on Mental Illness among Latinos (n=6)

Lack of Education on Mental Illness among Latinos represents a key driver of the stigma Latinos in mental health recovery face. A major subtheme was an unwillingness to talk about mental illness and mental health. Lack of awareness of the medical nature of mental disorders and how they should be treated was a common subtheme. Viewing mental illness as transitory was also recurrent. Here, this belief appears to inhibit the need to self-educate.

Lack of Education on Mental Illness Among Latinos

(ID-03): I think Latinos are very unaware of symptoms and what the mental illnesses are. Maybe lack of education for them about the illnesses. And family is sometimes negative. And I believe vibes of negativity will be me being negative. So if they are positive to me, I’d be positive. So basically, it’s probably lack of education in Latino families, is probably what it is.

(ID-06): They didn’t understand – you know, my son-in-law would be like, “He’s just lazy. You should make him do this. You should make him do that. I don’t know why you can’t make him do this or that.” And it’s like, you just don’t understand. I mean, it was like talking to a wall. And they just could not and would not understand how the illness really was.
(ID-08): I never really knew a lot of what depression meant. Until I started going through it myself. And it got explained to me. Because, like I said, I didn’t know it.

(ID-09): Don’t get me wrong. I think there’s a stigma with mental health regardless. But I feel like that their stigma is so much more. I feel like maybe we’re starting to get some understanding of different diagnoses and things of that sort. And not automatically calling people crazy. But in the Hispanic culture, it’s kind of like, “They’re crazy.” Cause they don’t have the information. They don’t have the knowledge on this kind of stuff. That is so easy to come by other ways.

(ID-11): A lot of Hispanic individuals…and I see it more often where they’re less educated. And if they come from a city background, where that’s where we came from – Guadalajara – it’s more of a city. My father and mother, they were born in rural areas. Ranches and things like that. They’re more prone to that kind of superstition. Even my sister believes that. And she wasn’t born in no rural community.

(ID-12): But I’ve also felt like they don’t have the schooling and the education to understand or comprehend. Or have never gone through it.

**Mental Health Education and Advocacy.** Table 9 reflects the key theme of MENTAL HEALTH EDUCATION AND ADVOCACY and its subcategories, including 1) One-on-One Advocacy, 2) Self-Advocacy, and 3) Mental Health Empowerment.

Table 9

**Outline of Core Themes: Mental Health Education & Advocacy**

| A) One-on-One Advocacy ($n=9$) |
| B) Self-Advocacy ($n=8$) |
| C) Empowerment through Mental Health ($n=2$) |

One-on-One Advocacy emerged as a distinct theme among Latino consumers, often in despite of the prejudice and ignorance they reported receiving from other Latinos. A large majority of our sample ($n=9$) discussed either wanting or actually finding ways to give back to family or others in recovery. Common themes of advocacy included ensuring children and grandchildren receive a quality education; sharing one’s
personal recovery story to the public; working with and leading local non-profits that
advocate for Latinos and individuals in recovery; and even most basically, working one-
on-one with friends to help them recover from mental illness.

One-on-One Advocacy

(ID-03): I hope I can make an impact to a lot of people by speaking for NAMI. And sharing my story with people. I think that would really help. Like I says before, I wouldn’t do it for myself. I would do it for all the mentally ill people around me.

(ID-05): I just yesterday at the store there was a lady that was in Claudia’s class [Latina support group]. And she remembered me. And she said, “Remember when the lady from the Y was there and she said about that banking and how they’d match the money?” She wants me to find where that lady is. They went to look for her but now she isn’t there. So now she wants me to do that for her. I told her, “Give me until Friday and I can see if I can get the information for you on Friday.”

(ID-06): Just accepting the fact that I know it wasn’t anything he did wrong or I did wrong. It’s just an illness. Just finally coming to the realization that it’s an illness. And I’m just taking care of my son and I’m going to do everything for him like he had gotten hit by a car and was paralyzed. And I would have to take care of him the rest of his life. Because I just realized there’s nothing I can do about it. And there’s nobody I can blame for it.

(ID-07): He always encouraged us about school. Getting an education. That he didn’t want us to be working in the fields or working hard like he had. He said he had an excuse. And that was probably that he never got an education. And he didn’t want us to be like him.

(ID-08): And I used to get angry at him because he just gave up. And I know I wasn’t going through what he was going through, but he always kept feeling like “Always me. Look at poor me. Why is this happening to me?” And I would have to tell him, “There’s people a lot worse than what you are.”

(ID-09): I’ve had people come by and say, “Hey. The fact that you talked about this…. Especially when we were in school going through the human service kind of stuff. They would… I’ve had a couple people say, “Hey, you really helped me out with the fact that you can tell me you have anxiety. I feel like I have anxiety too.” Like it’s one of those situations where it’s like – “Oh god! There’s somebody out there that gets it.”

(ID-10): I kind of help people start over with not only jobs and training, but sometimes they come from nothing and they have mental illnesses where I have to refer them to other organizations. So I’m trying to help and advocate for people who have mental illness now.
(ID-11): But he changed dramatically. He doesn’t drink that much. I feel like I probably played an important part in that. I got him into the whole gym thing as well. Eating healthy. Working out. And so I’m happy about that. Where I managed to change that on him. But we both helped out...helped each other out tremendously.

(ID-12): I think for me my goal is to make sure that I’m going to...like right now, one of my goals is – cause I lost my friend to cancer – is thinking about joining a cancer support group. Or one of my other goals is to do some outreach. Or something...you know, something that aspect where I’m getting a positive out of it.

Self-Advocacy also emerged as a major theme reflecting consumers’ desire to persevere and self-educate. This theme was endorsed by a majority of our sample (n=8). Fighting back against mental illness and prejudice was commonly cited as subtheme for consumers. Many in our sample supported the theme of “I don’t give up” (ID-8) as a personal mantra. Lastly, a strong desire to self-educated about one’s mental illness, the use of medication, and therapy services was also a frequent subtheme.

Self-Advocacy

(ID-03): I got a magazine, called Schizophrenia Digest. I was reading it. They have some commercials in there about newer medications. So I saw one they were working on called “Aeropiphial”, which is called Abilify. And I asked my doctor, I says, “Hey, can I try this pill?”

(ID-04): He was coming here with Ms. Anita.

(ID-05): Well, I can tell you that I’ve never been to a psychiatrist, a psychologist. I took the NAMI classes. I learned the mental health…I learned the classic things they teach – how to cope and deal.

(ID-08): Well, a friend of mine once told me, “How do you do it?” I says, “I don’t give up.”

(ID-09): I feel like I’ve made a lot of forward momentum. Okay. It might not be what my ideal life would have been. I don’t sneeze at it.

(ID-10): Now I want to educate myself more on not only mental illness, but drug addiction.

(ID-11): That’s is my biggest... I’m trying to think of that word... my biggest... motivator. Somebody says, “You can’t do it.” I always love to prove them wrong.

(ID-12): I think for me I’ve gone through my depression on certain levels. But I’ve always tried to...I fight. I’m a fighter. I always fight back. And I figured there’s a way to come back out of it.
Empowerment through Mental Health is a unique theme that emerged out of the dialogues of two of the consumers interviewed in this study. Several key subthemes of empowerment came out of their discussion of their experiences as Latinos, including experiences in treatment and their involvement in the larger community. These two consumers were distinct from the rest of our sample for several reasons. First, both consumers confidently stated they felt healthy and in control of their symptoms on a day-to-day basis. Both had also been connected to services or treatment providers that empowered them to understand their illness, its symptoms and the ways to manage it. Both consumers were also very vocal advocates for mental health and the mental health needs of Latinos. Both had also shared their stories of recovery at state and national events lead by the National Alliance on Mental Illness (NAMI) – including speaking publically on the steps of the Ohio State Capital.

These two cases also highlight a unique difference between them. For participant three (a mental health consumer), working within the mental health system has been a pivotal piece in his successful recovery. He reported having a long history of close, satisfying relationships with psychiatrists and therapists since his original diagnosis of paranoid schizophrenia disorder through his re-diagnosis of schizoaffective disorder. For participant number five (also a consumer), this formal treatment focus was not needed. Rather, she was able to work within the psychoeducation classes of NAMI of Greater Toledo to gain the knowledge she needed to manage her depression and even educate her family on the disorder. Together, these key themes suggest that full recovery for a Latino consumer must include psychoeducation on mental illness. However, formal medical treatment may not be required for a Latino consumer to be fully empowered.
within the community. The quotations listed below provide a summary of these themes in the two participants’ own words. A few quotations are repeated from other thematic areas discussed in this section, but are intended to highlight the consumers’ strengths as noted above.

Empowerment through Mental Health

(ID-03): I got a magazine, called the Schizophrenia Digest. I was reading it. They have some commercials in there about newer medications. So I saw one they were working on called aripiprazole, which is called Abilify. And I asked my doctor, I says, “Hey, can I try this pill?” Because none of the other ones really were working.

- And I do believe that talk therapy and medications are the most important things you need to be in recovery. I know for sure if, for two days, I went off my meds, I would be in the hospital for sure. That’s how I feel about it.
- My first psychiatrist. He had always been there. He was trying to keep me positive and telling me great things. Another person was a psychologist at his office. He was really nice.
- And then I went to the Zepf Center. They all are wonderful toward me. They all know my story. And that’s who I turn to.
- I’m able to do the things I used to do that I couldn’t do before…I’m now a spokesperson in public, it seems like. Because I’m sharing my story in from of people. I was unable to do that.
- I hope I make an impact to a lot of people by speaking for NAMI. And sharing my story with people. I think that would really help. Like I says before, I wouldn’t do it for myself. I would do it for all the mentally ill people around me.
- So, for 10 years, I’ve been in recovery. I’ve been doing really well.

(ID-05): Well, I can tell you that I’ve never been to a psychiatrist, a psychologist. I took the NAMI classes…I learned the classic things they teach on how to learn to cope and deal. NAMI’s like a…like you say – a backbone, you know?”

- I’m the first one that broke the door open [about depression]. Yup. I think at first I scared my family, because I was pulling out things they could relate with but were afraid. And now they’re not afraid anymore because everyone is getting some kind of education.
- We learned to deal, we learned to cope. We were all dealing with the same type of anxiety, the same type of depression. And teaching each other how to cope. And to this day, I’m still teaching my mom how to
cope with it. She’s teaching me breathing lessons and I’m teaching her coping lessons.

- Sitting behind the desk is not going to do anything. You know, it’s where it’s at. Outreach, outreach. And just listening to what [community members] have to say.
- Marci from NAMI. She’s the one that told me I had the core of NAMI. “You’re a consumer, you’re a mother, you’re a single parent. You struggle with depression, yet you’re out here making it.
- And being on the state level, going to Columbus and standing on the state steps and speaking [my recovery story] was a highlight too.
- Now, sitting on the Ohio NAMI state board. Now I know why I went through everything that I went through. And I honestly have to say I went through a test. You know…apparently, I passed the test.

**Individual Factors Influencing Latino Mental Health.** Table 10 reflects the next set of core themes, which includes *Individual Factors Influencing Latino Mental Health*. Both positive and negative themes are included, some including opposite dimensions of the same issue. Also of note, some of these factors were endorsed at higher frequencies than others. Thus, some factors are considered to be more provisional and minor components of the overall model.

Table 10

*Outline of Core Themes: Individual Factors Influencing Latino Mental Health*

| A) Isolation when Mentally Ill (n=7) |
| B) Spirituality |
| a. Support of Mental Health through Faith (n=6) |
| b. Lack of Connection to Catholicism (n=2) |
| C) Americanization |
| a. Support from Latino Community (n=3) |
| b. Lack of Identification with Latino Community due to Americanization (n=2) |
| D) Seasonal Work (n=1) |
| E) Length of Residency in United States (n=1) |
| F) Education Level (n=2) |
Isolation when Mentally Ill was the first major individual theme that emerged out of the data. This theme was endorsed by a majority of participants (n=7) as a common response of Latino consumers to mental illness. For some, isolation allowed the consumer to avoid criticism from family members for their mental illness. For others, appearing weak or ill was a source of shame or risk for embarrassment. One participant reported that the elders within her family would isolate themselves when mentally ill (ID-5). This theme provides an interesting paradox to the types of positive family support outlined in the FAMILY category. While Latino families can provide active, positive support and care for mentally ill relatives, negative family influence can cause a consumer to retreat from their family altogether.

*Isolation when mentally ill*

(ID-02): To me it felt like he was keeping everything to himself. Again, isolating himself from telling people things, exactly what he’s feeling.

(ID-04): He separated himself from us a lot. Yes, he responded well. It’s that he separated from us a lot. He was afraid. He was isolated.

(ID-05): If we do, we have family members that have some type of mental health, like the elders, they seem to want to be by themselves. They exclude themselves. A lot of times they just stay in their rooms. They don’t want to participate with the rest of the family.

(ID-06): When we lived in Florida, he isolated himself. Any time anyone came to visit he would go close himself off in his room. But now that we’re here, if somebody comes, he will come out and sit in the living room. He doesn’t really participant in the conversation, but he doesn’t isolate himself.

(ID-07): Like my dad didn’t want us telling nobody that he was sick. I did. Because especially too, some of the people that he knew. Because I felt that if anything would happen to him or they notice something going on, they could tell me. You know, cause he used to go to a prayer group. And I felt, well, if they see him acting funny or forgetting things, they would tell me and that way I could let the doctor know. And that. So that’s why, like I said, he didn’t want nobody to know.

(ID-08): Yeah, because I didn’t bother with my friends. I didn’t bother with anybody. You know, I just didn’t want to…basically be left alone. I
even told my kids, I even told the doctor one day, “I just wish I could get in a corner and just dig a hole and hide in it.”

(ID-11): And then, like, he didn’t want to be by nobody. He just wanted to be in his room. He didn’t want to see nobody at all.

Spirituality was another major individual factor discussed by participants and was included in a majority of the interviews (n=7). The theme itself broke into two groupings, including 1) Support of Mental Health through Faith, and 2) Lack of Connection to Catholicism. For individuals finding support through faith, common subthemes included finding guidance through prayer, believing in God as a provider of guidance, expressing gratitude for God’s support, engaging with clergy as a source of support, and actively seeking knowledge of the Bible and other religious sources.

Support of mental health through faith

(ID-01): Focus on my religion.
(ID-05): Praying. I should have put praying as my number one really.
(ID-07): When we used to go down there we sometimes would pray the rosary together. I think that made a big factor. As a matter of fact, when he was hospitalized right before he passed, we were all praying the rosary. And he wasn’t talking out loud, but I could see his lips like he was praying along with us.
(ID-08): And so that’s why like I said to me God is someone who’s helped me more. And I just thank him every day for giving me another day of life and to keep going. And to help who…to give me the right words to say to someone to give them peace.
(ID-10): I wasn’t able to accept any kind of recovery until I was good with myself internally and I was able to do that through faith.
(ID-12): I know I’ll tend to go to church. And I tend to light candles. And I tend to talk to the fathers and tend to embrace my Catholic faith.

Also included in the interviews were responses from consumers who lacked a sense of connection to Catholicism – which they recognized was the central faith for Latinos. Only small number of consumers (n=2) expressed a lack of connection to
Catholicism. However, their responses underscore that Catholic traditions are not always a source of support for Latinos in recovery.

**Lack of Connection to Catholicism**

(ID-10): I grew up Catholic. And of course that is the most…common in the Mexican culture – they’re Catholics. And so I left the Catholic Church. And I went to a non-denominational church. And that was a big issue. So something that was helping me come out of my depression and helping me walk away from the addiction was being frowned upon by my family as, “It’s not Catholic.”

(ID-11): Because in our Hispanic culture the Roman Catholic Church is a big, big part in our lives. But I feel like maybe we were born…no. Well, we were born in Mexico. But maybe if we were living in Mexico or some other state where there’s a lot of devotion, perhaps we would be more religious.

Americanization was another individual factor that resulted in a divide between participants. The factor broke out into two subthemes, including 1) **Support from Latino Community**, and 2) **Lack of Identification with Latino Community due to Americanization**. The Americanization subthemes were less pervasively discussed by participants. For participants identifying with the Latino community, emergent subthemes including feeling supported by being around similar others and feeling they should fight for the needs of other Latinos.

**Support from Latino Community**

(ID-01): Living in the Latina community at El Centro.
(ID-05): Cause we’re culture all together. We all fight together. I can actually say that.
(ID-07): You know, to speak the same language. And they lived in South Texas too. The fact that the majority of the people that were his friends were around. And family and neighbors. Church. So he’d made a big difference. His nurse and doctor were all Latino. So I think that had a lot of do with his recovery. He was able to communicate too.
Isolation from the Latino community as a result of Americanization also emerged from the data. For one consumer, she never learned Spanish and came from the only Latino family in town. Another consumer reported mostly identifying with friends and coworkers who are not Latino.

_Lack of Identification with Latino Community due to Americanization_

(ID-10): I didn’t learn the language. My parents would speak to me in English and I would reply in Spanish. So I grew up with a lot of white people.

(ID-12): I mean, to be honest, I don’t really have a lot of Latino friends. You know, it’s not one of those things that…not that I chose not to. It’s just in my jobs, my ventures, they’ve never… Like I said, it’s going down more to being Americanized.

Seasonal agricultural work was a minor factor impacting mental health that also emerged from the data (n=1). For this particular family member and immigrant, U.S. seasonal weather patterns had a negative effect on her husband’s mental health. Related, unemployment due to seasonal gaps in work also was a negative mental health factor.

_Seasonal Work_

(ID-04): Because his work is seasonal. And he was unemployed and he got sick. And I hope he doesn’t experience the same when work ends.
- I think because back in our country, he never saw either…was in the season of snow and had never seen, been here. And being unemployed…watching the snow…he got sick.

Length of Residency in United States was another minor factor that emerged from one interview (n=1). Having arrived to the U.S. one year ago to pursue seasonal agricultural work, the family member reported feeling very socially isolated.

_Length of Residency in United States_

(ID-04): Well, we practically don’t have any friends.
Education Level was another minor theme impacting mental health for participants. Subthemes included family dedication to educating children; generational barriers in access to education; current differential levels of education within the Latino community; and educational differences among socioeconomic classes.

Education level

[ID-05]: There were Mexicans not stuck out on the farms. They had nice homes. They came from well-educated people. And that made a difference. It can make a big difference. Especially with the education. That’s a lot of it too, is the education.

[ID-07]: But some of the families, and I know this for a fact, that some people...they’re adults, they have children. And they never got an education either. Some don’t know how to write. Some don’t know how to read. And there’s a lot of barriers where their children are growing. I know I was part of that. Because my mom, she never went to school.

- He always encouraged us to do for ourselves. To get an education. To make a difference in people’s lives. To really take advantage of anything he possibly could. He always encouraged us about school. Getting an education. That he didn’t want us to be working in the fields or working hard like he had.

Mental Health Treatment Experiences. Table 11 outlines the theme of MENTAL HEALTH TREATMENT EXPERIENCES and includes two categories 1) Positive Provider Experiences/Lack of bias and 2) Negative Provider Experiences.

Table 11

Outline of Core Themes: Mental Health Treatment Experiences

A) Positive Provider Experiences/ Lack of Bias (n=9)
B) Negative Provider Experiences (n=3)

As a part of the study, participants were questioned about their experiences with treatment providers or the experiences of their family members who were consumers.
Overwhelmingly, the majority of consumers and family members \((n=9)\) reported either non-biased or positive relationships with treatment providers. The overarching theme from these dialogues was that this sample of Latino consumers did not commonly experience prejudice from their mental health care providers.

**Positive provider experiences/Lack of bias**

(ID-01): [Denied negative provider experience]  
(ID-02): But I don’t think that he was treated badly or anything.  
(ID-03): I think I’ve been treated just as well as Caucasian or an African-American. I have been treated no differently at all. I really have been treated with respect from my former psychiatrist when he was alive to the Zepf Center. The Zepf Center, like I said, they understood totally where I’m coming from and my experiences with mental illness. I don’t see a barrier just because I’m Latino. I don’t see it.  
(ID-04): No. I don’t think it affects him. Everything is okay.  
(ID-06): Where I can say now the doctor he’s with, she spends a lot of time with him and talking with him. And with me. And so I feel a lot better about the care he’s getting now. But I’ve never really noticed any type of difference because of us being Latino.  
(ID-08): When I went to see the counselor, he was really good with me. If anything, I was very comfortable with him. I don’t think they put a difference. At least I didn’t see it at the time.  
(ID-10): I don’t think it was. And I was treated. And I did have to go to a drug and alcohol program. But I don’t think the being Latino thing affected anything.  
(ID-11): I don’t think so.  
(ID-12): [Denied negative provider experience]

However, not all participants have had positive or non-culturally biased treatment from care providers. Prejudice against being unable to pay was a subtheme for this group. Feeling like others viewed Latino consumers as wanting a handout was another subtheme. Even feeling prejudiced by signing in at the doctor with a distinctly Latino name was cited as a hesitation to seek treatment.
Negative Provider Experiences

(ID-05): And I just showed him, “Do you think this is just good enough for your parent? Is it good enough for your grandmother? Is this a breakfast?”… I said, “I don’t belong on this side. And when my parents come, I’ll be leaving.” So I don’t know if they thought we were just Mexicanitos that didn’t know better.

- That we not know as much. Or that we can’t afford it. I think that’s where that was being over there, the facility where I was when I had my stroke.

(ID-06): Like I said, those doctors were just like they really didn’t want to know anything about him. It was just like, “How you doing? Everything okay? Okay. Goodbye. Here’s your medicine and go.” So no real interaction. So I don’t know if there were biased feelings.

(ID-09): I think there is a way. I feel like it’s not…until they see me. They, usually, I feel like there is a bit of an “Oh, [Latino surname].

- I feel like there’s just kind of a “Yah… Here comes somebody else for a hand out.”

Advocacy for Classes and Services for Latinos. Table 12 provides an overview of the theme of ADVOCACY FOR CLASSES AND SERVICES FOR LATINOS, which include subgroups of 1) Psychoeducation, and 2) Community Resources.

Table 12

Outline of Core Themes: Advocacy for Classes and Services for Latinos

A) Psychoeducation (n=3)
B) Community Resources (n=2)

Another supplemental question of this study focused on consumers and family members’ recommendations for classes and resources for Latinos in mental health recovery. Two general subthemes emerged. The first focused on educating consumers – and even the public – about mental disorders and their treatments. Recommendations
included taking a university psychology course or getting formal psychoeducation from organizations like NAMI of Greater Toledo.

_Psychoeducation_

(ID-03): I really encourage anyone going to UT to take at least one class in psychology. They would know what it was like. And I think that stigma would go a lot further down, if people are educated about mental illness.

(ID-05): I wish that they would have had Family-to-Family [psychoeducation class]. It know that it has made a big difference in people’s lives. Especially for family members to help them understand what their loved one is going through. And also even for the peer-to-peer program too. That also helps the consumers be able to better understand their own illness.

(ID-12): And I think we’re missing values. I think sometimes that we should be teaching the kids about depression and bullying. And things that aren’t appropriate. And things we need to work on.

Greater access to services was also a common subtheme. Recommendations included teaching immigrant Latinos how to navigate the city of Toledo, use banking services, and reduce fear of prejudice to help them be more open members of the Toledo community. Another key recommendation was increasing the number of Spanish-speaking community service members available, including social workers, therapists, and psychiatrists. Advocating for bilingual students to pursue these professions was also recommended.

_Co m munity Services_

(ID-05): I want to bring more of the support groups in Spanish. And just reach out to the families out there. They’re afraid to come out. They’re afraid of deportation. Especially ones that don’t have their “papers.” They’re even afraid to go to the stores. They don’t let their kids out. The kids are running the families…you know what I’m saying. Because a lot of the families don’t speak English.

- I mean even down to riding the bus. You know, they have to show how to do that. You go to the different agencies and they teach you different things.
• Life skills. Yes. Basic, basic things. Banking. There’s so many different things they’re eligible for that they don’t know. So someone needs to teach them.

(ID-07): We don’t have enough social workers, therapists, clinicians, psychiatrists. There’s not one Hispanic/Latino in the state of Ohio, psychiatrists in the whole state. And they are always talking about how Latinos don’t seek mental health services. And it’s very, very true. But because of their language barrier, they just don’t go. Because they don’t have the resources. And if it were you or me, they would refer them to any of the mental health agencies. You know, it’s very hard for them to trust somebody that doesn’t speak their language. And, or somebody that doesn’t look like them for them to open up.

• And so I think that it’s very, very important that we start talking to the schools. And the principals and the teachers. Social workers, counselors. That those are all areas that maybe people…children that are bilingual that they might be able to go into those professions. Cause it’s something that we really, really need.

Together, these results indicate a dynamic array of factors that impact mental health recovery for Latino consumers. Family serves as both a source of support and source of judgment and isolation. Stigma and ignorance from other Latinos also appears as a key struggle for Latino consumers. Despite these issues, Latino consumers and their family members appear to take an active role in their recovery, in the health of others, and in the community. Latino consumers’ engagement in the community is also supported through positive interactions with care providers.
Chapter Four

Discussion

Mental health recovery has become the key focus in treatment for serious mental illness and is now standard U.S. governmental policy (Anthony, 1993; SAMHSA, 2012). Consumers have been a major driver in the shift in focus from seeing individuals living with mental illness as having deficits to people who are empowered by the process of recovering from mental illness (Chamberlin, 1990; Frese & Davis, 1997). One-on-one interviews with consumers have provided researchers important information on areas of recovery, such as what happens in early or later stages, sources of support, positive coping, and benefits of engaging in a psychoeducation program. However, sample groups for these interviews have been limited in terms of ethnicity and Latinos have been minimally represented in these kinds of qualitative studies (Corrigan et al., 1999; O’Rourke, 2009; Ridgway, 2001; Young & Ensing, 1999).

Given the size of the U.S. Latino population and the inherent language barrier, understanding how culture influences recovery processes and treatment utilization cannot be ignored (Alegría, 2002; Alegría, 2007; U.S. Census Bureau, 2011). A wide range of factors have been shown to affect mental health service utilization among Latinos – or even, at minimum, having access to care at all (Alegría, 2002; Berdahl & Torres Stone, 2009). Several cultural factors make Latinos stand unique among other ethnic groups, including such issues as gender roles, Catholicism, and immigration (Abdullah & Brown, 2011; Organista, 2007). Latino families, for example, are strongly collectivistic culturally. This tendency is especially high when caring for family members. This sense of closeness and community makes Latinos stand apart from other, more individualistic
U.S. ethnic groups such as Caucasians (Chang, Natsuaki, & Chen, 2013; Moreno & Cardemil, 2013).

The results of this study align with many of previously identified factors influencing mental health for Latinos. As noted by Chang et al. (2013) on family cohesion, the Latino individuals in the current study demonstrated strong connections with their families. Family involvement played an important role for consumers both in coping with mental illness and succeeding in recovery. Moreover, it was very common among participants to report that mentally ill family members were cared for in the home and that outside care facilities were consider a very last source of support.

In the Latino sample of the current study, stigma associated with mental illness was commonly reported in the Latino community. This finding aligns with previous research (Applewhite et al., 2009; Kouyoumdjian et al., 2003). Participants in the current study reported frequently experiencing stigma or seeing family members impacted by stigma from other Latinos. This stigma was rooted in common cultural misconceptions of what constitutes mental illness. Participants frequently reported family members and others believing that consumers themselves should easily recover from their mental illness. Others reported that family and friends believe the consumer’s mental illness is no big deal. Traditional gender roles were also a driver of stigma. Men especially were told to “just get over it” (ID-2) and that they were not ill, despite having clear psychiatric symptoms. This result is consistent with previous research on the traditional Latino value of machismo (Abdullah & Brown, 2011; Organista, 2007). Participants also commonly reported a general ignorance and even open unwillingness by other Latinos to educate themselves about mental illness and its treatment. Participants emphasized that this
pervasive ignorance compounds the cultural stigma already in place. Moreover, it may require targeted psychoeducation of friends and family members to change culturally-imbedded attitudes about mental health and recovery. While this theme was quite common among participants, lack of education among Latinos about mental illness has not been extensively or clearly established in previous research.

Family also had a paradoxical influence. While family was a significant and commonly cited source of support for Latino consumers, family support was also inconsistent. It was common for participants to report consumers receiving support from some family members, but not others. Excerpts from the interviews also highlighted that mentally ill family members tend to isolate themselves when ill. Also, and especially notable, one participant reported that it is common for Latino families to feel ashamed of mentally ill relatives and hide them from the public. Together, these results indicate that family involvement in recovery can come at a price. While family can be an important source of positive coping and caretaking, they can also be the harshest critics. The interplay of these family-related issues has also not been explicitly outlined in prior research. However, the positive influence of family and family caretakers aligns with previous research on familismo or the strong collectivistic bond in Latino families (Organista, 2007).

Spirituality was also a very common theme among participants. For most, it served as a protective factor against the stress engaging in recovery or assisting the recovery of family members. This result is consistent with previous research (Organista, 2007; Gallup, 2012). Unlike the prediction forwarded by Organista (2007), spirituality was always a source of empowerment for these participants and did not undercut self-
efficacy by encouraging them to wait for God to intervene. Rather, it was often an important “treatment” that provided participants hope and moral grounding in the face of stigma. An interesting subtheme of “Lacking connection to Catholicism” also emerged – though with only a small level of support from participants. For these participants, Catholicism came with many ills that included passivity and belief that mental illness is a religious curse. This subtheme has not been established in existing research.

Advocacy for one’s health and the mental health of others was also an important theme. Nearly all participants reported that taking care of others’ needs – especially mental health needs – was essential. All of these participants reported engaging in advocacy with other Latinos despite managing psychiatric symptoms themselves or caring for mentally ill relatives. This kind of advocacy is consistent with the later stages of recovery discussed by Young and Ensing (1999) with non-Latino consumers. Though not a central focus of this study, participants were asked what kind of services and classes they might recommend for Latinos. Many participants had a strong response to this question and emphasized that the gap in language-appropriate community and mental health services for Latinos has to be addressed. It was also very common for Latinos to advocate for themselves or family members through education on mental illness and medication. This result is similar to outcome studies of consumers’ recovery processes (Ridgway, 2001; Young & Ensing, 1999).

One especially unique result from this study was the emergence of Latinos “empowered” through attaining mental health. For these consumers, their symptoms were successfully managed, and they had moved on to be vocal leaders and advocates for Latinos and mental health recovery. Each took a unique path in terms of treatment, with
one seeking professional psychiatric help and the other finding guidance through NAMI courses. For both, their recovery goals had moved beyond their illness toward changing public policy. This result has also not been fully established in research.

Many other minor subthemes emerged in this study that may warrant future research. Relating to immigration, the issues of migrant work, short residency in the U.S., and education level all appeared to limit a consumer’s access to social support and regular care. For Latino consumers established in the U.S., Americanization had an isolating effect. However, other participants and family members strongly identified with the Latino community. Although these were minor subthemes that showed variability across the sample, these subthemes are not asserted as key, meaningful results for this study.

A final area of analysis reviewed consumers’ and family members’ accounts of interacting with mental health treatment providers. Overwhelmingly, treatment experiences were either at minimum non-biased to extremely positive. Of consumers experiencing negative treatment, the primary issues included having providers believe one could not pay due to being Latino and feeling prejudiced due to having a Latino last name. Previous research indicates that there are several reasons to expect that Latinos interactions with treatment providers would be negative (Alegría et al., 2002; Berdahl & Torres Stone, 2009; Cassa et al., 2006; Chang et al., 2013; Ishikawa et al., 2010; Kouyoumdjian et al., 2003; Moreno & Cardemil, 2013). Overall, the Latinos in the current study did not report any significant problems having access to mental health care services. All consumers expressed a strong desire to seek treatment. Consumers’ religious beliefs had no relevant influence on whether or not they sought care. None of
the consumers or family members voiced any concerns about confiding to provider outside of the family when needed.

**Implications**

The results of the current study put into question global assumptions that Latinos in recovery are impaired by their ethnicity both culturally and in seeking and receiving care (Chang et al., 2013; Cabassa et al., 2006; Ishikawa et al., 2010; Kouyoumdjian et al., 2003). As noted previously, all the participants in this study were recruited through NAMI of Greater Toledo and had received some kind of psychoeducation on mental illness. In fact, many were involved in either education or community advocacy through NAMI. This factor limits the generalizability of the study to extend to Latinos in recovery who do not have access to, or lack experience with, these community resources.

A key implication of this study is the importance of psychoeducation on mental illness. Latinos in this study reported a pervasive lack of knowledge of mental disorders, use of medication, and other treatments among others in the Latino community. Some of this lack of psychiatric knowledge may be driven by lack of exposure to mental health services and providers. Latinos are generally considered to be underrepresented among consumers receiving mental health care (Alegría et al., 2002; Ishikawa, Cardemil & Falmange, 2010). Issues related to poverty and accessibility may also be a factor at play in the lack of self-education among Latinos (BLS, 2013; Cabassa et al., 2006; Kouyoumdjian et al., 2003). Psychoeducation programs have generally been shown to support recovery in consumers, including promoting growth, overcoming prejudice, providing consumers a sense of belonging and equality, and “having fun” through both individual and group change processes (O’Rourke, 2009).
A major implication of the lack of psychiatric education among Latinos is the importance of including family in treatment. Family cohesion is strong among Latinos (Abdullah & Brown, 2011; Organista, 2007). Including family in treatment may provide an important source of psychoeducation and exposure to SMI treatment methods. Family psychoeducation has been established as an evidence-based practice that provides families emotional support, education, crisis resources and problem-solving skill building (Dixon et al., 2001). Whether it includes bringing family to a psychiatrist’s appointment or having a family education day for peer education programs like the Wellness Management and Recovery program in Ohio (WMR CCOE, 2012), involving family in recovery appears essential. Including family in treatment may also help crystallize an even stronger bond among consumers and family and maximize potential benefits of the collectivist attitude inherent to Latino culture. It is clear from the results of this study that Latino consumers look out for both themselves and others. Integrating family in treatment may simply involve empowering families who did not realize they were so essential to their loved one’s health.

A novel but well supported subtheme expressed across the sample was that Latinos are likely to isolate when experiencing symptoms of mental illness. This finding is especially relevant when compared to previous research focused on Latinos ability to afford and access care (BLS, 2013; Cabassa et al., 2006; Kouyoumdjian et al., 2003). While the results of this study show that Latino families on average are extremely supportive, this recurrent tendency to isolate within the home may leave important or especially severe cases of SMI untreated. In this case, basic psychoeducation about mental illnesses and mental health recovery may be all a family needs to realize that how
important psychiatric treatment is to their relative’s functioning. This issue also serves as a relevant problem that a community’s social services should consider when identifying individuals in need of intervention. Ultimately, both of these issues highlight the importance of normalizing SMI among Latinos and their families.

The high level of social advocacy among Latino consumers and family members in this study also highlights what an asset they are to the community. Not only do these individuals seek to actively manage their psychiatric disorders, they also pursue outreach in the community in a variety of ways on both small (local neighborhood) and large (regional, state, national) levels. A central cry among the Latino consumers and family members interviewed was the mantra of “I don’t give up.” (ID-8). Latinos bring the unique perspective of being a minority in treatment that may be useful to others. Lessons they’ve learned from attempting to access care, dealing with societal and cultural stigma, and general racial prejudice may provide important support to other ethnic minorities.

Lastly, the results of this study suggest that the overall recovery process for Latinos does not differ significantly from other ethnic groups (Ridgway, 2001; Young & Ensing, 1999). Common themes of recovery already established in earlier consumer studies were not reviewed and summarized in this study. Instead, the focal point was the unique cultural factors that impact recovery from the lens of being Latino. However, initial open coding of the participant interviews quickly discovered that general recovery themes such as “overcoming stuckness,” “discovering and fostering empowerment,” “returning to basic functioning,” and other recovery themes outlined by Young and Ensing (1999) emerged as just as relevant for Latinos as for the subjects of their study, on which this study’s interview protocol is based.
This result is important when evaluating how best to measure mental health recovery for Latinos. The Mental Health Recovery Measure (MHRM), for example, is a 30-item self-report measure of recovery that is based on Young and Ensing’s (1999) findings. The MHRM is uniquely relevant to this study, because it is commonly used by the Wellness Management and Recovery (WMR) peer education program that is conducted not only in the city of Toledo, but across the state of Ohio. Currently, the MHRM does not have a standardized version in Spanish. The results of this study strongly suggest that major Spanish-language modifications of mental health recovery measures, such as the MHRM, may not be needed. Latino consumers in this study appear to follow the same recovery domains already assessed by the MHRM. The unique factors impacting Latino consumers are almost exclusively connected to improving community social services and providing greater community acceptance of Latinos. The aspect of family is also notably absent from measurement on the MHRM.

**Limitations**

There are several limitations to the current study. First, as noted in the methodology, all of the participants had some affiliation with NAMI of Greater Toledo. Participants had all been involved in at least one of the psychoeducation classes that NAMI provides. As a result, participants may have been especially well-educated on mental health issues and also much more likely to pursue treatment than a less informed consumer or family member. This education and treatment experience may have made them more keenly aware of the mental health disparities Latinos face. Participants may have also felt more empowered to openly discuss stigma and lack of education unique to
Latinos. In this sense, participants may have all served as advocates for recovery, rather than consumers or representatives of consumers in early stages of recovery.

It is also important to note that not all participants were consumers and that most were of Mexican origin. Given the sensitive nature of consent for this population, both consumers and family members of consumers were recruited to ensure that thematic saturation could be met. Previous research on the recovery process has always centered on consumer interviews without input from family members (Corrigan et al., 1999; Ridgway, 2001; Young & Ensing, 1999). This study was intended to mirror the study conducted by Young and Ensing (1999). Including family members ($n = 4$) as a part of the sampling process may have made the final model more inclusive in examining the Latino experience of mental health recovery. However, it may also restrict comparisons to previous studies that only interviewed consumers. Another potential consequence of using family members in this study is that they may not accurately reflect the recovery experience of the consumer. Notably, when the gender of those participants who were mental health consumers is accounted for, the current study only includes the experiences of $n = 4$ female Latina consumers relative to $n = 8$ male Latino consumers. Thus, future research on Latino mental health recovery should consider maintaining a greater balance between genders. Achieving this balance may be important when considering Latinos, given the traditional values related to gender roles common in Latino culture (Abdullah & Brown, 2011; Organista, 2007). Lastly, 11 of the 12 participants in this study came from Mexican heritage, limiting how generalizable these results are to Latinos of other culture of origins.
Directions for Future Research

Including family members in this study’s sample may also provide important insight into the collectivism inherent to Latino culture and ways that it supports mental health recovery. In terms of mental health recovery measures, continued research should explore how collectivism and family relate to recovery and if it is appropriate to account for these issues in individualistic-focused measures, like the MHRM (Young & Bullock, 2003; Young & Bullock, 2005). It is quite evident from the results of this study that family plays a major role in recovery, and the pros and cons of this involvement should continue to be addressed. Continued research in this area may improve the effectiveness of mental health treatment providers and social services.

Extensions of this study could address a number of potential research questions related to providers and social services. Successful implementation of medical treatment and group psychoeducation may vary depending on a Latino consumer’s age, immigration status, country of origin, socioeconomic status, and even their regional location within the United States. Stages of treatment could also be examined to identify the ideal time to involve family members in consumer care and introduction to providers, as well as the treatment models that Latinos most relate to. Another question that could be addressed is how the mental health treatment community can best integrate with the Latino community to promote Latino mental health, help-seeking, and mental health care access. Lastly, the most relevant next step in this research is to evaluate how well Latino consumers recover from SMI relative to other ethnic groups.

Finally, one demographic issue to note is that nearly all the consumers and representative family members ($n = 10$) were U.S. citizens. Acculturation data
demonstrated that all participants strongly identified with a Latino identity, but also strongly affiliated with a U.S. identity. Several minor subthemes in this study related to immigrant issues. Future extensions of this research should attempt to include more non-U.S. citizens. By including this broader demographic, additional major theoretical categories may emerge, such as accessibility to health care and discrepancies in health care service utilization. Socioeconomic status was also not evaluated for this study. Thus, future research that includes a broader sample may better highlight how income level impacts recovery for Latinos.

This study ultimately provides an important first look into how Latinos recover from mental illness and opens up a wide array of questions of how communities can better meet the needs of Latino consumers. Outcome studies that examine how interventions (i.e., family psychoeducation) impact cultural stigma may provide important insight into how to best support recovery processes for Latinos. Monitoring outcomes of family involvement in the treatment process may also highlight whether mental health stigma and ignorance are transient issues that can be addressed through social services. Addressing these factors may ultimately help reduce the compounding effect of being a minority living with mental illness.
References


Appendix A

Semi-structured Interview Protocol – English Version

Opening Interview Questions – All participants

1) Do you identify as being of Hispanic, Latino or Spanish origin?
   ▪ If yes, what is your or your family’s country of origin?

2) How many years have you lived in the United States? _______

3) What is your relationship status?
   □ Never married
   □ Married
   □ Separated
   □ Divorced
   □ Widowed
   □ Living together/cohabitating

4) What is your living situation?
   □ Your own home or apartment
   □ A friend or a relative’s home or apt.
   □ Homeless
   □ Other (_____________)

5) What is your employment status?
   □ Employed full-time
   □ Employed part-time
   □ Unemployed
   □ Student
   □ Homemaker
   □ Retired
   □ Disabled
   □ Other (_____________)

6) How years of school have you completed? _______

7) Living or dealing with mental health problems or symptoms can have a significant
   impact on a person’s life. Some examples of symptoms might be feeling depressed,
   feeling like your emotions are erratic, or acting in very unusual or odd ways
   that disrupt your ability to go about your day-to-day living.
   Do you feel like this might be applicable to yourself, a family member, or a
   friend?
   □ Yes  Relationship: _________________________
   □ No

**Depending on who they indicate, either the “participant in recovery” or
“family member in recovery” interview format will be used (see below).**
For Participants in Recovery

1) Everyone who lives with a mental disorder like schizophrenia or bipolar disorder has their own way of living and coping with their disorder. This process is often called a recovery process. The recovery process is often thought of as a way of coping that allows the person to live beyond their illness, instead of being controlled by it. This means that the person makes an active effort to live a full, satisfying life despite the challenges caused by their illness.

Does this definition of recovery make sense to you? How would you describe the way you cope with your illness on a day-to-day basis? Is “recovery” a good word to describe this process? How does this process work for you?

2) Tell me about your experience with your own recovery. What are some of the challenges you’ve faced? How did you deal with those challenges?

3) How do you know if you’re getting better? How do you assess your improvement? Can you give me some examples? What are the different parts of your life that are affected by the recovery process? How are they affected? How do you think others perceive your recovery process? Who, if anyone, has influenced your recovery process? How have they been influential?

4) What factors have influenced your recovery process in a positive way? How have they influenced your process? Are there any kinds of classes or services that you think may be helpful?

5) What factors have influenced your recovery process in a negative way? How have they influenced it?

6) Do you have any general or specific recovery goals? What are they? How do you plan to work on them? Where do you think you are in the recovery process right now? Do you have a sense of what you need to work on next? Do you have any expectations for yourself? What are your hopes for the future? For example, what do you hope to be able to do in the future that you cannot do now? Where do you hope to be in the next five years?

7) Has being Latino influenced your recovery? If yes, how? Has being a part of the Latino community been important in your recovery? If yes, how?
8) Does your Latino background influence how you or your family views your mental illness? If yes, how?

9) Has being Latino affected how you’re treated by health care professionals? If yes, how?

10) Can you think of anything else you’d like to tell me about your recovery process?

For Participants Who Know Others in Recovery

1) Everyone who lives with a mental disorder like schizophrenia or bipolar disorder has their own way of living and coping with their disorder. This process is often called a recovery process. The recovery process is often thought of as a way of coping that allows the person to live beyond their illness, instead of being controlled by it. This means that the person makes an active effort to live a full, satisfying life despite the challenges caused by their illness.

Tell me a little about the friend/relative/partner you know living with a mental disorder. Does this definition of recovery make sense to you when you think about your friend/relative/partner? How would you describe the way your friend/relative/partner lives with their illness on a day to day basis? Is “recovery” a good word to describe their process? How does it work for them?

2) Tell me about your friend/relative/partner’s experience with recovery. What are some of the challenges they’ve faced? How did they deal with those challenges?

3) How do you know if your friend/relative/partner is getting better? Can you give me some examples? What are the different parts of their life that are affected by the recovery process? How are they affected? How do you think others perceive their recovery process? Who, if anyone, has influenced their recovery process? How have they been influential?

4) What factors have influenced your friend/relative/partner’s recovery process in a positive way? How have they influenced it? Are there any kinds of classes or services that you think may be helpful to them?

5) What factors have influenced your friend/relative/partner’s recovery process in a negative way? How have they influenced it?
6) Does your friend/relative/partner have any general or specific recovery goals? What are they? Do they work on them? Where do you think they feel they are in the recovery process right now? Do they have any expectations for themselves? What are their hopes for the future? For example, what do they hope to be able to do in the future that they cannot do now? Where do they want to be in the next five years?

7) Has being Latino influenced your friend/relative/partner’s recovery? If yes, how? Has being a part of the Latino community been important in their recovery? If yes, how?

8) Does your Latino background influence how you or others view your friend/relative/partner mental illness? If yes, how?

9) Has being Latino affected how your friend/relative/partner been treated by health care professionals? If yes, how?

10) Can you think of anything else you’d like to tell me about your friend/relative/partner and their recovery process?
Appendix B

Semi-structured Interview Protocol – Spanish Version

Preguntas Introductorias – Para Todos los Participantes.

1) ¿Se identifica del origen Hispano, Latino, o Español?
   • En caso afirmativo, ¿Cuál es su país de origen o de su familia?

2) ¿Cuántos años hace que vive en los Estados Unidos? ________

3) ¿Cuál es su estado civil?
   □ Casado nunca
   □ Casado
   □ Separado
   □ Divorciado
   □ Viudo
   □ Viviendo juntos/Cohabiting

4) ¿En qué tipo de lugar vive?
   □ Su propia casa o apartamento
   □ La casa de un amigo o familiar
   □ Sin hogar
   □ Otro (______________)

5) ¿Cuál es su situación laboral?
   □ Empleado a tiempo completo
   □ Empleado a tiempo parcial
   □ Desempleado
   □ Ama de casa
   □ Retirado
   □ Discapacitado
   □ Otro (______________)

6) ¿Cuántos años escolares ha completado? ________

7) Vivir con problemas de la salud mental o síntomas difíciles puede tener un gran impacto en la vida de una persona. Algunos ejemplos de síntomas incluye sintiendo deprimido, sintiendo que sus emociones son erráticos, o comportándose de una manera muy inusual o extraña que impide su capacidad para seguir con una vida normal.
   ¿Cree que esta descripción se aplica a usted, un familiar o un amigo?
   □ Sí Relación: _________________________
   □ No
**Depende de que la persona indicada, el investigador completará la sección "Participantes que Están Recuperando" o "Participantes que Conoce a Otros que Están Recuperando" (ver más abajo).**

**Para los Participantes que Están Recuperando**

1) Cada persona que vive con un desorden mental, como la esquizofrenia o el desorden bipolar, tiene su propia manera de vivir y hacer frente a su desorden. A menudo, esto se llama un proceso de recuperación. El proceso de recuperación se define frecuentemente como hacer frente a su enfermedad de una manera que le permite la persona a vivir afuera de su control. Este significa que la persona trabaja activamente a vivir una vida llena y gratificante a pesar de las dificultades causados por su enfermedad.

¿Tiene sentido para usted esta definición de recuperación? ¿Cómo describiría su forma de afrontar la enfermedad día a día? ¿Es “la recuperación” una palabra buena para describir su proceso? ¿Cómo funciona este proceso para usted?

2) Dígame sobre su experiencia con su propia recuperación. ¿Cuáles son algunos de los desafíos que enfrentó? ¿Cómo se encarga de estos desafíos?

3) ¿Cómo sabe si usted está mejorando? ¿Cómo evalúa su progreso? ¿Puede contarme algunos ejemplos? ¿Cuáles partes de su vida están afectados por su proceso de recuperación? ¿Cómo están afectados? ¿Cómo cree que los demás perciben su proceso de recuperación? ¿Quién, si alguien, ha tenido un gran influencia en su recuperación?

4) ¿Cuáles cosas han influido su proceso de recuperación de una manera positiva? ¿Cómo? ¿Hay algunas clases o servicios que piensa que sería útil?

5) ¿Cuáles cosas han influido su proceso de recuperación de una manera negativa? ¿Cómo?

6) ¿Tiene algunas metas generales o específicas para su recuperación? ¿Cuáles son y cómo intenta a trabajar en ellos? ¿En este momento, en dónde cree que está en su proceso de recuperación? ¿Piensa sobre qué debe hacer próximo? ¿Tienes algunas expectativas para su mismo? ¿Cuáles son sus esperanzas para el futuro? Por ejemplo, ¿hay habilidades que quiere alcanzar en el futuro que no puede hacer ahora? ¿Dónde espera estar en los cinco años próximos?
7) ¿Piensa que ser Latino afecta su recuperación? ¿Cómo? ¿Piensa que la comunidad Latino es importante en su recuperación? ¿Cómo?

8) ¿Piensa que ser Latino afecta como usted percibe su enfermedad? ¿O como su familia percibe su enfermedad?

9) ¿Piensa que ser Latino afecta el tratamiento que usted recibe de los profesionales médicos? ¿Cómo?

10) ¿Hay algo más que se gustaría contarme?

Para los Participantes que Conocen a Otros que Están Recuperando

1) Cada persona que vive con un desorden mental, como la esquizofrenia o el desorden bipolar, tiene su propia manera de vivir y hacer frente a su desorden. A menudo, esto se llama un proceso de recuperación. El proceso de recuperación se define frecuentemente como hacer frente a su enfermedad de una manera que le permite a la persona vivir afuera de su control. Este significa que la persona trabaja activamente a vivir una vida llena y gratificante a pesar de las dificultades causados por su enfermedad.

Dígame un poquito sobre su amigo/familiar/pareja a que conoce que viva con un desorden mental.

¿Tiene sentido para usted esta definición de recuperación cuando piensa de su amigo/familiar/pareja? ¿Cómo describiría la manera en que su amigo/familiar/pareja hace frente a su desorden día a día? ¿Es “la recuperación” una palabra buena para describir su proceso? ¿Cómo funciona este proceso para ello?

2) Dígame sobre su experiencia con la recuperación de su amigo/familiar/pareja. ¿Cuáles son algunos de los desafíos que enfrentó? ¿Cómo se encarga de estos desafíos?

3) ¿Cómo sabe si amigo/familiar/pareja está mejorando? ¿Puede contarme algunos ejemplos? ¿Cuáles partes de su vida están afectados por su proceso de recuperación? ¿Cómo están afectados? ¿Cómo cree que los demás perciben su
proceso de recuperación? ¿Quién, si alguien, ha tenido un gran influencia en su recuperación?

4) ¿Cuáles cosas han influido el proceso de recuperación de su amigo/familiar/pareja de una manera positiva? ¿Cómo? ¿Hay algunas clases o servicios que piensa que sería útil?

5) ¿Cuáles cosas han influido el proceso de recuperación de su amigo/familiar/pareja de una manera negativa? ¿Cómo?

6) ¿Tiene su amigo/familiar/pareja algunas metas generales o específicas para su recuperación? ¿Cuáles son y trabaja en ellos? ¿En este momento, en dónde piensa su amigo/familiar/pareja que está en su proceso de recuperación? ¿Tiene algunas expectativas para su mismo? ¿Cuáles son sus esperanzas para el futuro? Por ejemplo, ¿Hay habilidades que quiere alcanzar en el futuro que no puede hacer ahora? ¿Dónde espera estar en los cinco años próximos?

7) ¿Piensa que ser Latino afecta la recuperación de su amigo/familiar/pareja? ¿Cómo? ¿Piensa que ser parte de la comunidad Latino es importante en su recuperación? ¿Cómo?

8) ¿Piensa que ser Latino afecta como usted percibe la enfermedad de su amigo/familiar/pareja? ¿O afecta las percepciones de otros?

9) ¿Piensa que ser Latino afecta el tratamiento que su amigo/familiar/pareja recibe de los profesionales médicos? ¿Cómo?

10) ¿Hay algo más que se gustaría contarme sobre el proceso de recuperación de su amigo/familiar/pareja?
Appendix C

Interview Excerpts by Theme

Family

Positive Family Factors

Family Involvement

ID-01:
- Put my attention on my children.
- My children have a great influence on my recovery.
- Having my children together.

ID-04:
- Well, if his siblings come over, he feels good, I think.
- Our plans are to see if we can be here for the children to finish learning English. With him being ill, the truth is to say to see if they learn English for their future, for the children.

ID-05:
- So I was going to have this baby. And I’m glad I did. She’s made me a better woman.
- I’m the first one that broke the door open. Yup. I think at first I scared my family, because I was pulling out things they could relate with but were afraid. And now they’re not afraid anymore because everyone is getting some type of education.

ID-06:
- And I have to say that my in-laws have been fantastic. When we came back up here, they all were just like, “Hey [consumer’s name]! How you doing?” And made him…that’s why I think he feels so much better here. Cause our family here has made him feel like, “Okay. This is [consumer’s name]. Come on. No problem.”

ID-07:
- And I think the grandchildren brought him a lot of joy. We’re nine children. Then our nieces and nephews that were having children too. So I think that helped also with his recovery. Cause he had a love for family. He was family oriented.
- My mom helped a lot. Because she saw him as a person first and not the illness. And they would have been married for a long time. And he did have a good relationship with my mom. And I think the fact that they had that support with each other. That even though he was feeling sad,
that he had to be there for my mom too. So they kind of supported each other.

- He would be very proud to know that not only had he raised good children. And that our children have all done good for themselves. And now he would be a third great, great grandfather. And to see how far they’ve come. I think he would be very, very proud.

- I think he wanted to raise all of us kids. He always encouraged us to do for ourselves. To get an education. To make a difference in people’s lives. To really take advantage of anything he possibly could. He always encouraged us about school. Getting an education. That he didn’t want us to be working in the fields or working hard like he had. He said he had an excuse. And that was probably that he never got an education. And he didn’t want us to be like him. So I think that his big expectations about making sure that all of us nine kids, that were raised and had a better life than he ever thought.

- I think maybe… I don’t know…but he always tried to protect us. I think he was one of the biggest and great counselors that anybody could have.

- So she saw that our brains can get sick too. So she understood that part very well… And there was no stigma behind that either because the family understood that when something happens…you know, we can go into a depression.

- And I’ve just told them…from what I’ve learned about mental illness. So they see it. And I tell them it’s nothing to be afraid of or anything. And as a matter of fact, my sister – the one that has her son that has schizophrenia – and she says, “I wish you could come over here and get us all together and you can tell us more.” You know, because about mental health issues. And how they can deal with it. And talk to…for them to educate themselves a little bit more about mental illness.

**ID-08:**

- What helps me a lot are my kids and my grandkids. Because, to me, they are my world.

- It does. It does help a lot. And sometimes ti makes me think a lot about people that don’t have family members. Or people in their lives that can help them get through it. Because to me that is a lot of help. And the ones that don’t have it, I think about them and say a prayer for them. And wishing that they get the help that they need. It’s not easy. It’s not easy. It’s a battle and a process every day.

- And my son that called me, he used to have a softball team. And I loved to watch him play ball. So I was their cheerleader. And if it wasn’t for that…every summer I always looked up for that. Because it got me more out of the house. But it took a while for me to start getting out of the house because the way I felt and the way I hurt. Because, like I said, if it wasn’t for my kids being on me and after am and that, I don’t know – I probably would have already been in the nut house a long time ago.
Like when it was around Christmas one year, my kids go, “Aren’t you going to put a tree up?” I go, “What for?” I go, “I ain’t got any money. There ain’t gonna be nothing under there. So what’s the sense of it?” You know, and my daughter came over and she put the tree up. And she said, “You’re gonna put that tree up. We’re gonna put it up. Doesn’t matter what’s there. What matters is us.” Yeah, my kids are the ones getting me more…cause I didn’t want to do anything. I didn’t care about putting whatever…it didn’t matter.

But as long as you’re able to do something for them and help them – at least my part – it makes me feel good. But if I ignore it and try not to help them and something happens, then it’s even gonna make me feel more depressed. So that’s why I kinda like to do what I can for my parents.

Caring for Mentally Ill Family Members within the Household

ID-04:

And those of us in the family tried to tell him, “No, look. Nothing’s happening. Nothing’s happening. Everything is okay. It’s not that way. Look. It’s because you’re sick. But everything is okay. Nothing has happened or will happen.”

I wanted to bring him home because in the hospital I thought he was going to be okay. And now in the house, already watching me, being with us. And it’s better, he’s better. Spending time helping. That he gains confidence again. That he stops being afraid. That he’s talking.

I think I’ve helped him because it’s one’s job. When someone falls ill…

ID-05:

Yes. That I went for help. That I figured it out. That I’m not the only one with this problem. And my family. My daughter was suffering. My mother, my aunt, my grandmother, and Lord knows who else on that side. On the other side, there’s other issues of mental health. Depression is still one of them.

And it makes a difference too when you have family support. And they understand there’s a mental issue there. And, you know, I’m not the only one having this issue. And now the family knows where they can go. Where they can reach out. And I’m teaching the family too.

Once again, having that relationship with my mom and my daughter. Which was very influential in every way. We learned to deal, we learned to cope. We were all dealing with the same type of anxiety, the same type of depression. And teaching each other how to cope. And to this day, I’m still teaching my mom how to cope with it. She’s giving me breathing lessons and I’m teaching her coping lessons.

But we take care of our own. We don’t put them inside somewhere to be taken care of. We take care of our own. That’s just how I see it.
ID-06:
- By being supportive and making sure that his needs are taken care of and trying to encourage him to do something with his recovery to move it along.
- When he was in the assisted living facility… The director one day she told me, “You’re such a good mother.” She says, “You come visit him all the time.” I looked at her like, “What are you talking about? This is my son. Why wouldn’t I do that?” She goes, “Oh you wouldn’t know how many people come and they drop their family member off and they never see them again.” And that to me was just unthinkable. You know…you can’t do that. You just, that’s your family. You take care of them.

ID-07:
- But he had a lot of support from the family. And I think that is something that is very necessary. You know, to be able to have family support and people that really understand what he’s going through. And actually my mom was his care giver. And she and I, we spoke a lot together. Cause we shared a lot of intimate feelings about dealing with a person that has mental illness.

ID-08:
- Because, like I said, it took a while for me to start getting out of the house because of the way I felt and the way I hurt. Because, like I said, if it wasn’t for my kids being on me and after me and that, I don’t know – I probably would have already been in the nut house a long time ago.

ID-11:
- My mother, she also took the Family-to-Family course. So she knows a little bit more about it. And I was amazed when she would tell me, “Yes, I know what you’re going through. I know this is what you’re going through.” It was amazing.

ID-12:
- I feel like the Latin culture especially, we tend to head towards family and look for family support. Just to be able to – “Hey, let’s get together and have dinner.” It’s just… I mean, my Latin culture if anything has taught me “Family’s family.” We have our differences, but we’re always there.
Negative Family Factors

Lack of Understanding of Mental Illness and Recovery

ID-02:

- His mom and dad. Because they’re never been supportive with him. Because they never call to say, “Hi. How are you doing?”
- And his family, in general, aunts, uncles and everybody, they’re very negative. They’re just very hard on him. They’re just very mean to him.
- Especially with his family, because they’re like “Oh you’re stupid for feeling that way anyways.” Especially, because they… Latinos tend to believe when you have a mental illness, you’re crazy. And that’s exactly what his family thinks when you talk to him. And being very insensitive.
- What my dad says about him… He’s kind of mean…like he doesn’t think like a mental illness, like he’s depressed or anything. Or anxious. But he’ll be more like “Why would he be anxious anyways?” when I tell him. “He’s stupid anyways…not crazy… I don’t know why he’s thinking that he’s crazy. He’s not anxious.” And things like that. And he’ll be like “Snap out of it.”

ID-03:

- I read as much as I can because no one else will help me. My parents, they understand, but they don’t understand, if that makes any sense. They know I’m sick, they wanna…they’re still grieving about it. And they don’t want to believe it. And it’s been 20 years. And they’re still grieving about it.
- Family that has no idea what I’ve been through or what I’m going through. Especially outer family members. Not my inner ones. But my cousins, aunts, and uncles. Sometimes my brother. He’s probably the closest one that doesn’t understand. Which is unfortunate.
- Even though my parents understand, they are still grieving because they don’t want to believe I’m sick.

ID-06:

- In the beginning, yeah, I was embarrassed to even tell anybody. It was very, very traumatic for me when he first got sick and I was embarrassed to even tell anybody. And it’s just because in the Latino community, you just don’t bring this kind of stuff out into the public, in the open. You know, I remember when we were kids and we’d go to somebody’s house and they had a little boy that was very retarded. He still…he was probably 12 years-old, but he was in diapers and he drooled and whatever. And it was like they didn’t want people to know that they even had him. It was kept hidden, more or less. And I guess that’s
something I grew up with, thinking – you know you just don’t talk about these things. And you keep it private.

- He just has… could not accept that [consumer name] is really sick. You know, in his mind – “You should make him do this and you should him do that. You can’t let him do that.” And it’s like, you just don’t understand. And they really were embarrassed by him. They made no effort to try and understand the illness.

**ID-11:**

- So they’ll tell you, “Slip out of it!” “You’re not like this, you’re a happy person.” “You could be yourself.” Especially one of my cousins. Well, he’s not here right now. He’s in another part of Ohio. He would say, “Your problem is you’re depressed. But you could slip out of it.” I mean he knows that I was depressed. But he thought that it was like, yeah, flip a switch – bam!

**ID-12:**

- I don’t think I’d be one of those people that I can call my parents and say this. Cause I think in the Latin culture there’s a whole different way of handling situations. And I don’t think, you know, you can just call up… I mean, I think the Latin culture tends…Does a little blind eye to it. I mean they… I think they… they’re not as educated as they need to be. Or I think it’s more of a, “Well, he’ll get over it. We’ll be supportive.” But they don’t want to acknowledge it. I think they don’t want to…acknowledge a lot of things that are going on when stuff are going on.

- So to me, it’s harder to go to your parents. I mean it’d be one thing if I go to my parents and say, “I’m having problems with my Catholic faith.” It would be easier for me to talk to my parents about than to say I’m really depressed about this.

- Coming from a Latino family? Like I said before, I think they just kind of – “Well. He’ll get over it. He’ll handle it.” Or “Oh, let’s take him to the bar and let him have some beers.” And again, that’s where I feel like they aren’t educated the way it needs to be. Or they don’t know how to…prime example was…I don’t think they realize… Latin culture realizes that there’s help out there. And their sources.

**Stigma**

*Mental Illness Stigma Unique to Latinos*

**ID-02:**

- Latinos tend to believe when you have a mental illness, you’re crazy.
• Cause the people that have helped him, with like getting jobs, have helped him feel better about himself are always white. Never Latinos. If anything, Latinos he has been around have been very mean to him.

ID-03:
• My family or a lot of people think it’s a curse or something religious.
• And if I can teach them or just speak about my story and help them understand and not thinking, “Oh, this guy’s crazy.” Or it’s a curse. Or things like that. Or stigma.

ID-05:
• Because of stigma. We don’t talk about mental health.

ID-06:
• Cause I remember when I would try to talk him into joining groups and things. He was like, “I don’t want to hang out with those people.” I’m like, “What do you mean, those people?” So he doesn’t want to identify himself as mentally ill either. And if he ever talks to anybody…like when he would be at Latino Club and he would tell people he’s bipolar. He won’t admit he’s schizophrenic. That to him is like, “I can’t be schizophrenic.” That’s just the worst thing. Bipolar isn’t as bad, I’ll say I’m bipolar. Cause I think the stigma of schizophrenics. People out there are crazy, they’re maniacs. They’re violent. So in his mind, I’m sure that’s why he doesn’t want people to think of him that way.
• In the beginning, yeah, I was embarrassed to even tell anybody. It was very, very traumatic for me when he first got sick and I was embarrassed to even tell anybody. And it’s just because in the Latino community, you just don’t bring this kind of stuff out into the public, in the open. You know, I remember when we were kids and we’d go to somebody’s house and they had a little boy that was very retarded. He still…he was probably 12 years-old, but he was in diapers and he drooled and whatever. And it was like they didn’t want people to know that they even had him. It was kept hidden, more or less. And I guess that’s something I grew up with, thinking – you know you just don’t talk about these things. And you keep it private.
• When I finally came to realize it wasn’t anything I could do anything about, you know. I look at it now as no different than someone who has diabetes. It’s an illness. But at first, it was hard. It was very hard to get past that point. I mean, I had breast cancer. And his becoming schizophrenic was harder than getting my diagnosis of having cancer.
• He just has… could not accept that [consumer’s name] is really sick. You know, in his mind – “You should make him do this and you should him do that. You can’t let him do that.” And it’s like, you just don’t understand. And they really were embarrassed by him. They made no effort to try and understand the illness.
ID-07:
- I know that she did mention it to some people but not to everybody. Because she used to say some people didn’t understand. So maybe that might have been something was a little bit…there must have been some stigma there.

ID-08:
- So it’s…that’s like I said…some Latinos don’t talk about it. Don’t say anything.
- But, like I said, a lot of Hispanics don’t talk about it. You know, because I think it was only a couple of us there that were Hispanic. The rest were more Caucasian and all that. Because they’re not as open. They’re more private. And they’re always…well my mom used to say…or my aunt would say, “What are the people gonna say?” You know, like being embarrassed. Like, “Oh my god! What are they going to think about us now?” Or … they’re more private. They won’t say anything.
- And that’s why like I said, it’s more my kids that know about it. Cause I was brought up with “Shh!”

ID-09:
- Because we’re a culture that doesn’t like to talk about this at all. We’re very…kind of like…just don’t talk about it. You know what I’m saying. They don’t try to address it. They don’t like to…especially they don’t like to contact for help.
- I think that there is a stigma associated. Don’t get me wrong, I think there’s a stigma with mental health regardless. But I feel like that their stigma is so much more. I feel like maybe we’re starting to get some understanding of different diagnoses and things of that sort. And not automatically calling people crazy. But in the Hispanic culture, it’s kind of like, “They’re crazy.” Cause they don’t have the information. They don’t have the knowledge on this kind of stuff. That is so easy to come by other ways.

ID-10:
- Latinos, if something’s wrong, they like to sweep things under the rug. And that’s big in the culture because they don’t want to share it with anybody else. They’re very private.
- Because you don’t want to tell anybody that you don’t want to wake up the next morning. You don’t want to tell anybody that your life is worthless.
ID-11:
- I don’t know how they’d be able to help. Most often they’re not educated. So they’ll have the stigmatism.

ID-12:
- I don’t think I’d be one of those people that I can call my parents and say this. Cause I think in the Latin culture there’s a whole different way of handling situations. And I don’t think, you know, you can just call up… I mean, I think the Latin culture tends… Does a little blind eye to it. I mean they… I think they… they’re not as educated as they need to be. Or I think it’s more of a, “Well, he’ll get over it. We’ll be supportive.” But they don’t want to acknowledge it. I think they don’t want to… acknowledge a lot of things that are going on when stuff are going on.
- But I’ve also felt like they don’t have the schooling and the education to understand or comprehend. Or have never gone through it.

Ignorance

Lack of Education on Mental Illness Among Latinos

ID-03:
- I think Latinos are very unaware of symptoms and what the mental illnesses are. Maybe lack of education for them about the illnesses. And family is sometimes negative. And I believe vibes of negativity will be me being negative. So if they are positive to me, I’d be positive. So basically, it’s probably lack of education in Latino families, is probably what it is.

ID-06:
- Just excepting the fact that I know it wasn’t anything he did wrong or I did wrong. It’s just an illness. Just finally coming to the realization that it’s an illness. And I’m just taking care of my son and I’m going to do everything for him like he had gotten hit by a car and was paralyzed. And I would have to take care of him the rest of his life. Because I just realized there’s nothing I can do about it. And there’s nobody I can blame for it.
- They didn’t understand – you know, my son-in-law would be like, “He’s just lazy. You should make him do this. You should make him do that. I don’t know why you can’t make him do this or that.” And it’s like, you just don’t understand. I mean, it was like talking to a wall. And they just could not and would not understand how the illness really was.
ID-08:
- I think that a lot of people don’t realize that mental illness is an illness. I don’t know, there might have been some reservations there. You know, discussing things like that with other people.
- I know that she did mention it to some people but not to everybody. Because she used to say some people didn’t understand. So maybe that might have been something was a little bit…there must have been some stigma there.
- I never really knew a lot of what depression meant. Until I started going through it myself. And it got explained to me. Because, like I said, I didn’t know it.

ID-09:
- I think that there is a stigma associated. Don’t get me wrong, I think there’s a stigma with mental health regardless. But I feel like that their stigma is so much more. I feel like maybe we’re starting to get some understanding of different diagnoses and things of that sort. And not automatically calling people crazy. But in the Hispanic culture, it’s kind of like, “They’re crazy.” Cause they don’t have the information. They don’t have the knowledge on this kind of stuff. That is so easy to come by other ways.

ID-10:
- So Latinos blow it off as, “Just get over it. If you’re a man, be a man. If you’re a woman, suck it up.” That kind of thing.

ID-11:
- A lot of Hispanic individuals…and I see it more often where they’re less educated. And if they come from a city background, where that’s where we came from – Guadalajara – it’s more of a city. My father and mother, they were born in rural areas. Ranches and things like that. They’re more prone to that kind of superstition. Even my sister believes that. And she wasn’t born in no rural community.
- I don’t know how they’d be able to help. Most often they’re not educated. So they’ll have the stigmatism.

ID-12:
- I don’t think I’d be one of those people that I can call my parents and say this. Cause I think in the Latin culture there’s a whole different way of handling situations. And I don’t think, you know, you can just call up…. I mean, I think the Latin culture tends…Does a little blind eye to it. I mean they… I think they…they’re not as educated as they need to be. Or I think it’s more of a, “Well, he’ll get over it. We’ll be supportive.” But they don’t want to acknowledge it. I think they don’t
want to…acknowledge a lot of things that are going on when stuff are going on.

- But I’ve also felt like they don’t have the schooling and the education to understand or comprehend. Or have never gone through it.
- Coming from a Latino family? Like I said before, I think they just kind of – “Well. He’ll get over it. He’ll handle it.” Or “Oh, let’s take him to the bar and let him have some beers.” And again, that’s where I feel like they aren’t educated the way it needs to be. Or they don’t know how to…prime example was… I don’t think they realize…Latin culture realizes that there’s help out there. And their sources.

Mental Health Education and Advocacy

One-on-one Advocacy

ID-03:

- I hope I can make an impact to a lot of people by speaking for NAMI. And sharing my story with people. I think that would really help. Like I says before, I wouldn’t do it for myself. I would do it for all the mentally ill people around me. Like I says, people at the Zepf Center thank me so much, even for the articles in La Prensa. And they say thank you to me. And that touches my heart dearly. So, basically I want to help people understand, get rid of stigma.

ID-05:

- I just yesterday at the store there was a lady that was in Claudia’s class. And she remembered me. And she said, “Remember when the lady from the Y was there and she said about that banking and how they’d match the money?” She wants me to find where that lady is. They went to look for her but now she isn’t there. So now she wants me to do that for her. I told her, “Give me until Friday and I can see if I can get the information for you on Friday.”
- Sitting behind a desk is not going to do anything. You know, it’s where it’s at. Outreach, outreach. And just listening to what [community members] have to say. Listening to their questions.
- And I work with Bright Horizons. It’s an agency where we work with families with disabilities. And I’ve been doing Pack, Wrap Around. And this agency deals with both of those and I learned both of those working with NAMI.
- And I would like to work with Hispanic people. Not only in English, but it’ll be in Spanish.
- We went to the Hill, to Capitol Hill, and we invited the legislators, their liaisons who work with them very close. And out of 18, 14 showed up. And we had a luncheon and we learned so much about each different
legislator. And a lot of one on one. And it was awesome. And the bills, you learn about what type of bill you’re fighting for. And being on a state level, going to Columbus and standing on the state steps and speaking was a highlight too.

- Not only that is – I sit on the FLOC board too. And sitting on the FLOC board, you’re constantly working with Latinos. And especially for all the different issues we’re fighting for right now. So it’s a big thing.

ID-06:

- Just accepting the fact that I know it wasn’t anything he did wrong or I did wrong. It’s just an illness. Just finally coming to the realization that it’s an illness. And I’m just taking care of my son and I’m going to do everything for him like he had gotten hit by a car and was paralyzed. And I would have to take care of him the rest of his life. Because I just realized there’s nothing I can do about it. And there’s nobody I can blame for it.

ID-07:

- I think he wanted to raise all of us kids. He always encouraged us to do for ourselves. To get an education. To make a difference in people’s lives. To really take advantage of anything he possibly could. He always encouraged us about school. Getting an education. That he didn’t want us to be working in the fields or working hard like he had. He said he had an excuse. And that was probably that he never got an education. And he didn’t want us to be like him. So I think that his big expectations about making sure that all of us nine kids, that were raised and had a better life than he ever thought.

ID-08:

- And I used to get angry at him because he just gave up. And I know I wasn’t going through what he was going through, but he always kept feeling like “Always me. Look at poor me. Why is this happening to me?” And I would have to tell him, “There’s people a lot worse than what you are.” I says… and he would start with, “Well God’s punishing me.” I said, “Don’t ever say that because God doesn’t punish.”

ID-09:

- I’ve had people come by and say, “Hey. The fact that you talked about this….” Especially when we were in school going through the human service kind of stuff. They would… I’ve had a couple people say, “Hey, you really helped me out with the fact that you can tell me you have anxiety. I feel like I have anxiety too.” Like it’s one of those situations where it’s like – Oh god! There’s somebody out there that gets it.
ID-10:
- I kind of help people start over with not only jobs and training, but sometimes they come from nothing and they have mental illnesses where I have to refer them to other organizations. So I’m trying to help and advocate for people who have mental illness now.
- And that’s the thing I took away from her, because – I tell my kids too. They’ve come to me and, “My friend’s doing this and he’s in this situation – what can I say to help him?” And the first thing I tell them is, “Build them up.” Because they’re being judged by everybody else so they feel like, they feel like they’re being judged by everybody else. But they need somebody to build them up, not to judge them.
- I want to be able to help people that are going through similar things I have gone through.
- And just trying to get a counseling certification is what I’d like to do. I’m hoping I can do that.
- I want to get into helping the disabled and the elderly.
- We’ve talked about it [starting a business] and it would be like community care and transportation out here in the rural area. There’s a lot going on in the city, but there’s not much out in the rural area.

ID-11:
- But he changed dramatically. He doesn’t drink that much. I feel like I probably played an important part in that. I got him into the whole gym thing as well. Eating healthy. Working out. And so I’m happy about that. Where I managed to change that on him. But we both helped each other out tremendously.

ID-12:
- I think for me my goal is to make sure that I’m going to … like right now, one of my goals is – cause I lost my friend to cancer – is thinking about joining a cancer support group. Or one of my other goals is to do some outreach. Or something… you know, something that aspect where I’m getting a positive out of it.

Self-Advocacy

ID-03:
- I got a magazine, called Schizophrenia Digest. I was reading it. They have some commercials in there about newer medications. So I saw one they were working on called “Aeropiphial”, which is called Abilify. And I asked my doctor, I says, “Hey, can I try this pill?”
- I always ask my parents, “Hey, was that a voice there? Did somebody say my name?” Because in crowds, sometimes when someone says, “Hey man,” I think they say, “Hey Dan.” So my, all the commotion,
sometimes probably messes with my neurons firing. So I start to question myself, so are they there or is it a hallucination?

- And I do believe that talk therapy and medications are the most important things you need to be in recovery. I know for sure if, for two days, I went off my meds I would be in the hospital for sure. That’s how I feel about it.
- Well, like I said. You need to research as much as you can about your own illness, whatever that might be. If they have bipolar or PTSD. I think research and talk therapy are very important, as well as taking their medication. I do understand that sometimes people’s medication doesn’t work at all. If they’ve tried every single one. If that’s the case, I truly believe that talk therapy would help them just as much.

ID-04:
- He was coming here with Ms. Anita [outreach coordinator at NAMI].

ID-05:
- Well, I can tell you that I’ve never been to a psychiatrist, a psychologist. I took the NAMI classes. I learned the mental health… I learned the classic things they teach – how to cope and deal.
- Education. For instance, when you’re at the doctor’s office or speaking with the nurses, get to know the doctors and nurses one-on-one so you’re not in that position. And after you get to know someone one-on-one like that, you can see how you will be treated.
- If I feel like I’m going to be treated in a certain way, I have to speak up. Whether it’s for my parents. I had to do it a couple times at the hospital and they realized what was up. And we talked to the higher’s up and we got it taken care of that hour.
- And just how my parents raised me. We weren’t raised to give up.

ID-08:
- Well, a friend of mine once told me, “How do you do it?” I says, “I don’t give up.
- But if I feel and keep positive in my heart that I am doing better or having a good day. I’m not gonna let them put me… get me down.
- The pain. Yeah. The legal is just ridiculous. But like, I’m kind of understand their point. But at times I don’t understand it. I wish they would see more of the person that is going through it. Than just because some other people have faked it doesn’t mean that everyone is doing that. You know, and my doctors would tell me – they go, “We even see it in your face. How much pain you’re in.” You know, they don’t see me. So how are they gonna be able to tell me no on something that I need when they’re not seeing me and the pain that I’m in. So it’s just a battle. But I don’t give up.
ID-09:
- I feel like I’ve made a lot of forward momentum. Okay. It might not be what my ideal life would have been. I don’t sneeze at it.

ID-10:
- Now I want to educate myself more on not only mental illness, but drug addiction.
- The first step is learning about the whole thing and that’s one of the things I did at NAMI. So they helped me a lot.

ID-11:
- That’s is my biggest… I’m trying to think of that word…my biggest… motivator. Somebody says, “You can’t do it.” I always love to prove them wrong.
- But then I discovered this and was like, “Ah, so that’s what it is.” That’s the depression phase.

ID-12:
- I think for me I’ve gone through my depression on certain levels. But I’ve always tried to…I fight. I’m a fighter. I always fight back. And I figured there’s a way to come back out of it.
- I think with me, psychologically, I think if I get myself in to the point where I’m helping out and doing things and getting myself a little more organized with that – I think that’s probably where I’d be. Where I’m saying, “Yup. I’m doing fine.”

**Empowerment through Mental Health**

ID-03:
- I got a magazine, called the Schizophrenia Digest. I was reading it. They have some commercials in there about newer medications. So I saw one they were working on called aripiprazole, which is called Abilify. And I asked my doctor, I says, “Hey, can I try this pill?” Because none of the other ones really were working.
- And I do believe that talk therapy and medications are the most important things you need to be in recovery. I know for sure if, for two days, I went off my meds, I would be in the hospital for sure. That’s how I feel about it.
- My first psychiatrist. He had always been there. He was trying to keep me positive and telling me great things. Another person was a psychologist at his office. He was really nice.
- And then I went to the Zepf Center. They all are wonderful toward me. They all know my story. And that’s who I turn to.
I’m able to do the things I used to do that I couldn’t do before…I’m now a spokesperson in public, it seems like. Because I’m sharing my story in from of people. I was unable to do that.

I hope I make an impact to a lot of people by speaking for NAMI. And sharing my story with people. I think that would really help. Like I says before, I wouldn’t do it for myself. I would do it for all the mentally ill people around me.

So, for 10 years, I’ve been in recovery. I’ve been doing really well.

ID-05:

Well, I can tell you that I’ve never been to a psychiatrist, a psychologist. I took the NAMI classes…I learned the classic things they teach on how to learn to cope and deal. NAMI’s like a…like you say – a backbone, you know?

I’m the first one that broke the door open [about depression]. Yup. I think at first I scared my family, because I was pulling out things they could relate with but were afraid. And now they’re not afraid anymore because everyone is getting some kind of education.

We learned to deal, we learned to cope. We were all dealing with the same type of anxiety, the same type of depression. And teaching each other how to cope. And to this day, I’m still teaching my mom how to cope with it. She’s teaching me breathing lessons and I’m teaching her coping lessons.

Sitting behind the desk is not going to do anything. You know, it’s where it’s at. Outreach, outreach. And just listening to what [community members] have to say.

Marci from NAMI. She’s the one that told me I had the core of NAMI. “You’re a consumer, you’re a mother, you’re a single parent. You struggle with depression, yet you’re out here making it.”

And being on the state level, going to Columbus and standing on the state steps and speaking [my recovery story] was a highlight too.

Now, sitting on the Ohio NAMI state board. Now I know why I went through everything that I went through. And I honestly have to say I went through a test. You know…apparently, I passed the test.

Individual Factors Influencing Latino Mental Health

Isolation when Mentally Ill

ID-02:

Kind of isolates himself.

He doesn’t trust me enough to talk about it. And he doesn’t trust anyone to talk about it.

To me it felt like he was keeping everything to himself. Again, isolating himself from telling people things, exactly what he’s feeling.
- He is the challenge. Because he’s not open to talk about it. So I would see that, that’s the challenge.
- I don’t think nobody really knows that he’s going through anything. Because, like I said, he doesn’t…he doesn’t act like anything is wrong. He’s just good at making a happy face at the world, I guess. Nobody really knows.

ID-04:
- He separated himself from us a lot. Yes, he responded well. It’s that he separated from us a lot. He was afraid. He was isolated.

ID-05:
- If we do, we have family members that have some type of mental health, like the elders, they seem to want to be by themselves. They exclude themselves. A lot of times they just stay in their rooms. They don’t want to participate with the rest of the family.

ID-06:
- When we lived in Florida, he isolated himself. Any time anyone came to visit he would go close himself off in his room. But now that we’re here, if somebody comes, he will come out and sit in the living room. He doesn’t really participant in the conversation, but he doesn’t isolate himself.
- He never ever, ever references things about how he felt when he first started getting these voices and hallucinations. He would never talk about it. I don’t know how he really feels about the way things are and if he feels that there is any future.

ID-07:
- Like my dad didn’t want us telling nobody that he was sick. I did. Because especially too, some of the people that he knew. Because I felt that if anything would happen to him or they notice something going on, they could tell me. You know, cause he used to go to a prayer group. And I felt, well, if they seen him acting funny or forgetting things, they would tell me and that way I could let the doctor know. And that. So that’s why, like I said, he didn’t want nobody to know.

ID-08:
- Yeah, because I didn’t bother with my friends. I didn’t bother with anybody. You know, I just didn’t want to…basically be left alone. I even told my kids, I even told the doctor one day, “I just wish I could get in a corner and just dig a hole and hide in it.
And then, like, he didn’t want to be by nobody. He just wanted to be in his room. He didn’t want to see nobody at all.

**Spirituality**

Support of Mental Health through Faith

ID-01:
- Focus on my religion.

ID-05:
- Praying. I should have put praying as my number one really.
- I prayed a lot. I really did. I prayed a lot. Bible studies. Catechism teacher. I was involved with the school and church.

ID-07:
- When we used to go down there we sometimes would pray the rosary together. I think that made a big factor. As a matter of fact, when he was hospitalized right before he passed, we were all praying the rosary. And he wasn’t talking out loud, but I could see his lips like he was praying along with us. And I think to us it was… I don’t know how you would say it…it was a sign that he could hear us. And that was very pleasing to us too. I think comforting. And it was nice to be able to hear him. I mean see him. We felt like he was praying with us.
- My mom said she did talk…to the priest. And that sometimes there were illnesses – that it was beyond the church. And that it was okay for them to get mental health services.

ID-08:
- And I just…I pray a lot.
- I says, “I don’t give up.” And I pray. I thank God every day for giving me another day of life.
- And so that’s why like I said to me God is someone who’s helped me more. And I just thank him every day for giving me another day of life and to keep going. And to help who…to give me the right words to say to someone to give them peace.
- And when I get frustrated with other people too that… “Aw, I can’t do it no more.” I think about how…in the Bible I read about how Jesus…his enemies attacked him and hurt him. And what did he do? – he turned the other cheek. He didn’t give up on us. And he doesn’t give up on any of us. And so I feel that if I want to be with him, with God, I need to be able to try to do what he can, what he did. Put the other cheek and try to do the best I can and keep going.
- So I always try to just take it one day at a time. As long as God gives me another day of life, I’m still going.

ID-10:
- Now, I’m a woman of God. And that’s where I go is straight to God’s word.
- I wake up and if I wake up early enough I read the Bible. Spend time in prayer. Watch, as I’m getting ready for work, I watch a couple shows like Joyce Meyer – you know, pastors on TV. And then on my way to work I listen to Christian music, Christian radio. And throughout the day, if I find myself where I feel I need a little help, I have my phone – it’s really nice – to, you know, I have the Bible. I keep myself surrounded by it. And at night, if I have time, then I read books with anything that has good news in it.
- I think since I turned myself around through faith, that’s when my life started changing.
- A lot of times I went straight home and started reading the Bible.
- Having friends I could turn to that would speak faith into me, instead of lecturing me.
- For me, I would say that Bible studies are big because that’s what helped me. I participated in Bible studies and just learned more about my faith.
- I wasn’t able to accept any kind of recovery until I was good with myself internally and I was able to do that through faith.

ID-12:
- So to me, it’s harder to go to your parents. I mean it’d be one thing if I go to my parents and say, “I’m having problems with my Catholic faith.” It would be easier for me to talk to my parents about than to say I’m really depressed about this.
- I know I’ll tend to go to church. And I tend to light candles. And I tend to talk to the fathers and tend to embrace my Catholic faith.

Lack of Connection to Catholicism

ID-10:
- I grew up Catholic. And of course that is the most….common in the Mexican culture – they’re Catholics. And so I left the Catholic Church. And I went to a non-denominational church. And that was a big issue. So something that was helping me come out of my depression and helping me walk away from the addiction was being frowned upon by my family as “It’s not Catholic.”
- The discussions with my mom. Cause she was the biggest one telling me, “You’re Catholic and you’re supposed to stay Catholic. Now you’re not going to be able to be buried with us.” That kind of thing.
• Growth. Spiritual growth. Because I was not getting that with the Catholic. Not saying that it’s bad, but it wasn’t for me.

ID-11:
• Because in our Hispanic culture the Roman Catholic Church is a big, big part in our lives. But I feel like maybe we were born…no…well, we were born in Mexico. But maybe if we were living in Mexico or some other state where there’s a lot of devotion, perhaps we would be more religious. And in this particular area, I mean there’s devotion, but not like to that level. Where, like, when we went down to Mexico about 10 years ago, I was fascinated at how much devotion people have towards the religion.
• But I mean, that’s why I think religion, it’s a double edged sword. It’s good. It helps keep our faith up. Helps us want to keep progressing. On the other hand, though – people when they’re fanatical religious people, the can influence your mind really easily.

**Americanization**

Support from Latino Community

ID-01:
• Living in the Latina community at El Centro.

ID-05:
• Cause we’re culture all together. We all fight together. I can actually say that.

ID-07:
• You know, to speak the same language. And they lived in South Texas too. The fact that the majority of the people that were his friends were around. And family and neighbors. Church. So he’d made a big difference. His nurse and doctor were all Latino. So I think that had a lot of do with his recovery. He was able to communicate too.

Lack of Identification with Latino Community due to Americanization

ID-10:
• I didn’t learn the language. My parents would speak to me in English and I would reply in Spanish. So I grew up with a lot of white people.
• No. It was just my family. So it was just us and everybody else spoke English. [Researcher: So you just kind of fit in.] Uh huh.

ID-12:
• But I’m also more Americanized than I am Latin.
I mean, to be honest, I don’t really have a lot of Latino friends. You know, it’s not one of those things that…not that I chose not to. It’s just in my jobs, my ventures, they’ve never… Like I said, it’s going down more to being Americanized.

Dave says it all the time and other friends of mine say, “You act more white than you do Latino.” And it’s like, “Well. Sorry I understand my skin color. But it’s not representing who I am.”

**Seasonal Work**

ID-04:
- Because his work is seasonal. And he was unemployed and he got sick. And I hope he doesn’t experience the same when work ends.
- I think because back in our country, he never saw either…was in the season of snow and had never seen, been here. And being unemployed…watching the snow…he got sick.
- He came here temporarily and was here. He’d never been in the winter here. And now later, he can be here and of course…he feels like it’s coming again. Winter again.

**Isolation Being New to U.S.**

ID-04:
- Well, we practically don’t have any friends.

**Education level**

ID-05:
- There were Mexicans not stuck out on the farms. They had nice homes. They came from well-educated people. And that made a difference. It can make a big difference. Especially with the education. That’s a lot of it too, is the education.

ID-07:
- But some of the families, and I know this for a fact, that some people…they’re adults, they have children. And they never got an education either. Some don’t know how to write. Some don’t know how to read. And there’s a lot of barriers where their children are growing. I know I was part of that. Because my mom, she never went to school. She came to the U.S. at the age of 5. My dad was 13 years old. And they never received any education. They were here in the U.S. but they didn’t go to school. And to this day, my mom doesn’t know how to read or write. And by working with the Latino community, I know that’s still a big barrier, a big issue. You know, and a lot of
people, they can only print. They have no idea what cursive means or what it looks like because they were never taught.

- He always encouraged us to do for ourselves. To get an education. To make a difference in people’s lives. To really take advantage of anything he possibly could. He always encouraged us about school. Getting an education. That he didn’t want us to be working in the fields or working hard like he had.

**Mental Health Treatment Experiences**

**Positive provider experiences/Lack of bias**

ID-01:
- [Denied negative provider experiences]

ID-02:
- And like I mentioned with the whole therapy thing, I don’t…I think it just had more to do with him than the therapist. Where he just didn’t feel connected. But I don’t think that he was treated badly or anything.

ID-03:
- I think I’ve been treated just as well as Caucasian or an African-American. I have been treated no differently at all. I really have been treated with respect from my former psychiatrist when he was alive to the Zepf Center. The Zepf Center, like I said, they understood totally where I’m coming from and my experiences with mental illness. I don’t see a barrier just because I’m Latino. I don’t see it.

ID-04:
- No. I don’t think it affects him. Everything is okay.

ID-06:
- I haven’t noticed any problems.
- Where I can say now the doctor he’s with, she spends a lot of time with him and talking with him. And with me. And so I feel a lot better about the care he’s getting now. But I’ve never really noticed any type of difference because of us being Latino.

ID-08:
- When I went to see the counselor, he was really good with me. If anything, I was very comfortable with him. I don’t think they put a difference. At least I didn’t see it at the time.

ID-11:
- I don’t think so [regarding having negative treatment experience].
Then again, my primary health care physician – and he’s Latino as well. Psychologist, he’s African-American. So I don’t know if there would be.

ID-12:

[Denied negative provider experiences]

**Negative provider experiences**

ID-05:

- And I just showed him, “Do you think this is just good enough for your parent? Is it good enough for your grandmother? Is this a breakfast?”… I said, “I don’t belong on this side. And when my parents come, I’ll be leaving.” So I don’t know if they thought we were just Mexicanitos that didn’t know better.
- That we not know as much. Or that we can’t afford it. I think that’s where that was being over there, the facility where I was when I had my stroke.

ID-06:

- All the doctors he’s had in the past, they were just like, “Okay. How you doing? Okay. Here’s your medicine. Goodbye.”
- Like I said, those doctors were just like they really didn’t want to know anything about him. It was just like, “How you doing? Everything okay? Okay. Goodbye. Here’s your medicine and go.” So no real interaction. So I don’t know if there were biased feelings.

ID-09:

- I think there is a way. I feel like it’s not…until they see me. They, usually, I feel like there is a bit of an “Oh, [Latino surname].”
- I feel like there’s just kind of a “Yah… Here comes somebody else for a hand out.
- I feel like there might be somebody that might not fully comprehend my cultural necessities or what is seen. Once I’m sitting down, since I’m very about mental health, I tend to give the person the benefit of the doubt that you’re going to try and help me regardless of what your own personal issue are.
Advocacy for Classes and Services for Latinos

Psychoeducation

ID-03:
- I really encourage anyone going to UT to take at least one class in psychology. They would know what it was like. And I think that stigma would go a lot further down, if people are educated about mental illness.

ID-05:
- The classes for NAMI. Oh, Family-to-Family.

ID-08:
- I wish that they would have had family-to-family. I know that it has made a big difference in people’s lives. Especially for family members to help them understand what their loved one is going through. And also even for the peer-to-peer program too. That also helps the consumers be able to better understand their own illness.

ID-12:
- And I think we’re missing values. I think sometimes that we should be teaching the kids about depression and bullying. And things that aren’t appropriate. And things we need to work on.

Community Services

ID-05:
- I want to bring more of the support groups in Spanish. And just reach out to the families out there. They’re afraid to come out. They’re afraid of deportation. Especially ones that don’t have their “papers.” They’re even afraid to go to the stores. They don’t let their kids out. The kids are running the families…you know what I’m saying. Because a lot of the families don’t speak English.
- I mean even down to riding the bus. You know, they have to show how to do that. You go to the different agencies and they teach you different things.
- Life skills. Yes. Basic, basic things. Banking. There’s so many different things they’re eligible for that they don’t know. So someone needs to teach them.
- Sitting behind the desk is not going to do anything…Outreach, outreach. And just listening to what they have to say. Listening to their questions. And I say honestly in Washington they had many questions for me and I had answers because of what I’ve asked the people here. “What do you want me to say? What’s bothering you? What’s going
on?” And there were like four questions they asked me and I had answers. And the answers were from the community.

- And I would like to work with Hispanic people. Not only in English, but in Spanish.
- And being on a state level, going to Columbus and standing on the state steps and speaking was a highlight too.
- Not only that is – I sit on the FLOC board too. And sitting on the FLAC board, you’re constantly working with the Latinos. And especially for all the different issues we’re fighting for right now. So it’s a big thing.
- At the time, when I was younger, it was a black and white world. When I was younger. And really the only Latinos you were really progressed about were the farm workers. So I wanted to be someone to help those people, so they wouldn’t be all gathered up in one house the way they were. I felt they were discriminated against. I wanted to help those people. And I can actually say my daughter worked with Adelante and got to be one of those people who went out there to work with those kids. Work one-on-one with the kids. What she wanted to do she got to do. Now I’m on the FLAC board too, so that makes a difference. I picked up where she left off.

ID-07:

- We don’t have enough social workers, therapists, clinicians, psychiatrists. There’s not one Hispanic/Latino in the state of Ohio, psychiatrists in the whole state. And they are always talking about how Latinos don’t seek mental health services. And it’s very, very true. But because of their language barrier, they just don’t go. Because they don’t have the resources. And if it were you or me, they would refer them to any of the mental health agencies. You know, it’s very hard for them to trust somebody that doesn’t speak their language. And, or somebody that doesn’t look like them for them to open up.
- And so I think that it’s very, very important that we start talking to the schools. And the principals and the teachers. Social workers, counselors. That those are all areas that maybe people… children that are bilingual that they might be able to go into those professions. Cause it’s something that we really, really need.